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Editorial

Graham Connelly

Welcome to *SJRCC* Volume 18, Number 1, the first of four issues planned in 2019. In this issue we provide the usual varied selection of peer-reviewed articles, commentaries and book reviews.

Later this year the world will be marking the 30th anniversary of the adoption by the United Nations of the Charter on the Rights of the Child. While the UK ratified the UNCRC in 1991, its provisions remain to be incorporated into domestic law. In Scotland, the Commissioner for Children and Young People, Bruce Adamson, a highly respected legal expert on children's rights, has expressed concern at the delay in confirmation by the Scottish Government that the Charter will be incorporated into Scots Law in the current Scottish parliamentary session. Writing to the Minister for Children and Young People, Adamson expressed concern: 'that 6 months on from the Programme for Government commitment, there has yet to be a clear outline of timescales for the consultation on models of incorporation, or indeed of a legislative timetable'. The Commissioner noted in his letter that a draft Bill exists, drawn up by his office in collaboration with Together (the Scottish Alliance for Children's Rights). As well as making provision for full incorporation of the Preamble, the Charter, and Optional Protocols, the draft Bill includes provision for a Children's Rights Scheme setting out the arrangements for the incorporation of the CRC in Scotland, and for its review every three years. The full statement by the Commissioner and the draft Bill are available here.

The Scottish Parliament is currently scrutinising the Children (Equal Protection from Assault) (Scotland) Bill draft legislation, very much in the spirit of the UNCRC. If passed, the effect would be to remove the defence of 'justifiable assault' (dating from 2003) and the older common law defence of 'reasonable chastisement' that can be advanced by a parent of a child under the age of 16 in distinguishing the use of physical punishment as a method of discipline from common assault. CELCIS fully supports the Bill and interested readers can read CELCIS's response to the public consultation written by Lizzie Morton here, and a discussion of the potential impact of the proposed legislation by Louise Hill here.

Hill argues that evidence from countries which have enacted similar legislation: 'suggests that legal reform accelerates the decline in use of physical punishment, further decreasing the risk that services will be overwhelmed as physical punishment becomes less prevalent'. Much of the public discussion in relation to the Bill has centred on a concern that parents risk being criminalised for 'smacking' children in ways that may have been widely regarded as acceptable in the past. A typical example given is seeking to prevent a child from putting fingers into an electrical socket by delivering a slap to the back of the hand. Critics of the Bill point out that the existing law allows no defence in the case of shaking a child, a blow to the head or the use of an implement to strike a child. Supporters of the Bill cite the UNCRC as the source of the child's right to equality, arguing that legislation is required to set down a marker about the unacceptability of violence in society, and point out that 58 countries have now passed similar laws. But, in an article in the *Sunday National* on 7 April 2009, the law lecturer and writer Andrew Tickell – who admits he finds the idea of smacking a child 'deeply upsetting – warns against thinking it is possible to enact a law which removes the defence of 'justifiable assault', while simultaneously believing this will not result in criminalising parents who run foul of the law. In his article, Tickell says: 'This confusion is just the latest symptom of treating criminal laws as tools to "send messages'" quietly ignoring their practical implications'. As someone who supports the aim of proposed legislation, and who responded to this effect to the consultation, I have to say that Tickell's warning gave me pause for thought. What do the readers of *SJRCC* think? Do you have direct experience of similar legislation in another country?

Turning to the current issue: in the first of two peer-reviewed articles, Angela Evans writes about the taboo of love for children in care. The author, a child and adolescent psychotherapist, observes that 'love is not a central theme in the care system, despite its direct relevance to children who have not experienced adequate love in crucial developmental months and years' and concludes that to 'reach loving feelings, children and young people with developmental trauma need to work through hatred and love in therapy, and they need adults who care for them to help them to know and accept love by overcoming their barriers against it'.

The second peer-reviewed article in this issue, Youth Engagement and Participation in a Child and Youth Care Context, is co-authored by Canadian-based researchers Lindsay Sinclair, Melissa Vieira and Vanessa Zufelt. Noting that young people in care experience barriers to engagement, they argue that: 'Positive youth engagement is achieved when young people are seen as experts in their own lives and are engaged as primary stakeholders in their own plan-of-care meetings'.

The first of three shorter articles, by Melissa Hunt, is a reflection on the legacy of Lord Kilbrandon in the present-day Children's Hearing System. In the second article, Kiran Modi and Kakul Hai explain their use of awareness of Adverse Childhood Experiences (ACE) in Udayan Care's children's centres in India. Through the medium of two case studies, they describe the impact of adverse experiences on childhood and how it shaped the children's lives. In the third article, clinical psychologist Shona Quinn outlines how residential school staff built their own model 'to define the features of a care environment that allows a child to feel safe enough to begin to heal'. Quinn says that: 'Fundamental to this model, and taking on board the importance of cultural factors along with practice factors, is that *everyone* within the environment needs to experience what it feels like to be safe, to have relationships, to experience emotional containment and to build their skills and resilience'.

Finally, in this issue, we have two book reviews. Robert Porter reviews *Children, Autonomy and the Courts* by Aoife Daly, and finds he is impressed. 'The book is engaging and easy to comprehend throughout, while presenting a persuasive argument for the next step in the realisation of children's rights'. Mike Findlay reviews *ACEs in the Shadows: Understanding Adverse Childhood Experiences*

by A Survivor, 'in part a guidance and introduction to the concept of ACEs and current public thinking around the topic, and in part an autobiographical account of someone with real life experience of ACEs and their consequences over a lifetime'.

We hope you enjoy this issue, and particularly the facility to download the entire issue as a single pdf file. Please share with colleagues and use your preferred social media channels to engage with the contents.

The *SJRCC* will be back in June with a special issue to coincide with the 20th anniversary Scottish Institute of Residential Child Care conference. Happy reading.

The Taboo of Love for children in care: its emergence through the transference relationship and in the system around the child

Angela Evans

Abstract

This paper explores the taboo of love for children in care. A taboo is a social custom setting a thing apart, prohibiting association with a person, place, or thing (Oxford English Dictionary 2012). Love can become a taboo for children in care, something that they unconsciously forbid themselves from experiencing due to fears of further loss and pain. It can also become a taboo for many adults working with traumatised young people. The author, a Child and Adolescent Psychotherapist, presents her work with individual children and with the network of adults around them. She proposes that love is not a central theme in the care system, despite its direct relevance to children who have not experienced adequate love in crucial developmental months and years. The implication of this proposition is that unloved children are at risk of remaining unloved within the care system. The application of this to professional practice is immense. The author calls for more support for professionals to perform their vital work in promoting a loving approach in the system.

Keywords

Love, care, developmental trauma, idealisation, transference, loss, fear, containment, countertransference

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Introduction

This paper highlights the need for children and young people in foster care (all of whom have developmental trauma as evidenced in the Department of Education statistics 2017) to have life changing experiences to help them to recover and to find love.

Love is fundamental to human existence. Each child brought up in a 'normal' loving family has an experience from birth of being noticed and loved by parents who themselves are experiencing intense loving emotions, which are conveyed to the infant through their behaviours, their voices, their gazes and their attentiveness. The parents will also have conflicting feelings but, with resilience and with support, they generally manage these. This is how love grows, and by the time the infant approaches the end of his or her first year, s/he has an awareness of being in a loving relationship before having a verbal understanding of it.

Bowlby (1952, p.59), the founder of attachment theory, stated that:

> 'maternal care in infancy and early childhood is essential for mental health. This is a discovery comparable in magnitude to that of the role of vitamins in physical health.'

Sixty years after Bowlby, Rutter et al (2003-2009) followed a group of 165 Romanian orphans adopted in Britain to test to what extent good care could make up for poor early experiences in institutions. All the orphans had developmental trauma, where the trauma happens during critical early development and impacts on it (Herman 1992). One of their ground-breaking findings was that the lack of love in infancy for these orphans *had a bigger impact on development than the infants' physical neglect*.

It is clear therefore that traumatised children and young people in foster care need life changing experiences both internally, through therapeutic processes, and externally, by being cared for and supported by adults who can understand the enormous barriers these young people have against love. Internally, these

children and young people did not have an early experience of being in a good enough loving, reciprocal relationship, and more likely suffered abuse, neglect and/or trauma (Department of Education statistics 2017). This leads to an internal belief that they are in some way bad, that adults are not to be trusted and that the world is a dangerous place (Bowlby 1969). Love does not feature in this internal belief system. The external systems around them often consist of adults who inadvertently become pulled in to a toxic mix of rejection, fear and anger.

Those adults in turn need therapeutic support to recognise and process the profound and frightening emotions that can be evoked in them as carers and providers. Unless this happens, love – which is fundamental to human existence – remains unknown or hidden by rage.

The Team around the Child

Many children in care with developmental trauma have, at best, a compromised experience of love. Winnicott (1971) expressed the idea that the first mirror through which the infant can verify his existence is the mother's face. We might say that this is the first experience of love that the infant has as he learns that he exists within an interpersonal relationship, and that he experiences the deepest interpersonal affection with his mother (Stern, 1977, 1985). Many of the children and young people I have worked with did not have that experience. Both parents suffered from a combination of mental illness, drug and/or alcohol abuse, and their fathers were often absent or violent.

Even if love is known, it is a concept that can be very confusing. Sexual desire and a need for power and control can be expressed in the guise of love, or even alongside love. I worked with a young man whose mentally ill and sadistic father had ritually sexually and physically abused him and his siblings every morning. After the ritual of abuse, he would hug them and read to them. The young man I worked with was in a frozen state, obsessed with computer games, unattached to his foster carers and even to his siblings. Love and filial affection for him equated with pain and terror.

The Looked After Child and Adolescent Mental Health service I worked in for fifteen years functioned together as a close, multi-disciplinary team. The task for

such a team is to gradually introduce the concept of love to traumatised children and to help them to process the many confusing experiences they have had. This NHS team consisted of clinical psychologists, family therapists, specialist nurses, and child and adolescent psychotherapists, the last of which was my role. We held regular meetings and reviews with social workers, foster carers, key workers, Special Educational Needs Co-ordinators, virtual school teachers[1] and any other involved professionals. The most successful interventions were unequivocally those where the network around the child consisted of strong and reflective professionals who could communicate well with each other and with the child.

The part that each professional plays within the network can involve being the recipient of an enormous amount of negativity:

1. The foster carer/key worker needs to provide not just food and shelter but also availability, regularity and dependability, all of which are needed for the growth of love. This is often in the face of acute rejection from their foster child and, in some cases, verbal and physical attacks on family members.
2. The social worker is crucial in guiding and containing not just the child, who may feel angry about decisions made, but also the foster carer/key worker with the day to day challenge of negativity.
3. The teacher provides containment, encouragement, boundaries and social opportunities in schools, often in the face of angry, confronting behaviour.
4. Specialist teachers liaise with other professionals and provide extra support; they are at risk of being seen by other staff as being equated with these troublesome children, and can experience a sense of isolation in schools, making their already challenging task even more so (Evans 2013).
5. The task of the child and adolescent psychotherapist is to help the growth of love through containment, attention to detail, and working closely with social workers, foster carers, key workers and teachers with a view to modifying the impact of the trauma. The therapist absorbs the terrifying

[1] Virtual schools work for the benefit of children in care, providing a head teacher to oversee the work and teachers to visit schools with a view to directly helping the children in their education.

processes of transference (see next paragraph) and acting out. This therapeutic process can be invaluable and life-changing for so many children and young people, as I have experienced many times throughout my work.

Central to the psychotherapeutic process is the transference relationship, in which the client can transfer earlier, infantile relationships onto the therapist and rework them through the therapeutic relationship (Freud 1905). The client experiences vulnerability, which needs to be supported by the therapeutic boundaries of time and room, and by the regularity, predictability and availability of the therapist. It can be a slow process. I was interested to read a short article in The Guardian Weekend magazine (2018) where transference is discussed in the context of the writer falling in love with her therapist. She writes about the loss of her therapist together with her gratitude as the therapy came to an end, after only twelve sessions. I was struck by the emotional healthiness of the writer, how much she processed during those twelve weeks.

In contrast, for children in care the development of the transference relationship is delicate and at times may feel dangerous; even the first stirrings of love often also come with overwhelmingly negative emotions. Love is a taboo internally, not to be thought about, let alone talked about.

As well as needing a strong network, my most successful work with traumatised children has been that which was long term – lasting two or more years. Policy makers find this concept difficult because it is costly, but the processes a traumatised child must endure to begin reaching the kind of emotions expressed by the Guardian writer are long and complex. The child in care slowly and laboriously experiences a growth of love through this enduring therapeutic relationship, alongside adequate containment in the home and school.

Typically, this growth of love might be traced through the following therapeutic processes, which fall into three phases:

1. Love is awakened, often by the therapist becoming intensely interested in the child. Children who have lacked any sense of an interpersonal relationship, and who have no or very little experience of lighting up a parent's face, need their capacity to love aroused; they have been

unloved and are not interested in it until they can begin to experience being genuinely delighted in and adored.

2. Hatred and intensely negative emotions are acted out with the therapist. Winnicott (1947) wrote about the vital importance of hate in the countertransference[2] when working with traumatised and ill patients. He put forward the reality of the therapist hating their patient who gives them such a difficult time week after week. I have had many patients who I have not wanted to see, as they act out cruel games with the toys, often wanting me to play the part of an abusing parent, or to be the child who is being shouted at and treated cruelly. Or they ignore me and treat me with contempt. In these circumstances, it can become extremely hard to retain one's power of thinking whilst feeling.

3. An idealisation process will often come about in the transference relationship. Alvarez (2012) speaks of idealisation as a development sooner than as a hindrance. Infants need to idealise their primary caregiver, as this gives them a sense of protection and security. The reunion of secure infants and their parents is like the reunion of long-lost lovers. Alvarez refers to seriously deprived children as not having had an opportunity to experience that delight, both to receive it and to bring about such love in another. They need to go through this idealisation process before being able to reach a normal loving relationship.

Lanyado (2017, p.209) talks of attending to the first tiny green shoots of new developmental growth within a therapeutic relationship with fostered and adopted children. She states that:

> 'these small changes in the child can grow and expand across the developmental spectrum: emotionally in the growth of new loving and trusting relationships: in the dawning of a capacity to mourn the life that went wrong and to appreciate the life that can now be lived.'

[2] Countertransference is a process whereby the therapist experiences the client's feelings as if they are his or her own (Freud 1910)

I will bring to life these three processes of the growth of love in the following presentation of Tanya, where I focus mainly on the clinical work in the room between us, initially with the key worker, then individually, alongside meeting with the social worker and the personal tutor. This is an example of the value and essential nature of multi-disciplinary work together with clinical work in the therapy room.

The Taboo of Love in Traumatised Children's Inner Worlds

The therapeutic journey with Tanya depicts how she began to make a slow and painful move towards love whilst in weekly psychoanalytic psychotherapy. It also depicts how negative emotions in adults who care for traumatised children can be mitigated against with careful and empathic therapeutic work in the system.

Tanya

Background

Tanya[3], of Bulgarian origin, was a thirteen-year-old girl when I first met her. She had been referred to me by a children's residential unit, which she had recently joined, because she had had numerous placement breakdowns.

Tanya's birth parents abused drugs and alcohol and there was domestic violence. When Tanya was ten years old, her mother left her and her younger siblings in the care of her sexually abusing step-father. Tanya eventually told a friend's parent that she had been sexually abused since the age of five. She disclosed this information because she was scared that she could no longer keep the younger siblings safe from abuse. This led to the children all being taken into care. It emerged during the four years of therapy, as she began to disclose her past abuse, that Tanya had also been physically abused by her mother and step-father. Her limbs had been broken; she and her siblings had been locked in dark cupboards and frequently starved.

Tanya's three younger siblings were adopted and Tanya was put into foster care as she was too old for adoption. In summary, at ten years old, Tanya was

[3] Name anonymised and some details are a composite of several cases for confidentiality

removed from the children she had mothered and from her step-father, some of which was a huge relief but most of which she experienced as confusing and cruel. She was suddenly alone when she went into care, although towards the end of her therapy with me, she told me she had always felt completely alone for as long as she could remember.

Reason for Referral

Tanya was referred to me because she was showing increased aggression in the residential unit, and rejection of Lynn, her key worker to whom she had previously been close, albeit on her own terms. She became increasingly challenging in the school provided by the unit. The thinking in the residential unit and school was that Tanya was of an age where she was wanting to make sense of her identity, and that she had a yearning to reconnect with her birth family. Tanya had had no contact with her birth mother since she had abandoned Tanya to her abuser; her whereabouts were unknown. Tanya would often tell staff that she had seen her mother and sister while shopping, and that they had given her a big hug. Her fantasy world brought her comfort but, as she turned to it, she turned away from her other supportive adults. I agreed to assess Tanya, which involved seeing her for some individual sessions, visiting her at school and reading relevant documentation.

Forsaken child

When I first met Tanya in her school I was struck by her hard smile, which looked false, with eyes that didn't match it. I thought about Winnicott's false self (1965) where a defensive self is erected, hiding the more vulnerable self. Tanya was described as a loving and affectionate girl, but her eyes told me something of her cold, hard defensiveness.

During the five individual assessment sessions, Tanya made sand trays of Jesus on a cross on a mound, surrounded by babies who were looked after by an alien. Tanya said she was a baby, but that the alien looked after her. I was struck by the projections of parts of Tanya's self into this sand world; parts that felt crucified, alone and forsaken. She was the baby being looked after by aliens (her two parents); she was the small child trying to do the alien job of looking after

three smaller siblings; she was identifying with Jesus on the cross who cried out, 'My God, why hast thou forsaken me?' (New Testament).

Next Steps

After the assessment I met with the network, which consisted of keyworker Lynn, social worker Mark, personal tutor Carrie and myself.[4] This meeting was a good opportunity for me to share my observations with the people who knew Tanya well, and for them to link these observations with what they saw and experienced in their different roles. At the end of the meeting we all had a shared picture of Tanya. Given Tanya's background of adults who had fought, broken her trust, abused her and abandoned her, we agreed that it was crucial that she experience a team around her who could work closely together therapeutically.

[4] Names anonymised for confidentiality

Working with Tanya and Lynn – bringing about loving feelings

It seemed important, initially, to try to work with Tanya and her keyworker Lynn together, to observe their attachment to each other and to help Lynn to manage Tanya's rejection and aggression. After the first few sessions Tanya told us both about her mother being a victim of her husband, the cruel stepfather whom Tanya referred to as 'it'. The blame was all put on him, which was understandable, but it was a convenient platform from which Tanya could deny any responsibility by her mother. This is not unusual. It is a common phenomenon for traumatised children in care to yearn for their birth parents, compelled to keep holding on to the lost, precious, first relationship, however terrifying, disappointing and confusing it may have been (Durban 2017).

In the initial sessions with Lynn and Tanya, it felt as though Tanya was not able to relate to a therapist and keyworker who wanted to relate to her and think about her together. Lynn's role was that of real-life mother, as opposed to the fantasy mother, and she was in the position of being constantly rejected by Tanya with almost everything she said in the sessions. After perseverance, with Lynn tolerating being ignored in the sessions, and Tanya attempting to divide us in the room, Lynn and I managed to hold a safe space for Tanya where we presented as a thinking couple working together with her. Tanya began to use drawing pads and pens to illustrate for us some poignant emotions towards her mother, culminating in a card she wrote for mother with a message inside saying that she knew she might not even see her again, but that she would always love her. Tanya was beginning to access some grieving for her mother and for her history. She began to accept Lynn's empathy in the sessions, although Lynn had to be careful not to get too close.

Processing the hatred to reach the love

A year into the work, Tanya began to challenge me more than Lynn in the sessions. She ignored me or was verbally aggressive. On one occasion, she threatened to break the glass doors in the therapy room with a crystal, one that she had always admired and loved in therapy.

> She stared through me, menacing, holding the crystal up, ready to throw hard. I held her gaze, trying to see the hurt child underneath and trying desperately to put to one side my fear and anger. She looked over at Lynn, who also held her gaze, calmly and quietly. Finally, she put it down, and swore heavily at me instead. (Session 41)

I was beginning to dread Tanya's arrival, wishing she would just go away and that I could end therapy with her; at the same time I was moved by her and awaited each session with a sense of anxious anticipation. Strong elements of hatred and love were entering our therapeutic relationship. Tanya was experiencing something of the world of a healthy infant, who can feel delight in her mother's presence alongside her rage towards her(Alvarez 2012). From the early stirrings and discoverings of being seen and noticed, Tanya was now able to express her hatred and envy of my therapy room by threatening to attack it with her 'loved' crystal. The therapy room and the crystal both represented me, possessing all the goodness, which Tanya simultaneously envied and loved (Klein 1946).

Reviewing the work

When we met again as a team, Lynn reported an improved relationship with Tanya. Carrie, her personal tutor, reported that things were still difficult at school and that Tanya's academic work was not going well. Mark, the social worker, had heard from an older half-sister of Tanya's who wanted contact with her. We agreed that Tanya and I would move into individual therapy, as her relationship with Lynn had improved but there were still clearly some powerful emotions that needed to be worked through in a therapeutic relationship, and this processing would inform us when Tanya might be ready to see her half-sister.

Absorbing the terrifying emotions

For the first year of this individual work, I continued to feel simultaneous dread and excitement about Tanya's arrival, as she continued to let me experience her intense polarised feelings. Every week on arrival, she stood at the door with her back to me and her arms folded, telling me she didn't 'f---ing like therapy' and that she was only there because staff made her go. My emotions ricocheted between despair, anger and confusion. These powerful countertransference responses were undoubtedly Tanya's experiences and those of her carers. She was, at times, loving and wanting to reach out to me, whilst simultaneously feeling intense despair, confusion and hatred.

Staff support was essential to keep Tanya coming to therapy through this period, and to support me in the form of regular meetings with the network. At times, I was tempted to stop the therapy, but staff encouraged me to keep it going, coming up with ideas to support it. I could have re-enacted Tanya's mother walking out on her, had it not been for the staff support, the loving holding of me in my work.

Reaching beyond the abuser and the abused – green shoots of love

Rustin points to many traumatised children trying to please adults in a way that they think could be loving, with no real knowledge of love. There can be an 'identification with the aggressor, confusions about intimacy, idealisation of perversity' (Rustin 2006, p 109). Tanya's sexual abuse featured throughout this part of the treatment. There were many times when I felt that Tanya was unconsciously testing me to see how much she could trust me not to be an abusing adult.

> Tanya said she would show me her latest dance. She put on her music and adopted a dance pose, looking directly at me. At an opening loud beat, she began to move her hips seductively from side to side, then fell onto the floor, raising a leg high into the air. She jumped up and wiggled her top half, grinning at me cheekily with big eyes. I felt very protective towards her and was

> aware of how much she seemed to want me to adore her, like an adoring mum at her daughter's first dance show. At the same time, I felt as if I was being tested. She seemed to be trying to seduce me into looking at her body in a sexual way. I felt like I was on show instead of Tanya. She was watching my every move. (Session 53)

I believe that part of what was happening internally for Tanya as she danced for me was her 'coming alive for me', compelling me to gaze at her, and watching my every move to make sure I kept looking. Winnicott's (1971) idea of the mother's face being the mirror for the infant was powerfully in the room. Her experience was akin to that of an infant realising that she is important to her mother and that she matters. This seemed to be the first 'green shoots' of love stirring in the transference relationship. I could gaze at her with an alive interest (Alvarez 2012) without my gaze becoming that of an abuser.

At other times I felt as if I was being subjected to having pornographic material thrust on me, without my consent and beyond my control, as little Tanya would have felt. This was a powerful projection of her experience of sexual abuse. Sex and love often become confused for abused children and young people, which impacts significantly on their future relationships.

Working with the network – managing challenging feelings

As my individual work progressed, the meetings with the network increased to every six weeks. If someone couldn't attend, they phoned into the meeting. At this time, I shared some psycho-education on how our brains work (Siegel YouTube video clips) and we discussed projective processes.

Carrie was still struggling with Tanya at school and I agreed to meet monthly individually with Carrie for a while. During these meetings, Carrie shared with me her feelings of 'blocked care' (Hughes and Baylin 2012) for Tanya. A sense of exhaustion seemed to emanate from her; she was an empathic tutor but found Tanya's seductive and manipulative 'tactics' with other young people in school very challenging. As I contained these emotions for Carrie, we reached a stage where she could think about my suggestions to be more playful, accepting,

curious and empathic with Tanya.[5] As Carrie felt more held, so she could make Tanya feel more held and loved.

Can I be loved for myself?

In our final sessions, having worked for several months on the ending of therapy, Tanya finally outpoured to me her feelings around the abuse and neglect. She had found a coherent narrative.

Around the last few sessions, Tanya said to me, 'I think we should give you wings so you can be an angel. You'd make a great angel.' She seemed to be entering the beginning of an idealisation process with me as the idealised, and her as someone who could express her feelings to me with a trust that they wouldn't be rejected or denigrated, but would be received with gratitude. This idealisation felt to me like a very necessary development, that both touched me and intensified loving feelings in the therapeutic relationship.

During the last session, Tanya was unable to talk about her feelings towards me but spent most of her time making a card whilst talking to me. She thrust it into my hand ten minutes from the end. Inside, she had written, 'Thank you my lovely you for everything.' When I explored the message with her, Tanya said I had just stayed with her. I hadn't left her even though she had been 'such a bitch'. She had told me previously that her mother had left her because Tanya had been a 'bitch' child. Rustin (2006) points to possible anxieties about being such a bad child that affectionate, loving feelings cannot be elicited in the birth mother.

Winterson, a writer and speaker who was herself adopted, wrote that when you have experienced severe trauma as a child, it is 'impossible to believe that anyone loves you for yourself' (2011, p.7). Tanya had not believed that anyone could love her for herself. Her internal view was that she was a 'bitch' and drove everybody away. I think that in the card, Tanya was saying that she was perhaps just beginning to believe that she could be loved for herself, and that she had reached a sense of gratitude which is so much a part of love (Klein 1946).

[5] PACE approach, where P is playful, A is accepting, C is curious and E is empathic, aimed at helping adults to bond with traumatised children and young people (Dan Hughes 2011).

At this time, Tanya's behaviour and her relationships with others were improving, both in the residential unit and at school. She was more regulated in her emotions. Successful contact was arranged between her and her half-sister. She went on to form a more lasting relationship with a young man. It was not the healthiest relationship, with elements of co-dependence, but they claimed to love each other.

Discussion - The Taboo of Love in the Care System

Keys (2017, p.37) promotes the view that having a theory of loving in therapeutic relationships helps to 'ensure the highest standards of professional accountability in a culture of suspicion and surveillance'. This is sadly contrary to the reality of what happens in many care systems around vulnerable children and young people. Indeed, it is because of the culture of suspicion and surveillance that many adults working with traumatised young people feel that love, and even talking about love, is taboo. Additionally, there are powerful emotions that drive love into a taboo state. I have focused on two of them. One is loss: to protect everyone against intense loss, love is avoided as a concept and as a reality in the care system. The second is fear: this is linked to our culture of suspicion and surveillance and is powerfully projected from fearful children into the system around them.

Loss

The complex and seemingly irreversible inner experiences of traumatised young people impact on all adults around them. When met with adults who cannot reach out to them in a 'live' way (Alvarez 1992), these young people are unlikely to form new bonds where love can grow within a trusting relationship.

Love involves risk; it comes with negative emotions as well as positive ones. Normal loving parents are familiar with the emotions of sorrow, guilt and anxiety that are experienced alongside an intense love for their child. Many children in care cannot begin to understand what love is unless their new carers take the risk of 'falling in love' with them. The paradox is that foster carers will often unconsciously, and even consciously, avoid 'falling in love', to protect themselves and their foster children against the extreme pain of taking a child into their hearts when there is a possibility of losing him or her. Foster carers who do manage to take that risk will often be met by children and young people who cannot bear to be loved, who will reject them. The children are wary of love and so are the foster carers.

Klein (1935) summarised the growth of love as happening when the developing infant becomes aware that his mother can leave him. By this, Klein meant that when we really 'fall in love' with someone we become acutely aware that we could lose them. This helps us understand why many traumatised children in care hide loving feelings behind those of hate. It is easier to hate than to experience loving someone and subsequently suffer the unbearable pain of losing them. Sadly, many children and young people in the care system experience such losses repeatedly, leading to the avoidance of loving feelings by them and their foster carers.

Boswell and Cudmore (2017, p.248) wrote about their research into children who move from foster care to adoption. They found that during the two-week transition from the foster family to the adoptive family, it was hard for the foster carers and social workers to remain fully in touch with the children's emotional state and the fact that, in addition to making a new relationship with adoptive parents, they would also need to grieve the loss of a loved foster carer. Yet it

was clear that the foster carers were experiencing a lot of pain. When interviewed, one carer said:

It doesn't give you any time to think and re-adjust. I found it difficult. Maybe I'm just – you know, there's love involved.

Foster carers and adopters appeared to manage many of these difficult feelings by subtly changing their use of language, which became more procedural and less personal. In reading this research, I was struck by how love gets forgotten as the loss around it is so painful. The children are not given an opportunity to adequately process the feelings of sorrow, guilt and anxiety that they undoubtedly experience. It seems to me that the pain of potential loss is experienced so hugely by children, carers and social workers alike, that without emotional support to process each child's move from foster care into adoption, they could not possibly manage to be in touch with the rawness of the emotions involved.

Fear

During my years of working with foster carers I have seen a pre-occupation with feelings of fear. This is partly due to their over-interpretation of guidelines, which is undoubtedly driven by anxiety. For example, when I have talked about the importance of creating close and intimate times with their foster children, carers have regularly responded fearfully: they wouldn't cuddle up too close to their children because of the risk of being accused of inappropriately touching them; they couldn't speak of loving their foster children, for fear of creating a lie in case they had to move on.

Another source of fear comes from children's backgrounds. Children in care often come from such violence and terror in their birth families that professionals are understandably afraid of what they will bring with them. They are especially afraid that they will see the violence emerge in the foster child.

Fear infantilises people, stops them thinking and promotes unregulated reactions. One child I worked with who had a history of witnessing extreme domestic violence fought regularly with her younger sister. One time she lashed out at her sister with particular force when provoked, hitting her and kicking her to the ground. The carers called the police instead of pulling her off and

restraining her. Their three-year relationship with the child ended abruptly, as they asked for her to be removed immediately. In that attack, she had become to them a scary, unknown child instead of the girl of whom, despite her problems, they had grown so fond. Their reaction had allowed no room for repairing what had happened.

I believe that fear is projected from traumatised children and young people into the system. When infants and young children are abused and neglected, their destructive impulses are greater than loving impulses, and they fear their destructive powers. When coming into care, they need foster carers who can 'contain' these impulses.[6] In a 'normal' loving family, it is hard enough, at times, to contain a screaming infant. The power of the destructive impulses of some traumatised children and young people is so great that they need an entire network of containing adults around them, containing not just the children but also each other. Winterson (2011, p.34-35) commented that: 'In therapy, the therapist acts as a container for what we daren't let out, because it is so scary, or what lets itself out every so often, and lays waste to our lives.'

It takes time to contain adults working with traumatised young people, and it takes time to contain the young people; there is no quick fix.

Conclusion

In 2017, Scottish First Minister Nicola Sturgeon ordered an Independent Care Review intended to improve quality of life and outcomes for young people in care. She stated that:

"The care system must and can do better by our most vulnerable children and young people. They need to know they are loved and feel cared for - this review is not about determining if this can be achieved, but how we create a system that puts love for the children it cares for at its heart."

I have attempted in this paper to outline the complexities of human dynamics and processes that surround Nicola Sturgeon's laudable aim. To reach loving feelings, children and young people with developmental trauma need to work

[6] Containment here refers to the mother's capacity to act as a container for the infant's projections of anxiety about their destructive impulses, to make sense of them, to transform them and to return them to the infant in a more thought about and acceptable form. Bion (1962)

through hatred and love in therapy, and they need adults who care for them to help them to know and accept love by overcoming their barriers against it. Those adults need support to recognise and process the profound and frightening emotions that can be evoked in them as carers and providers. Work with children and young people with developmental trauma takes time and resources. Close liaison and joint support between professionals is needed to even begin to reach the lifelessness, the hatred and the confusion. Yet such work is surely essential to reach feelings of love.

Winterson (2011, p.76-77) wrote aptly about the unreliability of love, 'When love is unreliable and you are a child, you assume that it is the nature of love – its quality – to be unreliable… I had no idea that love could be as reliable as the sun. The daily rising of love.' Our aim, as professionals around vulnerable children and young people in the care system, should be for them to know the reliability of love, and to believe that it is their human right to receive it. We have not yet achieved that aim, despite the many excellent workers in the field. It is my view that policy makers need to be more aware of the extremely complex and powerful work involved, so that they can support it more. If professionals in these vital roles are adequately funded and supported in their very challenging work, their endeavours can come together to provide a nurturing environment for the child at home, at school and in the community.

Rumi, a 13th century Persian poet and Sufi mystic, expressed perhaps something of the journey of children in care, and of the adult help they need, when he wrote:

Your task is not to seek for love, but merely to seek and find all the barriers within yourself that you have built against it.

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Youth Engagement and Participation in a Child and Youth Care Context

Lindsay Sinclair, Melissa Vieira, Vanessa Zufelt

Abstract

Youth participation and engagement were examined and reviewed using three core Child and Youth Care (CYC) contexts: engagement, relationships and self. It was found that meaningful youth participation occurred when a tangible change process followed young people's engagement with adults. Different types of youth participation were reviewed. The research revealed several barriers to meaningful youth engagement, such as tokenism, social power imbalances, and biases on the part of both the young people and the practitioners. Young people in care, in particular, face barriers to youth engagement. Positive youth engagement is achieved when young people are seen as experts in their own lives and are engaged as primary stakeholders in their own plan-of-care meetings. This process can be augmented by the presence of youth engagement facilitators, which CYC practitioners are ideally suited to be. Critical self-reflection can help practitioners become aware of their own definitions of and biases towards youth engagement. Given that there is no one agreed upon definition of youth engagement, it differs between individuals and organisations. Youth are often engaged following the completion of a programme. Scholars purport that youth should be engaged in the planning, creation and final evaluation stages of programme administration.

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The practice of youth participation has gained more acceptance in recent years amongst practitioners, advocates and researchers (Akiva et al., 2014). Youth participation can take place in a variety of settings, including community service centres, educational institutions, governmental organisations and child welfare agencies (Checkoway, 2011). The following research centres on how youth participation is mobilised through Child and Youth Care (CYC) practice. In order to provide an understanding of youth participation from a CYC lens, three concepts central to CYC practice – engagement, relationships and self – are used to outline research specific to youth participation. The dynamic of youth participation and engagement is examined herein as it exists between adults and young people, not between young people and other young people.

Engagement

An important aspect of youth participation is youth engagement (Shaw-Raudoy & McGregor, 2013). In order for youth engagement to occur between adults and young people, there must be youth-adult partnerships present. Engagement is a foundational aspect of CYC practice, which should ideally be present in the spaces where young people live their lives, and in the relationships young people share with their Child and Youth Care Practitioners (practitioners) (Gharabaghi & Stuart, 2013). It often begins with a practitioner expressing interest in a young person’s everyday experiences, such as who their friends are or which games they are currently playing. When young people were asked what the most important aspect of youth engagement was to them, they reported that it was when adults behaved like “allies, supports, and resources” (Shaw-Raudoy & McGregor, 2013, p. 400).

Tokenism

In much of the literature on youth engagement, researchers extensively discuss the dangers of tokenism (Bulling et al., 2013; Hart, 1994; Wong, Zimmerman, & Parker, 2010). One example of tokenism is when a small subset of young participants is asked to engage with adults, while it is assumed that the specific subset of young people speaks for all young people who share their life circumstances. This can lead to individual experiences being restrictively listened to by adults, versus purposeful youth participation which involves a more transformative and perennial approach. The same is true of youth participation of minority young people, who are often invited to participate as a means of decoration, as opposed to being given any actual influence (Guinier & Torres, 2002). Researchers warn that adults in privileged positions within society are often unaware of the role they play in inviting minority young people into spaces merely to advance their own adult-driven agendas (Wong et al., 2010).

Young people report not liking when adults ask them to meetings and then proceed to ask them questions the adults already know the answers to (Shaw-Raudoy & McGregor, 2013). This extends to asking young people questions which adults think they *should* be asking of young people, instead of stopping to think about the actual subjective experiences of the participants with whom they are speaking. Additionally, youth participation can be viewed as tokenistic when young people are asked to share their thoughts and opinions, but no actual influence or decision-making occurs as a result. Researchers stress the importance of tangible change in true youth participation; otherwise, asking young people to speak to adults is nothing more than surface level tokenism. It is suggested that tangible change can be accomplished by actively engaging young people throughout all stages of programme development and implementation (Head, 2011; King, Cianfrone, Korf-Uzan, & Madani, 2015).

Theories of Youth Participation

Deliberative democracy is a type of youth participation which involves open dialogue, listening, contemplation and engagement (Bulling et al., 2013). Deliberative democracy extends beyond merely voting on issues; it involves meaningful conversations through which parties speak to their experiences,

whilst respecting the opinions of others who are present. Another key component is the absence of a power hierarchy between adults and young people. There have been many positive international examples of this, such as youth juries in Australia, governmental meetings with young people in the United States, municipal 'Dialogue Days' in Finland and community-organisation deliberations with young Indigenous people in Canada (Bulling et al., 2013). From these case studies, came evidence that adult decision-makers are less influenced by youth participation if it is shared with them after the fact by a third party, versus if they were physically present with the young people and engaged with them one-on-one. This has implications for policy level changes which are based on 'citizen-engagement research', versus when adult policymakers physically hear from young people.

In one Canadian journal article, Transformational Learning Theory values were woven into the concept of youth engagement. The values of this model include a holistic method of youth engagement, whereby young people are engaged through a youth-centric process and empowered to exercise their own choices, autonomy, civic involvement and experiential learning (Shaw-Raudoy & McGregor, 2013). In this model, tokenism does not occur. Youth engagement is seen as the catalyst for broader psychological, societal and policy-level changes. In this model, researchers advise practitioners to overcome the tendency in traditional adult-youth partnerships - to conceptualise young people as powerless or novice, versus powerful or expert. The objective of this kind of engagement is not to help young people become law-abiding adults, but to engage them in political and social change processes, as meaningful contributors to society from where they are currently at.

Throughout the literature, the Typology of Youth Participation and Empowerment (TYPE) Pyramid framework of youth participation appears central to many national and international organisations. This framework presents itself as youth-centric and argues that other frameworks such as Hart's Ladder of Participation and Shier's Models of Participation are inherently adult-centric (Head, 2011; King et al., 2015; Roach, Wureta, & Ross, 2011; Wong et al., 2010). This framework outlines three aspects of youth participation starting from "symbolic participation", to "shared control" between young people and their

adult partners and commences with "independent participation", whereby adults concede power to young people (Head, 2011; King et al., 2015, p. 649). The purpose of this framework is to establish trusting relationships between young people and adults within service organisations. Based on an empowerment framework, adults are viewed as possible resources to young people, with young people continuously encouraged to share their experiences and use their voices to inform the surrounding environment. However, this framework is often not representative of the general population and is more often found in communities with higher socio-economic statuses and education levels (Head, 2011; King et al., 2015). Due to its focus on youth-led relationship-building within adult run organisations, this framework could be useful in improving youth engagement in practitioner-occupied spaces.

Empowerment theory is predicated on the idea that young people are competent citizens, rather than just recipients of services (Checkoway, 2011). Several case studies have shown that, in order for young people to feel as though they can participate in meaningful policy-level decision-making, they must first feel empowered to do so (Bulling et al., 2013; Vromen & Collin, 2010). Based on an empowerment perspective, young people who participate in decision-making practices gain important information about their rights and options, develop decision-making skills, and experience enhanced feelings of self-esteem and self-efficacy (Augsburger, 2014; Huang, Duffee, Steinke, & Larkin, 2011; King et al., 2015). This allows young people to feel as though they have the space and opportunity to speak their truths and be listened to by the adults around them.

Youth-adult partnerships are defined by Zeldin et al. (2013), as the "practice of multiple youth and multiple adults deliberating and acting together in a collective manner over a sustained period of time, through shared work intended to promote social justice, strengthen an organization and/or to affirmatively address a community issue" (p. 390). Bronfenbrenner's well-regarded developmental-ecological theory provides insights into how practitioners can influence young people to participate in decision-making through youth-adult partnerships. Bronfenbrenner emphasised the importance of ongoing interactions, which are characterised by reciprocal activity and the shifting of power between the systems that influence a person's development (Akiva,

Cortina, & Smith, 2014; Zeldin et al., 2013). From a developmental-ecological perspective, it is argued that individuals gain more control over their environment when they use their voice and assume responsibility within settings. These settings are ideally characterised by a system of shared beliefs, an atmosphere of emotional support, opportunities to assume diverse roles, and leadership roles that are committed to change.

A number of helping professionals point out that central to the ecological theory is 'perspective mentoring relationships'. Though this sounds positive, often in these relationships, adults maintain a high degree of control and fail to successfully engage young people (Zeldin et al., 2013). This often leads to a build-up of tension and disconnection between young people and practitioners. Relationships between young people and adults, which are characterised by a balance of power, are relationships which are most likely to create true engagement and promote positive youth development. Essentially, youth-adult partnerships otherwise referred to as practitioner-young person relationships, include the types of interactions that underlie positive human development and empowerment.

Relationships

Decision-making made by young people has the potential to take place in contexts which are both goal-directed and relational (Zeldin et al., 2013). Relationships represent a central feature of effective CYC practice (Garfat & Fultcher, 2012). Relationships are described as the 'co-created' space between a practitioner and young person, whereby both parties contribute to making the relationship meaningful. A number of studies focus on the perspective of young people, highlighting their experiences of participation and how it affected them. Many young people expressed that they felt as though they had limited opportunities to participate in decision-making processes in their lives (van Bijleveld, Dedding, & Bunders-Aelen, 2015). They also reported that they were not well informed about what was going to happen to them, what they should expect in the near future, and what changes would be taking place in their lives. Additionally, many felt that their views were not acted upon or valued. Diversely, Leeson (2007) notes that young people felt good when practitioners valued their

views, took their concerns seriously and provided realistic options for them. Even when the young peoples' choices did not work out in reality, many still reacted positively and felt valued when they felt they were being listened to.

Power

Power, according to Gharabaghi (2008), is located within gender stereotypes, age, race and ethnicity; it is also located in contexts that are not identity-based, such as education and access to information. Beyond many material factors, power is also located within the social role of the 'helper' versus the person who receives the help. Children with disabilities are often socially constructed as being in need of help. More recent definitions of disability focus on social obstacles as the main barrier to full participation, rather than personal deficits (Marshall, 2017). Institutional dynamics bring awareness to the power imbalances within practitioner-youth relationships, which develop because of cultural contexts that create opportunities for power imbalances. Developmental relationships, which are characterised by a balance of power among both parties, are relationships which are most likely to create proper engagement and promote youth development (Zeldin et al., 2013).

Power should not be manifested in youth participation solely by adults or solely by young people (Wong et al., 2010). Both parties have teachings and experiences to bring to youth participation and, in working together, adults and young people can learn from one another. There have been examples where young people have been left to completely run their own programming and, with limited experiences in leadership and coordination, their programming soon fell apart (Larson, Walker, & Pearce, 2005). Adults play an important role in facilitating participation for young people. However, adults are still granted more power in society and should, therefore, scaffold this power onto young people in order to help them learn ways in which to navigate using their own power as they get older (Wong et al., 2010). There is little to no evidence that if adults alone wield power or young people alone wield power that young people ultimately benefit in some way.

The existence of power dynamics between adults and young people has to be acknowledged in order for it to be critically examined. For young people, it is

normal for one or two main caregivers to make decisions on their behalf (van Bijleveld et al., 2015). For young people in care, however, this power is divided up amongst many different human service professionals, such as social workers, case managers, practitioners and parole officers. Gharabaghi (2008) argues that the process of agenda setting is a way in which institutional dynamics set the context for power within practitioner-youth relationships. By the time a practitioner meets a young person, they have already set up an agenda made of predetermined goals and objectives that the young person often has no real input on. Young people in care face greater challenges having their voices heard compared to young people who are not in care (van Bijleveld et al., 2015). Youth participation is dampened by the fact that young people in care usually lack safe attachments with adults they feel comfortable confiding in. Often young people purposefully withhold their experiences and opinions from their social workers, because they fear that it will be used against them by professionals at a later date. Additionally, social workers tend to have heavy caseloads which lead to young people falling through the cracks when it comes to participating in their case planning. This is particularly true of young people in the justice system.

Aspects of Positive Youth Participation

In order to work towards taking a needs-led approach to practice, and view young people as a resource rather than being in need of help, practitioners should actively engage in critical self-reflection (McMillan, Stuart, & Vincent, 2012; Metselaar, van Yperen, van den Bergh & Knorth, 2015). When this is done effectively, the practitioner will defer to the young person when it comes to creating their care plans. It is argued that this gives the young person a sense of autonomy and control over their care, which is often lost within child welfare systems (McMillan et al., 2012; Metselaar et al., 2015; Roach et al., 2013). This aspect of youth participation requires a practitioner to practice empathy, understanding and client empowerment (Metselaar et al., 2015). Young people report that they found practitioners who engaged in this type of reflective practice to be the most useful in helping them to achieve their goals, because they felt their voice was taken seriously (McMillan et al., 2012; Metselaar et al., 2015). Therefore, viewing the young person as their own resource in their care

provision, allows a practitioner to work towards increased meaningful change for the young people with whom they work.

Additionally, young people report feeling empowered when they are consulted during the creation, implementation and evaluation stages of programme development. It is argued that programmes which are aimed at young people will be more effective if they consider a youth perspective throughout all of their stages (Head, 2011; King et al., 2015). When young people are engaged at all levels, they report developing a sense of belonging while, concurrently, their self-esteem improves (Huang et al., 2011; King et al., 2015). For example, an Australian mental health literacy organisation involved young people at all three stages of development of their phone-based application, which would be used to disseminate mental health education, resources and coping strategies for young people (Head, 2011; King et al., 2015). Young people were involved in how the application would look and function, while also informing what type of content would be included in the application. Additionally, after the application was disseminated, young people were consulted on what they thought worked well and what they thought needed improvement (Head, 2011; King et al., 2015). Therefore, it is important to not only consult young people once they have begun using a programme or service, but also to engage them throughout said programme's development and implementation.

Barriers to Youth Participation

Historical perspectives of spatial isolation among generations, and the lack of understanding among the younger and older generations, have led to current barriers to youth participation (Zeldin et al., 2012). Age segregation has long been identified and still manifests itself in many institutions which serve young people. What was once done to protect young people from exploitation now serves to reinforce the 'outsider' status of young people. Skott-Myhre (2006) argues how current practices in the field of CYC are established in the construction of 'otherness' that originated during the Enlightenment and colonial periods of European history.

Although many adults agree that involvement of at-risk young people is a basic right, at-risk young people are often excluded from participating in decision-

making processes. This leads to decisions being made for them regarding their treatment and placements (Oppenheim-Weller et al., 2017). While contemporary thoughts on youth engagement have begun to shift from deficit-based models towards youth-centred approaches, it is still difficult for practitioners to challenge contemporary media portrayals of young people as 'victims of poverty', 'troubled', or 'passive recipients of services' (Checkoway, 2011; Wong et al., 2010). Often adults engage in 'adultism', whereby they assume that they are better and more entitled to act on behalf of young people without their permission. Studies show that providing young people with the opportunities to express their voice in their treatment planning can result in positive outcomes, enhanced child safety and improved relationships with child protection services (Oppenhiem-Weller et al., 2017).

Much of the literature indicates that the intent to involve young people in decision-making is present, but that service professionals continue to demonstrate ambiguities and reservations about the specific roles young people should play as participants (van Bijleveld et al., 2015). Though many practitioners readily accept the idea of youth involvement, the practice itself is much more challenging and extends beyond just inviting young people to be physically present in meetings (Hubberstey, 2001). Even when young people are invited to participate, their attendance rates are low, particularly because the meetings held by the adults responsible for young people are not youth-friendly or youth-centred (Oppenhiem-Weller et al., 2017). Often practitioners and decision-makers believe that co-learning and working with young people is a one-off activity which can be undertaken by planning a meeting with youth once a year (Shaw-Raudoy & McGregor, 2013). Researchers advise that, in order for meaningful cross-generational engagement to take place, sufficient time and broader organisational shifts must be built into settings which serve young people.

Methods of communication are also important when it comes to youth participation. For example, some deliberations may take place wherein adults and youth speak different languages and thusly problems unfold due to stakeholder ideas being lost in translation (Bulling et al., 2013; Vromen & Collin, 2010). Not only does this create barriers for young people who do not speak the

corresponding language used by practitioners, it also creates barriers for young people who do not understand the language because they have not been educated in CYC specific jargon. In Hubberstey's (2001) study on the challenges young people and practitioners face in regard to participation, practitioners expressed concerns regarding the capacity and ability of some young people to participate in multidisciplinary meetings. Along with those whose first language was not English, many practitioners were worried that those with mental health issues would be overwhelmed and not comprehend the information being discussed. Young people with disabilities report they want to be directly spoken to by practitioners about their disability and plans-of-care (Marshall, 2017).

Adults admit to sometimes underestimating the intentions of young people and their capacity to follow through on the agreements that they have made with adult decision-makers (Bulling et al., 2013). When decision-making adults undermine the abilities and intentions of young people engaged in a participatory process, this leads to barriers in idea-exchange. It is additionally of great importance that if young people are being invited to speak about different policies or referendums regarding their communities, that the issues be explained to them in clear terms. Young people should be made aware of what it is they are being asked to participate in. Language and tone must be considered when policy processes, research projects or adult objectives are being explained to young people.

Judgement appears to bar both young people and adults from meaningfully engaging one another in youth participation (Bulling et al., 2013; Vromen & Collin, 2010). It appears that young people judge adults based on whether or not they are worth collaborating with. Conversely, adults judge young people based on whether or not they are able to make sense of the issues at hand and how maturely they appear to be responding to them. Adults sometimes report feeling as though young people will not be able to understand the complex issues being discussed (Vromen & Collin, 2010). Some practitioners feel that youth participation is not warranted due to the subject matter of the young person's case not being appropriate for a 'younger audience' (van Bijleveld et al., 2015; Oppenhiem-Weller et al., 2017; Vromen & Collin). Perhaps more

attention should be attributed to preparing young people prior to a meeting they attend, and to creating a more youth-centred and youth-friendly atmosphere.

When cases revolve around abuse and neglect, practitioners are less likely to seek youth participation in case-planning meetings (van Bijleveld et al., 2015). Cross-cultural judgement also influences meaningful participation, whereby if participants believe there is a hierarchy in the social dynamics between those involved in the participatory process, meaningful exchanges cannot take place (Bulling et al., 2013). Practitioners' perceptions of the appropriate age at which at-risk young people can and should make decisions may differ (Oppenhiem-Weller et al., 2017). One study found that in several international case-studies, young people under the age of 16 were not represented in adult-youth participatory processes (Bulling et al., 2013). It would appear that the literature does not reflect the value that all young people should be included in youth participation.

Self

Since self and the understanding of one's own 'self' is an important aspect of CYC practice, it must be considered when discussing the participation of young people in spaces such as child welfare agencies. The understanding of self will vary among different practitioners and, therefore, its implementation in youth participation will look different based on each individual's practice. It is important to consider this dynamic relationship when conceptualising self within youth engagement strategies.

Practitioner Reflective Practice

One meta-analysis of how clients and social workers perceived youth participation in child welfare and child protection agencies showed that workers hold vastly different interpretations as to what youth participation really is (van Bijleveld et al., 2015). There appears to be a fundamental gap between worker-conceptualisations of theory versus actual practice within systems of care. Social workers, by and large, agreed that youth participation was important. Some cited the United Nations Convention on the Rights of the Child in their reasoning and some saw it as an integral part of gaining access to information specific to their clients. When it came to youth participation in practice, however,

significant differences were present in how each worker mobilised youth participation. Some workers felt that consulting the young person was enough. Some thought giving young people space to express themselves was true youth participation. Others felt that it encompassed explaining clearly what was to happen to them in an inclusive way. Some actually allowed their clients some degree of autonomy in decision-making processes, however, this varied markedly from social worker to social worker.

Skott-Mhyre (2006) notes that practitioners need to recognise their existing privileges, biases and resultant power relations with young people. Based on the personal nature of CYC practice, it is important to note that everyone holds biases and judgements (Gharabaghi, 2008). Judgements can be about more than one specific young person. They can be about how one feels about involving young people in decision-making, how much information should be disclosed while young people are present, at what age one feels young people can appropriately be involved, what type of young people have the privilege to partake in decision-making, and the degree to which the young person's opinion should influence final decisions. While it is natural for all individuals to hold biases and judgments, it becomes problematic in CYC practice when those biases and judgments are not acknowledged or challenged. One cannot simply say that young people should participate and have it be so in practice. As previously outlined, according to Bulling et al. (2013), in order for youth participation to rise above simple tokenism, it must be mobilised towards some kind of actual influence. This is where practitioners must engage in critical self-reflection in order to examine how they perceive youth participation and how they will go about mobilising youth influence in their respective settings.

Facilitators

In some forms of youth participation, particularly isolated formal meetings, trained facilitators can be invited to the meeting to ensure that young people's voices are heard by adults (Bulling et al., 2013). There is a documented tendency for adults who have agreed to hear from young people to then dominate the conversation with their own voices. This is particularly true when it comes to some of the most marginalised young people in society, specifically those with disabilities. Facilitators are responsible for setting the tone for the

interactions between adult and youth participants. In some instances, they can act as advocates for the young people, ensuring that the decision-makers at meetings actually hold true to their respective roles and respond to the requests of the young people participating in deliberations. The degree to which young people can represent themselves and confidently express their own opinions, needs and preferences, varies with age and developmental capacity (Roach, Wureta & Ross, 2013; Wong et al., 2010). The roles and scope of adult facilitators, who are helping young people, should be negotiated between the young people and the facilitator. Researchers cite practitioners as the ideal professionals to act as this type of intermediary, due to a foundational aspect of their practice centring on listening to young peoples' voices (Bulling et al., 2013).

When asked, young people report that entering into a partnership with their practitioner, where both they and the practitioner actively engage in building the relationship, is the most effective way to engage a young person (McMillan et al., 2012). Across several studies, young people continuously reported that when they feel they are a part of the decision-making team alongside their facilitator, they feel empowered and more able to benefit from their care (Bulling et al., 2013; King et al., 2015; McMillan et al, 2012; Shaw-Raudoy & McGregor, 2013). Since entering into relationships alongside young people is so often presented in CYC practice literature, it could be suggested that asking young people to engage equally in said relationship building is essential to CYC practice. Additionally, these participatory partnership-based relationships have shown to have a long-term impact on young people who reside in communities identified as at-risk. For example, young people who entered into a partnership with their practitioner were more likely to increase their grades in school by 10%, were more likely to graduate from high school and were more likely to obtain employment after meeting with their practitioner, in comparison to other young people living in their community (Roach et al., 2013). Therefore, it is suggested that by giving young people an equal voice throughout the relationship development process, youth-adult partnerships such as these improve statistics regarding school performance and attendance in communities identified as at-risk.

Implications for Practice

Researchers advise that it is the role of adults in adult-youth partnerships to ensure that spaces are open, safe and accepting for young people, in order for them to feel safe to share with others (Wong et al., 2010). It is precisely because of the power adults yield in society, that they are uniquely stationed to use their influence to create the opportunities for young people to engage with adults in co-learning exchanges. There are, however, many influences that affect the process of youth involvement. For example, while the number of young people who attend meetings has increased over recent decades, Leeson (2007) argues that when young people attend meetings they are often only physically present, rather than active participants.

Young people's feelings about attending care-meetings are mixed. While some young people, for the most part, feel positive about their participation, some acknowledge feeling very uncomfortable and intimidated while sitting in a room with a large number of people present (Hubberstey, 2001; van Bijleveld et al., 2015). Most young people expressed that they wanted to know what was being said about them and needed reassurance that their views were being represented. Hubberstey (2001) notes that practitioners often revealed that they themselves felt uncomfortable disclosing their feelings and important information while young people were present. This has implications for shared decision-making and for maintaining trusting practitioner-youth relationships. The frequent changing of practitioners who are involved in a young person's life can lead to barriers to honest communication, trust building and an absence of meaningful relationships (van Bijleveld et al., 2015). Perhaps the lack of agreement amongst practitioners as to their understanding of what youth participation entails, and what weight it should be given, provides a reason for many of the aforementioned barriers.

Conclusion

The most important aspect of youth engagement, which sets it apart from surface level participation or tokenism, is when it leads to tangible change or influence. When discussing youth engagement and participation through a CYC lens, one can consider how participation manifests itself in the contexts of

engagement, relationships and self. Practitioners tend to agree that young people should actively participate within their organisations, in care meetings and other modes of intervention; however, there appears to be a large discrepancy in how youth participation is actually mobilised. Therefore, it is important that practitioners identify and understand the multiple barriers to participation which are present, and actively work towards dismantling them. The foundational practice-based aspect of critical self-reflection is an important part of practitioner-facilitated youth participation. Practitioners must remember the integral role they play in care milieus and live up to their roles as the professionals 'who listen to young people's voices'. Since practitioners hold a position of power in young people's lives, it is important for them to critically reflect on that power and use it in ways that work towards improving youth engagement and overall participation in the aforementioned areas of CYC practice.

About the authors

All three authors were students of the undergraduate Child and Youth Care and the graduate Child and Youth Care programmes at Ryerson University in Toronto. Lindsay Sinclair holds over ten years of experience serving children, youth and their families, within community, mental health and hospital settings. Melissa Vieira holds ten years of experience working with youth in a number of community, school, recreational and hospital settings. Vanessa Zufelt holds more than fifteen years of experience working with young people and their families in schools, homeless shelters, international contexts and within their homes.

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Enduring principles in a changing world

Melissa Hunt

Abstract

I have spent a large part of my professional life working in the Children's Hearings System in Scotland. This piece is about how and why the Children's Hearings System continues to be the way in which we try to improve the situation for children and young people who face adversity of different kinds. I look at the founding principles of the Children's Hearings System and how they have continued to be relevant in Scotland. The piece is also about the current challenges faced by the volunteers, professionals and families who are involved in the system and the work that is ongoing to address these challenges. The piece is a personal reflection – not a statement of the position of either the Children's Hearings System or the Scottish Children's Reporter Administration. Some of the reflections also formed the basis for an opinion article by the Principal Reporter, Neil Hunter, titled "Agenda: The new dialogue around the Children's Hearings system" which was published in Scotland in The Herald on 30th April 2018.

Keywords

Children's hearings, children, young people, adversity, behaviour, welfare, justice, offending, rights, best interest, professionals

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Children's Hearings in Scotland are very different today. They are still called the same thing, Children's Hearings. They are still where a Children's Panel makes a decision. They still consider what is happening for children and young people who are in need of help. But they are not the same as they were. In 1971, the panel members in the Children's Hearing received the written information about the case – the parents or carers of a child did not here. In 1971, there were no timescales, checks and balances or regulations in respect of locking children up here. In 1971, parents could have a solicitor represent them in a hearing, if they could afford to pay. Children have been able to have a legal representative appointed for them in certain situations since 2002. Relevant people have been able to have a legal representative appointed for them in certain situations since 2009, and the Children's Hearings (Scotland) Act 2011 made legal representation an unequivocal right for any child or relevant person who would wish it here.

And, at the same time, Children's Hearings remain very true to their original incarnation in many ways. When Lord Kilbrandon died on 10th September 1989, aged 83, his obituary in the Herald newspaper referred to him as 'the architect of the children's panel system in Scotland and arch-devolutionist', who had written reports that led to the Children's Hearings System here and a report which proposed a Scottish Assembly here. Scotland in 2018 is a country which continues to owe much to Charles Shaw – Baron Kilbrandon – but Scotland is also a country which is changing. Devolution has given Scotland a voice and the political passion for a Scottish solution. On 23rd November 2017, Nicola Sturgeon, First Minister of Scotland, gave the 15th Kilbrandon Lecture at the University of Strathclyde and concluded her speech by saying:

> "We must ensure that we provide additional help, support, care or protection to the young people who need it most. It is an essential part of providing every child with the best possible start in life.
>
> That needs strong support for universal public services. It requires a continuing focus on improving children's services specifically. It involves respecting, protecting and enhancing

> children's rights. And in my view, it means involving and listening to young people whenever we make decisions about their lives.
>
> By doing that, we can deliver on the aspiration that the welfare of our children is paramount. We can build, together, a more prosperous, fairer, happier Scotland. And we can live up to the inspiring and challenging legacy of Lord Kilbrandon."

That the Kilbrandon legacy is still inspiring and challenging Scotland is testimony to its relevance; it is testimony to the insight of the Kilbrandon Commission and to the way in which Scotland as a country continues to strive to look after its children.

The Children's Hearings System still relies on its volunteers from local communities – people who choose to give their time to help those children in their community whose circumstances have brought them to a Children's Hearing. It has not been radically 'professionalised' and remains a system where, fundamentally, the people you live amongst are making decisions about what should happen for you. The African proverb says 'it takes a village to raise a child'. In Scotland we use the village to find solutions to the often significant and severe problems families face in raising their children.

In 2017 there were approximately 2500 panel members sitting across Scotland. They sat in 34,106 Children's Hearings in 2016/2017. There are also 22 Area Support Teams, made up of approximately 250 people. Panel members and area support teams all volunteer to work with Children's Hearings Scotland. This is a massive volunteer resource to be trained, organised and supported in order for us to get it right in the decisions we make for children in Scotland. Children's Hearings have not been widely replicated – which may be seen as an indicator that they are not as successful as we may think. Perhaps it is this massive volunteer base which makes replication of the Children's Hearings System difficult.

Replicating the Children's Hearings System may be difficult, but it is not impossible. In 2008, the Bailiwick of Guernsey established The Child Youth and Community Tribunal, to offer children and young people in need or in trouble the opportunity to have their case heard outside of a court environment – a system

based on the Children's Hearings System (both in principle and operation, with some differences here).

So, Kilbrandon's legacy is multi-faceted. His legacy is in a system which separates out the finding in fact from the decisions about what should happen next. His legacy is in a system that identifies the 'children in trouble' as a result of their behaviour or the behaviour of others and recognises that any child's 'needs and deeds' should be addressed together. His legacy is in a system that seeks to engage the child, their family, involved professionals and members of the community (the three members of the Children's Panel) in a constructive dialogue. In order for there to be a dialogue, there has to be an equal playing field, and for children and families who have experienced or who continue to experience adversity this may mean they require additional support, legal representation or advocacy in order for them to participate fully and effectively. Lord Kilbrandon's legacy is in a system which recognises that your family is vital and has to be actively involved in decision-making.

His legacy is in a system where the focus should be on the child and the child's welfare, and where decisions are made in the child's best interest – and those working in the system today would all say they try to adhere to this. However, we also know that losing sight of the child is very easy in a meeting where there is conflict, no clear consensus and many, at times very loud, adult voices. His legacy is in a system where minimum intervention in the life of a child and family is the approach taken by the system, but that is very difficult to explain when a Children's Hearing convenes for 3 children, all of whom have a representative and a solicitor (9 people), four relevant people, all with representatives and solicitors (21 people), 3 different schools (24 people), 3 different social workers (27 people) and their team leaders (30 people). The principles are sound, but can, at times, be difficult to reconcile with the practical realities of the cases being dealt with by the Children's Hearings.

Back to the legacy – it is no wonder really that Kilbrandon's legacy is in a system which continues to be, at its best, flexible and responsive. The Children's Hearings can react at very short notice, for example, when a child protection order is granted, or when a child requires to be admitted to secure accommodation on an emergency basis. The Children's Hearings can act in

preventative ways: the most 'common' ground for referral to a Children's Hearing is "the child is **likely** to suffer unnecessarily, or the health or development of the child is **likely** to be seriously impaired, due to a lack of parental care". A Children's Hearing can also be educational in its approach, asking parents or adult carers to make positive changes, and / or asking a young person subject to a Compulsory Supervision Order to engage with a number of measures, intended to improve their circumstances.

Kilbrandon's legacy is also now in a system which operates in an increasingly complex legislative environment, alongside other 'systems' also necessarily focused on the protection of children and the administration of justice. The Children's Hearings 'system', the child protection system, the health system, the education system, and the legal system in the criminal and civil courts, all run alongside each other and at times overlap with each other. The Kilbrandon legacy is a 'system' which jostles with the other 'systems' that children and families have to navigate on a daily basis and which, for those families, can – on occasion – be confused and confusing, misunderstood, misrepresented and misdirected. Everyone working in all these systems is human, after all.

Modern life is complex. When systems and professionals become involved, and when families do not agree with their involvement, life becomes even more layered and complicated. A Children's Hearing takes place when two factors are present: 1) evidence for grounds for referral to a Children's Hearing and 2) when compulsory measures of state intervention in the life of a child or young person is required – very often because a family, for whatever reason, is unable or unwilling to engage on a voluntary basis with professionals and / or the plan developed by professionals. Children's Hearings, particularly at the beginning of the process, are not meetings where everyone is in agreement. People can fundamentally and vocally disagree – about the reason for the hearing; about responsibility and culpability; about the impact of life events on children and about the recommendations being made for children by professionals (for example). Children's Hearings can be difficult meetings – in all the senses of the word – problematic, hard, tough, trying, grim, challenging, demanding, testing – for all those present; children, families and professionals.

In addition to a Children's Hearing often being inherently 'difficult', recent Scottish Children's Reporter Administration research looked at child protection and complexity, and concluded that the lives of parents and the problems they face, and the systems around child protection in Scotland, have become more complex over time. The report concludes:

> **"Yes - child protection in Scotland has become more complex over time.** There are multiple factors that affect the care and protection of children which have become more complex, in particular the extent of problems faced by parents. Legislation and practice change to protect looked after children has also added complexity to the lives of vulnerable families both directly through their involvement in legal processes and indirectly through increased family fragmentation through interventions to take children into care. This increased complexity in child protection has implications for all professionals working within the Hearings System, especially for the training of Children's Panel Members and professionals and in their decision-making to protect vulnerable children. Importantly, it has implications for those families who find themselves involved in an increasingly complex legal system."

Some of the figures and statistics about the observed changes are interesting, including an increase in emergency protection and appeals, and an increase in the amount of information which has to be carefully handled (non-disclosure orders which specify that someone is not to receive certain pieces of the information they are entitled to):

Frequencies of complex Children's Hearings-related events from 2003-04 to 2015-16

% INCREASES	**% DECREASES**
19% - Children Protection Orders	**0.2%** - Hearing held
87% - Pre Hearing Panels/Business Meetings	**2%** - Children with SCOs
115% - Appeals	**8%** - Applications for proof concluded
137% - Interim Compulsory Supervision Orders/Warrants	
191% - Non Disclosure Orders	

In addition, Children's Hearings all recognise that children and young people have agency, can make decisions and will have a view on the situation they are in, as well as a view about any changes which should or could be made. Children and their families are actively encouraged to fully participate in Hearings, and their participation should be effective – and appropriately supported so that this can be a reality. Children, young people and their parents or relevant people have rights – and the system has to respect and uphold those rights wherever possible.

This means that the power in a Children's Hearing probably now sits with the people whose rights and responsibilities would be directly affected if a Children's Hearing makes a decision that allows the state to intervene in their lives – not with the decision-maker in the process. If a family accepts the validity of professional concerns and agrees to work to address them then there is no need for any compulsory measures to be put in place; no need for a compulsory supervision order, or indeed a Children's Hearing. However, in reality, children, young people and their parents or relevant people do not see, or feel, that they have this power and can, at times, feel very powerless in the face of the full force of the state; hence the ongoing need for them to be supported – through effective and available advocacy, legal representation or other means.

It is remarkable that, in 2018, Children's Hearings are still fundamentally the same and that Lord Kilbrandon's founding principles endure. But they have shifted shape – every time Children's Hearings convene to consider the situation for a child and their family, they are, in their new guise, genuinely trying to effect change in new ways - through positive and effective engagement, through transparent planning, through honest dialogue, and through structured and agreed review.

Children's Hearings have embraced and assimilated the challenges of rights, of agency and of fairness, and are well placed to continue to face the challenges of the digital age as they move into the future.

About the author

I am the Police & Public Affairs Manager for the Scottish Children's Reporter Administration (SCRA) in Scotland. SCRA is a non-departmental public body employing Children's Reporters – officials who decide whether children and young people aged 0 – 18 require a Children's Hearing in order to consider whether there should be a Compulsory Supervision Order put in place for them. SCRA works alongside Children's Hearings Scotland – a public body who supports the volunteer Children's Panel members across Scotland who make the decisions in Children's Hearings. Before working in policy I was a Children's Reporter – and I became a Children's Reporter after I left a teaching post in a Sixth Form College in the North East of England to complete further study in Psychology and Criminology & Criminal Justice.

Parents or carers for a child began to receive papers following the case of McMichael Vs United Kingdom (1995); children began receiving papers in 2001.

Secure accommodation regulations were introduced by the Health and Social Services and Social Security Adjudications Act 1983.

Children's Hearings (Scotland) Act 2011, Section 78 and 2013 Rules r.11 (2).

Lord Kilbrandon chaired the Committee on Children and Young Person's Scotland, who first met in 1961 and reported in 1964. The Social Work

(Scotland) Act came into force in 1968 and the Children's Hearings system began to operate from 15th April 1971.

From 1972 to 1973 Lord Kilbrandon chaired the Royal Commission on the Constitution which made recommendations which led to the referendum in the late 1970's.

http://guernseyroyalcourt.gg/article/1756/The-Child-Youth-and-Community-Tribunal for more information on what happens in Guernsey.

Trauma Informed Care for Adverse Childhood Experiences among Out-of-Home-Care Children - Developing an understanding through Case Studies from India

Kiran Modi & Kakul Hai

Abstract

The Adverse Childhood Experiences (ACE) model propagates a life perspective where children exposed to traumatic and stressful experiences during childhood tend to grow up with social, emotional and behavioural difficulties, leading them to adopt health-risk behaviours that cause disease, disability, and ultimately an early death. In this paper, using the ACE model, we give case studies of two Out-of-Home-Care (OHC) children, raised in Udayan Ghars, (Udayan Care's model of Child Care Institutions) describing the impact of adverse experiences on their childhood and how it shaped their lives. In the case of Sonia, her traumatic childhood led her to experience extreme social, emotional, and behavioural problems that she was unable to overcome. Priya, on the other hand, exercised resilience and despite her traumatic childhood, was able to regulate her emotions and behaviours, becoming better-adjusted. Trauma Informed Care (TIC) was used in both the girls' cases during their rehabilitation at Udayan Ghars. However, success with Priya and failure with Sonia highlights the challenges caregivers face when caring for children with extreme ACE issues.

Keywords

Adverse childhood experiences, Out-of-home-care, Trauma informed care, Case studies

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The Adverse Childhood Experiences (ACE) study conducted by Felitti et al. (1998), found a strong graded relationship between adverse trauma experienced in childhood and deterioration of health through adoption of health-risk behaviours, which could prove fatal and lead to early death in adulthood. The study elucidates how ACE leads to cognitive, emotional and behavioural malfunctions in children, causing them to adopt health-risk behaviours. This results in disease and debilitation, which could also cause early death among those who have experienced single or multiple ACEs in their childhood (Felitti & Anda, 2010). These results were found among a sample of adults raised in primary care settings, which brings up the concern – how much more could be the inherent vulnerabilities of children growing up in alternative care, since a majority of OHC children living in alternative care have a past history of single or multiple traumatic experiences (Sridharan, Bensley, Huh, & Nacharaju, 2017). A Trauma Informed Care approach must be used when dealing with children with severe ACE histories living in alternative care settings.

Trauma Informed Care (TIC)

TIC is a strengths-based framework that looks at behaviour, not in isolation but as a manifestation of response to trauma (Hopper, Bassuk, & Olivet, 2010). TIC advocates that caregivers focus on the strengths of children, rather than solely helping them overcome past traumatic experiences, with the objective of building resilience. TIC is, therefore, responsive to the impact of trauma, emphasising physical, psychological and emotional safety for child survivors, and creating opportunities for survivors to rebuild a sense of control and empowerment (DeCandia & Guarino, 2015). TIC also involves anticipation and avoidance of individual practices and organisational processes that may retraumatise individuals with histories of trauma.

Udayan Care's Child and Youth Care Model

Udayan Care, an NGO based in New Delhi, India, has the vision of "regenerating the rhythm of life of the disadvantaged." Unlike large residential institutions, Udayan Care has developed a model of small group homes called Udayan Ghars (Sunshine Homes, hereinafter referred to as 'homes'), providing care and

protection to a maximum of 12 children per home. All standards of care practiced at the homes reflect the requirements of the Juvenile Justice (Care and Protection of Children) Act 2015, Juvenile Justice (Care and Protection of Children) Model Rules 2016, Integrated Child Protection Scheme (ICPS) of the Government of India, the UN Convention on Rights of the Child (UNCRC), and the UN Guidelines on Alternative Care (UNGAC). All children are placed in Udayan Ghars through orders of the statutory body under the Juvenile Justice law, the Child Welfare Committee (CWC), between the ages of 6-16, in gender segregated homes. In most cases, the range of age at entry point is 10-12 years. Currently, there are 17 homes in four states of India, and two Aftercare facilities supporting youth over 18 years of age transitioning out of care. Over 990 children have been touched by the Udayan Care Ghar program in its journey of 25 years.

Udayan Care follows an indigenously developed L.I.F.E (Living In Family Environment) model. Each home has a carer group, consisting of at least two full-time residential caregivers, a group of 2-5 long-term volunteers, called Mentor Parents, a social worker and a part-time mental health professional. Full-time managers work centrally to provide legal, psychological and financial support and training. All homes are located in middle-class neighbourhoods, drawing the support and strength of local communities. Mental health counselling and mental well-being of children and youths, as well as caregivers, is ensured. Children are supported to develop holistically through education, talent and skill development. Individual focus and attention is paid to each child growing up in the homes, factoring the need for individualised care planning. For understanding the developmental growth of the children, Erik Erikson's theory of Psychosocial Development (1968) in combination with Bronfenbrenner's Ecological Model (1979) is used. Tenets of Bowlby's Attachment Theory (1969) and principles of TIC are followed to address the ACEs of children, understand their needs and devise ways to adequately fulfil them. After 18 years of age, through the Aftercare programme, smooth transitioning from child care to youth care and thereafter independent living is ensured, with the open window of coming back whenever needed.

As part of Udayan Care's practices, the carer group are provided training workshops on TIC on a regular basis. The carer group are educated about traumatic stress, to recognise that many behaviours and responses of the children are ways of coping with past traumatic experiences. Safe physical and emotional environments are established across the homes, where the children's needs are taken care of, all safety measures are ensured, and the carer group's support remains respectful, consistent and predictable, which helps the children regain a sense of control over their lives. The decision-making process is shared across all levels of the organisation, for matters concerning everything from the daily life of the children to policies and practices.

Care at the home is holistic, giving due attention to the psychological, physical, social and spiritual health of the children. The understanding that healing can happen through trustful, positive and authentic relationships is put into practice at the home, between the children and carer group, and successively among broader systems of support. The carer group works with the understanding that recovery is possible for all children, regardless of the nature of their ACE, providing care that instils hope for children to build a brighter future for themselves. Regular workshops are conducted for children on all matters pertaining to their health, well-being, education, protection and life skills. In an effort to enhance the care services provided to children, Udayan Care is presently conducting a longitudinal study in collaboration with Duke University, to evaluate the mental health outcomes of orphaned and separated children living at Udayan Care, specifically taking into consideration measures of peer and guardian attachment, self-concept, depression, ego-resiliency, and trauma symptoms.

The emotional distress and/or burnout that the carer group may experience when supporting children with ACE is considered equally important in their training and support. Trainers and supervisors help them recognise and work through their own responses to trauma, providing psychotherapy, reflective supervision and psycho-education.

Case Studies*

Research has found early exposure to traumatic ACEs to have two different impacts: a) later life psychopathology and negative reactions to further traumatic experiences (Breslau, Davis, & Andreski, 1995; Foa, Stein, & MacFarlane, 2006), and b) building resilience (Bonanno, 2004), where the more traumatic the ACE, the greater is the potential for experiencing resilience and personal growth (Paton, 2005).

In this section, two case studies are presented, corresponding to the two points made above. First is the case of Sonia who, unable to transcend her traumatic childhood experiences, found herself falling down the spiral of retraumatisation, and second is Priya who, on the other hand, recovered from her traumatic ACE and, functioning from resilience, became well-functioning and well-adjusted.

Case of Sonia

Sonia came to the home when she was 10 years old. While taking her case history, she revealed that her father had been physically abusive towards her and her mother, and who one day beat her mother so severely that she succumbed to the injuries. He was imprisoned, after which Sonia was sent to live with her maternal grandmother. She became an angry child, without understanding what exactly made her angry. Unable to control her emotions, she started acting out and hitting those around her. Her grandmother resorted to hitting her in order to discipline her. Faced with violence and abuse once again, Sonia ran away from home. She stole enough money to buy a railway ticket and got onto the first train bound for Delhi. After spending a few days on the streets of Delhi, she was found by the CWC and brought to the home.

Initially, Sonia was not happy being placed in the home. Too young to realise that the carer group at Udayan Care had her best interests in mind, she was quick to treat everyone and everyone’s attempt to befriend her with mistrust. Due to her family's interpersonal violence that she was exposed to from early childhood, Sonia had been unable to resolve the crisis of the first stage of her psychosocial development, leading to mistrust, especially of strangers. Her intense mistrust made her physically aggressive and verbally abusive towards the carers as well as the other children.

The carers understood that Sonia's behaviour was a manifestation of the ACE experienced by her and that her inability to regulate her emotions reflected the social environment she had grown up in. The psychologist advised the caregivers to supervise Sonia's interaction with the other children. The psychologist conducted individual play therapy sessions with her, to unveil the deeper repercussions of the ACE. The psychologist also advised that Sonia's grandmother be located and contacted for her case history, since ACEs have been found to disrupt autobiographical memory formation (Felitti et al., 1998). However, the carer group were unable to get the grandmother's information from Sonia. The psychologist observed Sonia's mistrust, and the first step in her recovery, therefore, was to help Sonia learn how to trust people. From a TIC lens, this would require her to form secure attachments with the carers, since mistrust is strongly associated with insecure attachment (Bowlby, 1969), and is also a repercussion of ACE.

As Bonnano (2004) asserts, many traumatic ACE survivors experience psychological problems and poor functioning for a long period following the ACE. Sonia continued to exhibit disruptive behaviours in the home, despite the attempt of the carers to calm her down. In fact, Sonia perceived the carers' attempts as inhibiting her autonomy and instilling guilt and shame in her instead. It was assessed that at 10, which is the age of Erikson's fourth stage of psychosocial development, Sonia had not successfully resolved the crises of the previous stages of development. Not all individuals may be ready to address their traumatic experiences (DeCandia, Guarino & Clervil, 2014). Sonia remained defiant and uncooperative at the home, at school, and during therapy sessions. On two occasions, Sonia even tried running away. She resorted to self-harm by cutting herself. The self-harm was indicative of the health-risk behaviours that children who experienced ACE resorted to (Felitti & Anda, 2010), also signifying a greater risk of early death. Such is the debilitating impact of ACE from which the survivor may never recover. The effort to bring her out of the ACE stage continues even today at the home.

Case of Priya

Priya, when placed in the home at the age of 12, was a socially unresponsive child. She would mostly sit by herself and not speak with anyone. At first, the

carer group assumed her to be a shy or introverted girl. The carer group believed that she may start feeling comfortable after a while, but soon it was discovered that she was totally disengaged from her surroundings and had terrible stranger anxiety.

Rather than looking on the child as obstinate and defiant, the carer group understood that her tendency to seek isolation could be the result of her past traumatic experiences. A psychiatrist and clinical psychologist (part of the mental health team at Udayan Care) were consulted to understand Priya's concerns. Both the mental health specialists closely examined Priya and recommended that no one communicate with her forcefully, rather that she be given her space, until the counsellor had built rapport and trust with her through individual therapy sessions. Play therapy was used with Priya since it is largely non-verbal yet helpful for the child to communicate and express her thoughts and feelings. In an effort to ensure accurate diagnosis, Priya's aunt, with whom she lived prior to coming to the home, was called in. It was then that her aunt revealed that Priya's father had abandoned her at her mother's death when she was 5 years old, after which Priya was under her aunt's care (kinship care). However, her aunt's husband had sexually abused her, and when the aunt became aware of this she did not want her to continue living with them. Through her case history and therapy sessions, Priya was diagnosed with mild depression and post-traumatic stress disorder due to the experience of Child Sexual Abuse (CSA).

With this diagnosis Priya's rehabilitation process began with individual counselling sessions. Soon, the counsellor commenced treatment that addressed her trauma, its impact on her psychological and physical health, and the subsequent mistrust she developed. Simultaneously, the carer group was advised to use tenets of the TIC approach when dealing with Priya, such as ensuring trauma knowledge, creating a safe and supportive environment, and empowering the child (DeCandia & Guarino, 2015). A psychologist started working on strengthening her skills to cope and remain resilient during crisis. After a few months of intervention, noticeable changes were observed in Priya. She was able to recover from stranger anxiety, turning into a confident girl who does not shy away from others. According to the Ecological Model, the

environment that children are raised in have important effects on their behaviour, learning and growth (Bronfenbrenner & Morris, 1998). Priya's Mentor Mothers and carers helped her identify her talent in art and encouraged her to develop her skills. She began taking part in various competitions at school, for which she received accolades. She began to appreciate her individual strengths and capabilities, seizing further opportunities to grow. As of today, she continues to shine……

** Names and details of children in case studies changed to protect identity.*

Conclusion

Trauma and its prevalence in the lives of children in OHC must be acknowledged when supporting them. The objective of the Udayan Care Child and Youth Care model is that erstwhile traumatised children grow up in secure, loving homes, learn social skills, gain education, and develop resilience, mental well-being and a wholesome attitude to life, the lack of some or all of which they were exposed to before coming to the home – such that their ACE and trauma are identified and addressed appropriately. The two case studies presented above, however, indicate that further study and assessment on TIC approaches, to uniquely address the needs of each child, must be done, to ensure recovery for all children and to enable them to reach their full potential.

About the author

Dr. Kiran Modi started Udayan Care, an NGO based in Delhi, India, with the vision 'To Regenerate the Rhythm of Life of the Disadvantaged'. A doctorate from IIT, Delhi, Dr. Modi is a person of varied experience in diverse fields, such as media, health care, and children's theatre. Dr Modi is the Founder Liasioning Editor of an international bi-annual journal on Alternative Care: 'Institutionalised Children: Explorations and Beyond', (ICEB). She has also been publishing papers as well as organising training and national and international conferences on standards of care in institutions. Besides her management responsibilities, she is a Mentor Mother to many children and youths in care.

Dr. Kakul Hai works as Assistant Professor in Psychology at Amity University, Uttar Pradesh, India. She holds a PhD in Psychology and two Masters degrees

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Layers of Healing Care

Shona Quin

Abstract

With growing pressure on child and adolescent mental health teams to meet the needs of young people in care, alongside limited resources, there is an increasing need for care settings to consider their role in providing trauma-informed, healing care environments. This article describes the process of developing a therapeutic framework within a small residential care setting in Scotland. The framework encapsulates the importance of attending to the needs of the organisation as a whole in order to provide a safe, attuned and responsive environment, highlighting the fundamental layers of care necessary to provide a foundation upon which the healing journey can begin.

Keywords

Therapeutic framework, healing care, psychology in residential care, layers of care

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Layers of Healing Care

The Development of a Framework to promote Healing Care in a Residential Care Setting

With growing demands upon child and adolescent mental health teams and limited resources to respond, the need for the residential care environment to provide an environment that meets the psychological needs of young people is paramount.

Children in care are more likely to experience adversity and trauma in childhood, such as neglect, physical, emotional and sexual abuse, loss and the effects of substance misuse. In addition to this, all too often their experience in care can reinforce feelings of loss and abandonment, blame and shame. These experiences often result in feelings of insecurity, difficulty making and sustaining relationships due to a fundamental mistrust in adults, emotional dysregulation and disengagement from education.

Recent studies on the impact of adverse childhood experiences (ACEs) suggest that there is a cumulative relationship between adverse childhood experiences and psychological wellbeing in adulthood (Hughes et al., 2017). In a recent Scottish Public Health Network report, 'living in care' itself is considered to be an adverse childhood experience under the category of household adversity (Couper and Mackie, 2016). Having developed an interest in the experiences of young people in care, it became clearer to me that there was much support that could be offered to these environments in an attempt to improve young people's experience of care, developing resilient teams that can offer the nurturing care and containment required for young people to grow and develop.

If our environments shape the people we become, then we have to consider that the answer to healing lies too within our environment. Originally, there was much demand for me to see young people individually for therapy, to support them to acknowledge and 'work through their traumatic life experiences.' From a trauma informed perspective, however, I was well aware of the fact that to explore traumatic experiences with a young person they have to feel safe, both physically and emotionally, be stabilised in placement, having built an attachment to at least one trusted adult, and have some degree of self-

regulation. It became clear that I had a responsibility as a clinician to explore these factors with staff teams in order to focus on the development and sustainability of the healing environment.

In a document entitled 'Key Ingredients for Successful Trauma Informed Care Implementation', Menscher and Maul (2016) talk about two factors that are essential to consider when developing trauma informed care provision, namely, organisational factors and clinical factors. Considering the environment or culture of a care setting is vital in the process of providing quality care experiences for young people.

Kim Golding's Pyramid of Need (2007) has been a model I have returned to over and over again within child and adolescent mental health services, to support systems to recognise the foundations required before a young person is likely to engage in a formal therapeutic relationship.

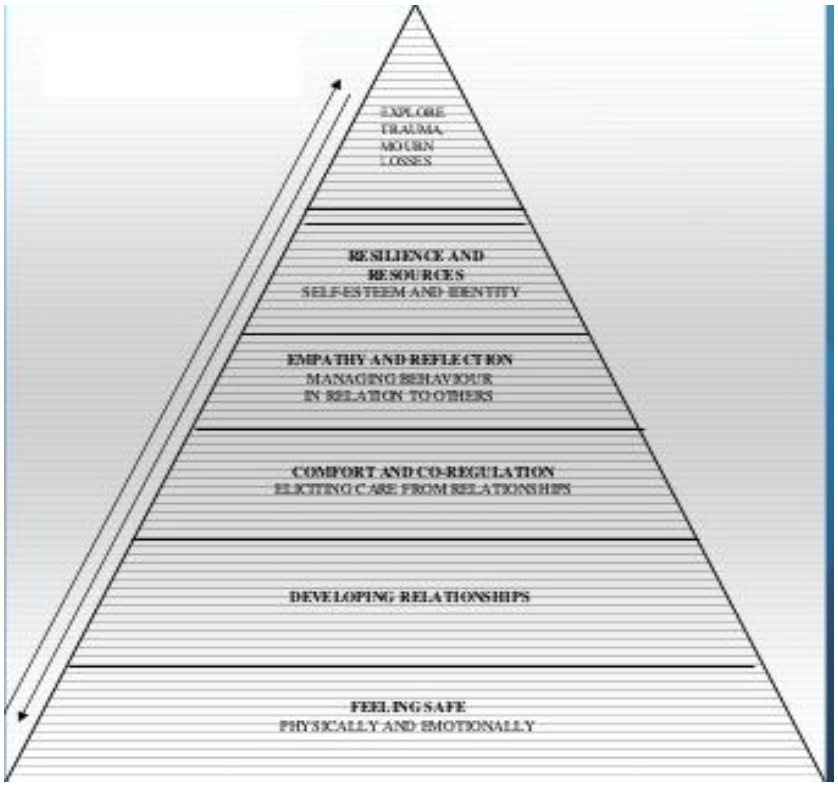

Figure 1: Pyramid of Need, Kim Golding (2007)

I have found this model very useful in supporting adults to identify their role within the healing process. Creating safety for a child is the foundation of any caring, trauma informed environment. If a young person continues to live in chaos, their resources are ploughed into survival, they retain their defences and

return to habits of behaviour that have enabled them to cope within this chaos. A child's safety and security must always come first. We must facilitate their connections with trusted and available adults, work towards building skills to sit with and contain distress, building emotional regulation and social skills, while giving young people plenty of opportunities to achieve. Moving too quickly towards individual therapy risks positioning the problem within the child, as opposed to understanding the role the environment has played in shaping development.

Drawing on these ideas, I have recently been involved in developing a framework to inform the therapeutic culture at Balnacraig Residential School, a small residential setting in Perthshire, Scotland. It was important that this framework was grounded in theory while also being accessible to teams. Having worked for many years with Kim Golding's Pyramid of Need, it became clear to me that, through defining what was required for a young person to be in a position to engage in formal therapy, she had given us a starting point to consider, environmentally, what is required for a young person to grow and develop.

If the environment is going to provide a culture that promotes growth and development, it is important to support the adults to feel empowered in their role. To support them to begin to believe that their role is paramount in creating an experience of stable, attuned, nurturing care from a secure base. During this process, I asked one young person how he would define a 'therapeutic environment', his response was 'warm milk and honey'. He went on to tell me that his favourite foster carer would make him warm milk and honey before bed every night. This was a memory that represented 'therapeutic' care and helped reinforce my belief that small acts of attuned care are the foundations for healing.

Drawing on Golding's Pyramid of Need, and through consultation with the team, we began to build our own model to define the features of a care environment that allows a child to feel safe enough to begin to heal. Fundamental to this model – and taking on board the importance of cultural factors along with practice factors – is that *everyone* within the environment needs to experience what it feels like to be safe, to have relationships, to experience emotional

containment and to build their skills and resilience. Uncontained adults will struggle to provide the level of containment a child requires. As such, in order to effectively look after our young people in care, we must look after our supporting adults and the organisation as a whole. The basic framework is illustrated below:

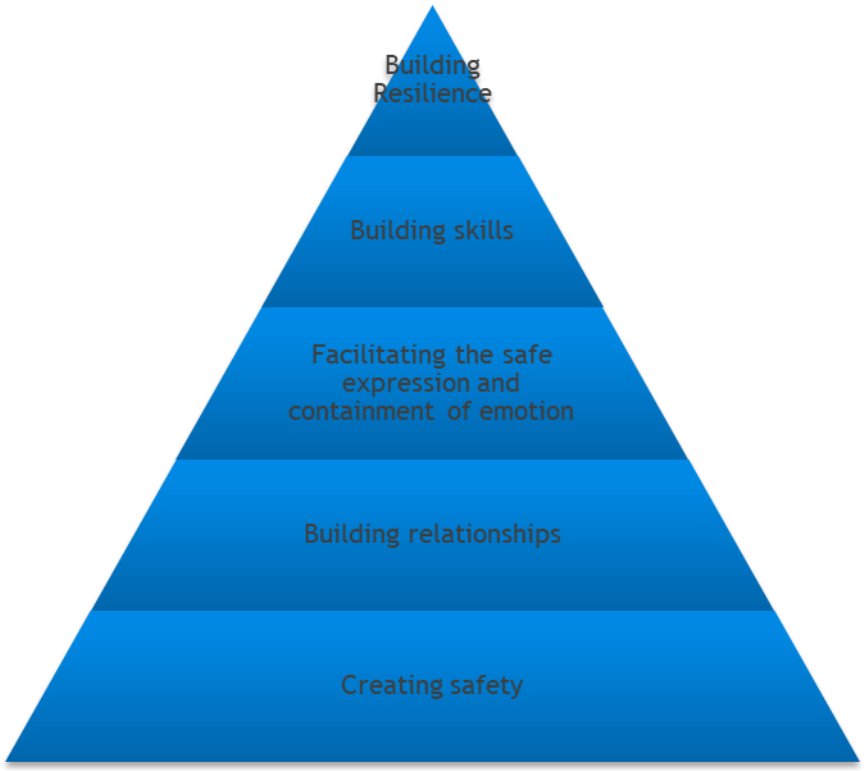

Figure 2: Layers of Care

This framework encompasses a natural developmental progression from building a safe environment through to building the skills and resilience required to support young people and adults beyond the secure base. The assumption being that unless attention is paid to each layer, a child will find it difficult to progress through the levels.

Through consultation with adults and young people, we developed the fundamental features of each stage of the model in terms of practice, but also organisationally. Some of the ideas generated are included in the table below.

Stage of the Model	Practice Features	Organisational Features
Creating Safety	• Understanding attachment and developmental trauma • Creating safe spaces • Building trust • Claiming young people • Creating consistency through good communication, • Creating rituals (warm milk and honey) • Clear expectations and boundaries • Establishing routines and structure	• Job security • Clear expectations in terms of adults' role • Appropriate ratio of adults to young people • Clear processes to manage risk • Building trust
Building Relationships	• Understanding the process of attunement and re-attunement • Drawing on principles of Dan Hughes' PACE • Restorative approaches • Encouraging relationships with the system / family where appropriate	• Creating supportive teams through team building • Recognising supportive teams • Encouraging / supporting conflict resolution • Having fun • Safe sharing / mistake making
Facilitating the safe expression and containment of emotion	• Acknowledging and naming emotion with young people • Supporting young people to make sense of their own emotional	• Training on emotional development and the process of emotional containment • Ensuring opportunities within the system to share feelings and personal

	experiences, reducing shame • Being available for young people • Modelling empathy	traumas, e.g. supervision, reflective practice • Supporting teams to recognise each other's needs • Building confidence to share own emotions
Building Skills	• Opportunities to build life skills, academic skills, social skills • Creating an environment that supports the development of interests	• Annual programme of training • Supporting further education (SVQ etc.) • Opportunities to take broader responsibility
Building Resilience	• Providing positive feedback • Opportunities to achieve • Celebrating successes • Encouraging young people to take responsibility • Goal setting • Providing opportunities where young people can take control • Building connections beyond care	• Celebrating success • Ensuring adults feel valued and good practice is recognised • Appraisals, goal setting • Building connections with other care environments

Figure 3: Features of the Layers of Healing Care

In order to conceptualise how the model informs culture as well as practice, I introduced to the team the analogy of Russian dolls. At the centre is the young person, psychologically 'held' by the layers of their system. However, in order to provide the healing care a young person requires, each individual adult within the child's system also needs to be psychologically 'held,' experiencing safety in

their role, building relationships with each other and the child, and experiencing emotional containment. Essentially, unless the adults within the system feel safe and supported, they cannot provide the safety and containment required by a child in their care.

Developing the framework has been a relatively straightforward task, generating a broader organisational commitment of staff containment and support. The on-going challenge is how the model is applied amidst dynamic challenges. It has offered a shared language within the team and is readily used to structure discussions around challenges faced within the environment, to facilitate reflective practice and supervision and to inform service provision, training and development.

However, not dissimilar to the process of healing, challenges are an inherent part of the process. Balancing the safety needs of adults with the safety needs of young people can prove incredibly challenging, particularly when resources are stretched and turnover is high. Where traumatic experiences have shaped experiences of attachment to others, building and sustaining relationships is not only difficult, for some it can be incredibly frightening. Developing self-awareness is a challenge for us all, but is absolutely crucial within the context of providing a healing environment for young people in care. This requires adults to reflect on their own experiences of care and nurture in order to recognise the complex dynamics at play in their role as carer.

Skilling-up teams to sit with and tolerate difficult emotions, along with traumatic stories, requires a considerable investment in terms of staff support. In addition to this, expectations for success can quickly result in frustration and a feeling of failure across the organisation. Re-framing and acknowledging each small step within the process is crucial for morale. The impact of low morale from one or a small handful of adults, can be catastrophic across the organisation as a whole. Creating a nurturing culture – where senior management are accessible, open and honest, accepting challenges, recognising that mistakes are part of the process of development and growth, offering containment and encouraging professional development – models the nurturing care response we hope adults within the care setting can provide for our young people.

Bryson et al (2017) highlighted that there are five fundamental factors for implementing trauma informed care in youth (residential) settings: senior leadership commitment, sufficient staff support, amplifying the voices of (young people) and their families, aligning policy with trauma informed principles and using data to inform change. Broadening this framework's application to incorporate some of the factors highlighted in Bryson's paper provides focus for potential additional developments.

Many young people in care are not in a position to respond in a meaningful way to formal therapeutic intervention because the fundamental features of a safe and containing environment are not always available to them. Recognising that, in order to respond to the psychological needs of young people in care, we must focus on empowering carers to consider the layers of care necessary for a healing environment, will provide the foundations of safety and containment a young person requires to build psychological wellbeing, growth and resilience.

About the author

I am a clinical psychologist working independently across residential care environments. Between 2001 and 2015 I worked within child and adolescent mental health services in England and Scotland while developing my interest and practice in residential care. I work with four care organisations within Fife and Perth and Kinross, mainly offering training and consultation. I am particularly interested in how we support and empower care teams to provide therapeutic care, building their understanding of the challenges our young people face while also equipping them with strategies to meet the needs of our young people and support them to heal from trauma.

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Book Review

Book title:

Daly, A., (2018). Children, Autonomy and the Courts: Beyond the Right to be Heard. Leiden: Brill Nijhoff. 9789004355828

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'Children, Autonomy and the Courts' is based upon Aoife Daly's PhD thesis, and presents her argument that Article 12 of the United Nations Convention on the Rights of the Child – which she refers to as the 'right to be heard' – does not go far enough in securing the rights of children in relation to court proceedings. In particular, Daly focuses on those proceedings where 'best interests of the child' is the paramount concern, and although there is a focus on private law, it is also of interest to those involved in child protection and welfare decision-making in public law. That this is an adaptation from a thesis is clear in the style and structure of the book. This is no reference book, nor a book that can be easily dipped into to extract particular information, but it takes the reader on a compelling journey, from illustrating the limitations of Article 12, through to the need for, and arguments in favour of, an autonomy principle, and its implementation.

The book is not a short one, running at over 440 pages, but this simply reflects the thorough approach taken to the topic. Beginning with the centrepiece proposal: To replace a right to be heard with a 'Children's autonomy principle'. This is founded in an argument that the existing Article 12 right does not provide the protections and opportunities that were envisaged when it was drafted. In particular, Daly emphasises (with clear examples) that the right to be heard as it is currently performed in courts and tribunals does not provide the protection envisaged, and does not go far enough in promoting the rights and interests of children and young people.

This book does not shy away from challenging 'accepted wisdom' or current practice. In particular, highlighting that individual autonomy is one of the cornerstones of our liberal society, Daly disputes the idea that children should be presumed to be less capable than adults of making their own choices, deploying both evidence and reason to convince the reader. These deployments are carefully orchestrated and managed, and as a result, bring the reader along with the author, presenting the evidence and drawing consistent, reasonable conclusions that steer clear of grandstanding or evangelising for a particular standpoint.

Daly presents these arguments throughout each of the first five chapters of the book, building a clear and coherent argument for her central thesis. However, the final two chapters go further, to begin to look at how an 'autonomy principle' might be put into practice. As a researcher with a practice-focused outlook, I found these chapters particularly interesting. Not just because they are often absent from many such books, with the author content to simply present the rationale and arguments for their case, but also because they address head on the argument that an autonomy principle may be fine in theory, but wouldn't work in practice. In chapters six and seven, Daly provides a blueprint for moving from our current 'competence' based approach, through to implementation of an autonomy principle, and the support that would be necessary to make it a reality.

Coming from Scotland, and with a particular interest in the Children's Hearings System, I was curious as to how this system would be presented or addressed. While there are references to the Hearings System, and it is often cited as an example, the private law focus of the book means there are limits to its relevance. However, there is still much that can be taken as learning within the Hearings System, with the caveat that there will be many more cases where the risk to the child or young person means that their autonomy must be overruled. The adoption of an autonomy principle might well provide for greater engagement in the hearings, and create additional pressures to ensure decisions are clearly reasoned. Accordingly, there is much to be taken from this book for those concerned or in contact with both public and private law.

Finally, it is important to note that, throughout the book, the voices of children and young people are clearly represented and prioritised. Each chapter has a quotation from a young person as an epigraph, as well as frequent and apposite quotes throughout both descriptions and arguments in the text. Daly's concern for children and young people and their lack of agency or autonomy in courts jumps from the page. This is particularly clearly demonstrated in the presence of a 'Child-Friendly Summary' which lays out the basic argument of the book in seven bullet points and less than 115 words, an innovation that I have certainly not come across before in legal textbooks, and shows Daly leading by example.

In summary, 'Children, Autonomy and the Courts: Beyond the Right to be Heard', pushes us to think about the voice, participation and representation of children and young people in all legal settings. The book is engaging and easy to comprehend throughout, while presenting a persuasive argument for the next step in the realisation of children's rights.

About the author

Robert is a social legal researcher with a background in Psychology and PhD in Law. He has a particular interest in the Scottish Children's Hearings System having previously been a Panel Member. Robert currently works at CELCIS, carrying out evaluation and research activity. His recent research has included looking at decisions relating to contact, as well as the role of solicitors, in the Hearing System.

Book Review

Book title:

By A Survivor, ACEs in the Shadows – Understanding Adverse Childhood Experiences, ISBN: 9781723070754

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I came across this book by accident when it appeared as a recommended read on Amazon. The fact the author wasn't named (A Survivor) intrigued me. I was curious as to what their motivation was for writing.

Having the book in hand, it does look like a classic self-publish job: no page numbers, a few spacing issues between paragraphs and not much detail on the brains behind the text. But looks can be deceiving. What unravels throughout this book is an insightful narrative unpacking the 'ACEs (Adverse Childhood Experiences) Movement', as well as a personal account of someone who has experienced the long-term and damaging impact of early adversities in their life.

The book is a helpful introduction to ACEs. For those that are not aware of the public dialogue surrounding ACEs, Adverse Childhood Experiences relate to any number of events that can have a detrimental impact on a young person into adulthood. This includes: being physically, emotionally or sexually abused by a parent/care giver (or any adult in a position of caring/authority); neglect which takes the form of not having enough food, clothing or attention; and/or witnessing a parent or carer being abused – physically and/or verbally by their partner.

The original ACEs Study took place in the USA in the mid-1990s and involved two health care organisations: Kaiser Permanente and the Centre for Disease Control. It involved 17,000 patients being given a physical examination and completing a confidential survey about childhood experiences and their current state of health.

The light bulb moment for this study came when the researchers realised, beyond any doubt, that there was an association between childhood trauma (i.e. ACEs) and health and social problems later in life.

The book is in part a guidance and introduction to the concept of ACEs and current public thinking around the topic, and in part an autobiographical account of someone with real life experience of ACEs and their consequences over a lifetime.

The book's subject matter should appeal to a wide range of people, including professional groups with an interest in ACEs (e.g. social work, carers, health professionals and education professionals), and people with real life experience of trauma in early life.

Although written under a pseudonym, you quickly establish that the author is a man over the age of 60 from Cumbria. He has suffered in the hands of abusers while at home, by his stepfather, and while in a residential care home. He provides a brief but frank account of the sexual abuse he suffered over a period of three years, as well as divulging details of his medical history. This is challenging to read. The author equates this difficult experience to a high ACEs' score, related to the 10-question survey used to assess the number of adverse events that have been experienced in childhood. Research suggests that such a high score goes some of the way to explain the state of someone's physical and mental health later in life.

The author praises the work underway in Scotland just now supporting public understanding of ACEs, with the ambition of making us the world's first ACEs aware nation. He has the same ambition for his own home county of Cumbria.

Despite the complexity of the subject matter, the main messages from the author are fairly clear and straightforward – that ACEs are real and should be taken seriously, and that there is a direct and obvious correlation between ACEs and poorer physical and mental health in later life. It is clear the author wants to galvanise people into action by developing public understanding of ACEs further. He is also explicit in what he has done to contribute to this movement, and what he expects others to do.

What is fascinating about this book is that the author has asked three professionals to contribute to it by asking them what can be done about ACEs. This, combined with the author's own views and perspectives, gives the book more depth and credibility, in my opinion. I was heartened to read Edinburgh-based teacher and ADHD campaigner, Laura McConnell, waving a red flag surrounding the 'dangerous flawed practice' of considering a child's ACEs score within an education context.

This book is an enjoyable and easy read, but I would suggest not reading this in isolation of other text surrounding ACEs. Indeed, there are some questions that I felt were left unheard and unanswered. For example, how can a survey based on a middle-class population in America in the mid-1990s be applicable now? What research is being done to examine adversities experienced during adulthood and their impact?

The author also praises and appears in awe of American based paediatrician Dr Nadine Burke Harris – who was recently appointed California's first Surgeon General – and understandably so. She has pioneered much research and public dialogue linking adverse childhood experiences and toxic stress with poor health in later life.

Anyone who has seen Dr Burke Harris in action, and there are many of us (her TED Talk 'How Childhood Trauma Affects Health Across a Lifetime' has had over three million views), will know not only is she a leading light on everything ACEs related but she is also, helpfully, a very charismatic communicator, making the difficult and sometime bamboozling subject matter accessible to the masses.

The author takes the 'leading light' description of Dr Burke Harris further by suggesting she is almost a modern-day Florence Nightingale: 'another lady holding a lamp and instigating an equally radical paradigm shift.' His enthusiasm for her work is clearly infectious as, like a hypnotised patient, I followed his instruction and purchased her 'The Deepest Well' book after turning the last page of this book.

About the author

Mike Findlay is a Head of Communications within Scotland's third sector. He has worked for over sixteen years across a number of sectors including justice, children's health and higher education, supporting organisations in growing their external and media profiles.