

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

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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 con

trol 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 Liaisoning 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.

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