When something bad has happened

Handbook

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Preface

We, the authors of this book, work as psychologists at the Child and Adolescent Psychiatry Barnahus Team in Stockholm. We work with children who have been exposed to violence and abuse by parents or others they have a close relationship with. In the years since Barnahus was first established, we have accumulated both experience of and resources for important elements of crisis support for children and young people. We have now been given the opportunity to bring together the crisis support resources in workbooks for children, young people and adults and to write this accompanying handbook. Our hope is that the handbook will guide and inspire you in your work providing crisis support and that the workbooks will be helpful and beneficial for the families we support.

At Barnahus, the police, social services, prosecutors, paediatricians and child and adolescent psychiatry services all collaborate to provide support to children and young people who have experienced violence and abuse. Our Child and Adolescent Psychiatry Barnahus Team is usually contacted by social services or the police when a preliminary investigation has begun at Barnahus, so that we can provide crisis support. Consent from legal guardians will already have been obtained, which means we can quickly begin our collaboration to support the child.

We hope that the crisis support model we work with and which is described in this book will be useful for other practitioners working in various contexts and that it will come to benefit many children.

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Introduction

Experiencing violence or abuse during childhood increases the risk of physical and mental ill health over a long period of time and all the way into adulthood. The risk of long-term problems is greater when the perpetrator is an adult the child trusted, and when the child lacks a secure and supportive environment in the aftermath of the abuse. That is why it is so important that children and young people who disclose violence and abuse are quickly offered the support they need. This book describes a crisis support model for children and young people, which is based on the idea that swift intervention and psychiatric assessment can, for some children, be enough in itself, and, for others, is a good first step towards trauma-focused treatment.

Child psychiatric crisis support

When children or young people have been exposed to violence or sexual abuse, it is common for them to experience crisis reactions, which can manifest themselves in different ways and can be of varying intensity. Many will recover naturally over time, even without professional help (National Board of Health and Welfare, 2018). The type of event experienced, the degree of exposure, and a person's underlying strengths and vulnerabilities all affect how they react and how they recover. The event itself is usually referred to as a potentially traumatising event, because not everyone reacts in the same way. All children who have been through a potentially traumatising event, regardless of the symptoms they present, need emotional support from those around them, help to understand and verbalise what they have been through, and the opportunity to express their feelings about what happened. This type of support can come from many different sources, including parents, social services and children's support services. Not all children need psychiatric interventions.

It can be difficult to know which children need child psychiatric crisis support and which will be able to recover without it. Children who have been repeatedly exposed to traumatic events, those who have been exposed at a young age and those who are

vulnerable and lack social support tend to have the greatest need (Michel, 2014). Crisis support is the support that is offered when you are in the initial crisis, before the symptoms have been entrenched and developed into PTSD (post-traumatic stress disorder). Child psychiatric crisis support aims to reduce the risk of the child or young person's reactions persisting over time, by developing strategies to manage the symptoms, improving communication between the child and their caregivers and increasing the child's understanding of their own wellbeing. The crisis support also includes assessment of trauma-related symptoms and the child's further needs.

Why is crisis support necessary?

Contrary to what many people think, exposure to potentially traumatising events is common. Large-scale international studies have shown that around 56 to 60% of all young people have been exposed to an event of this kind (Michel, 2014). According to a Swedish study by Landberg, Svedin and Jonsson (2022), one in four young people have experienced sexual abuse. Jernbro and Janson's 2017 study of pupils in Sweden in year 9 (aged 14 to 16) and year 2 of upper secondary school (aged 16 to 18) found that 24% had experienced physical violence, 16% had experienced psychological violence and 14% had witnessed violence in a close relationship. In the course of their lifetime, over half the population are exposed to a potentially traumatising event. However, not everyone develops long-term difficulties. Lifetime prevalence for PTSD is estimated at 5% among young people in the USA (Merikangas et al., 2010) and it is estimated that 15 to 20% of children and young people who are exposed to a potentially traumatising event go on to develop PTSD (Alisic et al., 2014, Kassam-Adams & Winston, 2004). Lifetime prevalence in Sweden is 5.6%, but the risk is twice as high for women and people born abroad (Frans et al., 2005). In a Swedish study undertaken by Aho, Proczkowska Björklund and Svedin (2017), 5332 young people participated in a survey. It showed that 84% had experienced a potentially traumatising event and thereof 75% exhibited reactions connected with the event. The researchers concluded that there is a significant need for early assessment of crisis reactions in order to identify those who risk developing PTSD.

PTSD occurs as a result of an individual being exposed to a traumatic event. Symptoms include re-experiencing the trauma, avoiding memories, places and/or people that remind you of the trauma, negative changes in cognition and mood, and being tense and vigilant. Among young people, it most often presents as concentration difficulties and irritability. If the symptoms have not subsided after a month and are of sufficient severity, a diagnosis of PTSD may be appropriate. The symptoms will cause clinical suffering and impaired functioning (American Psychiatric Association, 2013).

Studies have shown that the more trauma-related events a person has experienced, the greater the risk of a long-term deterioration in health (McLaughlin et al., 2012 and Felitti et al., 1998). The risk of future psychiatric and medical disorders also increases (Felitti et al., 1998 & Irish, Kobayashi & Delahanty, 2010). It is therefore vital to identify children who may develop post-traumatic stress in order to reduce the risk of longer-term after-effects of potentially traumatising events (Nilsson & Svedin, 2017). According to a meta-analysis conducted by Hiller et al. (2016), for many people, trauma symptoms reduce over time, but it can take a long time.

Research on crisis support

Much of the research has focused on the needs of children and young people who have experienced a potentially traumatising event such as a car accident, war or natural disaster. However, few studies have been done on crisis support for children and young people who have experienced interpersonal trauma, such as violence and sexual abuse. Ten studies on early interventions were included in Nilsson and Svedin's Knowledge overview concerning support and treatment for children exposed to sexual abuse and physical abuse \[Kunskapsöversikt om stöd och behandling för barn som utsatts för sexuella övergrepp och fysisk misshandel] (2017). In only two of these was the target group children who had been subjected to maltreatment or sexual abuse. Both of those examined the Child and Family Traumatic Stress Intervention (CFTSI), a manual-based crisis support model that is provided over 5 to 8 sessions with the aim of increasing communication regarding the child's symptoms, reducing crisis reactions,

screening trauma symptoms and assessing further needs. In the knowledge overview, CFTSI is stated to have the most promising results when it comes to early interventions. They also argue that it is a major shortcoming that most early interventions for children and young people who have experienced potentially traumatising events are directed at children who have been exposed to physical trauma, such as car accidents, with few aimed at children who have experienced interpersonal trauma. Similar results were found in a review by the United Kingdom's National Institute for Health and Care Excellence (2018) of interventions for the prevention of PTSD in children and young people after a potentially traumatising event. This overview included 52 studies, of which one offered early intervention within one month of the event, which was CFTSI. Hahn et al. (2019) demonstrate in their study the importance for the children's recovery of parents being able to support their children after a potentially traumatising event. It has been observed that parents who themselves have been traumatised by their children's experiences have a negative view of their parenting skills and describe greater difficulties in their relationship with their child.

Why do we need another crisis support model?

There is, thus, insufficient research on effective crisis support interventions for children who have experienced violence or abuse. The intervention model which receives the strongest support in research, CFTSI, is used to a certain extent in Sweden, but has not yet been widely adopted. It is also not suitable for all children, as it should be commenced within 45 days of the event or disclosure, the child should be over seven years old and should not have been placed in short-term foster care. In this book, we describe the crisis support model we use when we assess that CFTSI is unsuitable. It is based on our experience of working with children who are living in stressful situations, as well as on CFTSI principles and the stabilisation elements of trauma-focused CBT.

Key principles and components of crisis support

Both in research and through clinical experience, we have seen that there are a number of important principles and components of crisis support. To be able to implement child psychiatric crisis support, the child needs, first and foremost, to be protected from exposure to violence and severe stress. The child needs to have access to a safe adult who can help and support them. We know that children and young people recover more easily if they have supportive and understanding adults around them (Bath & Seita, 2019; Smith et al., 2019; Michel, 2014). An important focus of crisis support is to improve communication between the child and their caregiver about how the child is feeling, in order to increase the emotional support for the child in their daily life.

Important components of crisis support include, firstly, helping the child to understand that crisis reactions are normal reactions to an abnormal event, and secondly, teaching the child strategies to be able to cope with their reactions and their emotions together with a safe adult. Adults may find it easier to support and understand the child if they too gain knowledge of common reactions to crisis and trauma symptoms.

For crisis support to be effective, an important factor is that it is offered within a short time of the potentially traumatising event taking place or being disclosed. Sessions should take place on a regular basis, preferably once a week.

How this book is intended to be used

This book is aimed at practitioners providing crisis support to children who have experienced violence and/or sexual abuse. Crisis support can be provided through child and adolescent psychiatry services, Barnahus or other service. As this book is aimed at practitioners providing crisis support in different organisations, adaptations may be required, depending where it will be used. This handbook is intended to be used in conjunction with the accompanying workbooks. There is one workbook for care-

givers, one for children (ca. 7 to 12 years old) and one for teenagers (ca. 13 to 18 years old). Our hope is to be able to also make a workbook for very young children in the future. Parts of the workbook for 7 to 12 year olds can be used for younger children as well. Some knowledge is required to be able to use our crisis support resources. We have chosen not to go into trauma theory in depth, as this is a more practical handbook which describes how crisis support treatment can be implemented. Our starting point is that practitioners who provide this type of crisis support need to have basic child psychiatry qualifications, be familiar with psychiatric diagnostics and assessment, have basic knowledge of trauma and be able to make differential diagnoses. In addition, it is important to read this handbook so as to understand how the workbooks are intended to be used. We recommend that you become well acquainted with the workbooks before starting to work with them, so that you can use the material flexibly. If you would like to deepen your knowledge of childhood traumatisation, you will find recommended reading at the end of the book.

Many of the children we meet have been placed in short-term foster care or longer-term foster care. We will therefore use the words caregiver, parent and safe adult interchangeably when we refer to the adult participating in the crisis support alongside the child.

The crisis support resources are a compilation of various elements and exercises which can be included in child psychiatric crisis support. It will rarely be possible to have the time to cover everything in the workbooks within the timeframe we propose (3 to 8 sessions). If you decide that certain parts of the workbooks are not helpful or suitable for the child in question, pages can be removed (e.g. in-depth information about sexual abuse where the child has solely experienced violence). The idea is to begin with an assessment and try to pinpoint the symptoms or difficulties of most concern, and then adapt the interventions accordingly. For some children, this will mean placing a lot of emphasis on psychoeducation, while work with other children may focus more on coping with strong emotions or creating context around their life story. It is the clinical assessment that will determine what should be included in the crisis support.
When you meet children with severe symptoms where it quickly becomes clear they will need therapy for trauma, it may make

sense to have a shorter crisis support intervention and proceed to trauma- focused therapy, or to make a referral for the child so that they can quickly access the right treatment. Aspects which should be included in all crisis support are traumatic events screening, screening for trauma symptoms, psychoeducation and communication between children and parents about the child's wellbeing.

The crisis support model has been developed on the premise that two practitioners work together on a case, whereby one practitioner has consultations with the child and the other has parallel consultations with the caregiver. Crisis support consultations usually start jointly with the child and parent both present to take stock of the situation, hear how the homework has gone, etc. This is followed by individual consultations with the child and the parent respectively. The session then concludes with them coming together for a short conversation during which information can be shared and new skills taught. If you are providing crisis support alone, however, the sessions can be extended, if possible, so that you can meet the child and parent individually and then have a joint consultation at the end of the session. Some children can wait in the waiting room by themselves, while others will need support. You and the parent can decide about this together. You can also schedule individual adult consultations and hold phone and video meetings where appropriate. Some issues and conversation topics are more sensitive than others. Conflicts between parents and children, a parent's own stress reactions and trauma symptoms, or own strong and negative emotions, are examples of talking points where meeting face-to-face is recommended. As the support of the parent or caregiver is central to the child's recovery, it is important for the adult to be actively involved throughout the treatment.

In other organisations than Barnahus, the conditions may be different. Sometimes information about traumatic events emerges during a session that was originally about something else, and you must decide whether to report a concern or file a police report, and shift the focus of the session. Sometimes there is no ongoing investigation by social services or the police and therefore no clear collaboration partner. There is nothing to stop you using this crisis support model in such situations and adapting as required by the circumstances. The most important thing is that children and young people who disclose frightening events receive support quickly, based on their specific needs.

Collaboration and initial meeting

n cases where there is an ongoing police preliminary investigation and a social services investigation at the same time as you are initiating crisis support, collaboration and effective communication between the different authorities and professions is important. Otherwise, there is a risk of making the conditions for each other's work worse, or of too many things happening at the same time. It is also important not to be too cautious or passive as a practitioner, for example by waiting until a preliminary investigation is finished before you meet the child. Many issues can be resolved through direct contact with case workers at social services or the police, and everyone involved is usually committed to making the process work for the child and understands that different needs may need to be weighed up against each other. Check your local regulations to understand under what circumstances that authorities can or must collaborate.

If the crisis support begins while a preliminary investigation is ongoing, it is a good idea to contact the police case officer to coordinate before the first meeting with the child. As it is important that the child's statement is as free from influence as possible, it is usually a good idea to wait until the first interview with the child has been conducted before the practitioner meets the child. If the child is feeling very bad or if the process is taking too long, it may be appropriate to meet the child nevertheless. In those situations, it may be wise to start by focussing on stabilisation rather than mapping out what the child has been through. Decisions around this are weighed up together with the police and social services.

Even outside those circumstances, it is of great benefit if the crisis support can be carried out in close collaboration with social services. It is usually recommended to hold an initial meeting with the caregiver and social worker in charge of the case to receive background information and hear about social services' planning, and to be able to plan together to make sure the child is protected and has as much stability as possible. Older teenagers can also participate in this initial meeting if they wish. After the first meeting,

it is important to receive updates from social services about expected changes in the child's life so as to be able to plan crisis support sessions as well as you can. For this to be possible, check what kind of consent may be required in your context for confidentiality to be lifted, for example to social services and the crisis support practitioner having continued direct communication. An exception applies when the child is being cared for under the Care of Young Persons Special Provisions Act, in which case social services can take decisions on healthcare. Open communication and joint planning of interventions is usually a relief for the parents, who otherwise are the ones who need to transmit relevant information between the different authorities and actors. If it is not possible to hold the initial meeting together, telephone contact with social workers to obtain relevant information is recommended.

During the initial meeting, social workers and legal guardians need to provide as clear a picture as possible of the child, what they have been through and how they seem to be doing. The aim is for the crisis support practitioner to be well prepared before the meeting with the child so that they do not need to tell them everything from the beginning and so that you can tailor your approach. It is helpful to know how the child refers to their experience, so that the practitioner can use the same words, and to know who knows about what happened and to whom the child has spoken about it. How have they been able to talk about the event(s) at home? Does preschool or school know about what happened so that they can support the child in the best way possible?

During the initial meeting, the practitioner also describes what child psychiatric crisis support is, the difference between that and longer treatment, and why it is considered better to offer crisis support now. Make sure you provide information about the duty of confidentiality and the duty to report, and about the caregiver also having the opportunity to talk to the practitioner individually during the session. The goal is that at the end of the meeting, there will be a plan in place for continued crisis support that everyone present is clear about. A prerequisite for crisis support is that the child can come with one or more safe adults with whom the child either lives or who are part of the child's everyday life. The crisis support is about the child, but the adults around the child are crucial for the child to be understood and supported. Teenagers also need to have

an adult with them who can actively participate in the crisis support. Occasionally a teenager may not have a safe adult who can participate in the crisis support sessions. In such cases, the sessions must be adapted and you should work with the teenager individually and try to find someone who can support them between sessions. The child psychiatric crisis support described in this book is provided to children together with an adult who was not the person who exposed them to violence or abuse. If social services assess that the child should live with the parent who exposed the child to harm and the parent is denying what the child describes, it is social services that must intervene. Crisis support will not be offered at Barnahus in those cases, because without a safe accompanying adult who believes what the child is disclosing, the conditions required for talking about the violence are not there.

Initial session with the child

How the crisis support sessions are conducted depends on the individual child and their needs. The first session tends to follow a similar structure. The subsequent sessions will vary depending on the assessment made and are therefore described in terms of their possible content rather than session by session (see the chapter on Components of crisis support).

The first session starts as a joint discussion between the practitioner, the child and the caregiver. It is important to be clear about the context in which the support is being provided, as children and parents often meet lots of professionals. If the crisis support is taking place on Barnahus premises, you can show everyone the diagram of the different Barnahus "rooms" using the worksheet We work here and explain what distinguishes the different parts to provide context.

It is generally important to be transparent and straightforward with the child about what you know, for example that the child has met with the police and had contact with a social worker. It is also important to clearly define what the child was exposed to in order to show the child that they can talk about what happened in a

straightforward way. Avoid being too general or vague, as this can reinforce any avoidance behaviour. The signal to the child should be that you, as a practitioner, are used to talking about things like this and you do not think it is a burden or hard. Only say what you know to be true and be specific about how the information was disclosed. For example, say "I know that you told your mum that your grandad touched your vulva and vagina" rather than "I know that your grandad touched your vulva and vagina". You can ask the child how they themselves refer to what happened. If the child has been vague when disclosing violence or abuse, it may be appropriate to describe it in the same way as the child has. For example, you could start by saying that you know the child has spoken to the police, because there has been trouble at home, or that you know that a person touched the child's private body parts in a way that adults are not allowed to. It is important not to add your own interpretations or guesses based on what the child has disclosed, as this increases the risk of misunderstandings, but rather to emphasise that you do not know exactly what happened. You can start by telling them what the session will contain, what is going to happen and what will be discussed, as this tends to feel reassuring for the child. You can write or draw an agenda on the whiteboard or a piece of paper and then strike through each item once it has been done.

During this first session, explain the purpose and framework of the crisis support, why you are meeting, and that you are going to work individually and sometimes together with their parent. It is usually comforting for the child to hear that they are not alone in experiencing such events and that the practitioner is used to meeting children who have been through difficult events. It is important to convey hope that many of the things that feel hard now will get better with time, that they usually do, and that you will work together to find ways to feel better. Often both children and parents need to ask questions. If it becomes clear that the parent's issues would be better dealt with with the parent individually, for example because the parent has serious concerns or a strong focus on the child needing to stop arguing, the parent will be referred to the parent's consultation instead, where those issues will be addressed.

After the presentation, the child and parent each have individual consultations with their own practitioner. If the child is younger, you

can choose to hold the whole session with the caregiver present, depending on how safe the child feels and what is deemed to be appropriate.

Child consultation

In the individual consultation with the child, the focus is on getting to know the child and learning what the child likes to do, what makes them happy, their hobbies and friends. The workbook can be introduced and you can start working with it, for example by making a network map. With younger children, bear cards or similar aids can be introduced as a way of describing and talking about emotions, for example. The practitioner can then also form a judgement about the child's ability to do that. The time this part takes will vary and sometimes it is all you will manage to do in the first session. The session usually ends with an activity that the child sees as positive, such as an educational game about different emotions or a relaxation exercise which you can introduce now and then the child can practice at home with the adult before next week.

If the child is older, during the first session you can start to map out trauma symptoms (see the chapter on Assessment for trauma). At the same time as asking about trauma symptoms, you provide psychoeducation about symptoms and normalise the symptoms the child is describing. It is particularly important to describe and normalise feelings of guilt and shame so that the child understands that most children feel that way and that it is completely normal. Be clear that it is never the child's fault when an adult has exposed them to violence or sexual abuse.

At the first session, it is also important to ask if the child has had thoughts about not wanting to be alive anymore or if the child has harmed themselves. You can also ask whether the child sometimes ends up in dangerous situations or if there are things that the child is worrying about just now. If they do get suicidal thoughts, a suicide risk assessment must be conducted and a decision needs to be taken regarding who should receive that information and how. A crisis plan must be drawn up.

Caregiver consultation

In the first individual consultation with the parent or short-term foster parent, you start with a mapping exercise using the workbook. You can start by mapping out what is needed to promote stability and the which stressors are present in everyday life. Sometimes the adult finds themselves in such a severe crisis of their own that you need to discuss the parent's need for support from social services, adult psychiatric services or other authority to help them manage stress, anxiety or depression.

After the mapping exercise, the assessment for trauma can begin by identifying trauma symptoms the child is experiencing (see the chapter on Assessment for trauma). At the same time as asking about trauma symptoms, you provide psychoeducation about the symptoms and normalise the symptoms the caregivers describe.

It is important to inform the caregiver that the session may evoke reactions and emotions in the child, and at the same time ask what usually helps the child if they are worried. Emphasise the importance of planning for something nice together after the session, such as going for a snack together, playing in the park for a little while or doing an activity the child likes to do.

Joint conclusion of a session

The session is drawn to a close with both the child and their caregiver coming together. You can go through what you and the child agreed you will tell their parent about what the session covered and the symptoms that came up. For example, perhaps you agreed that the child is going to try out a breathing or relaxation exercise, which you can now practice together with their parent. If the child is younger, you might plan how the caregivers are going to help the child to wind down by practising child massage or another relaxation exercise.
Depending on how much the child knows, it may be necessary, with the help of the parents, to clearly explain to the child what the situation is right now. In the case of younger children, pedagogical resources can be used to talk about and clarify, for example, current living arrangements, who lives there and where others are living (for

example, the suspected perpetrator), so that the context becomes clear to them. This can be visualised with dolls or by drawing. For older children, you can take advantage of the workbook and fill in Important people in my life/Network map. It is important to help create context and make it crystal clear who the child can turn to when they have a problem. This can be especially important for children who are placed in short-term foster care and perhaps do not have contact with their family of origin.

Ending the joint part of the session with a fun and positive activity is usually beneficial, especially if you have spoken about things during the session which evoke reactions or difficult emotions. Activities may need to be adapted according to age. Many people enjoy playing a game or drawing together.

Useful resources in the workbooks for children and young people

- Welcome
- Important people in my life/Network map
- When life changes
- Common reactions after difficult events/Common reactions
- Examples of common trauma symptoms
- The brain's alarm system
- Ideas for feeling better
- Reducing stress (Workbook for young people)

Useful resources in the workbooks for caregivers

- Crisis support

- Violence against and abuse of children
- Reactions after violence and abuse
- What you can do as a parent

Assessment for trauma

A trauma assessment in the context of crisis support is a mapping of potentially traumatising events the child has experienced and trauma-related symptoms the child is exhibiting. The aim of the assessment is to provide a basis for determining the immediate and long-term needs of both the child and the parent. Initially, the parents' account is the primary source of information about how the child has been and how they seem to be doing. Added to this is the child's account, as well as the assessments and observations made during the crisis support. It is important to remember that a child psychiatric assessment that is undertaken in the context of a crisis lacks certainty. Children are severely affected by ongoing stress. A revised assessment may need to be done once the situation is more stable.

When a child is referred for crisis support, there is always information indicating potentially traumatising events have taken place in some form, and by verbalising what you know, you are showing the child that it is possible to talk about the bad things that happened. As in all child psychiatric assessments, the goal is to create the conditions for children and parents to feel it is safe to talk about difficult events and emotions (Almqvist, Norlén & Tingberg, 2019).

The assessments are based on a combination of discussions, trauma-specific rating scales, observations and information that is available from the child's network. In discussions with children, it is necessary to adapt the methods according to the age, level of functioning and ability of the child. For younger children in

particular, visual supports can be helpful for questions about events and reactions, but older children too can find these helpful. Visual supports relating to traumatic events and trauma symptoms can be found, for example, in the workbooks (the worksheet Examples of common trauma symptoms). You can also find visual support resources relating to frightening events and symptoms online. Drawing and making games about what happened can be another way of encouraging children to communicate in their own way.

In cases where a police investigation is still ongoing and the child may need to testify, you can postpone asking lots of questions about what happened and instead focus more on symptoms here and now (see chapter Collaboration and initial meeting). For the purposes of the assessment, it is not necessary to go into the details of the events themselves, if this is not something the child/ young person initiates themselves.

Structured assessment tools

Even if you often know part of the child's traumatic history at the start of the crisis support, there may be other potentially traumatising events in the child's history which have not yet come to light. It is therefore important to ask about various types of events in a structured way. Interviewing the child and the parents on the bas is of the questions in the forms will give you a more nuanced picture and reduce the risk of misunderstandings.

The forms primarily contain more general questions and sometimes you may need to ask more specific questions. This is particularly the case if the child has told you something but does not how they should continue. About sexual abuse, specific questions might be, for example, whether the child was threatened, told to send pictures or videos or otherwise harmed online, or whether the child was abused by being paid for performing sexual acts. For children or young people who find it hard to generalise or children who do not speak or give developed answers, you may need to ask even more specific questions. The child may believe that sexual abuse necessarily involves threats and violence, and therefore not think that they have been abused. Questions that you could ask are, for example, whether anyone has shown them porn,

touched their vulva/vagina/penis/bottom/breast/other private body part, masturbated in front of them, told them to touch their penis/vulva/vagina/bottom/other private body part, or taken pictures of their body naked. It is also sometimes useful to give further examples of psychological and physical violence in addition to those shown on the forms. Seek out national language forms in relation to traumatic events, symptoms of trauma and forms with more specific questions on dissociative symptoms. Examples from Sweden which may be available to translate into your language can be found on the Barnafrid knowledge portal. Barnafrid is a Swedish national centre charged with gathering and disseminating knowledge about child abuse and violence against children.

CATS – Child and Adolescent Trauma Screen

CATS is a self-assessment questionnaire which aims to measure experiences of potentially traumatising events and symptoms of PTSD for children aged 7 to 17 years old. There is also a questionnaire for legal guardians. A total number of points of 20 or higher indicates clinical difficulties.

Assessment forms 'Traumatic events' and 'Traumatic events (short version)

The form Traumatic events for young people is intended to go through events that can be experienced as frightening or traumatic. Traumatic events for young people is a refinement of the form Linköping Youth Life Event Scale (LYLES) and intended for use in clinical settings for young

people aged ca. 12-19 years old. The form contains 23 main questions with follow-up questions. They were developed in line with the standards for child questionnaires in Sweden. Check that these align with your own national or organisational standards.

The form Traumatic events for parents: your child's experiences of difficult events corresponds to Traumatic Events for Young People but is meant for parents. The form Traumatic events (short version) has six questions on common potentially traumatising events. It is intended to be used a quick screening tool or for children aged around six and above.

Assessment form 'trauma symptoms' (3 versions)

The aim of this form is to measure symptoms with regard to re-experiencing, avoidance, bad thoughts and emotional reactions, high tension, and dissociative symptoms. There are self-assessment versions with 26 or 12 statements, as well as an assessment form for parents to fill in with 26 questions. The assessment form for parents of children aged 0 to 6 years old includes 21 statements. The person filling out the form comments on how often the symptoms described have occurred in the last month, from not occurring at all to occurring often. The assessment form for parents can also be used with short-term foster carers. The assess -ment forms for children were developed to be in line with Swedish standards. Check that these align with your own national or organisational standards. The assessment forms for parents were not developed to adhere to any set of standards.

Trauma Symptom Checklist for Young Children (TSCYC)

As the forms described above are not designed for younger children, it may be necessary to use the TSCYC to assess very young children. For young children who have difficulty filling in forms on their experiences of traumatic events, and where legal guardians are not always aware of every -thing the child has experienced, it is easier to report trauma-related symptoms than events (Almqvist, Norlén & Tingberg, 2019). The TSCYC is a questionnaire used to measure post-traumatic symptoms in children who have experienced traumatic events. The questions are answered by parents or guardians of children aged 3 to 11 years old and you need to be a certified psychologist to use the form (Briere, 2012).

Information from parents and school or preschool

To get as full a picture as possible of how the child is getting on and of any symptoms, it is a good idea to gather information from several sources. Children and young people usually behave differently in different contexts and everyone involved in the child's daily life have important pieces of information that make up the whole picture. The starting point for the assessment is usually what the parents or, in the case of children living in care, social services can tell us about the child's wellbeing. It is also important to pay attention if parents have any particular concerns about the child.

You may need to obtain information from school or preschool about how the child is getting on in their daily environment outside the home and how their performance level and mood has changed over time. Important questions to answer are whether the child is affected by recent changes in their daily life or if there are longer-standing issues and symptoms, as well as whether symptoms can be considered to be a consequence of traumatic events or whether there may be other difficulties and conditions that need to be looked at more closely.

Observations in the treatment room

Observations you make as practitioner during the session may provide information on the child's wellbeing and their level of functioning, and give clues as to how to adapt the situation to create a secure environment (Almqvist, Norlén & Tingberg, 2019). How does the child feel about talking about what happened? Does the child like to work with exercises and information from the workbook or do they need frequent breaks with more play built in? Here, levels of activity and concentration can play a role, but so too can how difficult the child finds it to think about and talk about what they have been through. Does the child react negatively to talking about it, or is the child very evasive and show you they do not want to talk at all? How does the child's behaviour and emotion expression change depending on the activity? Is there a significant difference in how the child is when you are talking about the frightening events compared to when the conversation concerns more neutral subjects or when it is time to play? Does the child react strongly to outside noise or do they seem worried in general? There may be other more general observations about social interaction with a new adult, or the child's mood.

Interaction with parents can also be observed in the room. This is often more obvious in younger children, but it is important in respect of older children too. Can the child turn to the parents for support when things get tough? Are the child and parents able to have fun together? Are the parents angry or blaming the child? Is the child prepared to be alone in the room with the practitioner or does the parent need to be present to make them feel safe? Any difficulties observed in the interaction can be discussed with the parent to explore if any support is needed in this respect

Differential diagnosis

It is common to have co-existing conditions alongside trauma-related conditions, which makes it all the more important to undertake a broad assessment. Depending on how the child or young person came to receive crisis support, other psychiatric symptoms may have been explored to a greater or lesser extent. Where there are many other psychiatric symptoms, trauma-related symptoms may have been overlooked, and conversely, if there are other psychiatric disorders, trauma-focused treatment

may be less effective. It is therefore vital to identify comorbidities in every case to be able to plan treatment and adapt to the child's needs.

Conditions that may be important to consider as differential diagnoses include developmental disorders, behavioural disorders, risk-taking and self-harming behaviours, and difficulties regulating emotions. Developmental disorders include intellectual impairment, ADHD and autistic spectrum disorder. Examples of behavioural disorders which are important to identify are acting out behaviour, impulse control disorder, conduct disorder and problematic sexualised behaviour. Significant difficulties in regulating emotions are observed, for example, in cases of emotional instability, depression, bipolar disorder or anxiety-related conditions such as social anxiety, obsessive compulsive disorder or eating disorders (Gillberg, Fernell & Råstam, 2015).

Assessment for trauma in young children

Assessing the history of trauma and trauma-related symptoms of young children has already been discussed, but generally it is good for young children to be able to express themselves in different ways, for example through play, drawing or using visual aids to help answer questions. Depending on the child's speech and language skills, games or drawings can be used to varying degrees as a basis for discussion and pose further questions. Children can usually differentiate between a made-up game and something that actually happened (Almqvist, Norlén & Tingberg, 2019). It is a good idea to have games that make it easy for the child to portray what they have gone through, for example police cars, ambulances, dolls or animal figures (Lieberman, Ghosh Ippen & Van Horn, 2015). Young children who are traumatised may also exhibit repetitive play that does not seem enjoyable (Almqvist, Norlén & Tingberg, 2019).

In terms of young children who cannot talk, making a definitive diagnosis can be more difficult. Sometimes those children exhibit emotion regulation difficulties, which can present with inconsolable crying, motor impairments, outbreaks of anger and behaviour such as hitting their head against the wall. They may also have difficulties eating, sleeping and going to the toilet. All of these behaviours or difficulties are common among young children for periods of time, but among traumatised children they

can be more persistent, difficult to control and tend to return in stressful situations. Developmental regression, for example, urinary incontinence in a child who was previously dry, or developmental delay, are also symptoms which young children typically exhibit and which can be difficult to detect through trauma-specific forms. Difficulties are especially important to identify, as they can lead to stress for parents, which in turn can contribute to the child being treated in a way that perpetuates the difficulties (Lieberman, Ghosh Ippen & Van Horn 2015).

Communicating the assessment

The practitioner and the child summarise the trauma assessment together. You summarise both the events and the symptoms and decide how they are going to be presented to the parent. It is important that the child can influence what is going to be communicated and how, but it is also important to get across the information the adults around the child need to know to be able to best meet the child's needs. It is usually possible to find a way to share the assessment that the child feels good about. Although a summary of the assessment is presented towards the end of the crisis support, it is important to continually share, throughout the process, information and assessments you feel should be highlighted, in order to promote communication.

It is beneficial to also inform social services about the assessment after the crisis support has ended. Depending on the child's age and maturity, they may wish to be involved in deciding what will be communicated to social services.

Assessment of the caregiver's traumatisation

When parents come to crisis support or therapy, they are determined their child is going to receive help. It is not uncommon, however, for the child's experiences and trauma symptoms to evoke the parent's own memories and symptoms. Thus, it often becomes important to map out the caregiver's history of traumatic exposure too, in order to be able to support them to manage their own symptoms so that they, in turn, can better support their child (Lieberman, Ghosh Ippen & Van Horn, 2015). At times it may be necessary to help a parent to seek treatment for themselves.

During discussions with caregivers, it is also important to show that it possible to speak freely about experiences of trauma, and, where necessary, carry out a structured screening of trauma symptoms. Forms which can be used for this include, for example, PCL-5 (Posttraumatic Stress Disorder Checklist, version 5), which is a self assessment form with 20 questions based on the DSM-5 diagnostic criteria for PTSD (American Psychiatric Association, 2013).

Working with caregivers during crisis support

Parents and caregivers have an important part to play in crisis support, as they have such a crucial role in the young person's life. Adults who are close to the child who can give emotional support, who can help the child to manage their feelings, reactions and difficulties in life, and who can ensure the child's fundamental needs are being met, provide important protection against the child developing, for example, PTSD. Functioning and secure relationships with one or a few significant adults make a huge difference to children and young people's ability to get through difficult events and crises.

During the crisis support work, parents often come to more sessions than the child. Although crisis support is also aimed at parents in crisis, it is done with the child in mind. A fundamental difference is that in the conversations with parents, time and attention is dedicated to the parent's experiences, health and current circum-stances. Those questions are asked because the parent is the most important person in the child's life, so it is vital that they too are as well as possible. Helping the parent to be the parent they want to be is a core objective. This is described with the help of the Oxygen metaphor in the Workbook for adults.

Parents in crisis support work

External stability often becomes an initial focus of parental sessions, either during the first individual consultation with parents or at the initial meeting which is also attended by social services. Protection against violence, basic security, school/preschool, the parent's

own needs, stress factors in the child's and parent's life and ongoing social service interventions such as family therapy, are all examples of key issues which are examined as soon as possible. At the same time, information about crisis support, what to expect and why, is provided, and future meetings are scheduled.

It is important to check how the parent themselves is feeling as soon as possible. Is what the child has been through a traumatic experience for the parent as well? Is the parent themselves a victim? What past experiences does the parent have? It is not a health check, but rather aims to find how the parents are doing after everything that has happened, and find out what is affecting them.

The parent's unique knowledge about the child is important in crisis support work, and their concerns are usually important observations from which to start. But sometimes parents' concerns can become unmanageable. This can manifest itself in frequent questions to the child about what happened or a preoccupation with what may have happened that the child has not disclosed. Parents can also be overly interpretive. The child's behaviour, games or words are then subject to interpretation in a way that seriously damages the parent-child relationship. Such a situation needs to be addressed quickly in a separate parental consultation, in which parents can be offered support to manage their concerns in a different way and be provided with psychoeducation, information and alternative strategies for helping the child.

If a parent has doubts about or does not believe the child's account, it is very difficult to carry out the crisis support with that parent, as the child needs to be believed and validated in order to be able to recover. To avoid mistrust arising unexpectedly, the parent's stance must be clearly established before the child comes for their first session. Usually their opinion becomes clear when the parent describes what happened to the child. It is important to point out that it will be very difficult for the child to talk about their experiences and emotions if the parent does not believe the child, and that, for the child's recovery, it is important they feel supported and validated by their parent. The experience of being believed is also a protective factor for the future, as the child knows that they will be taken seriously if they tell someone about frightening or difficult events and experiences. When a parent does not believe their child's account, there may be grounds to consult social services and potentially report this concern.

In certain situations, the parent's uncertainty about the child's

account may be justified, for example, if the child's information is very vague or the parent has a different view of the same sequence of events, as they themselves were present. As a practitioner, you cannot know what happened. In those situations it is important to talk to the parent about what support the child needs based on the child's experience of the event.

The content of the crisis support is then largely the same as for the child: psychoeducation, communication, coping strategies and exercises. The chapter Components of crisis support describes how this can be done in more detail. The assessment of trauma symptoms is an ongoing process based on forms and parental observations. The work with the parent often requires to be adapted to the work with the child. What does the child bring up? What seems to be most important to focus on? What does the parent think about that? If, for example, sleep problems, aggressive outbursts or problems at school are having a significant negative effect on the child, this needs to be prioritised. Other issues necessitating more direct action are a high risk of suicide, self-harm or serious depression.

Psychoeducation is part of the crisis support work with the parent all the way through (see section "Psychoeducation for caregivers" in the chapter Components of crisis support). Increased knowledge of trauma symptoms gives parents the foundations for understanding their child better. Behaviours or reactions which can be challenging or worrying are easier to deal with if you know what lies behind them. It also makes it easier to talk about needs and adjustments that the parent needs to put in place, and to support the child's communication in relation to what happened and negative feelings and thoughts.

Communication between the child and parent is encouraged at every crisis support meeting. The easiest way to do this is to conclude the session by you, the parent and the child jointly reviewing what the child has done and what has been discussed. The practitioner will have prepared this with the child, for example, they will have decided what is going to be discussed and who will talk when the parent is present. It is important to consider first how the parent may react to what the child is disclosing. Some parents fear that their reactions will harm the child. Feelings of guilt, anger or tears can be difficult to deal with. Parents who are worried about crying in front of their child can find it helpful to normalise this and to have a plan for such situations, such as to sit until it passes, tell the child why you are sad and that tears are not dangerous. The practitioner may describe what happened to

help both the child and the parent. Anger sometimes requires a degree of caution and more time may be needed to assess how to proceed. Situations which may remind the child of previous violence or abuse should be avoided. Another important aspect of supporting communication is demonstrating how parents can be active listeners and how they can validate their child's feelings and experiences (see section "Dealing with difficult thoughts" in the chapter Components of crisis support). Validating the child means communicating to them that their feelings and experiences are valid. The basis of validation is active listening and showing understanding through words and actions. This can be discussed and practiced during the individual consultation with the parent before then trying it out during the joint concluding discussion with both the child and the parent, or as homework.

Use of play and games during the joint concluding discussions with children is discussed in several chapters of this handbook, as it is useful for several reasons. It can help both parents and children to defuse things that feel difficult or too challenging.

When working on exercises and coping strategies for the child, the parent is always involved. The child practices with the practitioner and then shows their parent how it works. Children and parents are often asked to practice at home together. It is important to clarify when, for example, a breathing exercise should be done and why. Follow-up takes place at the next session when the parent also has the opportunity to talk about it when the child is not in the room. If the exercise has been difficult to do at home, it may also be difficult to talk about it with the child present.

The exercises introduced during the crisis support can all be done with a parent. The parent is either directly involved, as in the case of massage, or performing the exercise themselves beside the child. Parents are expected to have an encouraging and supportive role, and also to take the initiative to use the strategies and exercises as and when they are required, for example, reading the child's signals and, if one is needed, initiating a calming activity or exercise. The parent is also the one who should make sure routines involving exercises are maintained at home, such as doing a relaxation exercise before going to bed. In addition to exercises and strategies that are directly related to trauma symptoms, playing together and positive interaction on the child's terms are also encouraged. Some -times parents can forget that it is important to have fun together.

Throughout the crisis support, it is essential to pay attention to the

parent's own situation, health and reactions. Parents of children and young people in crisis are often in crisis themselves. It is also not unusual for the situation to lead to significant life changes and increased stress as a result. This might involve a parent's own trauma symptoms, own psychological or physical ill health, economic and social stress or vulnerability. If a court process is underway, a witness hearing, trial or being notified of the judgment can lead to renewed crisis or heightened stress for both parents and children. If the practitioner has initially managed to convey to the parents an understanding that factors which negatively affect parents can also negatively impact the child, they have a good basis on which to discuss this again as and when needed.

A large proportion of children who are exposed to violence or sexual abuse in the home live in precarious social and economic conditions. It is not uncommon for them to have had prior contact with social services and the police. These are experiences parents carry with them in this current crisis and which influence their ability to cope with it. Hopelessness, mistrust and a feeling of being judged the whole time all have an effect on parents, and practitioners need to demonstrate an understanding of this.

Parents with difficulties of their own

Parents who have difficulties of their own, either due to what has happened to the child or as a result of their own vulnerability or otherwise mental ill health, often require there to be adjustments to the crisis support work. This is to ensure that the parents, and thus the children, perceive the crisis support work as manageable and achievable. The parent should be a resource and not a patient, but sometimes the parent's own difficulties and concerns mean that sensitive aspects of parenting need to be addressed. It is important for the practitioner and parents to agree that that is in the best interests of the child. If the parent describes their own ill health as having a negative effect on their parenting, the practitioner can encourage the parent to seek help for themselves. Practitioners may also make contact with social services, and attend meetings with social services or others whenever necessary. Relatives or other important people in their network can be invited to provide support. If there is ongoing contact with social services or an intervention such as family therapy is underway, it may be appropriate to organise joint meetings, both to help the parent to express their needs and to avoid duplication which can lead to confusion. It may

be that some interventions need to wait until others are finished, so as not to burden the family with too many meetings per week.

In direct crisis support work, the structure of the work ahead should be set out clearly, both for the crisis support work as a whole and for the individual sessions. Preparation, predictability, transparency and follow-up are key words which become especially important at meetings with parents who have their own difficulties. Delicate moments such as during the joint conclusion of a session may need to be planned in detail. What are we going to do? What is the parent expected to do? How long will it take? Sometimes focussing on creating a positive moment together is a sufficient goal for the joint conclusion of a session with the parent and child.

Individual sessions with the parents alone are often required for adaptations have the intended effect. We need to give parents the space they need to calmly talk about any stress, challenges and difficulties they are experiencing.

Working with short-term foster homes during crisis support

Children who are exposed to violence or sexual abuse in the home are sometimes placed in short-term foster care, either on an emergency basis or as a planned placement. The circumstances around the crisis support will be different and working with foster parents is different from working with biological parents. The child and the caregiver are new to each other. The child arrives at the short-term foster home with negative experiences - which have led to their placement in foster care - and oftentimes the short-term foster parents will only have limited information about what the child has been through. In addition, the child has usually been uprooted from their normal daily life, school, activities, friends and family. This is challenging for both the child and the foster parents. In the book Trauma-informed care by Howard Bath and John Seita (2019), which is summarised in the workbook for adults, the authors describe how caregivers can help children who have experienced potentially traumatising events. The most important components are:

Creating safety physically, emotionally, relationally, and culturally.

Helping the child to develop positive relationships with caregivers so that the child feels part of an understandable context.

Helping the child to develop coping strategies to deal with internal and external stress.

It is important for the short-term foster home to get to know the child and to communicate with the child about their experiences, feelings and thoughts, and for the foster carer to have a positive and secure relationship with the child, which promotes their development. The short-term foster carer also needs to be involved in the work on coping strategies in crisis support, just like biological parents.

When crisis support is initiated for children living in short-term foster care, it is often social services that set it up. By then, social services should have investigated the legal guardian's view of the crisis support intervention. Has the legal guardian has given their consent and if not, how are social services planning to deal with that? If the legal guardian says no, it is possible for the local authority to decide that the child is to be offered treatment against the legal guardian's will, if that treatment is deemed to be necessary.

At the initial meeting with the short-term foster parents and social services, it is important to clarify what information the short-term foster carers have about the child's background, what they have been through and any particular difficulties and needs. It also helps to know what support the short-term foster carers are receiving, for example, whether they have a mentor or supervisor. Is the division of responsibilities between social services the short-term foster carers clear as regards school and healthcare? How is the communication between social services and the short-term foster carers? It is sometimes difficult for social services to say how long the child will be living with the foster carers and what will happen afterwards. Nevertheless, the question needs to be asked, as talking about the future is an important aspect of crisis support work.

Another important question is whether there is ongoing contact with parents and, if so, how that is arranged. The contact needs to be discussed with social services, and sometimes with the short-term foster carers as well, on the basis of the child's specific needs and wellbeing. Short-term foster carers often have an important part to play in the actual contact and, because of their relationship with the child, can see how the child is affected when they spend time with their parent. Social services and parents plan contact together. In some cases, social services may decided to restrict

contact. Sometimes it may be necessary to suspend contact with a parent who is suspected of abusing the child for the duration of the crisis support to allow for proper intervention and assessment. In addition to the negative impact that contact could have on crisis support efforts, it can be difficult to distinguish between the consequences of previous frightening events and reactions to stress caused by contact. Social services usually take into consideration the child psychiatric assessment regarding the child's wellbeing and stress with respect to contact with parents. Sometimes during the crisis support it comes to light, either through the child's description of it or the foster carer's observations, that the contact is causing the child a lot of stress. Continuous collaboration with social services is, therefore, important for knowing how best to support the child, and it helps a lot if the short-term foster carers and social services communicate well with each other. How the child reacts to contact is important information for social services, which must assess if interventions are needed for the parent to have effective contact with the child. If the child is in care, it is important to help them to have contact with important people in their life, like family, siblings, relatives and friends. In this regard, short-term foster carers play an important role as a representative voice for children in their care.

Before the crisis support work begins, it is important to clarify right away what expectations the short-term foster carers have, how they see their own role in the crisis support work and what, on a practical level, could impact on their ability to actively participate in crisis support (for example, long distances to travel, or other children in their care with their own treatment sessions or special needs). At the initial meeting, clear information is provided on what crisis support is, why it is to take place and how, in order that the short-term foster carers can then prepare the child for it. The foster carers will also have the opportunity to directly share any concerns they have or anything they are finding difficult to understand or manage. During crisis support, the sessions with foster carers are, in principle, the same as those with parents. A crucial difference is that the foster parent is not in a crisis of their own. On the other hand, it is important that the practitioner take into account the fact the child and foster carer are new to each other, perhaps only having lived together for a few weeks or months. For obvious reasons, it is difficult for short-term foster parents to answer questionnaires with certainty or provide detailed observations. With younger children or children who demonstrate their needs, feelings and reactions clearly through their behaviour and reactions, establishing a fruitful working relationship with the foster parent is usually quick and easy. It is more challenging

when children retreat to their rooms, are unwilling or unable to communicate with the foster carer, or say that everything is fine. Psychoeducation, patience and continued cooperation with foster carers will hopefully lead to more open communication - or to the conclusion that the child is in fact doing quite well.

Sometimes the foster carers are a somewhat too passive or prefer to wait and see, and that they do not find a way to actively work on their relationship with the child. In that case, the practitioner needs to discuss this with the foster parent and find a way together to initiate conversation and contact, and a way to build a safe relationship with the child. Practitioners must be clear that, regardless of how long the child will live in the short-term foster home, the relationship with the foster parents is of the utmost importance, and a key factor in the child's continued development. For some foster parents, it can be difficult to manage children's need for closeness while knowing that they are only going to live with them for a limited amount of time. It can be hard to be a significant person for the child. If it appears that this is the case, this needs to be addressed, and sometimes the foster carer may be advised to talk about this with their mentor or in their own supervision.

Short-term foster parents are expected to support children in important and potentially sensitive processes and situations, for example contact with parents, as described above. In those situations, the child's need for supportive and significant relationships increases. Hopefully, the foster carer can help the child to express their needs and wishes, and ensure that those then reach the right recipient, for example, social services. Not all short-term foster carers understand this role, and not all are comfortable with taking on this responsibility. Supporting foster carers with this is, therefore, an important part of crisis support work. Children and young people receive help during crisis support to articulate their stresses, needs and wishes, and foster carers are informed of what they say those are. At the end of the crisis support, the practitioner and the young person write down questions together which the young person wants adults to answer, and thoughts about what could help the young person to feel good and thrive in their daily life. It might be that they would like to bring things that are important to them to the short-term foster home, such as games, particular clothes or toys. It might be that they want to continue their clubs or activities, or meet their friends, siblings or relatives. Children and young people may have questions about when they will be able to see their parents, how long they are going to live at the short-term foster home, how their parents and siblings are,

what is happening with the police and whether a parent will end up going to prison. These are important questions which the short-term foster carer needs to help with, either by answering them themselves or by asking the right authority to do so.

A child is placed in a short-term foster home to protect them, stabilise their world and bring about positive changes in the child's life. Sometimes it does not go as expected. If the child needs to move (to a new short-term foster home, a longer-term foster home or home to a parent), it needs to be considered whether it would be better to start the crisis support with the caregivers the child is going to be living with. It is a good idea to involve social services in this assessment. Sometimes a move cannot be anticipated, which can lead to the crisis support taking place with different adults. It can be difficult to make an assessment for trauma when there is a change in caregivers, as this often a crisis in itself and evokes strong reactions. Sometimes crisis support then needs to be extended in time to allow them to feel secure in their new home. It is important to convey to the new foster carers what is known from the crisis support thus far about the child's wellbeing and reactions, so they can understand and respond to the child in a positive way. When a child changes short-term foster home, it is recommended to hold a meeting with the foster home and social services to talk about the child's needs and to plan the support the foster carers will need.

Components of crisis support

This chapter sets out the components that are usually included in the crisis support, as well as which parts of the workbooks for children, young people and adults can be used for the respective components. The sequence can vary depending on the individual child's needs, but the workflow set out below is usually a good starting point. The words in italics refer to specific worksheets or exercises in the workbooks.

Mapping and creating context

After violence or abuse have come to light, there are often many changes in the child's life. Contact with a parent may cease and the child may move to a short-term foster home or safe house. Life can feel chaotic and the future uncertain. An important task for crisis support practitioners is to help the child to create context and understand more about their situation. Knowing some of the child's life history, past and current stressors, relationships with family and friends and their school life are of great help in the assessment.

One way of quickly building a picture of important relationships is to make a network map early on in the sessions (Network map in the young persons book and Important people in my life in the workbook for children). The child can fill in the names of important people they have around them. Sometimes it starts a conversation about emotional support and who knows about what they have experienced, and sometimes it is enough just to have made the map which you can then go back to during subsequent discussions. If the child is having trouble thinking of people to put on the network map, this may be important information to communicate to social services, as interventions may be needed to widen the child's network of contacts. It is important that it is the child who decides who is to be included in the network map and who is not. It is common for a parent who subjected them to violence or abuse to be left out altogether, for example.

Another way of mapping out the child's life and past experiences is to make a life timeline (My life timeline in the workbooks for children and young people). The child is usually asked to fill in important events or periods in their life, both things that were good and things that were bad or scary, as well as their approximate age when the events took place. Examples include the places they have lived, the births of siblings, their parents' separation, when they made a friend, the first time they suffered violence, and when they told someone about what happened. It usually helps to begin with when the child was born - where did they live at that time and with whom? What do they know about that time? An alternative is to begin with their current situation and then work backwards. Here too, the child takes the lead. As practitioner, you can help with the information you have, but it is the child who is the expert in their life and how they have experienced what has happened in it. If key events the practitioner knows about are left out, for example frightening events, this may be a sign of avoidance which should

be explored further. For some children, working on a life timeline together with their parent is a good way to create a shared account of the child's life.

Even when the crisis support is coming to an end, it generally helps to assist the child create context and understanding of their situation. For children who have experienced major changes in their life following disclosure of violence or abuse, such as contact with family members completely stopping or having to move to a short-term foster home, the page When life changes in the workbooks may be helpful to capture the child's thoughts about these changes. The child is given the opportunity to reflect on what has changed since disclosure, both what has felt good and felt hard. When the list is complete, different colours can be used to mark which changes feels like an improvement and which feel hard. The worksheets My important list in the workbook for children and My questions for persons of authority in the young person's book are intended to be used as preparation for the final meeting with parents and social services. Here the child is given the opportunity to write down things which are important to them to feel good, both big and small. Sometimes information is disclosed that needs to be passed on to social services, for example that they would like more or less contact with relatives. Talk to the child about who should see the list and who can help with the different things on it.

The worksheet Time to sum up is used for the final session with the child. The aim is to sum up the crisis support sessions, but also the feelings and thoughts which they had before, their wishes for the future and strategies for coping with potential future problems.

Useful resources in the workbooks for children and young people

- Important people in my life/ Network map
- My life timeline
- When life changes
- My important list
- Questions for persons of authority
- Time to sum up

Improved communication between children and parents

An important aim of the crisis support is support is to help children and parents to communicate with each other, both about how the child is feeling and about what happened. Parents who themselves are in crisis after their child has suffered violence or abuse risk falling into two traps: either talking too much about what happened and worrying excessively about the child's wellbeing, or not talking at all to protect the child or themselves from painful thoughts and feelings. Children who have suffered abuse are often anxious not to burden others or to make a parent sad and upset, and therefore may avoid talking about what happened and how they are feeling. At worst, the family as a whole avoids talking about the child's experiences and wellbeing, which risks increasing the child's feelings of guilt and shame. Children's recovery from difficult events depends on the child's caregivers being able to see and respond to how they are feeling, and it being possible to talk about what happened as a family. Work on improving parent-child communication is conducted both individually with the parent and when they come together with the child at the end of the crisis support session.

Talking to your child about how they are feeling

There are different ways of increasing communication between children and a safe adult during crisis support. The joint concluding part of the crisis support sessions should be used to work on this aspect, in a thoughtful way, based on the individual family's needs. One way which has already been mentioned is for the child to show the parent what they have been working on in the workbook, and talking about this together so the parent has the opportunity to ask questions. This needs to be prepared with the child individually so as to agree in advance what is going to be shared. There are of course exceptions, such as when the child discloses serious and worrying things such as suicidal thoughts, self-harming behaviour, new abuse or suchlike. Another way to talk about how the child is feeling is, after trauma screening has been done with the child and the parent, to compare their respective answers to see what they assessed as the same and as different, and to talk about how the child can communicate with the adult when they are finding things tough.

A further way of increasing communication is joint exercises with a focus on psychoeducation on trauma symptoms, for example, the quiz game "What do you know?", or about emotions, for example, by playing charades with different emotions. Other types of interaction exercises or games can also be introduced. For some children, it is good to just do something fun with their parent at the end of the session, so they end on a positive note and get help to deal with their emotions.

Joint homework between the sessions can also focus on interaction and communication, for example, the family is given the task of talking every day about something that has happened that day and what feelings they have had.

Talking to your child about what happened

When something scary or bad has happened, it can be hard as a parent to know how to talk about it with you child. Which words should you use? How much should you say? How will the child react? Here the practitioner may need to support the parent to communicate about what happened, to avoid confusion and misunderstandings, and so that the child is not left alone with difficult questions. Good communication also involves protecting the child, as this increases the chances that the child will tell you about other difficult things now or in the future. As a practitioner, by talking in straight-forward and precise way yourself, you can demonstrate to the child and their parent how to talk about what happened. It is easy to become unclear and vague when talking about difficult things, for example, saying "trouble" instead of saying "mum screamed and pulled your hair". But by expressing yourself clearly and precisely, you make a distinction between what is okay (arguing) and not okay (intimidating or hurting someone). As a practitioner, you can help children and parents to use the same words as each other to describe what happened, for example, "violence", "being hit", or "sexual abuse". It is usually important to the child that their parent conveys to them that they believe them, even if the parent is uncertain about what exactly happened, and the parent in interested in the child's experience, thoughts and feelings about it. The aim is not for the family to be constantly preoccupied by bad experiences, but that what happened can be spoken about as a part of the child and family's history. It is beneficial if the parents can find a way of being sensitive to the child's need to talk or not talk about what happened, without reinforcing avoidance.

The child and parent's conversations about what the child experienced also depend on what stage the legal process is at. While an investigation is ongoing, the caregiver must think about how to ask a child about what happened in a way that does not risk influencing the child's account and thereby reduce the child's chances of a fair trial. Children are not helped by being "interrogated" by their parents about exactly what happened, but at the same time they must be able to talk about what happened, which can be a difficult balance. Often parents will not have received very much information about what the child has said in a police interview, which can make it difficult to talk to each other openly about what happened. It is always good and helpful to listen to your child when they are telling you something, to show them that they can tell you anything they want, and to talk to them and ask how they are doing and feeling.

Psychoeducation

Psychoeducation for children and young people on common trauma symptoms

Getting help to understand more about common reactions after potentially traumatising events is a core part of crisis support for all young people and their parents. This normalises the reactions and makes it easier for the child or young person to understand and validate themselves. It is usually helpful for practitioners to refer to having met lots of children who have gone through similar things, since it is normal to feel different or that you are the only one who has been exposed to violence or abuse. Use the child's own words for what they have experienced. If the child does not have words for it or uses words which diminish what happened, it can be important to give them the correct words, for example, sexual abuse, violence or being hit.

For younger children, especially where there is information about sexual abuse, it is advisable to talk about private body parts and body rules (see worksheet in the Workbook for children) at an early stage of the crisis support, before further psychoeducation is provided. This provides a more concrete explanation of what sexual abuse is, that is to say, that someone has broken the body rules, and helps the child to understand what type of touching is okay and not okay. This also gives you shared words for the body's private areas, which reduces the risk of misunderstanding. Ask the

child to tell you which words they use for the body's private areas; help them by pointing to pictures. The word private can be difficult to understand for younger children, but is usually explained as the parts of the body that you have complete control over. If the child does not have words for private body parts, it is important to give examples of common words, for example, breast, vulva, vagina, penis and bottom. Some children want to add body parts they think are private or sensitive, for example, hair or tummy.

The worksheet on private body parts and body rules can also be used as a way to map the child's exposure to violence or sexual abuse, especially for children who find it difficult to express themselves or to talk about it. The practitioner can ask the child if they have experienced someone breaking the body rules, and if they answer in the positive, ask the child to mark where on the body with a pen.

In the workbooks for children and young people, there are also sections about good and bad secrets. This is an important subject to bring up. Often it has taken time for the child to dare to tell someone what happened, and living with secrets is exhausting and lonely.

In the workbooks for children and young people, there is information about Common reactions after difficult events, Examples of common trauma symptoms and The brain's alarm system. For children who have difficulties communicating and answering questionnaires, the section Examples of common trauma symptomscan also be used as part of the assessment by asking the child to point to reactions they themselves experience. This psychoeducation is always provided orally during sessions, but some children and parents are helped by also receiving the text to take home and read in peace and quiet.

Useful resources in the workbooks for children and young people

- Common reactions after difficult events /Common reactions
- Examples of common trauma symptoms
- The brain's alarm system
- Private body parts (Workbook for children)

- Body rules (Workbook for children)
- Good and bad secrets/Secrets
- Sexual abuse
- Violence
- Online harms

Psychoeducation for caregivers

Psychoeducation for parents is also about creating an understanding of common reactions after frightening events, both generally and specifically for their own child. Parents usually find it helpful to understand more about how the brain is affected by stress, for example, using the behaviour patterns below.

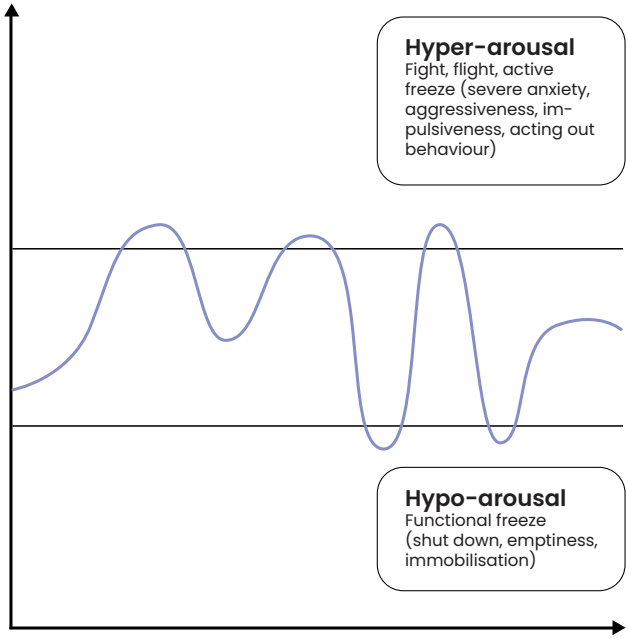
Fight, flight and freeze

When we are exposed to a very frightening or stressful event, the body reacts quickly and instinctively. Reactions come automatically and are not something we can control. The brain deals with the perceived threat based on survival mechanisms in the autonomic nervous system. We usually talk about three such responses: fight, flight and freeze.

- **Fight** means we try to protect ourselves physically by resisting or fighting back.
- **Flight** means we try to get away from the situation.
- **Freeze** means that the body stiffens up and we feel as though we are paralysed and incapacitated. This reaction is common in the case of sexual abuse and kicks in when a dangerous situation is perceived as overpowering.

Window of tolerance

The window of tolerance is a pedagogical model that shows how stress and strain affect how we function. When we are in our window of tolerance, we have the ability to cope with the perceived stress; we can get along with other people, we can focus and reflect on different experiences and emotions, and we have control over how we want to react. But when we are under too much stress, feel threatened or very anxious, we find it difficult to regulate our emotions and we find ourselves outside our window of tolerance. When we are outside our window of tolerance, we are not in touch with the more developed parts of the brain and therefore cannot reason, analyse a situation or think about the consequences. The child either reacts with anger, acting out behaviour or impulsivity, which is called hyper-arousal (over-activation), or they react with hypo-arousal (under-activation), as in depression, disengagement, withdrawal or dissociation. When children react in these ways, they need help to regulate their emotions to feel safe again and thereby return to their window of tolerance.



Dissociation can be regarded as the inability to integrate the experience or one or more traumatic events with other memories. It can lead to feeling disconnected from reality or oneself. You can have the feeling of being in a film or in a dream or being outside yourself or your own body. Dissociation can mean you have difficulty reconciling your internal experiences with your external ones, and you may feel confused, absent or disconnected. It is common to "disappear" from time to time and become difficult to get in touch with. Afterwards, the person may feel confused and have no idea of the time that has passed or of what happened or was said in the room during the period of dissociation (Boon, Steele & van der Hart, 2018).

When under increased stress caused by traumatic experiences, it takes less to push us out of the tolerance window - our tolerance window narrows. We develop a sensitivity for threats and often display reactions like fight, flight and freeze. Those reactions are appropriate and helpful in a dangerous situation, but unfortunately they can be problematic when the child is not in danger. Reminders of past trauma can cause dysregulation, a state of being so overwhelmed by strong emotions that you cannot cope with the situation or your reactions. It is common not to know yourself what has triggered your emotions, and for an adult who is close to the child, it can be hard to understand the child's strong reaction. During crisis support, it is therefore important to map things that remind the child of traumatic experiences, as this helps both the child and the people around them understand when the child is triggered.

Once the child is calm and in their window of tolerance, you can talk about what happened, so that you are better able to anticipate and avoid the child getting into these difficult situations again. It also gives the parent a better understanding of how they can help the child to calm down. When the child ends up outside their window of tolerance, they need help to get back in. By receiving support with this from significant adults, children gradually learn to self-regulate their emotions. When a young child cries, we comfort them so that they calm down after a while. In the same way, we help a child who is sad and hiding in their bed to come out and continue to play with their friends. What we are doing there is giving the child strategies for managing their emotions as an older child and later as an adult. When a child is in crisis, they need increased support to regulate their emotions and may act like a younger child in this respect. When working with parents, the window of tolerance tends to be a good model to use to talk about what helps the child in different situations. You can make a plan together based on

the child's age, write a crisis plan or prepare a crisis card with things they can do together which may of help. Different strategies may be needed for different situations or different degrees of dysregulation.

The model can also be used to talk about when parents become dysregulated and what parents can do to manage their emotions and come back into their window. Feel free to discuss basic vulnerabilities which can narrow the window: the fact we need to keep under review our sleep, food and stress, balance activity with rest, and make sure we have pleasurable things in our daily life. The model can also be used to talk about the parent's own health, health care, any medication they take and the fact alcohol/drugs can affect their own window of tolerance.

A child who has not had help to regulate their emotions may develop difficulties in managing their emotions and frustration. The experience of having strong emotions may have been so frightening and distressing that they develop a fear of emotions in general and may feel empty, disengaged or disassociated. Other strategies which become destructive in the long run include dealing with sadness and shame with anger and aggression, self-harm, seeking distraction by creating thrills or drama, or entering destructive relationships to numb feelings. It can be helpful to think about a child's destructive expression of their emotions as a way of trying to manage their emotions without access to more appropriate strategies. This may make it easier to validate the emotion behind the behaviour and eventually help the child to find other ways cope with difficult things.

Red and green lights

Another concept for describing the same thing is to liken the brain's two systems, the sympathetic nervous system and the parasympathetic nervous system, to traffic lights which are either red or green. This metaphor can be used with children, teenagers and parents to explain why we practice, for example, relaxation techniques and shifting focus. In simple terms, the brain can be said to have two systems, but only one system is activated at a time. The green system (the parasympathetic nervous system) is activated when we are relaxed. In this state, we have access to our abilities and resource, we can learn new things and get along well with others.

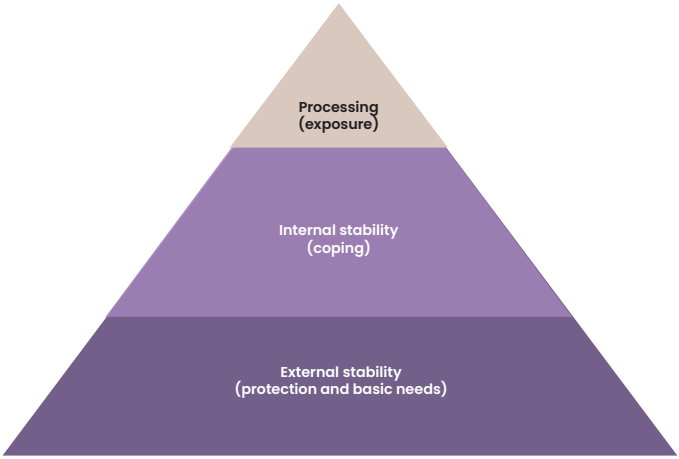
The red system (the sympathetic nervous system) is activated when we are preoccupied by danger, and our body is programmed to detect threats and prepared for danger. The body is tense. This is an important system which enables us to act quickly and protect ourselves. If we have been through frightening events or if over a long period we have had to be prepared for dangerous things to happen, it is natural that the brain activates the red system to a higher degree. We learn through our experiences, and dangerous experiences in particular are something the brain is designed to emphasise. However, it is not good for us to always, or very often, have the red system activated. When the body is in stand-by mode, we can experience pain in the stomach, head or other parts of the body. It can be more difficult to concentrate, learn new things, relax, wind down and sleep. It may also be harder to enjoy ourselves and have fun, as the body is focussing on threats. When the red system is activated, we are more likely to interpret others as angry or unpleasant, because our brain is sensitive to potential dangers.

This model can be used as a basis for teaching our body to increasingly go into the green system. This can be done through relaxation techniques and activities where we are focused on what we are doing in the moment, such as playing, socialising with others and physical exercise. For adults, it is a good model for explaining the purpose of regulating emotions.

The stability pyramid

This model illustrates the needs of a child who has been through frightening events. It can be used to talk to the adults around the child, for example, parents, social services and school, about their basic needs and how these needs must be adequately met for other interventions and measures to be effective.

At the bottom of the pyramid is what all children who have experienced potentially traumatising event need, that is, external stability. This could be, for example, that they know where they are going to live, where they are going cool and that they are protected from being hurt again. It is often referred to as warmth, rest and nourishment. In other words, children need to be loved and cared for, to sleep and be comfortable, and to be properly fed. A stressed nervous system needs calm and safety to be able to recover. External stability thus means having a safe and secure living environment.



The next level of the pyramid is internal stability, meaning reasonable stability on the inside. This is where a lot of the work that is done in crisis support comes in: internal stability means that the child and significant adults understand the reactions people can have after potentially traumatising events and emotions and reactions are normalised and validated. Communication between the child and important adults is of vital importance, as is the child being able draw on or learn strategies for dealing with reactions and problematic situations. Younger children cannot regulate their emotions themselves. They need help to do this from a safe adult. Older children and teenagers also need a lot of emotional support after frightening events.

For many children, receiving help with a secure and stable external living environment is enough. With social support and strategies, they can cope with stressful events. However, some children need continued trauma-focused therapy, which also includes work on processing. This is the top section of the pyramid.

The work with external stability primarily involves areas of responsibility which are within the remit of social services and the legal guardians, such as ensuring protection and a stable environment. Crisis support may partly relate to external stability, but mostly concerns working with internal stability together with the child and parent or caregiver. The top part of the pyramid, processing or exposure, normally takes place in the context of trauma-focused therapy for those children who are assessed to need it after the crisis support has ended.

Useful resources in the workbooks for adults

- Crisis support
- Violence against and abuse of children
- Reactions after violence and abuse
- Parents' own reactions
- What you can do as a parent
- Secrets
- Trauma-informed care

Psychoeducation on emotions

In the workbooks, you will find both psychoeducation on emotions and exercises for naming and talking about emotions. Going through traumatic events has a major impact on both our emotions - we may be more afraid, sad, angry or feel strong guilt and shame - and how we handle them. Internal and external avoidance is a way of not being reminded of or having to feel difficult emotions. Avoidance itself is a major component in the development of post-traumatic stress. Increasing communication about emotions and improving strategies to manage them is, therefore, an important part of dealing with difficult experiences. he first step is to talk about different emotions and why we have them, that they are essential to our survival, even if experiencing them can be hard. Understanding why we as human beings react with emotions can reduce our fear of them. Putting our feelings into words can in itself have a calming effect.

The time spent talking about emotions can be varied in different ways through games and exercises. You can play games about emotions, such as Emotion Charades or Finish My Sentence, where one person has to finish the other's sentence (for example, "the last time I was scared was …", "I am angry which I think about …", "when I am sad, I normally…"). Another method is to write down all the feelings that come into your head on a whiteboard together. Sometimes, a good starting point is to talk about where in the body different emotions are felt (see worksheet in the Workbook for children Emotions are felt in the body), and let the child colour them in.

Beginning to understand your emotions and then communicate them to important adults is central to the healing process. It provides the basis for the child to understand themself and validate their own feelings. The also helps others to understand the child better and know how to respond to and validate the child on the basis of the child's experiences.

Recognising that sometimes we have one feeling but display another is important in order to reduce misunderstandings. A child or young person who wants to be close, but is afraid of being rejected, may outwardly show anger or arrogance to try to protect themselves from being hurt. It is also common for a child with experience of trauma to react with anger. These children have an overactive alarm system and need to be reassured rather than responded to based on the anger they show. Some children want to please and avoid showing "troublesome" emotions for fear of being rejected. They may also have the experience of emotional expression being punished or ridiculed. If an adult is curious and tries to understand their child's experiences, this creates a good basis for talking about emotions in a positive way. As an adult, you can be a role model for how to talk about and deal with emotions, for example, by seeking comfort when you are sad, asking for help when you are scared, or taking a break when you are angry.

Useful resources in the workbooks for children and young people

- Different emotions/ Emotions
- Why do we have emotions? (Workbook for children)
- Emotions are felt in the body (Workbook for children)
- Emotions can be felt differently (Workbook for children)
- How are our emotions affected by thoughts and what we do? (Workbook for young people)
- Emotions behind other emotions
- My list of emotions

Useful resources in the workbooks for adults

- Emotions

Reducing crisis reactions

Once a clearer picture of the child's symptoms has been obtained through mapping and psychoeducation, it is time to identify the main concerns for the child and parents, in order to work on coping strategies. It may be, for example, difficulties sleeping and nightmares, anxiety and fears, depression or aggressive outbursts, which are causing the most disruption to their life. On that basis, you can select the exercises it will be the most important to work on during the sessions and as homework.

Sleep problems

It is very common for sleep to be affected in children who are in crisis. It may be due to a general increase in stress and problems winding down. Sometimes a person is so tense and stressed that is hard to relax. Bad thoughts and flashbacks also tend to increase when you are trying to relax and all around you it is quiet and calm. This can lead to fear and nervousness before going to bed. Where this is the case, is it important to work on sleep hygiene, for the large part together with caregivers. Children and young people who have been through difficult events need extra support and closeness at night, for example, by sleeping next to or in the same room as their parent or a safe adult for a period. During crisis support, sleep routines need to be mapped out in order to see which parts may need to change. Is it because of sleeping during the day or thinking about bad things when it is time to sleep or using screens late at night so you do not notice when you start to feel sleepy? After identifying the issues, you can use the section on sleep hygiene in the Workbook for adults and decide together which changes you want to try. The worksheet Sleep diary which is in the Workbook for adults is used both for mapping sleep and for monitoring how it is going with the work on different strategies.

If sleep does not improve despite working with sleep hygiene and creating good routines and strategies for relaxation and shifting focus, a doctor can be consulted to decide on the support of medication for a period of time.

Useful resources in the workbooks for children and young people

- Sleep (Workbook for young people)

Useful resources in the workbooks for adults

- Sleep
- Sleep diary entry

Nightmares

Nightmares are another cause of poor sleep, and are common among children who have experienced frightening events. It is not at all uncommon for children to report a higher occurrence of nightmares than their caregivers do, which can be an indication that the child is not seeking comfort and support when they need it. This is particularly common among children who are placed in a short-term foster home and live with adults they do not know very well. It can be difficult to know what you can and are allowed to ask for help with, and many vulnerable children are used to coping with difficult situations by themselves. In that case, there may be grounds to support children and adults with what to do when the child has nightmares, and ways to help the child settle down again. For example, is it possible to make the bedroom feel safer for the child with a night lamp, soft toy or something similar?

If the nightmares are causing the child significant distress, there is an intervention that is part of crisis support which can be implemented with the child and the parent. The work on nightmares in crisis support is inspired by Imagery Rehearsal Therapy (IRT), which has been shown to work well in research. The idea is to change the contents of the nightmare so that it goes from being really scary to a dream which is not as scary anymore. You begin by choosing a specific nightmare, for example one that is recurring. If they have several such nightmares, you can start with one which is less scary. First, the child tells you about the dream, and then you work together to change the content of the dream so that it is not scary anymore. It is important that the child feels that it will become a dream that the child wants to have. Either you can talk through the new dream orally or write it down. Then the child can practice it. The child should talk through the new dream with the help of an adult every day before bedtime. When the child is ready to deal with the next dream, do the same with that dream, until the nightmares no longer cause distress. There is a worksheet for this in the Workbook for young people.

Useful resources in the workbooks for children and young people

- Nightmares (Workbook for young people)

Useful resources in the workbooks for adults

- Sleep

Stress and relaxation

Most children who become eligible for crisis support live with a high degree of stress, both as a result of past frightening events and due to disclosure, child interrogation, investigation by social services, parents' stress and such like. This usually manifests itself in the form a stomach ache, headache or a constant feeling of being on edge.

Many children have not realised that their bodies are tense until they start practicing relaxation. Relaxation exercises can take different forms and should be selected for and adapted to the child you are supporting, their level of development and personality. It usually works well to start by doing the exercise together with the child in private, and thereafter to go through the exercise with the child and parent during the joint concluding part the session. The child can of course be the one to show and explain it to their caregiver. The parent is tasked with ensuring that they practice relaxation at home, preferably together. An exception is teenagers who may prefer to try new strategies themselves. In that case, the parent can play an important role in encouraging and reminding them to practice at home.

A good way to start is with exercises which focus on tensing and relaxing the muscles (Cooked spaghetti and Muscle relaxation in the Workbook for children). Another way to relax is through breathing exercises (Belly breathing in the Workbook for children, Breathing exercise and Focus on breathing in the Workbook for young people). For young children, child massage often helps. During the session, parents receive instructions for a simple and playful massage. The child's task is to feel what feels good, and to tell their parent if they want more or less of something. At the same time, it becomes an exercise in interaction and in recognising and setting boundaries around physical touch. It is important, however, to be

sensitive to the fact that if the child does not want or feel comfortable with that type of touch, then other exercises are preferable.

For some children, it is very difficult or even uncomfortable to relax. Sometimes you may need to try several different variations of relaxation exercises to find something that is right for that child. Sometimes it is more suitable to use regulation exercises which are more active but require focus and interaction. Examples of these can be found in the workbooks.

Useful resources in the workbooks for children and young people

- Relaxation
- Relaxation exercises (exercises and worksheets in the Workbook for young people)

Useful resources in the workbooks for adults

- Relaxation

Dealing with difficult thoughts

Having intrusive thoughts about things that happened in the past or a lot of anxious thoughts about the future is common among child who receive crisis support. Sometimes it becomes something that interferes a lot with everyday life and affects how the child functions at school or at home, and this then requires special attention in treatment.

In the case of intrusive thoughts, exercises on shifting focus are a way to bring you back to the present moment and avoiding getting stuck in memories of past events. There are various exercises of this kind, and sometimes the child has their own suggestion or method for shifting focus. It is important to highlight the difference between trying to avoid something and shifting focus. You can use the metaphor of a beach ball. The bad memories are like a beach ball you do not want. You therefore hold the beach ball under water, but it just keeps popping back up to the surface. It takes a lot of strength and energy to hold it down, and you find it hard to enjoy the other things around you. In the metaphor, the focus shift would be to let the beach ball come up to the surface, but at the same time focus on something

else in the water or on the beach, like the waves or other beach toys. So it is not a question of "not thinking about" the bad thing, but of shifting your focus to something else for a little while. Suitable exercises include Shifting focus in the Workbook for children and Shift focus using your senses or Shift focus with the help of breathing in the Workbook for young people. Another way is to focus on describing the room you are in or, for example, finding three objects which are red, yellow, green and blue to bring you to the here and now. Shifting focus is a skill that needs to be practiced repeatedly in less difficult moments in order to then be able to use it in more difficult moments, for example when you have intrusive images or thoughts.

When we have gone through difficult things, this often affects how we think about ourselves, about others and about the future. Negative things adults said to us may have become "truths" about how we are: lazy, stupid or hard work. In crisis support, there is not always time to work on cognitive restructuring in the way you would in longer treatment, but you can begin to practice paying attention to what you think about yourself and about others. Many children and young people can have judgemental, invalidating and critical thoughts about themselves in all kinds of situations. It is a good idea to ask the child what they think about or say to themselves. The first step is to recognise the thoughts and how they affect how you feel. To talk about this, you can use the worksheet How are our emotions affected by our thoughts and actions? from the Workbook for young people and Emotions are affected by thoughts and behaviour in the Workbook for adults. It is important to be able to differentiate between thoughts, feelings and behaviour in order to be able to influence how we feel (by becoming more conscious of our thoughts and how we act). Here you can practice paying attention to when you invalidate yourself and see if it is possible to describe a situation or experience in a more neutral way instead. You should be careful when you find yourself regularly using words like "should", "always" or "never", as that can be an indication of self-invalidation, for example, "I should have understood", "I am always difficult" or "I never do anything right".

One step towards self-validation is to put into words how you are feeling without judging yourself, and realising that what you are feeling is not strange but, on the contrary, completely reasonable based on what you have been through or how things were. Here, it is important that adults model normalising and validating the child's feelings. With teenagers you can talk about the concept of self-validation and what it means: to have a more understanding and affirming relationship with yourself. For some, this can feel like pretending to like yourself or praising yourself, but that is not what validation means. It is about striving for a more descriptive and non-judgemental approach towards yourself, your feelings and experiences.

There are exercises in the workbooks about self-validation (Expressing and validating emotions in the Workbook for young people) and shifting focus (Safe place, Shifting focus in the Workbook for children, Shifting focus using your senses, Shifting focus with the help of breathing, Leaves on a stream in the Workbook for young people). In the Workbook for young people, there is also a worksheet for problem-solving (Tackling a problem), which is intended to be used by the young person and caregiver together.

Useful resources in the workbooks for children and young people

- Mindfulness (Workbook for children)
- Shifting focus (Workbook for children)
- Safe place (Workbook for children)
- Crafts and games (Workbook for children)
- How are our emotions affected by thoughts and what we do? (Workbook for young people)
- Expressing and validating emotions (Workbook for young people)
- Shifting focus using your senses (Workbook for young people)
- Shifting focus with the help of breathing (Workbook for young people)
- Leaves on a stream (Workbook for young people)
- Calming down in a safe place (Workbook for young people)
- Tackling a problem (Workbook for young people)

Useful resources in the workbooks for adults

- Emotions

Depression

For some children, the main symptoms which present after frightening events are depression, tiredness and disengagement. Many express very negative thoughts about themselves and a lack of confidence

in others being able to help them. Here it is important to help children and parents find the right level of activation in their daily life, and to do more of the things the child previously enjoyed or which gave them energy. The caregiver plays a very important role in taking responsibility for ensuring the days are filled with meaningful content, and preferably that they incorporate activities the child and the adult do together, because good relationships with adults in the child's life necessary for them to be able to get help when things are difficult.

Outbursts, aggressiveness and conflicts

In many families, conflicts increase after something bad has happened. Younger children, in particular, can display more acting out behaviour when they have been through something frightening, but it occurs at all ages. It is important for the child's life to feel predictable and secure through boundaries and routines, and it is important to communicate these in a calm manner. Behind the child's challenging behaviour is an immense need to be loved and cared for. Lots of different things affect how much conflict occurs in a family. It might relate to moving home, a police investigation, the child's deteriorating wellbeing or other stressful things around them.

In crisis support work with children who exhibit a lot of anger and acting out, it can be important to identify the situations the child feels angry in, what triggers anger or outbursts and what the child might need at that time, and to talk to the child and the parent about this. As least as important is addressing this problem in the individual consultation with the parent. The work with parents in cases where there is considerable anger or family conflict is based on principles inspired by parenting programmes in Sweden. Much inspiration can also be found in the literature on trauma-informed care in terms of understanding the child's behaviour through the lens of previous traumatic experiences, and the importance of being curious about the emotion or reaction that lies behind the behaviour. Because crisis support is a limited intervention, it cannot encompass comprehensive training for parents, but there are useful strategies which can be used as a starting point. A number of these are described below.

A good principle for the child-parent relationship is the 5:1 Ratio, that is to say, there should be five times more encouragement and positive interactions than demands and reprimands (Forster, 2009). If a lot of conflicts are arising, you may need to add more

positive interactions and encouragement. When arguments are breaking out regularly and you have low energy levels, it is easy to reduce the positive time together instead, with the result that conflicts and nagging just increase. Here are some exercises and techniques which can be helpful for balancing this.

Child-led time

Parents set aside 10 to 15 minutes and let the child choose between a few activities the child likes. Parents should give the child their full attention during that time and let the child lead and put what they are doing into words. It is a good to try to have s period of child-led time every day.

Recognise what works well

Getting attention is important to everyone, and getting a parent's attention is especially important to children. Behaviour that is noticed is behaviour that will increase, irrespective of whether the attention is positive or negative. It is therefore good to recognise positive behaviour and try to minimise attention in relation to less good behaviour - trying to divert attention instead of telling off or shouting at the child. Think of it as picking our battles; in other words, just let go of the less important thing for now. This helps reduce the number of negative interactions between parent and child, and because it reduces the attention around the unwanted behaviour, that becomes less interesting for the child. Sometimes we need help to reflect on our daily lives to figure out what matters most and what can be put to one side for now.

Preparations

Are there situations where conflicts tend to arise? Times of day at which problems typically arise are when we are getting ready in the morning and just before going to bed at night. Is it possible to avoid those situations? By writing down clearly the routines that were agreed upon at a time of calm, we can reduce the number of conflicts which arise during the morning or evening rush. A piece of fruit in the afternoon at pick-up time may avert the worst of anger caused by being hungry.

Before changing a child's activities or introducing new things, it is a good idea to prepare a child in a calm and clear manner. As parent, you can make sure you have the child's attention and express yourself clearly, kindly and by making one request at a time. After that, give the child time to do what you have asked and try not to nag them.

Problems at school

It is common for difficulties the child is experiencing following severe stress to become noticeable at school too. They might have difficulties concentrating, be acting out or frequently absent from school. Since school is such an important part of the child's life, and school attendance is key to continued positive development, if the child has problems at school, it is important this is pick up early. The practitioner should support the parents in maintaining close contact with the school and ensuring action is taken to find workable solutions. Sometimes it may be appropriate for the practitioner to be in touch with the school or to attend meetings, both to gather information about how the child is getting on and potential symptoms that have been noticed at school, and to increase knowledge and understanding among staff of how reactions to severe stress and trauma can manifest. It is usually important for at least one adult at the child's school knows a bit about what the child has been through and what is currently happening. On the one hand, this gives them a greater understanding of the child's behavioural changes and, on the other, the child then has an adult to turn to at school in moments of strong emotions or reactions. It is generally recommended that someone should know about the child's situation, irrespective of the child's view on this, but that the child can be involved in deciding who should be informed.

Useful resources in the workbooks for children and young people

- Ideas for feeling better
- Reducing stress (Workbook for young people)
- Relaxing
- Tackling a problem

Useful resources in the workbooks for adults

- What you can do as a parent
- Relaxation
- Emotions

Adaptations

Adaptations according to age

Crisis support needs to be adapted to the child's age and level of maturity. The workbooks are designed for children aged between 6 and 17 years' old; the Workbook for children is intended to be used for children up to around 12 years' old, whereas the Workbook for young people is more suitable for teenagers. There is, however, no fixed dividing line, and practitioners can decide which workbook is best suited to the child, depending on their level of maturity. The Workbook for children can also be used for children under six years' old or for teenagers if that is deemed appropriate. With older children and teenagers, it is usually good to talk, whereas younger children need more playful elements. When working with teenagers, give them their own space to express themselves and, during the joint consultation, work to increase communication between the teenager and their parent/caregiver.

For the youngest children (up to around six years' old, depending on verbal language skills and maturity), the workbooks may be too advanced. However, younger children are also exposed to different types of violence, and there is a risk those children will not be pick up on, as they do not exhibit the same type of symptoms as older children (Scheeringa, 2008). Below are some suggestions for adjustments that can be made to crisis support for the youngest children.

0–3 years

Although there are significant differences between children at this age, a common denominator is that it is difficult to base crisis support on verbal communication. You should also consider that the child will need to have their caregiver with them in the room to a large extent. Sometimes all sessions with the child will take place with the parent present. Together with the child, you can use aids like dolls or soft toys or draw to illustrate reactions and events.

In cases where the child cannot talk and tell you how they are feeling, it is particularly important for the parent to discuss the child's symptoms and, based on what the child has been through, be helped to understand them, and for them to receive psychoeducation on how younger children express how they are feeling. It can be

helpful to think about crisis support for the youngest children as an interaction intervention in which you ensure the child has a way to express what they have been through, whilst simultaneously encouraging the parent to create a sense of security for the child, recognising the positives and reflecting together the things that can be difficult in the interaction. Parents may need support to help their child regulate their emotions, based on a sense of security and closeness, and to help their child to understand events and put emotions and reactions into words.

3–6 years

Children of preschool age often begin to become more verbal and are able to alternate playful moments with conversation and, in some cases, structured forms. At this age, it still works well to use of dolls or soft toys to depict the child's history, emotions and reactions together. For example, you can use different sizes of soft toys to represent a scale, from a little to a lot, to help the child to answer questions on the extent of symptoms. Reading and looking at books about feelings or about being exposed to violence and abuse can be a good starting point for conversation and psychoeducation with younger children.

When we talk about events or emotions, it is a good idea to use visual aids to make it easier for the child to understand what you are asking them about. A lot of the crisis support with children of preschool age will take place with the parent in the room, but you should try to have a moment with the child alone to give them the opportunity to express themselves without thinking about how their parent will react. It is not uncommon for young children to need to take breaks from talking about or dealing with what happened. For example, a child can be very focused when you are sitting together using dolls to show what happened, only for them to go off and play with something completely different in the room the next moment. Sometimes parents need to be supported to let the child self-regulate in this way.

Adjustments in the case of neuropsychiatric disorders

Children with disabilities are more vulnerable to violence and sexual abuse (Svedin, Jonsson & Landberg, 2016), and in crisis support, it is common to encounter children with neuropsychiatric, intellectual or communication disabilities. Adaptations need to be made in such cases to ensure the child benefits from the crisis support. It is a good idea to gather information about the child before you meet for the first time. You can talk to parents, foster carers or others who know the child about what usually helps the child and whether there is anything they find stressful. Sometimes social services have important information about the child, and sometimes there is important information in medical records and reports. It is useful to know what type of aids or cognitive support the child usually uses and feels comfortable with so they can benefit from those during the session. It might be aids which provide structure and an overview of time, or aids the child wants to have in their hands to enable them to focus or feel calmer.

It is generally particularly important to these children to have structure and clarity. Having a clear agenda that is either drawn or written on a whiteboard helps the child to understand what is going to happen, and you can tick off items as you complete them. For children with a short attention span and difficulties understanding the purpose of the session, a simple agenda could be that the practitioner decides the activity for one third of the time, the child decides for one third and the last third is a joint discussion with the parent. You can use existing visual aid cards, make your own visual support resources using a website or use a whiteboard for explaining things with the help of pictures and/or words. Predictability creates calm and reduces stress.

When mapping traumatic events and trauma symptoms, forms with visual aids can be used to support an assessment. For some children, it may be difficult to describe the frequency of symptoms and you may need to rely on whether the child is experiencing the symptom or not. You can ask which of the symptoms the child finds the hardest or most distressing and, through those questions, try to get an idea of the extent of the symptoms.

For children and young people with autism spectrum disorder, it is essential to provide clarity and predictability in order to reduce anxiety. It is important to stick to the plan for the session and be

realistic about what you can do in one session. Social small talk can be exhausting for children and young people with autistic spectrum disorder and thus it may be a good idea to begin the session by going over the plan for that day. Some children with autistic spectrum disorder find it difficult to answer open questions, in which it can be helpful to give them alternative answers to choose from. For many, visual supports are helpful. For children with autistic spectrum disorder and intellectual impairment, it can be difficult to understand the purpose of what you are doing, so you may need to be particularly clear about this.

Where the child has difficulties concentrating or has a short attention span, the session will need to be adapted, and you may need to add breaks for physical activity. The length of sessions may also need to be adapted so that the child is able to cope with it and does not get too tired. You may need to talk to the parent about what time of day is most suitable and make sure that the child does not have other strenuous activities before or after the session. It would also be good to know if the child has medication for ADHD and whether they have taken their medicine or not.

Crisis support with children and young people with intellectual impairment must be adapted to the child's needs. You may need to consider adjusting the language you use, visual supports and the length and contents of the session. For teenagers with intellectual impairment, sometimes the Workbook for children may be more suitable and the pictures in the book can be used as visual supports, for example, when providing psychoeducation on trauma symptoms.

For children with an intellectual impairment or language disorder, it can be stressful to talk too much. As a practitioner, you may need to find clear expressions and explanations that are at the right level for the child. It may be advisable to check with the child if everything is clear, as many children do not ask if they have not understood.

Working with instable life circumstances

Many children do not receive support and psychological treatment, because their circumstances are not deemed to be sufficiently stable. There is a risk that these children fall between the gaps and will never receive the help they need (Save the Children, 2022).

The circumstances for providing crisis support are not always ideal and a lot can be happening simultaneously for the child and family who may have ongoing stress throughout the crisis support. The stress may be evident at the beginning or emerge during the crisis support. Part of the crisis support involves working to reduce those stressors. It often requires close collaboration with social services and adults around the child to achieve this. Instability is, however, no obstacle to working with the child and family, and it is of paramount importance that the child receives support in a crisis.

Children in protected accommodation

It is possible to provide crisis support to children who live in protected accommodation, but it can be hard to make reliable assessments of trauma symptoms, as life in protected accommodation is often very different from the child's normal daily life and thus the child will often exhibit reactions to ongoing stress. It can nevertheless be of great help to have strategies for relaxing, sleeping or managing strong feelings and a stressful situation. Taking a child psychiatric perspective is also important. What is required for the child to feel as well as possible at the accommodation and to build structure, daily activities and support? Furthermore, you need to work on increasing communication between child and their parent, and to help the child to put their experiences and emotions into words. It is very important that the parent receives their own support, and you need to collaborate with social services and the accommodation provider to discuss what support and relief the family can access. For a parent who is often traumatised themselves to be able to be there for the children's needs, they have to have as much daily structure as possible.

When school is not working out

In a crisis, ideally as many things as possible should stay the same and there should be a predictability to everyday life. In this respect, planning with the school how to respond and help the child after something bad has happened can be crucial. You may need to plan which adults at school or preschool are going to be informed about what happened, what the child will want to say if other children ask about it, who the child can turn to if things get tough and the type of support or adjustments the child wishes to be in place for them at school during this period. School staff must be conscious of the fact both concentration and the capacity to

absorb new knowledge can be limited during a period of severe stress. Performance indicators may need to be adjusted for a period of time - the most important thing is that the child goes to school and participates in their social context and activities. Many children want to continue with their normal day-to-day life, to take a break from thinking about bad things and instead talk about normal things and play with friends.

If the child's school life is not working out, it is vital to collaborate with social services and the school to address this. One important aspect is understanding what is becoming an obstacle for the child and which interventions are required in order to create a positive environment. If the child is not currently going to school, planning is also needed in order to ensure a daily structure and activities. The prerequisites for taking in and applying strategies for feeling better are that the child's everyday life has positive social contexts and they have the opportunity to play, learn and develop.

Behaviours of concern

During a crisis support session, it is imperative to ask about suicidal thoughts, self-harm, online or other sexual abuse, use of alcohol and drugs or whether there is any destructive or dangerous behaviours. If any of these are found to be occurring, a crisis plan must be drawn up with the child or young person and this information must be given to the legal guardian. If there is deemed to be a heightened risk of suicide, it is imperative to contact child and adolescent mental health services and ensure that a medical assessment is carried out. If there is a risk of a child being harmed, this information must be brought to the attention of social services.

Working with an interpreter

If a child is being abused by a parent or relatives and only a small group of people speak the child's native language, the child might be worried that the interpreter will know the family and that news of this will get back to the suspected perpetrator. It is essential to talk to the child about the fact interpreters also have a duty of confidentiality. Using a telephone interpreter instead may be less tense and you can agree not to say names to increase the child's sense of security. It is also important that the practitioner, child and parent discuss how it went with the interpreter. If you find an interpreter with whom it works well, it is preferable to have the same

interpreter for all sessions. It is an advantage if the interpreter has expertise in healthcare (healthcare interpreter).

Extended crisis support plus a short trauma story

In some crisis support cases, it will become clear early on that continued trauma-focused therapy is not going to be needed after the crisis support. An example of such a case might be a younger child who was exposed to a single frightening event but who otherwise has had a secure and stable environment and does not have extensive symptoms. For some children, therefore, crisis support may need to focus more on talking about the actual event than is usually done in crisis support, and on more concrete help to create a context to what happened with a beginning and an end. In such situations, it can be helpful to produce a short trauma story with the child, drawing and writing using a structure and wording which the practitioner has prepared. This can be done in the form of a little book which the child and the practitioner make together, and which the child then can take home with them alongside their workbook. The trauma story should be short and not very detailed and, therefore, it is not appropriate in cases where for example TF-CBT is planned after the crisis support, as trauma narratives are a key part of that treatment. This methodological element is an abridged and modified version of the "The book about what happened" ("Boken om det som hände", Söderström, 2004), which is described in a short manual which can be ordered from the Child and Adolescent Psychiatric Trauma Unit in Stockholm (only available in Swedish).

The purpose is to acknowledge what happened, strengthen the child's autonomy and integrity, make sense of what happened, validate and normalise the child's reactions and encourage the child to express their emotions, memories and thoughts, as well as give hope for the future (Söderström, 2004). This can be regarded as a methodological element that is part of crisis support, but usually requires two to three sessions, which may mean that the crisis support intervention needs to be extended. Normally this would done at the end of crisis support, when you have got to know the child and the child has been able to tell you about what they experienced. It is also a way to summarise the crisis support sessions in a bit more detail than would normally be done in the workbooks (using the worksheet Time to sum up). The book about

what happened also forms a visual support about what happened and about the crisis support sessions, for children who need that. Normally children feel very pleased and proud that they have made a book and they then get to read it with their parent.

In short, this is a chance to draw and write a short book with the child about what they have been through, based on a given structure. The practitioner should first agree with the parent that the book is going to be made and then plan a rough script for the contents in advance, on the basis of what they know about what happened to the child. The practitioner prepares wording, which the child can help shape, and the practitioner and the child draw simple pictures together. The child should be involved as much as possible. Ideally the wording will be simple and precise and based on the child's own words about what happened. The structure could be as follows (examples in brackets):

1. *A short phrase about the child which puts distance between what happened and now ("When Sara was little")*
2. *Something about the person who abused the child and what they did that was not allowed ("she sometimes lived with her daddy. Daddy hit Sara and touched her vulva and vagina.")*
3. *Something about how the child reacted ("Sara was scared and wanted to escape.")*
4. *Something about what the child or others did to make it stop ("Sara told her teacher what happened. That was brave.")*
5. *Something about right and wrong ("No one is allowed to hit children or touch their private body parts. That is for bidden.")*
6. *Something about how it ended and how supportive people reacted ("The police thought so too. Now daddy is in prison and Sara doesn't see him.")*
7. *Something about the help the child received afterwards ("Sara cameto Barnahus and met Maria. It felt scary at first but then good.")*
8. *Something affirming about the child as a person ("Sara is a good and brave girl who no one is allowed to be horrible to.")*
9. *Something positive about the child in the future ("When Sara grows up, she is going to be a doctor and have two children.")*

The structure and contents can be adapted to the child's experiences and needs. It is important that all the wording in the book has been discussed and agreed with the child so that it feels

like the child's own book. With older children and teenagers, the same principles can form the basis of writing or drawing their trauma story. You might need to adapt the language and way of working according to the child's maturity and how they wish to express their story.

Confidentiality and record-keeping

When healthcare is provided with a focus on a suspected offence and a preliminary investigation and/or a social services investigation is taking place in parallel, there are important aspects to take into consideration in relation to documentation of healthcare. Even if medical records must be scrutinised before being disclosed to legal guardians, with the practice of collated medical records, there are risks associated with so many people having access to the information contained in the records. If detailed information that has come to light during a crisis support session is disclosed, the child's legal certainty and general safety is put at risk. On these grounds, it is important to be aware of the procedures for record-keeping for patients with special protection needs that exist within the organisation you are working for, for example, hidden modules in the medical record system or paper records for part or all of the records.

Sometimes the child will tell you about events without being asked, and it is then advisable to make accurate notes for the records in a protected module or paper record, as it may be that you will be called as a witness or that the police request access to the records. It is also advisable to document whether the information was raised spontaneously or in response to a direct question about exposure to violence. Sometimes new information comes to light during a crisis support session which may require reporting a concern to social services. If the information concerns a suspected criminal offence against the child, check your local regulations to know if the legal guardian would be informed about the report of concern being submitted, or if the information may require social services to file a report to the police without the legal guardian's knowledge. Depending on your local regulations, the incident can also be reported to the police.

If as a practitioner you receive information directly from the police regarding a preliminary investigation, for example that they are planning to interview the child, this information may be covered

by a duty of confidentiality. When a child is to be interviewed by the police, depending on your system, the legal guardians might only be informed about the interview after it has taken place if the suspect is one of the legal guardians. It is therefore imperative that as practitioner you do not tell the legal guardians if you have had contact with the police or if you have information about the child being interviewed. This is to ensure the child is not influenced by their legal guardian before the interview. When initiating a crisis support session, consent might need to be obtained from the legal guardian. If one or both legal guardians are suspected perpetrators, it can be difficult to obtain consent, for example, if you as practitioner are unsure what the legal guardian knows or because a legal guardian has been detained on remand. You can get help from social services who often already have established contact with the legal guardians and can obtain consent. If your system can appoint a guardian through the courts, this may be another avenue to obtain consent.

Conclusion and assessment

At the end of the crisis support sessions, an assessment is made regarding the child's continuing needs. Does the child need trauma -focused therapy? An assessment of possible differential diagnoses should have been carried out to find out whether the child needs further child psychiatric help with other problems such as anxiety or depression, suicidal thoughts, or neuropsychiatric or similar disorders. Is the family in need social service interventions such as family therapy? Sometimes there is found to be a need for support within the family as regards conflict management, improved communication or to strengthen parenting skills. In order to stabilise the child's living environment, identified needs such as family therapy should then be brought to the attention of social services or a referral made to the body that can best offer the family help. One-on-one, the practitioner and the child summarise the session and describe the assessment made. The child should be informed of the practitioner's view on whether there are continuing needs. The Time to sum up sheet in the workbooks can be used to summarise the sessions. Before the sessions come to an end, the child should fill in the My important list and the worksheet My questions for persons of authority, which can be found at the end of the Work-

book for children, or My questions for persons of authority which can be found at the end of the Workbook for young people. The child can also be given a certificate (which can be found at the end of the Workbook for children) to reinforce to the child how well they have worked during the sessions. The parent or caregiver is then informed of the child's progress, the assessment and any recommendations. It might be necessary to have individual adult conversations so that the right questions can be answered. Bringing some refreshments and treats to eat at the last session is a nice way to celebrate completing the crisis support work.

Sometimes children and young people can have unanswered questions regarding the legal process. If so, you have the option of contacting the police or the lawyer who has been assigned by the state to assist the child or young person (if applicable) and inviting them to a joint meeting. After concluding the crisis support sessions, it is recommended to hold a feedback meeting with the caregiver and social services, both to give them the results of the assessment and so they are able to draw up a plan together. If the child is in short-term foster care, the legal guardian may also have access to information via social services. This is also a good opportunity, where necessary, to obtain consent for a referral for continued child psychiatric care. If it has been assessed that social service interventions are required, this is a good opportunity to plan those with the legal guardians and social services. Social services usually appreciate receiving the assessment as part of their investigation. At the closing meeting with the caregiver and social services, they are shown the sheets My important listand My questions for persons of authority to represent what the child themselves has expressed as being important for their wellbeing.

Sometimes there are legal guardians who give their consent to the crisis support, but do not actively participate in it, for example in situations where the child is living in short-term foster care or a legal guardian is suspected of committing a criminal offence against the child. Even if the legal guardian has not been deemed to be a safe support for the child in the crisis support sessions, they have the right to be informed about the interventions and assessments made. Where appropriate, legal guardians who have not participated in the sessions are invited to a feedback meeting at the end of the crisis support, usually together with the social worker.

Working with crisis and trauma

Working with children who have been exposed to violence and abuse in different forms can evoke emotions in those of us who meet the child. How this affects us depends on many factors: our own history, our temperament and our current circumstances, the pressures we are facing and our opportunities to rest and recuperate. How our workplace is organised and our cooperation with colleagues and managers also influences how we deal with the pressures we encounter in our work. A secure work situation, good support from supervisors and management, a reasonable workload, access to counselling, as well as support in getting essential rest and recuperation, are all protective factors against vicarious traumatisation at work. Of fundamental importance is also feeling supported by colleagues and the working group you are part of (Isdal, 2017). The term vicarious traumatisation means that you, as a healthcare practitioner, may be strongly affected and have similar symptoms to your patients as a result of regularly hearing accounts of difficult events. The following focuses on important factors for coping with working with children and trauma and for reducing the risk of vicarious traumatisation and stress leading to ill health.

Your team as a resource

Promoting a safe and supportive environment in the team is important for everyone to be able to cope. There must also be time dedicated to talking about the cases which concern you and also how it affects you as a practitioner. It is a good idea to schedule check-ins with a colleague after sessions which you know usually evoke emotions, so that you have time to debrief before going home. It is beneficial if your team can agree, for example, on how issues are to be raised, or what would be needed to create a supportive group where colleagues can talk about their own vulnerabilities and what they are finding difficult. Working actively to create a safe space group is time well spent and something that any workplace counselling can focus on.

In care teams, it can be helpful to be clear about the type of feedback you want even before you make your case, for example “I would like suggestions on how to proceed” or “I just want to share how things have been for me and get support”.

One way of talking about how you are finding the work and your patient cases is to start off care team meetings or other joint meetings by rating stress/wellbeing on a scale of zero to ten. Zero means severe stress and an unsustainable situation, and ten means you are not stressed at all. Factors outside work also impact our working life and a difficult home situation, worrying about your own children or a separation all affect energy and wellbeing. It helps to know if someone in your team has additional stresses and strains so you can take into account the colleague not being able to cope with as much as usual, or that certain work tasks may feel particularly stressful for a while. Of course, it is up to every individual to decide what they feel comfortable sharing. An open culture of acceptance in the team can develop when people dare to show vulnerability and talk about what they are finding hard and what they appreciate. If someone is under extreme stress, it is essential to find out what support or respite is needed in order to reduce the stress.

Having a non-judgemental approach can be key to creating a team that feels more secure. Part of that is addressing in the team the fact that how we talk about patients, parents and partners also affects how we think and act. If we are judgemental of others, it is easy to fall into judging ourselves and each other. By describing instead of making a value judgement, we create a safer and more open working environment. Making a value judgement is natural and something we do to relate to the environment and incoming information - good, bad, nice, stupid, professional, unprofessional. It influences our thoughts. Thinking “I am bad” generates different emotions than “I was unclear when I was explaining”, which is more descriptive. Speaking to ourselves and others in an evaluative or judgemental way tends to strengthen feelings and reduce empathy both towards ourselves and others.

When working with trauma, you may need to share the accounts you have heard, and colleagues or supervisors are important here. It is a good idea to check with your colleague if they are able to listen to what you want to share, as sometimes we need to protect ourselves from hearing too many accounts of child abuse. We need to both be able to share heavy information and simultaneously be careful with each other. At times when are feeling more affected or stressed, we need to be clearer about our needs and boundaries. We may also need to control the information we receive from social services or the police, as there are times when it is better not to know all the details of the violence or abuse (Isdal, 2017).

Applying the same skills that we teach others

Applying the same skills to ourselves as we use when we see patients helps us and our team, for example, practicing non-judgemental attitudes towards oneself and others and practising self-validation and the validation of others. Other important skills include acceptance for those things we cannot change or control. We can get frustrated about decisions that are taken and be worried about how the child is going to get on in the future, as they may be placed in short-term foster care or live with a parent who previously was violent towards them. At such times, we need to reach out for help from our team to see what we can do and what we cannot do even though we want to, and keep focusing on the task we have been given. Accepting emotions that are connected to not being able to influence the child's situation in all areas is part of moving forward.

How we regulate our own emotions affects how we feel and how we cope. We ourselves may need to practice the very things we practice with the children we see, such as putting our feelings into words and validating and normalising our emotions and experiences. We can use the same skills as those we teach, which is to seek support and talk to someone we trust and do what makes us feel good in our free time. We can also make sure that we take care of ourselves so that we can cope with the pressures we face: make sure that we sleep, eat well, have time for physical activities and rest and recuperation. Other things that we may need to review are external stress and whether there are problems we need to solve, like workload and similar issues that may need to change in order for us to be able to manage stress and feel well in the longer term.

Relaxation, focus shifting and mindfulness are other methods that we can use to manage thoughts about work when we are off work, to let go of worries when we are going to sleep and to be present in what we are doing in the moment in order to recuperate. In this important and meaningful work with children, it is important to take care of ourselves in order to have joy, creativity and empathy, which are vital elements of working with children and their caregivers.

Literature and work material tips

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Rädda barnen. https://resourcecentre.savethechildren.net/sv/document/mellan-stolarna-barn-som-har-utsatts-for-vald-och-inte-far-hjalp-att-ma-bra-igen-ett-dubbelt-svek/

Sahlin, H. & Malmquist, E. (2018). ***Känslor som kraft eller hinder: en handbok i känsloreglering***. \[Emotions as power or obstacles: a handbook on emotion regulation] Natur & Kultur Foundation, Stockholm.

Websites

Visual supports
Webpages with ready-made visual support resources and the option to search for pictures and create your own resources.
https://widgitonline.com/en
www.myboardmaker.com

Save the Children
Collection of resources and leaflets on the body and boundaries, treating trauma and exposure to violence and abuse, as well as educational films about trauma which can be used for psychoeducational purposes. You can also download the app Safe Place for help with breathing or relaxation exercises. The information is available in several languages.
resourcecentre.savethechildren.net

UK Trauma Council
British webpage with research and educational resources in English.
www.uktraumacouncil.org

Books to use when treating children

Backberg, H., Borgelöv, M. & Thermaenius, H. (2020).

Resources for supporting communication in relation to difficult events, emotions and thoughts, and to manage restlessness.

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