# MI-07 Children's trauma, attachment and resilience: what protects

HEALING after the FALL, research library, MI-07

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Scope. This report covers what happens to children after loss, separation, war and disaster, what institutions did to them, how much caregiving a child needs and when, which school and play programmes have controlled evidence, and how a village cares for orphans without an orphanage. Adult trauma treatment, debriefing in adults, Psychological First Aid, narrative exposure therapy in adults and the four-week gate are in MI-01 and are cited, not repeated (THRIVING library, MI-01). Feeding a motherless infant is in MA-06 and the sick child in MA-07. Grief and mourning rites belong to the grief report (MI-03, being written alongside this one), and where this report touches a bereaved child it says so and stops. OR-01 and MI-13 are not yet written and their ground is left to them.

## Findings by section

### 1. What institutions did to children

**The record before 1945.** Institutions for infants killed them, and the record is consistent across countries and decades. In 11 New York State infant institutions between 1909 and 1913, deaths under the age of two ran from 183 to 576 per 1,000, an average of 422.5, against 87.4 per 1,000 in the general population of the same years (Chapin 1926). When babies from the marasmus ward of the New York Foundling Hospital were boarded out with families, their eventual mortality was 46 per cent, against near-certain death if they stayed (Chapin 1926, reporting a study by the Sage Foundation and Josephine Baker). Arthur Schlossmann's orphanage in Düsseldorf had an infant mortality of 71.5 per cent, while his own infant hospital, run on different lines from 1907 to 1912, had 16.8 per cent (Rowold 2019). The Dublin Foundling Hospital lost about 800 of every 1,000 children over its century (THRIVING library, MA-06). Much of this was infection and the absence of breast milk, which MA-06 covers. The question for this report is whether deprivation of a person killed children independently of milk and germs.

**Spitz's Foundling Home.** René Spitz compared two institutions in the 1940s, unnamed in his papers. In the Foundling Home, 91 infants were breastfed by their mothers or by other mothers for the first three months and then separated from them. Officially one nurse cared for 8 infants, in practice up to 12, which Spitz reckoned at about a tenth of normal emotional exchange. Hygiene, food and medical care were as good as or better than in comparable institutions. By the end of the second year the mean developmental quotient had fallen to about 45 per cent of normal, and at four most of the surviving children could not sit, stand, walk or talk. Of the 91, 34 (37 per cent) died by the end of the second year. In the comparison Nursery, a prison nursery where the infants' own mothers cared for them, about 220 children passed through in four years with 2 deaths, and 2 more in the six months after leaving (Spitz 1965, read in the Portuguese edition). Spitz also reported that if a separated mother returned within three to five months the infant recovered promptly, while separation beyond about five months produced deterioration that was at least partly irreversible (Spitz 1965). The study was attacked at the time for unstated sites and dates, small numbers and uncontrolled differences between the two houses (Pinneau 1955, Rowold 2019). It is a clinical series, not a trial. Its weight comes from agreeing with Chapin, Schlossmann and what followed.

**Contact lowered mortality even at a cost in infection.** At Bellevue Hospital in New York, Harry Bakwin introduced free parental visiting and cuddling by nurses, accepting the greater risk of cross-infection, and mortality fell (Rowold 2019, reporting Bakwin 1942). The opposite practice, infants nursed in glass cubicles to prevent infection, was debated in the British Medical Journal in 1944 (Rowold 2019). The lesson for a world without antibiotics is uncomfortable: isolation to prevent infection and contact to prevent wasting pull in opposite directions, and the historical record favoured contact.

**The Hampstead War Nurseries.** Anna Freud and Dorothy Burlingham ran residential nurseries in London and Essex from 1941 to 1945 for children separated by bombing and evacuation (Wikipedia, Hampstead War Nurseries). Faced with the same problems as Spitz, they broke large age groups into "artificial families" of 3, 4 or 5 children under one young nurse acting as foster mother, with a second nurse as the named substitute on days off. The children quickly formed strong and possessive attachments to their nurse, and development, including habit training, became easier (Freud and Burlingham 1944). This is the first documented dose of caregiving that worked inside an institution: three to five children per adult, the same adult each day, and a known substitute. It is a clinical report, grade B at best, and it describes development, not mortality.

**The Bucharest Early Intervention Project.** This is the only randomised trial of foster care against institutional care. In Bucharest in 2000 and 2001, 136 children aged 6 to 31 months living in institutions were randomised to remain (care as usual) or to be placed with foster families recruited and supported by the project, and compared with children who had never been institutionalised (Nelson 2007, King 2023). At 54 months mean IQ was about 109 in never-institutionalised children, 81 in the foster group and 73 in care as usual (NEJM Journal Watch 2008, a secondary summary [VERIFY]). The gains were larger the younger the child was placed, and 24 months emerged as the age after which gains were smaller (Nelson 2007). Children placed before 24 months were more likely to be securely attached at 42 months (Smyke 2010, exact percentages not obtained [VERIFY]). Signs of the withdrawn, inhibited form of reactive attachment disorder resolved quickly after placement and were indistinguishable from never-institutionalised children after 30 months, while the indiscriminate, disinhibited form resolved less well, and less so in children placed after 24 months (Smyke 2012). In a "Stranger at the Door" test, 41.9 per cent of children still in institutions, 24.1 per cent of fostered children and 3.6 per cent of never-institutionalised children walked away with a stranger (Gleason 2014). The quality of foster caregiving at 30 months predicted less psychopathology at 54 months, and this ran through the security of attachment (McGoron 2012).

The pooled analysis to age 16 to 18, with 7,088 observations, found the effect of foster care stable across development. Standardised effects were 0.39 on IQ, 0.28 on physical growth, and largest on IQ and on disorders of attachment. The advantage of earlier placement for IQ faded by adolescence, but every child had been placed by 33 months, so the trial says nothing about placement later than that. The effect on externalising problems was near zero early and medium in adolescence. In adolescence the strongest predictor was stability: children who stayed with their original foster family did markedly better (standardised effect 0.37) (King 2023). Grade A.

**Pooled evidence.** A meta-analysis of 75 studies of more than 3,888 children in 19 countries found a mean IQ of 84 in children's homes against 104 in families, an effect size of 0.74, moderated by age at placement and the country's level of development (van IJzendoorn 2008, search summary only). The Lancet Group Commission found the strongest associations of institutional care with physical growth, cognition and attention, and smaller but significant ones with social and emotional development and mental health. Moving to a family brought recovery in growth and cognition but not in attention. Longer stays went with worse outcomes, and the review could not separate duration from timing (van IJzendoorn 2020, abstract only). Its recommended order is birth family, then kinship care, then adoption, then good fostering, with institutions last.

**Can an institution be made safe?** In St Petersburg, training caregivers in warm, responsive care together with structural change, meaning fewer and more consistent caregivers per child and smaller groups, brought substantial developmental gains, while training alone brought much smaller ones (St Petersburg-USA Orphanage Research Team 2008, search summary only). The structure, not the training, did most of the work. This matches Hampstead.

**The kibbutz.** Israeli kibbutzim once had infants sleep communally in children's houses, watched at night by a single adult on duty [VERIFY], while parents cared for them by day. Among 48 kibbutz infants, 80 per cent of those who slept at home were securely attached to their mothers against 48 per cent of those who slept communally (Sagi 1994). Here is a cultural ideal of shared care, held with conviction and well resourced, that still cost attachment security when the infant had no familiar adult at night. Grade B.

### 2. Sensitive windows and the dose of caregiving

**When the harm becomes hard to undo.** Three sources converge. Spitz put the turning point at about five months of separation in infancy (Spitz 1965). The English and Romanian Adoptees study followed children who spent up to 43 months in Romanian institutions before adoption into UK families. Those who left before 6 months of age had symptom levels as low as UK-born adoptees into young adulthood. Those who left after 6 months had persistently higher autism-like symptoms, indiscriminate friendliness to strangers, and inattention and overactivity into their twenties. Their cognitive deficit had recovered to normal rates by young adulthood, but emotional problems rose late, between ages 15 and 25, and they had more unemployment and use of mental health services. A fifth of the late-adopted group (15 of 72) were free of problems at every assessment (Sonuga-Barke 2017, abstract read). The Bucharest trial puts its line at 24 months for cognition and attachment (Nelson 2007, Smyke 2012). Read together: a severely deprived infant should be in a family before 6 months if at all possible, and before 24 months at the latest, and the harm that persists longest is to attention and social judgement, not to intelligence. Note that the Romanian institutions were extreme, and these windows may be narrower than the windows for ordinary neglect [VERIFY].

**After infancy.** For children over two, the evidence shifts from deprivation to loss and fear. Here what matters is less a window than whether a stable adult is present at all, and for how long arrangements stay unbroken (King 2023, Betancourt 2020).

**The dose.** No trial has titrated caregivers against children, but the record gives bounds.

| Arrangement | Children per carer | Outcome | Source |
|---|---|---|---|
| Spitz Foundling Home | 8 officially, up to 12 | 37% dead by 2 years, development about 45% of normal | Spitz 1965 |
| Hampstead artificial families | 3 to 5, named substitute | Strong attachments, development eased | Freud and Burlingham 1944 |
| Kibbutz communal sleeping | One night watcher for the house | Secure 48% against 80% at home | Sagi 1994 |
| Bucharest foster care | 1 to a few, one family | IQ +0.39 SD, stable to 18 if placement stable | King 2023 |
| POFO institutions with under-twos | up to 16 | Not reported separately for infants | Whetten 2009 |

My inference: an infant needs one main adult who is there each day and a named second, and one adult should not carry more than three children under five or one infant plus two toddlers [VERIFY, inference from Hampstead and Spitz]. Stability counts as much as ratio. Each change of household costs the child something, and the Bucharest adolescents who stayed put did best (King 2023).

**What proportion recover with a stable adult and routine alone?** No study isolates that exactly. The nearest figures: - Children exposed to single traumatic events, mostly accidents, who were living with their families: PTSD in 21 per cent at one month, 15 per cent at three months, 12 per cent at six months and 11 per cent at a year. Most recovery happens by six months, and those still affected at six months tend to stay affected (Hiller 2016, 27 studies). So

about half of those with PTSD at one month recover without treatment by six months, and around 9 in 10 exposed children are free of PTSD at a year. - Children bombed in London while with their mother or a familiar substitute showed no signs of traumatic shock, and children reaching the rest centres with their families slept, ate and played normally (Freud and Burlingham 1943). - Of 323 former child soldiers in Sierra Leone followed to a mean age of 28, 213 were in a socially protected trajectory and 77 in an improving one, about 9 in 10 together, while 33 were socially vulnerable, with about three times the suicide attempts (Betancourt 2020). - In the Kauai cohort, about one-third of high-risk children never developed serious problems, and most troubled adolescents had recovered by their thirties (Werner 1993, abstract and secondary summaries [VERIFY]). - A fifth of children institutionalised past 6 months in Romania were problem-free throughout (Sonuga-Barke 2017).

My inference: after an acute disaster, with a familiar adult and the routine restored, roughly 8 or 9 in 10 children will not need anything more. After chronic war, displacement or loss of both parents the figure is lower and nobody has measured it cleanly [VERIFY].

### 3. War, disaster and loss: the course and what protects

**How common are problems?** Across 17 studies of 7,920 children exposed to war, the pooled prevalence of PTSD was 47 per cent, of depression 43 per cent and of anxiety 27 per cent. The range was 4.5 to 89.3 per cent, and heterogeneity was almost total (98 per cent), driven by place, measurement and time since exposure (Attanayake 2009, abstract read). This is the figure people quote when they want to show that children are devastated by war. My reading is that it is better taken as a figure about questionnaires used soon after events in heavily affected samples. It does not say what proportion will still be ill in a year, and Hiller's figures show that proportion falls steeply.

**Family presence is the strongest protection in the historical record.** Freud and Burlingham observed in 1941 and 1942 that war "becomes enormously significant the moment it breaks up family life", and that London children were much less upset by bombing than by evacuation to the country (Freud and Burlingham 1943). Small children took their cue from their mother's anxiety, and they credited the calm of the London population for the rarity of shocked children. The death of a father produced its own reaction, distinct from bombing.

The Finnish evacuation tested this at scale. About 49,000 Finnish children aged 1 to 10 were sent to Swedish foster families between 1941 and 1945, staying on average two years. In a comparison of evacuees with their own siblings who stayed at home (46,877 people, 1,425 evacuated), overall adult psychiatric admission did not differ, but evacuated girls had about twice the risk of hospital admission for mood disorders as their sisters who stayed (hazard ratio 2.19, 1.10 to 4.33) (Santavirta 2015). The daughters of those evacuated girls, born after the war, had about twice the risk of any psychiatric admission and 4.68 times the risk of admission for mood disorders (Santavirta 2018). Separating children from their families to protect them from war did not protect them, and for girls it did harm that reached the next generation. Grade B, two large registry studies.

**Acceptance by the community.** In Sierra Leone, 260 former child soldiers aged 10 to 17 were interviewed in 2002, 2004 and 2008. Having killed or injured others, and stigma after the war, raised hostility and other externalising problems. Community acceptance lowered both externalising and internalising problems, and social support, school and acceptance raised prosocial behaviour. Rape predicted later anxiety and depression (Betancourt 2010). Followed to 2016 and 2017, 47 per cent were above the threshold for anxiety or depression and 28 per cent for possible PTSD, but the trajectories separated mainly on social protection, not on what the young person had done or suffered (Betancourt 2020). Grade B.

**Ordinary systems.** Masten's review of resilience research concluded that resilience is common and arises from ordinary adaptive systems: attachment to a competent adult, normal brain development, self-regulation, and community and school. The greatest threats are those that damage these systems themselves (Masten 2001, abstract). In the Kauai birth cohort of 698 children born in 1955, the high-risk children who did well had at least one stable bond with an adult, often not a parent: a grandparent, aunt, older sibling, teacher, or a member of a church (Werner 1993, Educa-

tion Week 1990, secondary [VERIFY]).

**Help the caregiver to help the child.** In Bosnia during the war, groups for mothers meeting over five months improved the mothers' mental health, their children's weight gain and several measures of their children's psychosocial functioning, against basic medical care alone (Dybdahl 2001, 87 mother and child pairs, children aged about five). Programmes in Lebanon now target caregiver stress directly, on the reasoning that it carries much of the effect of war onto children (Miller 2020, development paper, not an outcome trial). Among carers of AIDS-orphaned children in South Africa, 35.2 per cent were depressed against 27.9 per cent of other carers, and food insecurity was a risk factor (Kuo 2012). A village that places an orphan in a household and then leaves that household hungry and overloaded has done half the job.

### 4. School, play and talking: what has controlled evidence

**Group programmes in humanitarian settings.** An individual-participant meta-analysis of 11 randomised trials, 3,143 children in low-resource humanitarian settings, found that focused psychosocial programmes reduced PTSD symptoms by a standardised mean difference of 0.33 after treatment and 0.21 at follow-up, and modestly improved function, hope, coping and social support. The effect was larger in 15 to 18 year olds (0.43) and in children who were not displaced (0.40), and smaller in younger and displaced children (Purgato 2018). About 31 per cent of the effect ran through improved daily functioning, and none through coping, hope or social support (Purgato 2020). These are small effects. They justify a programme for children still struggling after a month or more, not a programme for every child.

**The individual trials.** - Poso, Indonesia: 495 children with a mean age of 10 in 14 schools, randomised by school. Fifteen sessions over five weeks, run by trained local paraprofessionals, mixing trauma processing, cooperative play and creative expression. PTSD fell by 2.78 points more than in controls and hope was maintained, with no effect on depression, anxiety or function, and the assessors were not blind (Tol 2008). Grade A, one trial. - Nepal: the same programme for 325 children aged 11 to 14. Crude effects looked moderate, but once the analysis allowed for clustering by school there was no effect on any primary outcome. Some subgroups gained, such as boys with less aggression and girls with more prosocial behaviour (Jordans 2010). This is the trial to show anyone who quotes the uncorrected effect. - Nablus, Palestine: Teaching Recovery Techniques, a manualised cognitive behavioural group programme, delivered by school counsellors in classes randomised against a waiting list during ongoing violence, with 133 students aged 11 to 14. PTSD, grief and depression all fell (Barron 2013, abstract only, effect sizes not obtained [VERIFY]). - Northern Uganda (Gulu and Amuru): 15 class sessions of drama, movement, music and art with parent and community parts, in 21 schools, 203 children against 200 comparison children chosen by random quota but not randomised. Everyone improved over 12 months as peace returned. The programme children improved more by their own and parents' report but not by teachers' (Ager 2011). Grade B. - Child-friendly spaces, the play and activity areas set up in most emergencies: across 1,010 children in Ethiopia, Uganda, Iraq, Jordan and Nepal, children of 6 to 11 gained a little in wellbeing (effect size 0.18), adolescents of 12 to 17 did not, and results varied between sites (Hermosilla 2019). Safe places to play are worth having for protection and for parents' sake, but they are not a treatment. - Armenia after the 1988 earthquake: early adolescents in Gumri schools given brief trauma and grief psychotherapy improved while untreated ones worsened, in a non-randomised comparison forced by staff shortage (Goenjian 1997). At five years, the treated group's PTSD improvement was three times that of untreated Gumri adolescents, and untreated adolescents from Spitak, at the epicentre, stayed above the PTSD cut-off throughout (Goenjian 2005). This is the longest evidence that some children do not get better by themselves. - Sierra Leone: the Youth Readiness Intervention, a 10-session cognitive behavioural group for young people aged 15 to 24, improved emotion regulation, prosocial behaviour, social support and function, and later school enrolment and classroom behaviour. An education subsidy alone improved attendance only (Betancourt 2014). Grade A, one trial.

**Narrative exposure for children (KIDNET).** In traumatised refugee children aged 7 to 16, eight sessions of KIDNET against a waiting list reduced PTSD and the gain held at 12 months, while untreated PTSD persisted (Ruf

2010, 26 children). The Sri Lankan and Ugandan trials, including former child soldiers, are summarised in MI-01 (THRIVING library, MI-01). In a rural Tanzanian orphanage of 38 children, violence by staff inside the orphanage was more closely linked to ill health than violence before admission, and changing the orphanage's discipline system together with KIDNET brought large falls in violence and in PTSD (Hermenau 2011, uncontrolled). KIDNET is a treatment for a child with persistent PTSD, given after the four-week gate (THRIVING library, MI-01) by a trained and supervised counsellor. It is not first aid.

**Debriefing children.** After road accidents near Bath, 158 children aged 7 to 18 were randomised to a debriefing-style session or a neutral control. Both groups improved and debriefing added nothing at eight months (Stallard 2006). With the adult evidence of harm in MI-01, the rule stands: no single-session telling of the event to a child in the first weeks. Grade X for adults, grade A for no benefit in children.

### 5. Orphans, kin and the orphanage question

**The POFO finding.** The Positive Outcomes for Orphans study compared 1,357 children aged 6 to 12 in 83 institutions with 1,480 orphaned or abandoned children living in communities, in Cambodia, Ethiopia, India, Kenya and Tanzania. Children in institutions were no worse off, and generally better, on health, growth, emotional, cognitive and memory measures than children living with non-parent carers in the community. Type of setting explained only 0.3 to 7 per cent of differences, while differences between children within a setting explained 64 to 87 per cent (Whetten 2009). By age 13, 91.0 per cent of institutional and 92.4 per cent of family-based orphans had had a potentially traumatic experience, and the yearly incidence of physical or sexual abuse was lower in institutions, 12.9 against 19.4 per cent (Gray 2015). This is real evidence and must be taken seriously. Its limits: it was cross-sectional, only 5 per cent of the children had entered an institution before age two, the comparison was with orphans in poor community households rather than with good kin care, and institutions that agree to be studied may be better than those that do not. It shows that school-age children in a reasonable children's home do not do worse than school-age orphans in a poor, overloaded household. It says nothing about infants, for whom the trial evidence points the other way.

**Kinship care.** A Cochrane review of 102 quasi-experimental studies covering 666,615 children removed from home for maltreatment found that children placed with relatives had fewer behavioural problems (standardised mean difference 0.33), about half the odds of mental disorder (odds ratio 0.51), better wellbeing (0.50) and about half the odds of placement breakdown (0.52) compared with non-relative foster care (Winokur 2014). The evidence is observational with selection bias, grade B, but it points one way.

**AIDS orphans.** By 2008, 12 million children in sub-Saharan Africa had been orphaned by AIDS. In 1,021 South African children followed from 2005 to 2009, those orphaned by AIDS had higher depression, anxiety and PTSD that persisted and worsened, while children orphaned by other causes did not show this course (Cluver 2012). The difference is thought to come from stigma, poverty and a parent's long illness before death, which is a warning for any epidemic. Orphanhood does not heal by itself when the household around the child is poor and shamed.

**Losing both parents.** Six and a half years after the Armenian earthquake, adolescents who had lost both parents had higher depression scores (20.2) than those who had lost a father (16.6) or a mother (12.7), and orphans were above the clinical cut-off (Goenjian 2009). Double orphans need the closest watch. The grief side of this belongs to the grief report.

**The orphans of 1918.** In New Zealand, 6,415 children lost one parent and 135 lost both in the 1918 influenza. The government recommended adoption within families and paid relatives a maintenance allowance equal to what an orphanage place would have cost (Te Ara, Our Health Museum, secondary [VERIFY]). In South Africa, African, Indian and Coloured families absorbed orphans into the extended family as the norm, less so white families (KBHA bulletin, secondary [VERIFY]). I found no outcome data on these children. The New Zealand rule, paying kin what the orphanage would have cost, is the one worth carrying.

**Separated children.** The inter-agency principles agreed by the Red Cross, UNICEF, UNHCR and the major child

agencies in 2004 set the order: prevent separation, keep siblings together, register and trace, prefer care in the community, including fostering, over institutions, make no adoption, change of name or long move until tracing is exhausted, and make no permanent arrangements in the emergency phase. They note that most separated children have relatives willing to take them (Inter-agency Guiding Principles 2004, read through summaries only [VERIFY]). MI-01 Protocol 1 already registers each unaccompanied child with name, age, village and the adult holding them (THRIVING library, MI-01).

### 6. Three traditional claims tested

**"Children forget."** The tradition holds that a young child will not remember, so what happened need not be spoken of and will not mark them. The record: symptoms do fade in most children, about half of early PTSD clearing by six months (Hiller 2016). But Spitz's infants separated for more than five months did not recover fully (Spitz 1965), Romanian children deprived beyond six months carried effects into their twenties (Sonuga-Barke 2017), untreated adolescents at the Armenian epicentre were still above the PTSD cut-off five years later (Goenjian 2005), and Finnish girls separated in early childhood had more mood disorder as adults (Santavirta 2015). Inference: children forget the event more readily than adults, and many lose the symptoms, but they do not forget a lost or changed caregiver, and the body of the record says early disruption of care leaves the longest marks. Verdict: half true about events, false about caregivers.

**"Children are resilient."** The tradition is right more often than it is wrong. Most children exposed to a single disaster recover without treatment (Hiller 2016), and resilience comes from ordinary systems (Masten 2001). The claim fails when it is used to mean that children need nothing. Resilience in every study depended on a stable adult, acceptance and school, the very things a collapse removes. Verdict: true when the adults and routine are there, and an excuse for neglect when they are not.

**"Children must not be told."** The tradition holds that children should be shielded from news of death and from rites. Among 622 Swedish teenagers who lost a parent to cancer, 98 per cent said teenagers should be told when death is near, but only 59 per cent were told, and 43 per cent did not realise death was imminent until a few hours before (Bylund-Grenklo 2015). Those who had no acceptable way to grieve in the first six months had about four times the odds of grief that was still unresolved years later, and being discouraged from grieving or hiding grief to protect the surviving parent also raised the odds (Bylund-Grenklo 2021). These are Swedish teenagers, so the transfer to younger children and other cultures is an inference [VERIFY]. Verdict: false for the fact of a death. Children should be told the truth simply and early. But nothing here supports making a child tell their own story, which is the other half of the rule, and is harmful (Stallard 2006, THRIVING library, MI-01). How to tell and how to include children in mourning is for the grief report.

### 7. Culture: shared caregiving and Western norms

Attachment theory was built on Western middle-class households with one mother at home. Heidi Keller argues that in many rural farming societies attachment is spread across a network of responsibilities, that sensitive one-to-one responsiveness is not the universal ideal, and that importing parenting programmes built on it into subsistence communities is unethical (Keller 2018). Among the Efe foragers of the Ituri forest in the Democratic Republic of the Congo, infants are passed between many carers from birth and through at least the first 18 weeks, including being suckled by other women (Tronick 1987, search summary). Efe infants still formed a primary attachment to their mother by about a year (Morelli and Tronick 1991, cited in secondary sources [VERIFY]).

What this means for a village after the Fall: a child handed between aunts, grandmothers and older siblings in a familiar compound is not deprived. Shared care among known people is what most human children have had. What harms is care by strangers, by too many rotating adults, or with nobody who is that child's own (Spitz 1965, Sagi 1994, Smyke 2012). The kibbutz shows that even a willing and capable community, when it removes the familiar adult at night,

measurably lowers security. Do not judge an extended household against a nuclear-family norm, and do not mistake a rota for a family.

## Evidence grades

| Claim | Grade | Basis |
|---|---|---|
| Family placement beats institutional care for infants and toddlers | A | Bucharest RCT (Nelson 2007, King 2023), meta-analyses (van IJzendoorn 2008, 2020) |
| Infant institutions raised mortality several-fold | B | Chapin 1926, Spitz 1965, Rowold 2019, MA-06 |
| Harm is hardest to undo after about 6 months of severe deprivation, and after 24 months for cognition and attachment | B (A for the 24-month line in one trial) | Sonuga-Barke 2017, Nelson 2007, Smyke 2012 |
| Placement stability protects | A (secondary analysis) | King 2023 |
| Kinship care beats non-kin fostering | B | Winokur 2014 |
| Most children recover from single events without treatment | B | Hiller 2016 |
| Staying with a familiar adult protects against war stress | B | Freud and Burlingham 1943, Santavirta 2015 |
| Community acceptance protects former child soldiers | B | Betancourt 2010, 2020 |
| School group programmes reduce PTSD a little | A (small effect) | Purgato 2018, Tol 2008, Barron 2013 |
| Child-friendly spaces as treatment | B, weak | Hermosilla 2019 |
| KIDNET for persistent child PTSD | A (small trials) | Ruf 2010, MI-01 |
| Debriefing children | A for no benefit, X by extension from adults | Stallard 2006, MI-01 |
| Separating children from family for safety | X | Santavirta 2015, 2018, Freud and Burlingham 1943 |
| Shared caregiving among known kin harms attachment | Not supported | Keller 2018, Tronick 1987 |
| “Children forget”, “must not be told” | X as stated | Section 6 |

What the tradition says, what the record shows and what is inferred are kept apart in sections 1 to 7. The ratios in section 2 and the protocols are inference, marked.

## Means ledger

| Rung | What can be done |
|---|---|
| Hands and knowledge | One named caregiver, siblings kept together, routine of meals, sleep and chores, play, simple truthful telling, watching for red flags, no forced telling. This is most of the effect. |

| Rung | What can be done |
|---|---|
| Hearth | A household able to feed one more child. A lactating woman for an infant (MA-06). |
| Garden and still | Food support to carer households, so that taking an orphan does not mean hunger [OWNER]. |
| Village dispensary (300) | An orphan and separated-child register, a guardian named for each, a monthly visit, a school with a daily timetable, a play group, a mothers' and carers' group, one or two trained lay helpers who know the red flags. |
| District infirmary (3,000) | Tracing between villages, a supervised lay counsellor trained in a structured group programme and in KIDNET for children still affected after a month, a referral point for mute, self-harming or wasting children (MA-07). |
| Hospital before the Fall | Child psychiatry, assessment of attachment disorders, family courts and paid foster networks. Not needed for most children, and not what made the difference in Bucharest, which was a family. |

## Harm test

**1. Infant institutional care (the orphan house).** How it harms: wasting, infection, developmental arrest, indiscriminate attachment, later inattention and emotional problems. Who must never receive it: no child under two, and none under six months for any length of time if a household can be found. Signs it is going wrong: a baby who stops crying for attention, does not reach out, rocks, loses weight on adequate food, or goes to any stranger. What to do: move the child to a household with one named carer now, not after a review. Historical cases: Dublin Foundling Hospital, New York institutions 1909 to 1913, Spitz's Foundling Home, Romanian institutions (Chapin 1926, Spitz 1965, Nelson 2007, MA-06).

**2. Separating children from kin "to protect them".** How it harms: the separation itself is the trauma, and the effect may pass to the next generation. Who must never receive it: no child should be sent away from a living parent or familiar kin for safety unless staying means a clear danger to life [OWNER]. Signs it is going wrong: a child who was calm through danger and becomes withdrawn, sleepless or wetting after being moved. What to do: reunite or bring the familiar adult to the child. Historical cases: London evacuation (Freud and Burlingham 1943), Finnish war children (Santavirta 2015, 2018).

**3. Forced telling and debriefing.** How it harms: no benefit in children, harm in adults, and it can fix memories and shame. Who must never receive it: any child in the first four weeks, and any child who has not asked. Signs: nightmares or refusal to attend afterwards. What to do: stop, return to routine and the caregiver. Historical cases: Stallard 2006, MI-01.

**4. Exposure therapy by the untrained.** KIDNET and similar methods are only safe in trained, supervised hands with a stable placement. Who must never receive it: a child still in danger or without a stable caregiver, a child in the first four weeks, a child who is psychotic or actively suicidal [VERIFY, inference from MI-01]. Signs: rising distress across sessions, dissociation, self-harm. What to do: stop and refer to the district.

**5. Labelling grief as disorder.** How it harms: it turns a normal response into a stigma and starts treatments the child does not need. Who must never receive it: a bereaved child in the first months whose distress is shaped by the loss and who still eats, sleeps some, plays some and responds to their carer. What to do: support through the

household and the rite. The grief report sets the line between grief and disorder. Historical note: Attanayake's 47 per cent counts questionnaire scores, and many studies measured children within weeks of loss.

**6. Frequent moves between households.** How it harms: each move breaks attachment, and in Bucharest the children who stayed put did best (King 2023). Who must never receive it: no child should be moved more than once in the first year except for danger. Signs: a child who stops forming attachment to the new carer, or attaches to anyone. What to do: settle the child, support the household instead of moving the child.

**7. Violence inside care.** How it harms: in a Tanzanian orphanage violence inside the institution mattered more than past violence (Hermenau 2011), and abuse is common in families too (Gray 2015). Who must never be a carer: anyone who beats children [OWNER for the village rule]. Signs: bruises, fear of the carer, a child who will not go home. What to do: remove the child to kin, sanction the carer.

**8. Using children's stories.** How it harms: stories of child soldiers and orphans gathered for advocacy or fundraising select the worst cases, are often told to please, and fix a child in a role. The Sierra Leone cohort shows most did far better than the stories suggested (Betancourt 2020). Rule: no child is asked to tell their story to a visitor, and children's stories are not data unless collected as data.

## Red flags

Watch at one week, four weeks, three months and six months. Escalate to the district for any of these. 1. An infant who stops crying, smiling or reaching, or loses weight while fed (deprivation, see MA-07 for wasting). Act within days. 2. A child of any age who goes off with strangers without looking back (indiscriminate attachment, Gleason 2014). Settle with one carer, do not move again. 3. A child who has stopped speaking, eating or playing after the event (THRIVING library, MI-01, Red flag 6). Keep with a calm adult and routine, and refer if it has not eased within a few days [VERIFY, my threshold]. 4. Nightmares, flashbacks, avoidance or startle that are no better at four weeks and still present at three months (Hiller 2016). Offer the group programme or KIDNET. 5. Talk of death, self-harm, or giving things away, at any time. Same day. 6. A double orphan, a child who saw a parent die, or a child who did violence: watch more closely and longer (Goenjian 2009, Betancourt 2010). 7. A carer who is depressed, overloaded or hungry (Kuo 2012). The child is at risk through the carer. 8. Signs of beating, sexual abuse or exploitation in the placement household (Gray 2015). 9. A child shunned by the village, called cursed or blamed for a death (Betancourt 2010, Cluver 2012).

## The case against

**Institutions are not always worse.** POFO found school-age orphans in institutions no worse than those in poor community households, with less yearly abuse (Whetten 2009, Gray 2015). If kin are dead, hungry or abusive, a small, well-run home with stable staff may be better than a bad foster placement. The answer is that this does not apply to infants, that POFO compared institutions with poor care rather than with good kinship care, and that a home built on Hampstead lines, three to five children per named adult, is already halfway to a household.

**Attachment theory is culturally narrow.** Keller is right that one-mother, one-child sensitivity is not the human norm (Keller 2018). This report therefore asks for one named adult who is the child's own within shared care, not for exclusive mothering.

**The trial evidence for school programmes is thin.** Effects are small, one well-designed trial vanished once clustering was handled (Jordans 2010), assessors were often not blind, and most trials ran for weeks, not years. A village may do as well by reopening school and restoring routine as by running any programme. That is a fair reading.

**The trauma frame itself.** Summerfield and others argue that Western trauma categories medicalise suffering that is social and political (THRIVING library, MI-01). Attanayake's 47 per cent shows how questionnaires can inflate

caseness. On this view, children need justice, food, school and family, not therapy. The Armenian and KIDNET data say that a minority do need treatment, but the critique is right about the majority.

**Resilience as a slogan.** The finding that most children recover can be used to do nothing. The recovery happens because of adults and routine, and the minority who do not recover (about one in nine still with PTSD at a year in Hiller's data, more after war) are the ones a village must find.

**Old studies were weak.** Spitz's numbers were small and unverified, and his critics had a point (Pinneau 1955). The conclusion survives only because Chapin, Schlossmann, the Romanian studies and the Bucharest trial all point the same way.

## 10-line summary

1. Infant institutions killed: 42 per cent dead under two in New York homes, 37 per cent in Spitz's clean Foundling Home.
2. The only trial (Bucharest) shows a family beats an institution for IQ, growth and attachment, effects stable to 18.
3. Severe deprivation beyond 6 months leaves lasting marks, and placement before 24 months matters for attachment and cognition.
4. The dose that worked: 3 to 5 children per named adult with one named substitute, and no needless moves.
5. Most children recover from single events with a familiar adult and routine: PTSD falls from 21 to 11 per cent over a year.
6. Separating children from family for safety harmed them, and evacuated Finnish girls' daughters had 4.7 times the mood-disorder admissions.
7. Kin first: kinship care halves placement breakdown and mental disorder compared with strangers.
8. School group programmes help a little (effect about 0.33), KIDNET helps children still ill after a month, debriefing does not help.
9. Tell children the truth about a death, never make them tell their own story.
10. Feed and support the carer, or the placement fails.

## Open questions

- What proportion of children recover with a stable adult alone after mass death, not accidents? No study isolates it.
- Does placement after 33 months recover IQ and attachment as well as earlier placement? The Bucharest trial cannot say.
- Are the 6-month and 24-month windows the same for less extreme deprivation than Romanian institutions?
- How many children can one adult raise well in a shared-care compound with older siblings helping?
- What happened to the orphans of 1918 placed with kin under the New Zealand scheme? No outcome data found.
- Does a village programme for carers (Dybdahl) do more for children than a programme for the children?
- How should a village with no trained counsellor tell normal grief from disorder in a child? The grief report should answer the grief side.

## Sources to read in full

1. King 2023 (Bucharest to 18), read in full here. The core trial.
2. Sonuga-Barke 2017 (ERA), only the abstract read. The 6-month window.
3. van IJzendoorn 2020 (Lancet Commission), only the abstract read. The pooled picture.
4. Freud and Burlingham 1943 and 1944, read in full. Practice in wartime nurseries.

5. Whetten 2009 (POFO), read in full. The strongest case against.
6. Purgato 2018, only the abstract read. Which group programmes work.
7. The Inter-agency Guiding Principles on Unaccompanied and Separated Children 2004, not read directly. The tracing and care rules.
8. Betancourt 2020, only the abstract read. What protects former child soldiers into adulthood.

## At the bedside after the Fall

**Household.** Minimum: one adult who takes the child as their own, the child's siblings in the same house, meals and sleep at fixed times, chores and play. Needs: enough food for one more, a second adult who can stand in, permission to grieve. First failure: the carer is overloaded and hungry, the child is treated as a servant or an outsider, or the child is moved on.

**Village of 300.** If children are about a third of the population there are about 100 children [VERIFY, inference]. After a heavy epidemic or attack one might expect several to lose a parent and a few to lose both [VERIFY, inference, no source gives a rate for this setting]. Minimum: an orphan and separated-child register kept by a named person, a guardian named for every child without a parent within a day, kin found first, siblings never split, a monthly visit to each placement, school reopened within a week of the event even under a tree, a play group daily. Needs: a food share for carer households [OWNER], a carers' group, one or two adults trained in the red flags and the first-week protocol. First failure: someone proposes an orphan house to gather the children in one place, or children are sent to another village "for safety".

**District of 3,000.** About 1,000 children [VERIFY, inference]. Minimum: tracing between villages, with lists exchanged weekly, one supervised lay counsellor per few villages trained in a structured school group programme and KIDNET, a referral place for wasting, mute or suicidal children. Needs: a supervisor who checks counsellors' competence (THRIVING library, MI-01), records kept across villages, a rule against adoptions before tracing ends. First failure: an outside charity or a well-meaning leader opens an orphanage and families begin to place children there to be fed.

## Protocols

**Protocol 1. The first week for an orphaned or separated child** - Hour 0 to 24. 1. Keep the child with the adult they came with, unless that adult is a danger. Never let an unaccompanied child be taken by an unknown adult (THRIVING library, MI-01, Protocol 1). 2. Register name, age, village, parents' names, siblings and the adult holding the child. 3. Name one caregiver, kin if any can be found that day, and one named substitute. 4. Keep siblings together. 5. Food, water, warmth and sleep in the same place each night. 6. If the child asks what happened to a parent, tell the truth in simple words. Do not ask the child to tell what they saw. - Days 2 to 3. 1. Start tracing: send names to neighbouring villages. 2. Set a daily shape: getting up, meals, a small chore, play, bedtime, all at the same times. 3. The child goes with the household to any rite, unless the family says otherwise (THRIVING library, MI-01, Protocol 6). The grief report covers the rite. - Days 4 to 7. 1. School or a daily lesson with other children, even an hour a day. 2. Play with other children every day. 3. Check the caregiver: is there enough food, is the carer coping? 4. Record the first red-flag check. - Throughout. 1. No forced telling, no questioning by visitors, no photographs or stories for outsiders. 2. No moves to another household except for danger. 3. No adoption, name change or long move until tracing is finished [OWNER on how long, the inter-agency principles say not in the emergency phase].

**Protocol 2. The infant under two without a mother** 1. Within hours, a household with a lactating or relactating woman (THRIVING library, MA-06). Never an orphan house [OWNER]. 2. One main carer who feeds, holds and settles the baby, and one named substitute. No rota of strangers. 3. Daily holding, talking and face-to-face play, in addition to feeding. 4. Weigh weekly for the first month and then monthly (THRIVING library, MA-07). 5. Target: in a family before 6 months of age if at all possible, by 24 months at the latest (Sonuga-Barke 2017, Nelson 2007). 6. Same household for the long term. Do not move the baby once settled.

**Protocol 3. The watch schedule**

| When | Who checks | What |
|---|---|---|
| Day 7 | Guardian and register keeper | Eating, sleeping, playing, attending school, carer coping |
| Week 4 | Trained helper | Red flags 1 to 9, nightmares and avoidance |
| Month 3 | Trained helper | Persistent symptoms: refer to group programme or KIDNET |
| Month 6 | Trained helper | Still affected? Likely to persist (Hiller 2016), refer |
| Month 12 and yearly | Register keeper | Placement, school, weight, acceptance |

Double orphans, children who saw a death and children who did violence: add a check at week 2 and month 2.

**Protocol 4. A village organises orphan care without an orphanage** 1. Register: one named keeper, a book listing every child without a parent, their guardian, siblings, health and tracing status. 2. Order of placement: surviving parent, then grandparents or the parents' siblings, then other kin, then a household the child already knows, then another household in the village. Never an institution for a child under two [OWNER on whether a small home is permitted for older children when no household can be found]. 3. Siblings together. If no household can take all, the nearest households take them and they meet daily. 4. Support: the village provides the carer household with food or land work equal to what the child would cost in a home [OWNER], on the New Zealand 1918 model. 5. Carers' group: meeting through the first five months, the Bosnian pattern (Dybdahl 2001). Weekly is my suggestion [VERIFY]. 6. Visit: the register keeper or a deputy visits each placement monthly. 7. Ban: no child may be beaten or kept from school as labour in a placement [OWNER]. 8. Acceptance: the village elders speak publicly for any child blamed, shunned or returning from fighting (Betancourt 2010).

**Protocol 5. A school group for children still struggling** 1. Only after the four-week gate (THRIVING library, MI-01), for children whose symptoms persist. 2. Run by a trained, supervised lay facilitator. 15 sessions over 5 weeks, as in Poso (Tol 2008), or 5 to 10 sessions for older children (Barron 2013, Betancourt 2014). 3. Content: safety and calming skills, cooperative games, drawing or drama, and coping skills. No child is made to tell their story aloud. 4. Children still affected after the group go to KIDNET with a trained counsellor (Ruf 2010).

## Numbers to carry

1. 422.5 per 1,000: deaths under two in New York infant institutions, 1909 to 1913, against 87.4 in the general population (Chapin 1926).
2. 37 per cent: Spitz's Foundling Home infants dead by two despite good hygiene, at one nurse to 8 to 12 infants (Spitz 1965).
3. 3 to 5 children per named adult, plus one named substitute: the Hampstead dose (Freud and Burlingham 1944).
4. 6 months and 24 months: the windows after which deprivation is harder to undo (Sonuga-Barke 2017, Nelson 2007).
5. 21, 15, 12 and 11 per cent: child PTSD at 1, 3, 6 and 12 months after a single event (Hiller 2016).
6. 0.33: the effect size of school group programmes on PTSD (Purgato 2018).
7. 0.51: odds of mental disorder in kinship care against care by strangers (Winokur 2014).
8. 2.19: the hazard ratio for mood disorder in Finnish girls evacuated away from their families (Santavirta 2015).

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