THE SOCIAL CARE TRAINING HUB

TRAUMA & BRAIN DEVELOPMENT

Your Handbook

This handbook has been published by The Social Care Training Hub as part of its Training and Development Program for carers who work with vulnerable young people. The program which you have completed has been designed to assist carers with relevant and practical training practices which can be implemented into carers and young people lives.

This guide only covers the essential points of good practice when working with children and young people.

This handout provides more detailed information which you can download and review in your own time this way you can reflect and remind yourself of the key messages you have learnt.

THE
SOCIAL CARE
TRAINING HUB

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"Our brains are sculpted by our early experiences. Maltreatment is a chisel that shapes a brain to contend with strife, but at the cost of deep, enduring wounds."

--Teicher, 2000

As recently as the 1980s, many professionals thought that by the time babies are born, the structure of their brains was already genetically determined.

However, research shows evidence of altered brain functioning as a result of early abuse and neglect

Impact of Trauma

There is research to show that children who have experienced trauma show an increased incidence of:

- Coronary heart disease
- Cancer
- Chronic Lung disease
- Skeletal fractures
- Liver disease

Research on the Effect of Trauma on Memory

Research has shown that traumatized individuals respond by using a variety of psychological mechanisms. One of the most common means of dealing with the pain is to try and push it out of awareness. Some label the phenomenon of the process whereby the mind avoids conscious acknowledgment of traumatic experiences as *dissociative amnesia*. Others use terms such as *repression*, *dissociative state*, *traumatic amnesia, psychogenic shock,* or *motivated forgetting*. Semantics aside, there is near-universal scientific acceptance of the fact that the mind is capable of avoiding conscious recall of traumatic experiences.

Some research from Aug 2015

Special brain mechanism discovered to store stress-related, unconscious memories.

Some stressful experiences -- such as chronic childhood abuse -- are so traumatic, the memories hide like a shadow in the brain and can't be consciously accessed. Eventually, suppressed memories can cause debilitating psychological problems. Scientists have discovered how and where the brain stores those stressful memories and how to retrieve them. The findings could lead to new treatment for patients with repressed traumatic memories.

What is “normal” difficult behavior?

“Normal” Difficult Behavior

- Moodiness
- Less affection shown to parents
- Greatly influenced by peers

- Preoccupation with sex
- Masturbation
- Very occasional experimentation with cigarettes or alcohol
- Extremely self-involved
- Self- conscious
- Involvement with cliques

Cries for Help

- Regular use of alcohol and/or other drugs
- Sexual promiscuity
- Lying or stealing
- Destructive or delinquent behavior
- Poor school behavior
- Persistent Negative attitude
- Frequent temper outbursts
- Extreme fear of leaving home
- Self- Mutilation
- Suicidal ideas or suicide attempt

Young people at risk

“In the presence of a drunk or drugged parent, the child feels emotionally abandoned and frightened..”

“heavy use of alcohol and drugs distort, disrupt and disturb parent-child relationships..”

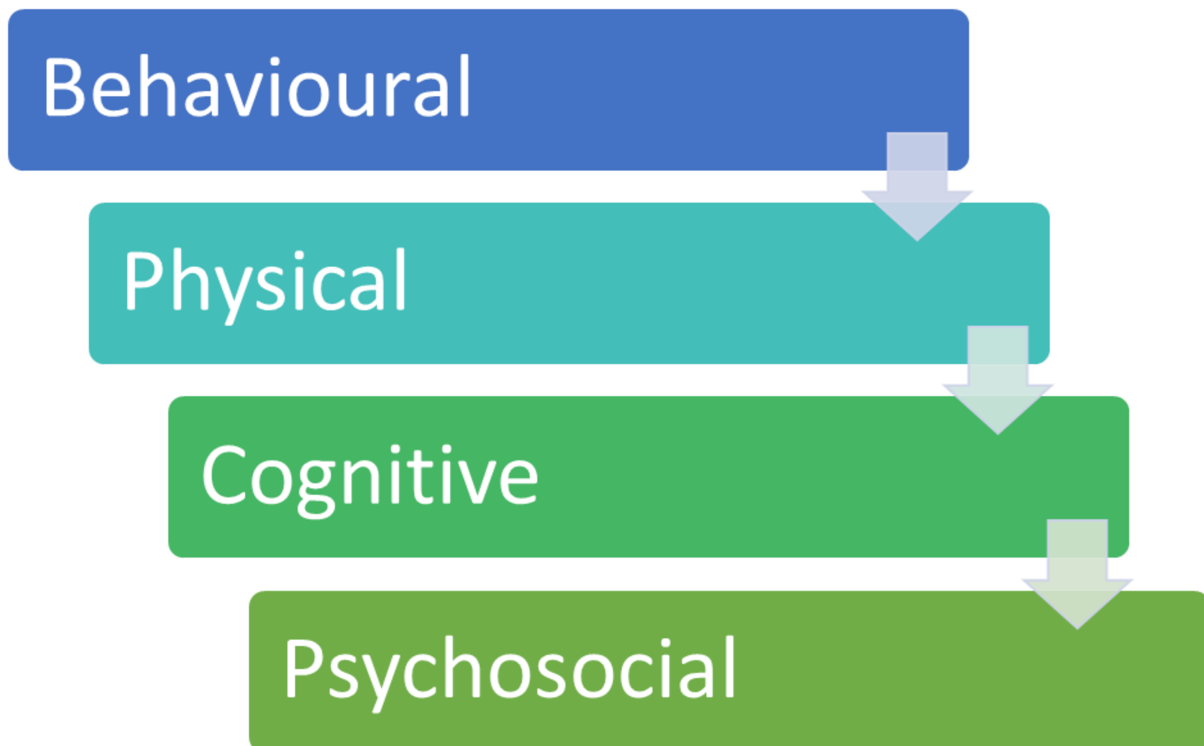
(Howe 2005, p184)

Adult offspring of problem drinkers report more traumatic childhood experiences; being less happy; having less cohesive and stable childhood relationships; violent family relationships and high levels of social isolation.

Often crises in the life of the adult dominate family life.

(Hart in Phillips 2004, p.257)

Signs and Symptoms of Trauma



***Behavioural symptoms*:**

- Substandard educational performance
- Difficulties establishing and maintaining interpersonal relationships
- The misuse of alcohol and/or other drugs
- Acting in a risky, reckless or otherwise dangerous manner
- Expressions of worthlessness or diminished self-esteem
- Self-harm

***Physical symptoms*:**

- Disrupted sleep patterns
- Suppressed or heightened appetite
- Increased heart rate

***Cognitive symptoms*:**

- Problems with concentration or focus
- Flashbacks (re-experiencing the trauma)
- Nightmares or night terrors
- Derealisation
- Depersonalisation
- Memory problems

***Psychosocial symptoms*:**

- Agitation and irritability
- Anxiety
- Depression
- Dramatic mood swings
- Inability to experience pleasure
- Suicidal ideation

Emotional Problems

Over-eating, excessive sleepiness and a persistent over-concern with appearance may be signs of emotional distress.

Anxiety may produce phobias and panic attacks. Research suggests that emotional disorders are often not recognised, even by family and friends.

At some time, 4 out of 10 adolescents have felt so miserable that they have cried and have wanted to get away from everyone and everything.

During their adolescence, more than 1 in 5 teenagers think so little of themselves that life does not seem worth living. In spite of these powerful feelings, depression may not be obvious to other people.

Effects of Complex Trauma

Without proper treatment, individuals who have been impacted by complex trauma may be at increased risk of experiencing the following negative outcomes:

- Strained or ruined interpersonal relationships
- Family discord, separation, and divorce
- Insomnia or hypersomnia
- Job loss and chronic unemployment
- Misusing alcohol and/or other drugs
- Co-occurring mental health disorders
- Social withdrawal and isolation
- Self-harm
- Thinking about and attempting suicide

Difficulties with personal relationships

Appropriate attachment experiences occur in the early years of childhood, affecting, in a positive way, our ability to securely relate to others throughout life. Therefore, if the ongoing traumatic experience occurs within the context of a care relationship (for example, a parent or caregiver may be abusive, neglectful or unpredictable), secure attachment is not generated. These experiences may then continue into adult life, making relationships with others difficult to establish and maintain.

For example, people suffering insecure attachment may grow up believing that others will always hurt them, leave them or both.

Adolescence is also an important time in determining how an individual relates to others. Young people become independent from those they have secure attachments with (for example parents or carers), and so are increasingly able to make their own decisions. This process entails

restructuring their network of significant others, with peers and romantic partners becoming increasingly more important, and deriving their self-identity from them to a greater extent.

Adolescents who have experienced early childhood trauma are less likely to have developed secure attachment relationships with their caregivers. Fears of physical danger undermine the adolescent's moves towards autonomy. Furthermore, feelings of mistrust, self doubt,

shame and guilt impact upon the individual's sense of self-esteem, affecting the development of secure peer and romantic relationships, and a stable sense of identity.

Difficulties regulating emotions

In addition to attachment difficulties, early complex trauma is associated with difficulties regulating emotions.

Emotion regulation refers to the process whereby a person attempts to manage or control strong, usually unpleasant, emotions – either before or after they occur.

These skills are learnt throughout life but childhood and adolescence are particularly important times for this.

If people are not taught to regulate their emotions, it can result in difficulties in controlling anger and other intense emotions, particularly in adolescence and adult life.

Infants who do not suffer abuse or neglect may learn that, by showing that they are distressed, caregivers will come and help. In this way,

emotional experiences are *validated, in other* words, the infant becomes aware that their distress is valid and others are available to care for them.

Later, when language develops, children may learn to describe their emotional state with the help of information from caregivers, through labels applied to specific emotions (for example, jealousy and anger).

Again, attention to these emotions validates them, and the child is taught strategies to manage them.

Throughout childhood and adolescence, a great deal is learnt about what emotions are acceptable and unacceptable because limits and boundaries are made explicit and adhered to.

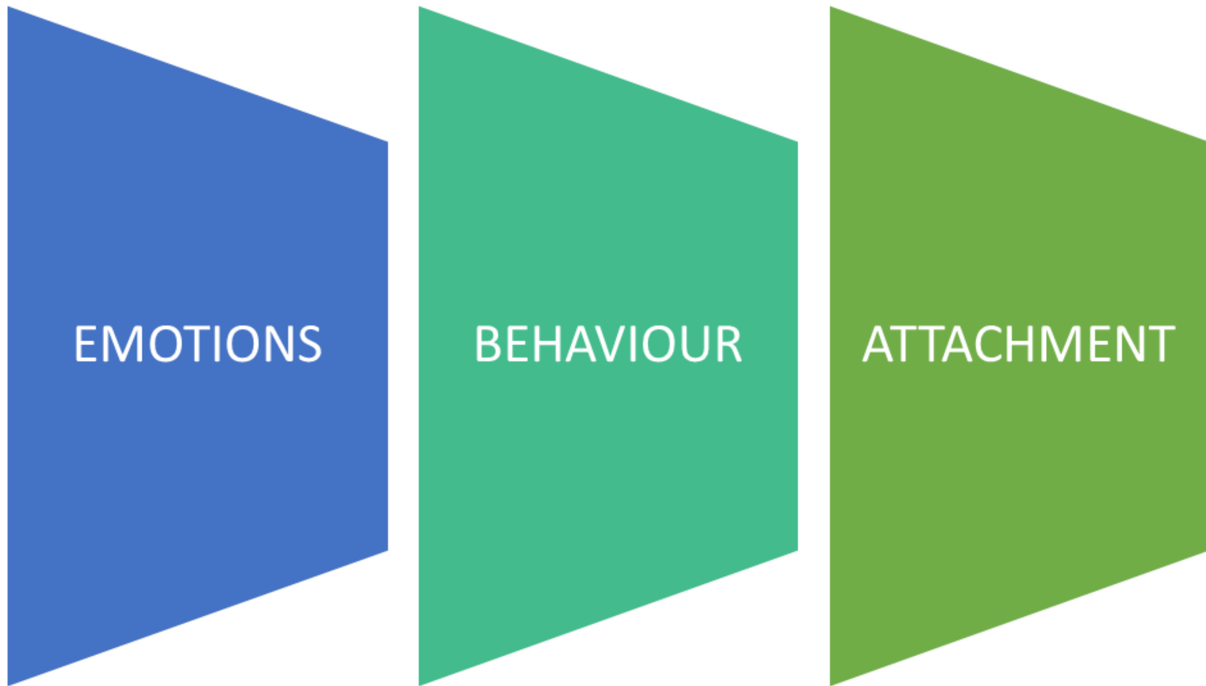
If the environment in which the child grows up does not serve these functions, the individual may grow up unable to calm themselves ('self soothe'), and may seek other ways of avoiding unpleasant emotions.

Two typical ways of coping with emotion dysregulation are substance misuse and self-harm.

These ways of coping can often lead on to other behaviours which may be deemed antisocial, bringing the individual into contact with the criminal justice system and incurring negative consequences in terms of how the wider community views them.

Key issues

There are three key issues that you need to consider in order to effectively manage and support young people displaying difficult behaviour linked to trauma.


EMOTIONS
BEHAVIOUR
ATTACHMENT

Emotions

Emotion regulation may be a primary factor, so teaching young people the skills to regulate their emotions or problem-solve ways to deal with them are important.

Emotions may result in what are called 'action urges'. An important function of emotions is to prompt behaviour *(for example, if we feel angry we may be prompted to fight, or if we feel fear we may be prompted to flee).*

The action itself is not part of the emotion, but the urge to do the action is.

Emotions can be either a reaction to events in the environment or to things inside a person (known as *prompting events). A person's thoughts,* behaviours and physical reactions prompt emotions. It is important for the young person to recognise these prompting events and, more importantly, their interpretation of them, if they are to effectively regulate their emotions.

Emotions involve changes in the body: for example the tensing and relaxing of muscles; and changes in heart rate, blood pressure and facial expressions. To be able to regulate emotions, the individual must be good at sensing what is going on in their own body. If the individual has practiced shutting off bodily sensations (as is the case with some people suffering complex trauma), this can be difficult.

Nevertheless, this is a learnt response and it can be reversed.

Another important function of emotion is to aid communication. We communicate our emotions to others using verbal and non-verbal signals. Some expressions of emotion have an automatic effect on others. When there is a difference between what a person communicates non-verbally and their verbal message, the other person will usually respond to the non-verbal expression.

One of the main problems experienced by young people with complex trauma is that their non-verbal emotional expressions do not match their feelings (for example, they may feel frustrated and angry inside but show no emotional expression on their face).

As a result, they are often misunderstood. This can lead to feelings of frustration, anger and sadness.

An individual is more vulnerable to negative emotions when they are physically unwell, tired, hungry, under the influence of mood-altering drugs, or when they are not participating in activities that provide a sense of mastery or accomplishment. By helping a young person to deal with these issues, you can help reduce their vulnerability to negative emotions.

Behaviour

Ensuring a good behavioural approach may be useful, ensuring that punishment contingencies are only used sparingly in serious cases and reward contingencies are used more often to shape behaviours.

Experience of working with children and young people with complex trauma suggests that punitive approaches to managing behaviour can serve to reinforce patterns of difficult behaviour; and that an emphasis on praise and positive reinforcement is more helpful. For example, excluding a child who has attachment difficulties may only serve to cause more distress that may be manifested as aggression. Punishment only really serves to teach children what behaviours to avoid, not which ones to adopt.

Likewise, experience of working with children and young people who have difficulty regulating their emotions suggests that certain well-tried and tested interventions, such as 'time out', need to be carefully considered. One of the functions of time out is that the child or young person has an opportunity to calm down. But if the person does not have the skills to calm themselves down, the intervention will not work and the young person may remain emotionally dysregulated (that is, upset) for much longer.

Also, for children and young people with attachment difficulties, time out can be seen as a withdrawal of a relationship with the carer for that time period (that is, the carer is not available), which can be re-traumatising for them and not useful to the longer term development of the relationship.

Attachment

Possibly most importantly, children and young people should be provided with a good quality attachment experience, particularly if it has been severely disrupted. Many forms of formal therapy work to achieve this but it can, of course, be achieved in the context of a good key-working or other relationship within the setting.

A child or young person may form a good attachment to another person, particularly if that person offers consistent, predictable care. This may be difficult, especially if the young person has learnt to avoid attachment experiences. Most formal psychological therapies work with attachment processes, explicitly or implicitly.

However, it is important for all staff to be aware of the consequences of disrupted attachment; and to be aware of what they can do to ensure that children are given the opportunity to form positive new attachments. In this context, it is very important that young people enjoy consistent and positive relationships with staff, particularly with their designated key worker.

When there is contact with an attachment figure, care should not be provided or withdrawn in order to reward or punish a particular behaviour as this could re-traumatise the child or young person.

How Nurture Becomes Nature

The Impact of Neglect and Trauma on the Developing Brain

At the Developmental Traumatology Laboratory at Western Psychiatric Institute and Clinics in Pittsburgh, Pennsylvania, researchers are conducting studies in traumatized children using the most up-to-date methods to study their stress circuits and brain development. In a recent report, they described their findings on maltreated children with PTSD who they compared to healthy, normal children and to children with clinical anxiety disorders who had not been maltreated. Many of the maltreated children had been sexually abused beginning between the ages of 18 months and 7 years. They had also witnessed domestic violence beginning early in life, and some had been battered by family members. For most of the children with PTSD, the trauma was chronic, lasting for several years before the children were rescued.

Unlike non-maltreated comparison children, the children with PTSD had elevated levels of the stress hormones adrenaline and cortisol, even on a normal day when nothing especially stressful was happening (DeBellis, Baum, et al., 1999). Thus, these children's stress systems seemed to be turned on even when they didn't need to be. Especially high stress hormone levels were found among the children who had been abused for longer and/or had more severe PTSD. Very similar results have been found for children rescued from Romanian orphanages, even though for the most part these children had been severely neglected rather than physically or sexually abused.

The Pittsburgh group also scanned the brains of maltreated children with PTSD. Even after they accounted for many things that could produce mistaken results, they found striking evidence of smaller brain volumes, with larger effects the earlier the abuse began and the longer it lasted before the children were rescued (De Bellis, Keshaven, et al., 1999). Similar results have been found at the CIVITAS Child Trauma Programs at Baylor College of Medicine. Did the abuse cause the brains of these children to be smaller? We can't be certain. Would the brains of abused children who did not develop chronic PTSD also show some reduction in size? We don't know. But this data and other studies currently underway certainly encourage concern about the impact that maltreatment may have on the child's developing nervous system.

Final top tips

- Ensure training is up to date
- Reflective practice is key to reviewing care
- Develop psychologically informed practice
- Be patient with the child / young person

Thank you and congratulations on completing your training, this is one of many steps you will take in your journey to becoming a successful carer. We hope you have found this handbook useful, please remember you can refer to this handbook anytime to help, guide and maintain your knowledge.

To discover what other courses we offer please visit us at www.thesocialcaretraininghub.co.uk

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