Beacon House THE STUDIO ONLINE

Module Four (A) Training Notes

Module Four Themes

- Co-morbid difficulties
- Risk
- Developmental Trauma in Adulthood
- Principles of Intervention

Co-morbid Difficulties

PTSD

Developmental Trauma without PTSD

Developmental Trauma with PTSD
An explicit memory for discrete traumatic incidents alongside the 7 areas of impact

PTSD

Co-morbid Difficulties

PTSD

Normal memory (Autobiographical memory)

- **Non-traumatic memory**
- **Stored using accessible words:** what happened, feelings, people, experiences
- **Memory forms part of a story:** what happened, actions, thoughts and feelings
- **Sequenced, clear and coherent narrative:** beginning, middle and end
- **Set in a timeline**: know when it happened, it feels like it happened in the past
- **Can be updated with new information:** feelings and thoughts can be changed after the event
- **Recall of the memory can be controlled**

Co-morbid Difficulties

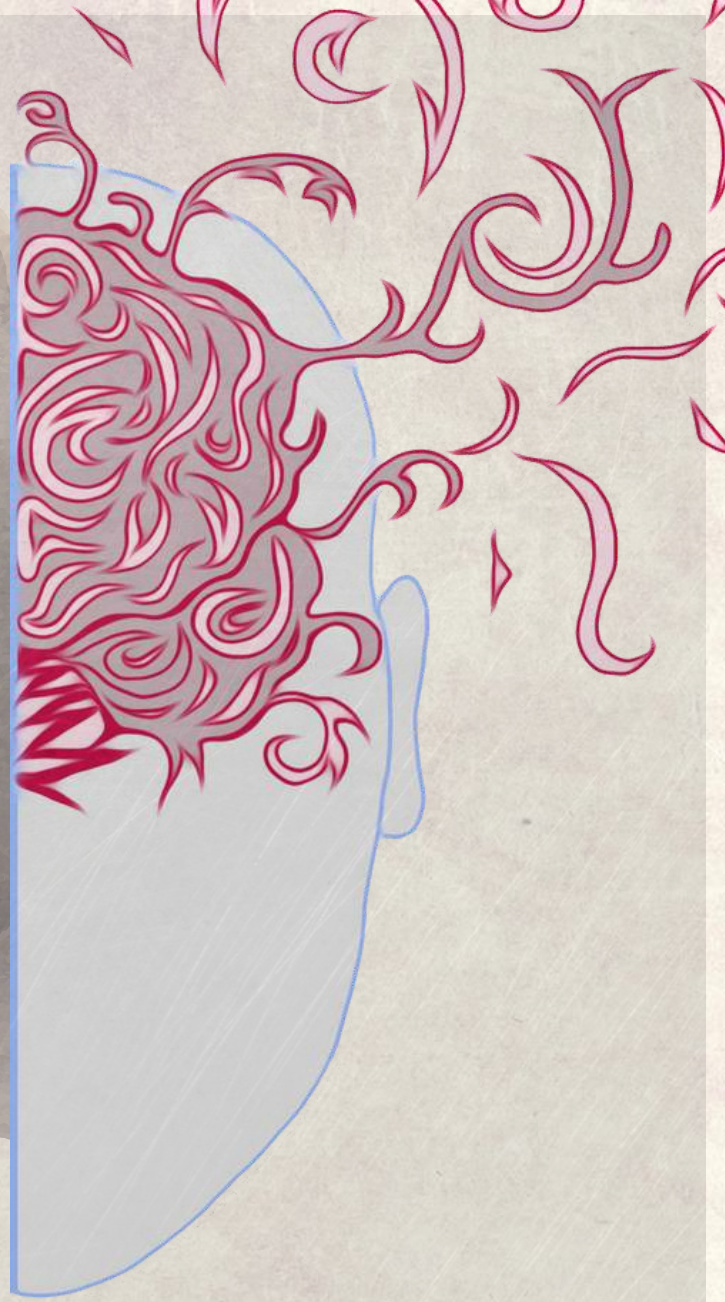
PTSD

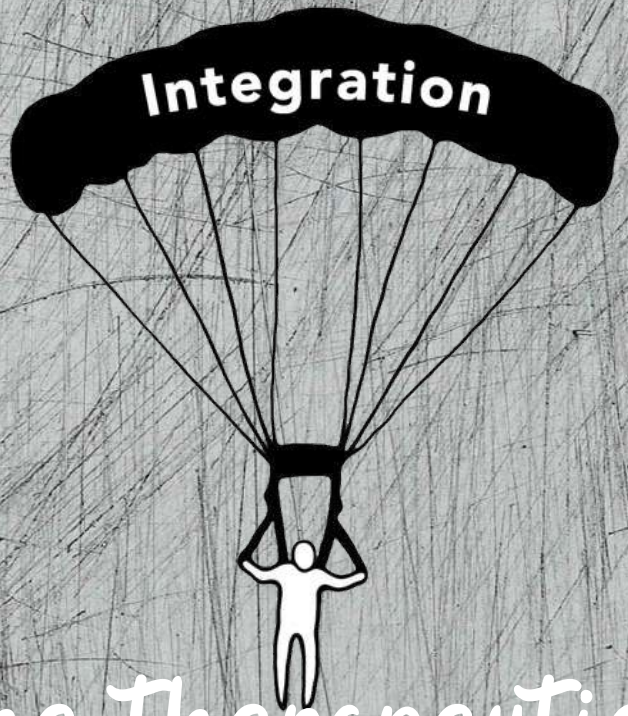
Trauma memory (Situationally accessible memories - SAMS)

- **Stored as a sensory memory:** smells, sounds, physical sensations, visual images
- **Memory is stored with no context:** Frozen in time, as if it is happening now. Feelings of acute danger in the present
- **Extra sensory stimuli:** During the event the brain pairs together the sensory experience with danger and subsequently triggers the sensory memory in the present
- **Recall is not controlled:** Memories intrude through external and internal triggers with little or no control and mastery over the memory
- **New information cannot be updated:** Beliefs, thoughts and feelings are stuck on a loop

"Following exposure to trauma, if integration does not occur, traumatic experiences are split off and an individual alternates between functioning as if the trauma is still occurring and functioning as if the trauma never occurred"

Nijenhuis, 2004



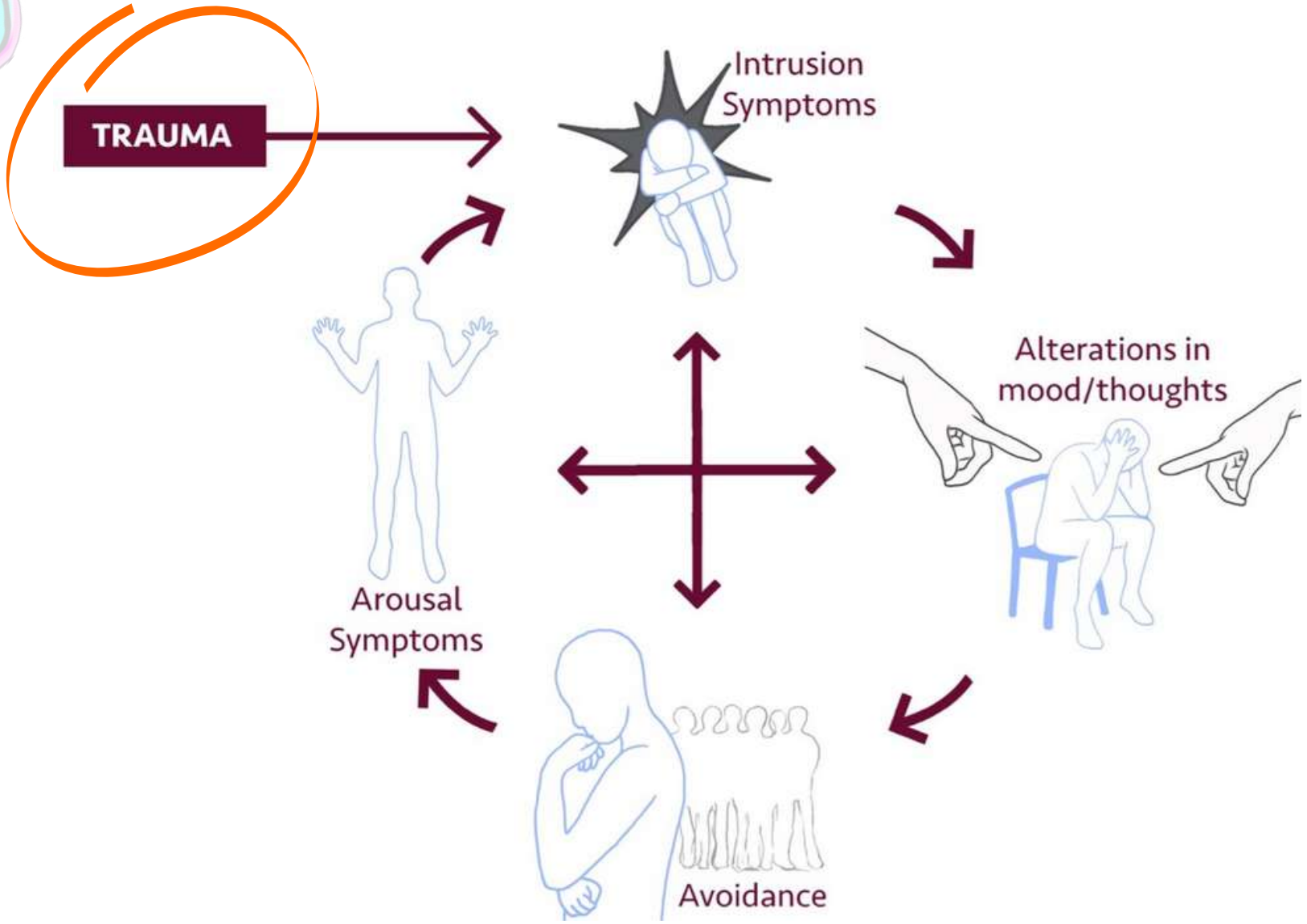


Integration is the therapeutic goal with PTSD

Co-morbid Difficulties

PTSD: Cluster of symptoms

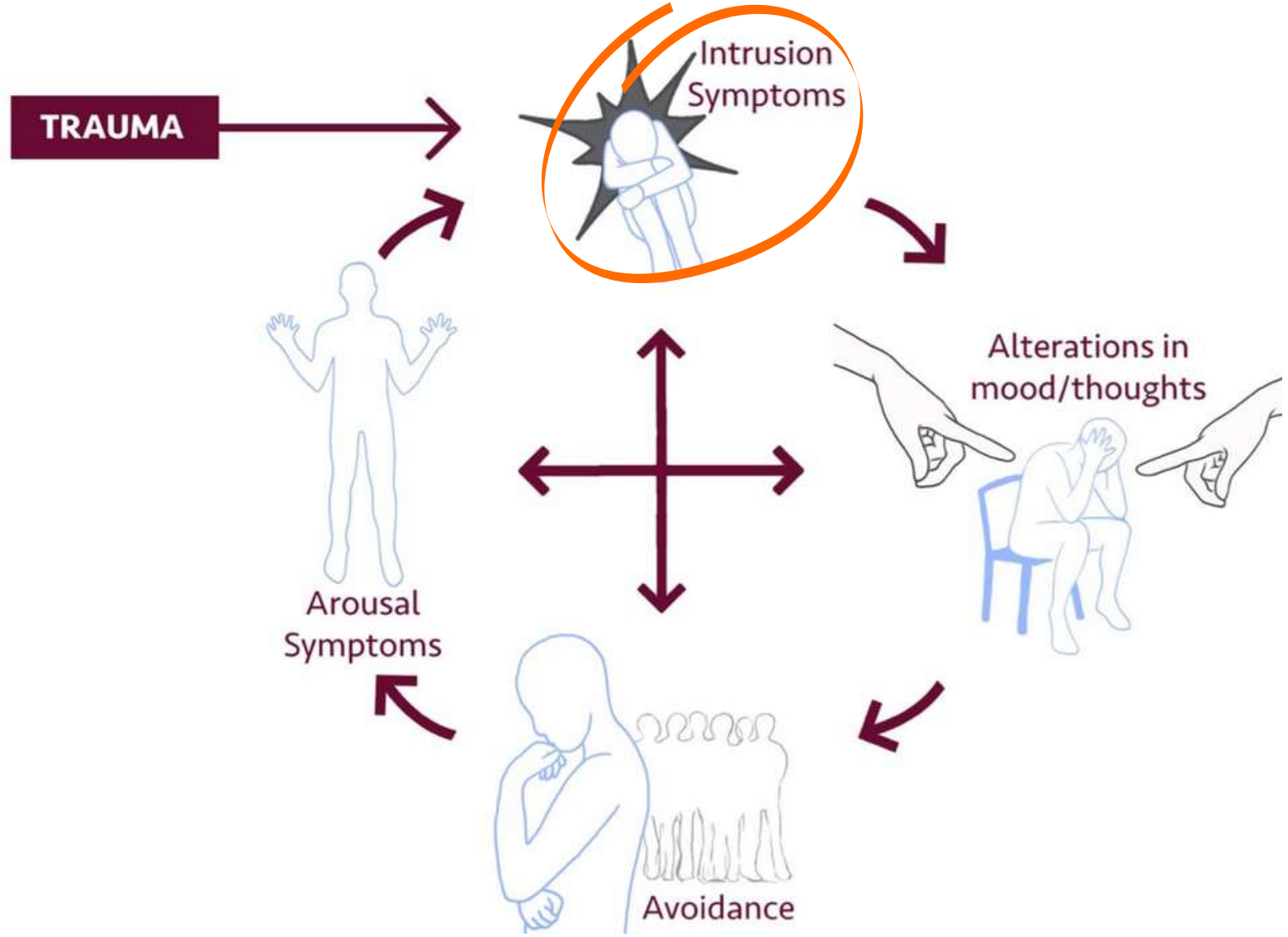
Trauma: An experience that poses a significant threat to self or significant threat to psychological integrity



Co-morbid Difficulties

PTSD: Cluster of symptoms

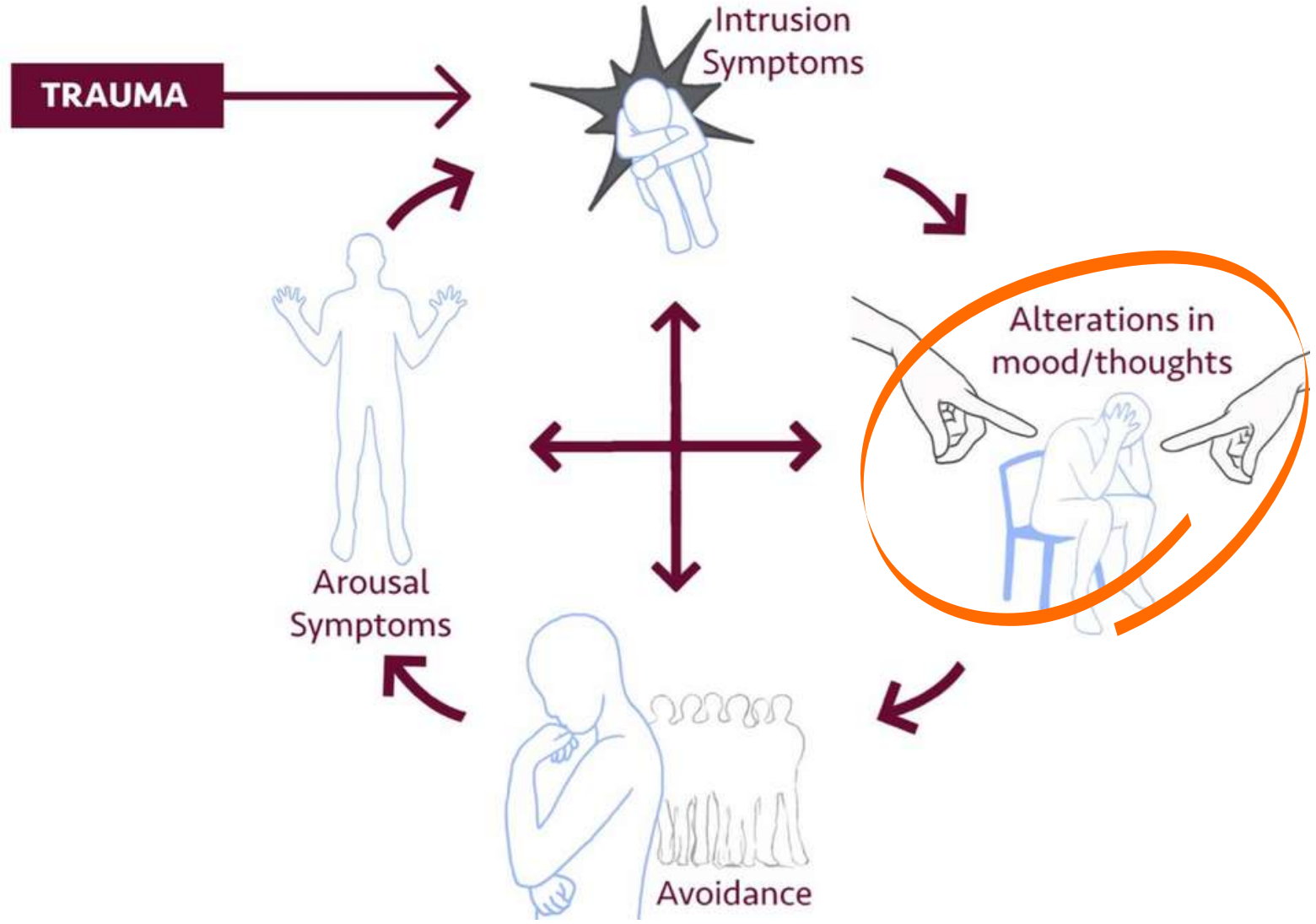
- Traumatic nightmares
- Dissociative reactions (e.g. flashbacks)
- Prolonged states of distress after exposure to traumatic reminders
- Marked physiological reactivity after exposure to trauma-related stimuli



Co-morbid Difficulties

PTSD: Cluster of symptoms

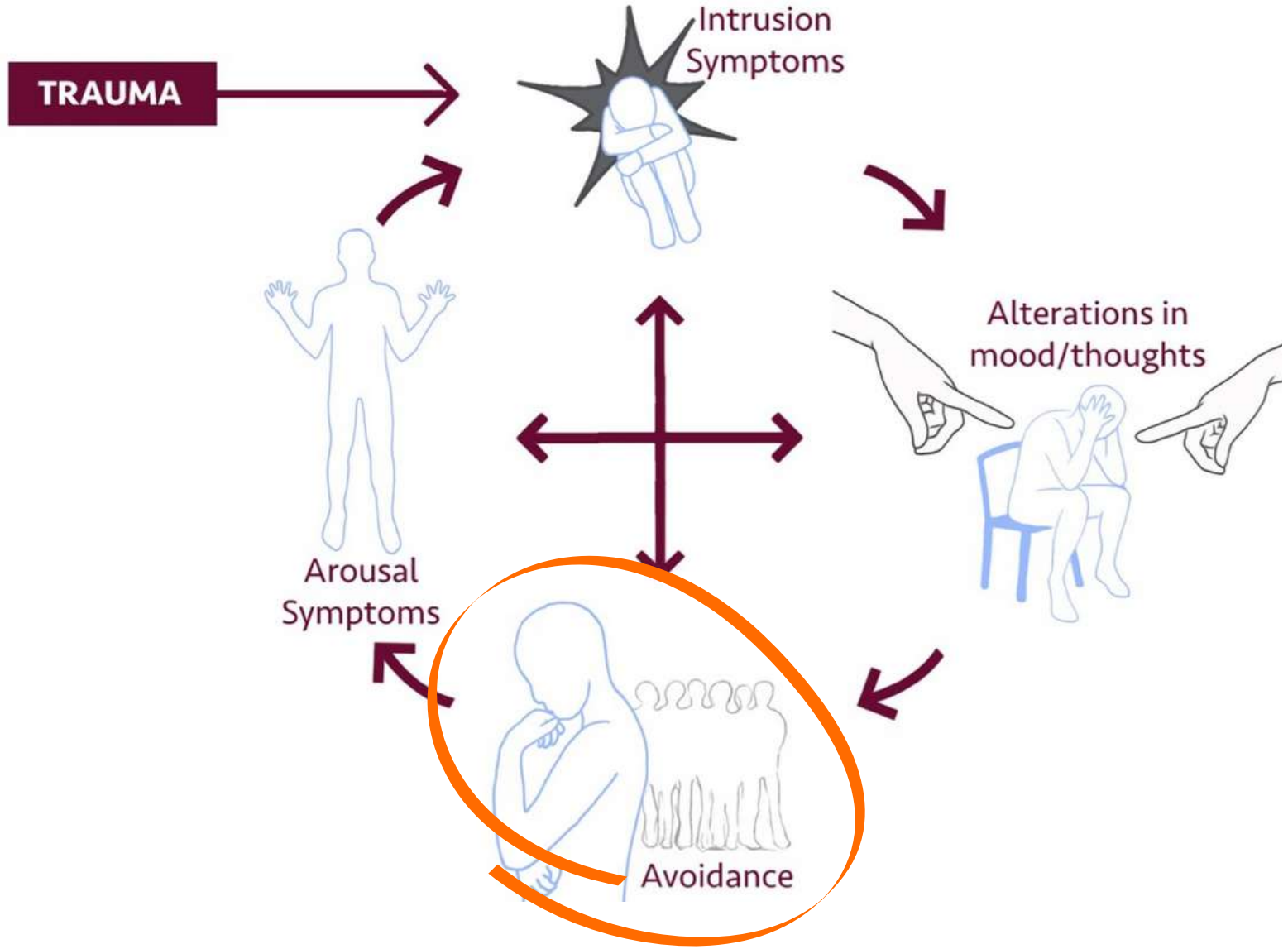
- Inability to recall key features of the traumatic event, fragmented memory
- Persistent, distorted negative beliefs and expectations about the self and the world
- Persistent distorted blame of self or others for causing the traumatic event
- Persistent negative trauma-related emotions (e.g. fear, horror, guilt, shame)
- Diminished interest in pre-traumatic activities
- Reduced range of feelings
- Feeling alienated or detached from others



Co-morbid Difficulties

PTSD: Cluster of symptoms

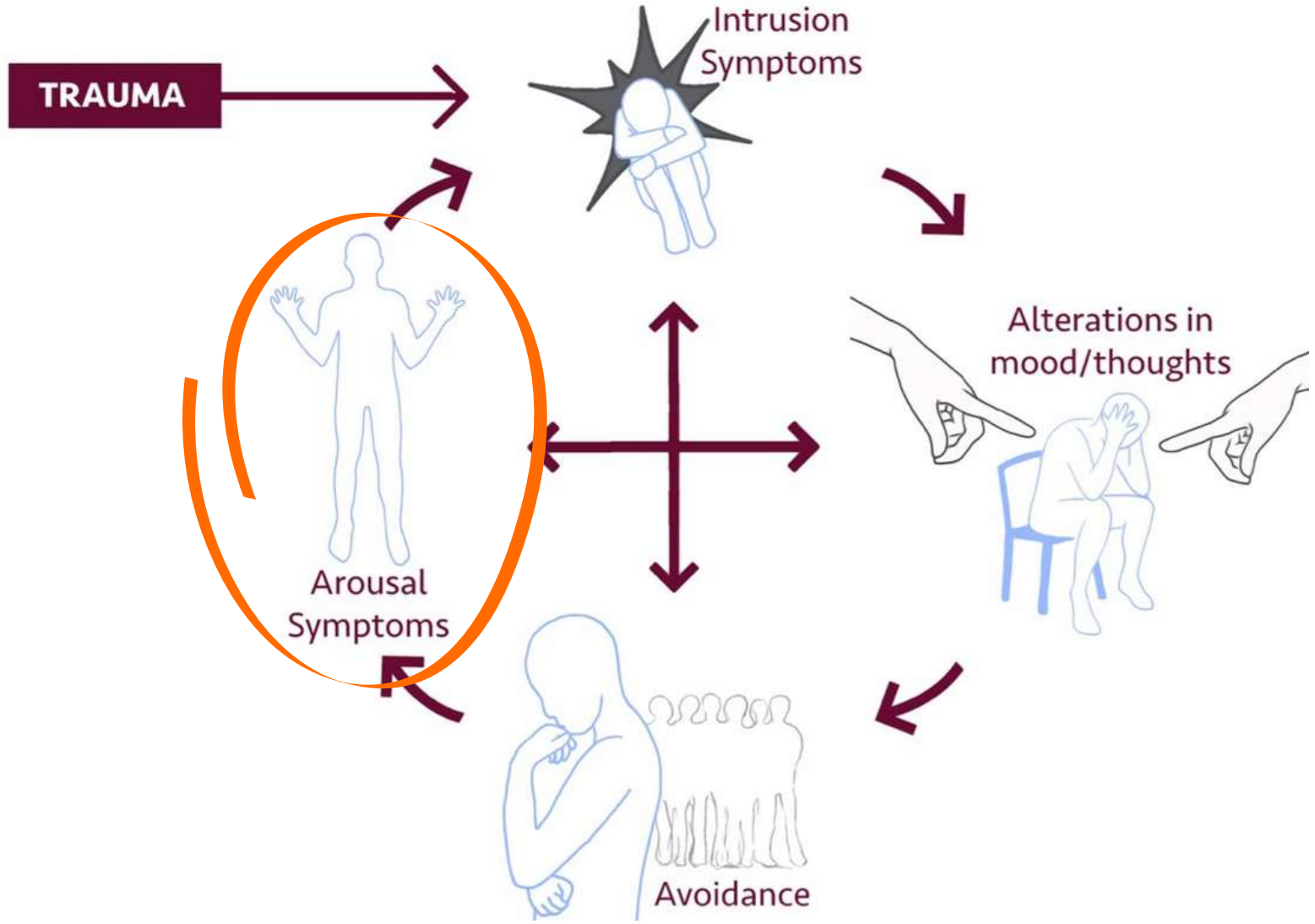
Powerful avoidance of anything that reminds them of the trauma (e.g. people, places, conversations, activities, objects or situations, sensory stimuli)



Co-morbid Difficulties

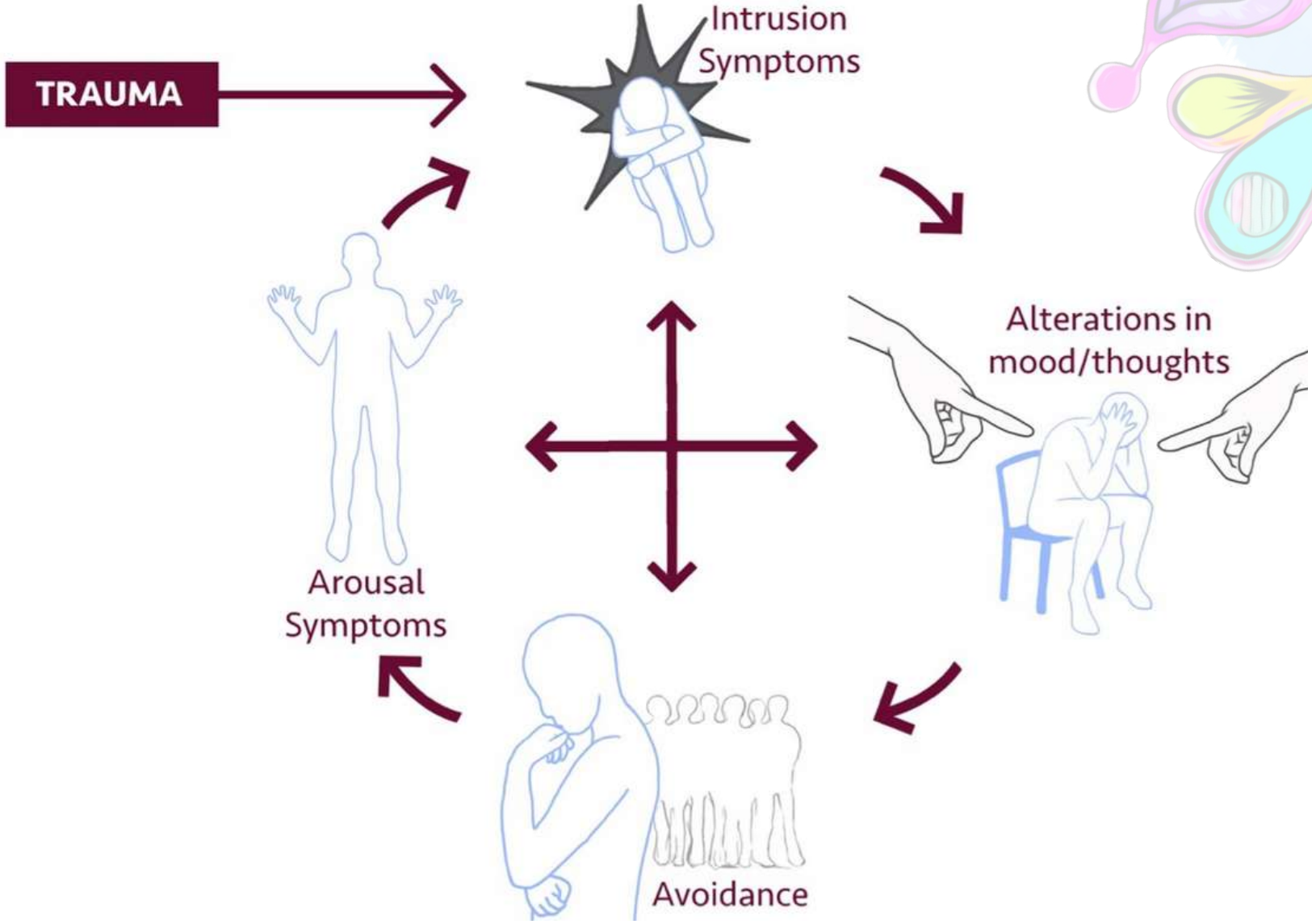
PTSD: Cluster of symptoms

- Hyper vigilance to ongoing threat and danger
- Exaggerated startle response
- Problems in concentration
- Sleep disturbance
- Self destructive and reckless behaviour



Co-morbid Difficulties

PTSD: Self-maintaining cycle



PTSD: Therapeutic intervention

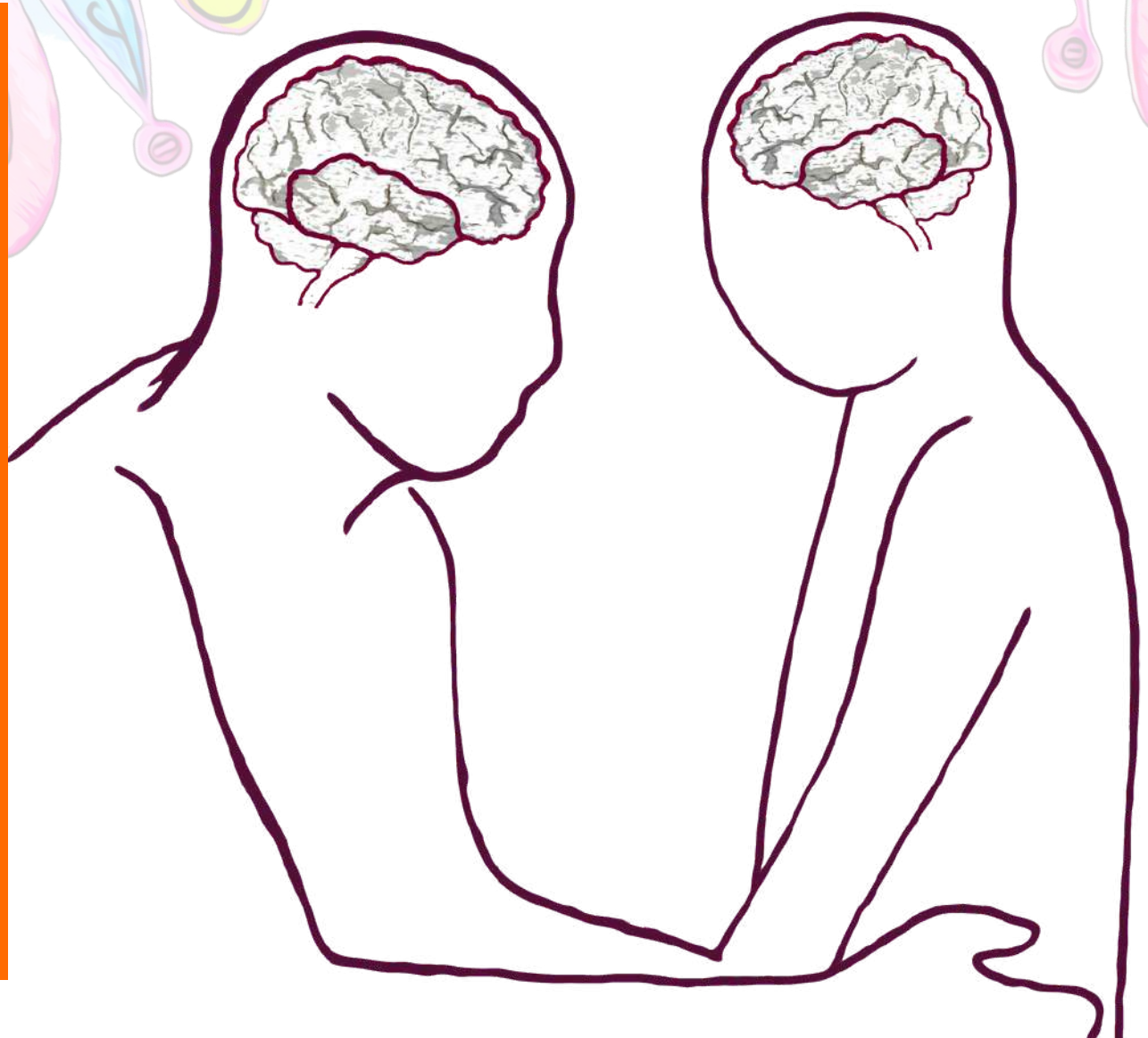
- **Trauma Informed CBT**
- **EMDR** (Eye movement de-sensitisation & re-processing therapy)

Co-morbid Difficulties

PTSD: Therapeutic intervention

EMDR:

- Particularly **helpful** for those who struggle to find words to **communicate** feelings, thoughts and needs
- Uses **bi-lateral stimulation**
- Can be used **creatively**
- Can **include** parent/carer



PTSD: Therapeutic intervention

- **Trauma Informed CBT**
- **EMDR** (Eye movement de-sensitisation & re-processing therapy)

Co-morbid Difficulties

Developmental Trauma with PTSD

Multiple interpersonal traumas combined with non-interpersonal trauma **requires a different intervention**

A child who has Developmental Trauma with PTSD is at **greater risk** of having problems with all areas of Developmental Trauma with a **particular impact** on their cognitive processing capacities

Co-morbid Difficulties

Implication for practice

Therapists: If a child has Developmental Trauma, assess for PTSD

Other professionals: Seek an assessment if you suspect PTSD

Co-morbid Difficulties

Autism and ADHD

A child with Developmental Trauma can also have signs and symptoms of ASC that can **not be explained by their experiences of trauma**

Children can be misdiagnosed with Autism and ADHD:

- Medical model; applying a diagnosis that fits the symptoms
- Autism & ADHD are more familiar than Developmental Trauma
- Autism & ADHD becomes the template to explain challenging and distressing behaviour

When Developmental Trauma is missed, it has a significant impact

- The intervention required is different, ideally a trauma informed assessment by a skilled, experienced mental health professional is needed

Explanation within an Autism Spectrum Condition framework	Examples of how the problem may show itself in a child's behaviour	Explanation within a Developmental Trauma framework
Social and emotional skills deficit	• Avoidance of relationships and intimacy • Avoidance of eye contact • No, or limited, peer friendships • Blunted emotional expression • Lack of empathy or insight into other people's feelings • Does not seek comfort and care when distressed	• Emotional regulation difficulties • Limited emotional literacy due to the impact on cognitive processing • Insecure attachment pattern
Communication and language deficit	• Struggles to start or keep conversations going • Difficulties in describing and expressing emotions • Difficulties in accurately reading social cues from others • Speech difficulties	• Global developmental delay due to the impact of early trauma • Cognitive processing difficulties due to the impact of fight/flight/freeze/collapse responses • Language inhibition due to fear response being activated
Inflexibility of thought and behaviour	• Dislike change • Difficulty with problem solving • Likes rigid routines • Obsession with particular topics or objects • Restricted range of interests • Quirky or repetitive movements	• Sensory processing difficulties • Attachment patterns which lead to controlling, coercive behaviour • Executive functioning difficulties due to the impact on brain development • High levels of need for predictability and contingency • Low mood and low self-esteem leading to restricted activities

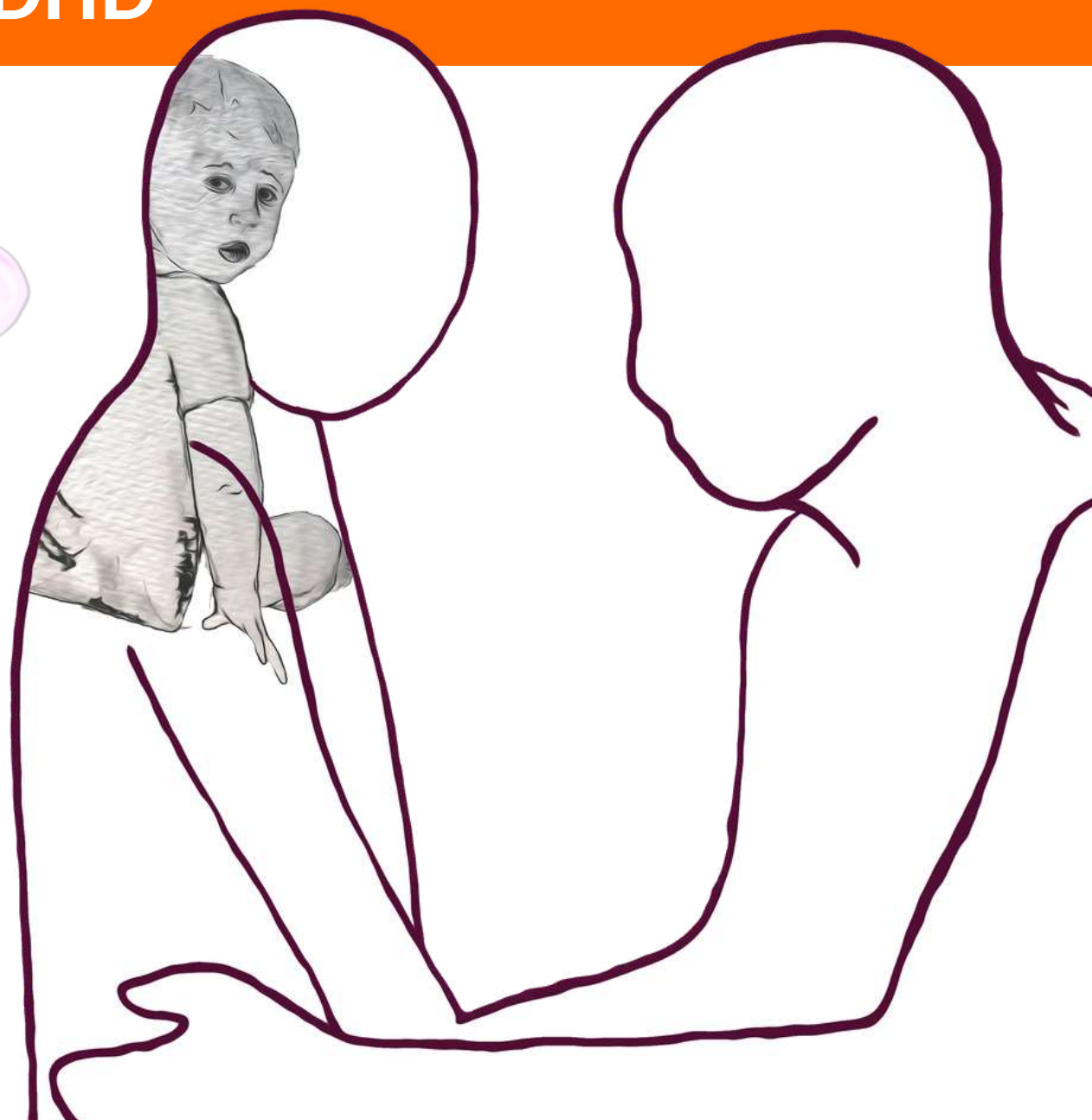
Co-morbid Difficulties

Autism and ADHD

If we know that a child has repeated experience of **interpersonal** trauma then we need to consider the **impact of the early experiences on their development**

Remember the interventions are different:

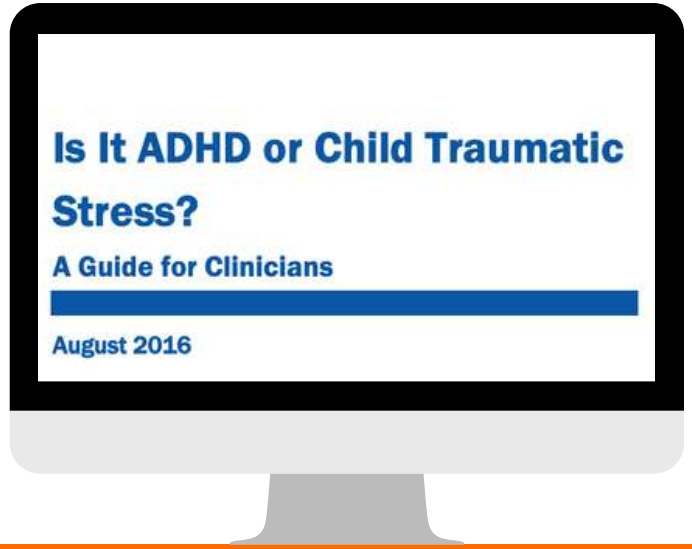
- Interventions for Autism are **behavioural**
- Interventions for Developmental Trauma are **regulatory and relational**



Explanation within an ADHD framework	Examples of how the problem may show itself in a child's behaviour	Explanation within a Developmental Trauma framework
Inattention	• Has trouble maintaining concentration and attention • Often does not listen when being spoken to • Cannot complete tasks • Has trouble organising tasks and belongings • Is avoidant of tasks which require sustained and intense cognitive effort • Is easily distracted • Often loses things • Is often forgetful	• Cognitive processing difficulties due to global delay or to the thinking brain being 'off line' during frequent fight/flight/freeze responses • Avoidant or coercive attachment patterns • Dissociation leading to short term memory problems • Sensory processing difficulties in a range of sensory systems
Hyperactivity and impulsivity	• Often fidgets with or taps hands or feet, or squirms in seat • Often leaves seat in situations when remaining seated is expected • Often runs about or climbs in situations where it is not appropriate • Often unable to play or take part in leisure activities quietly • Is often "on the go" • Often talks excessively • Often has trouble waiting their turn • Often interrupts or intrudes on others	• Sensory processing difficulties leading to restless movements and noises • Attachment-seeking behaviours meaning they seek adult or peer attention frequently • Flight responses leading to running, climbing, hiding • Hypervigilance and hypersensitivity to danger, threat, abandonment and criticism

Co-morbid Difficulties

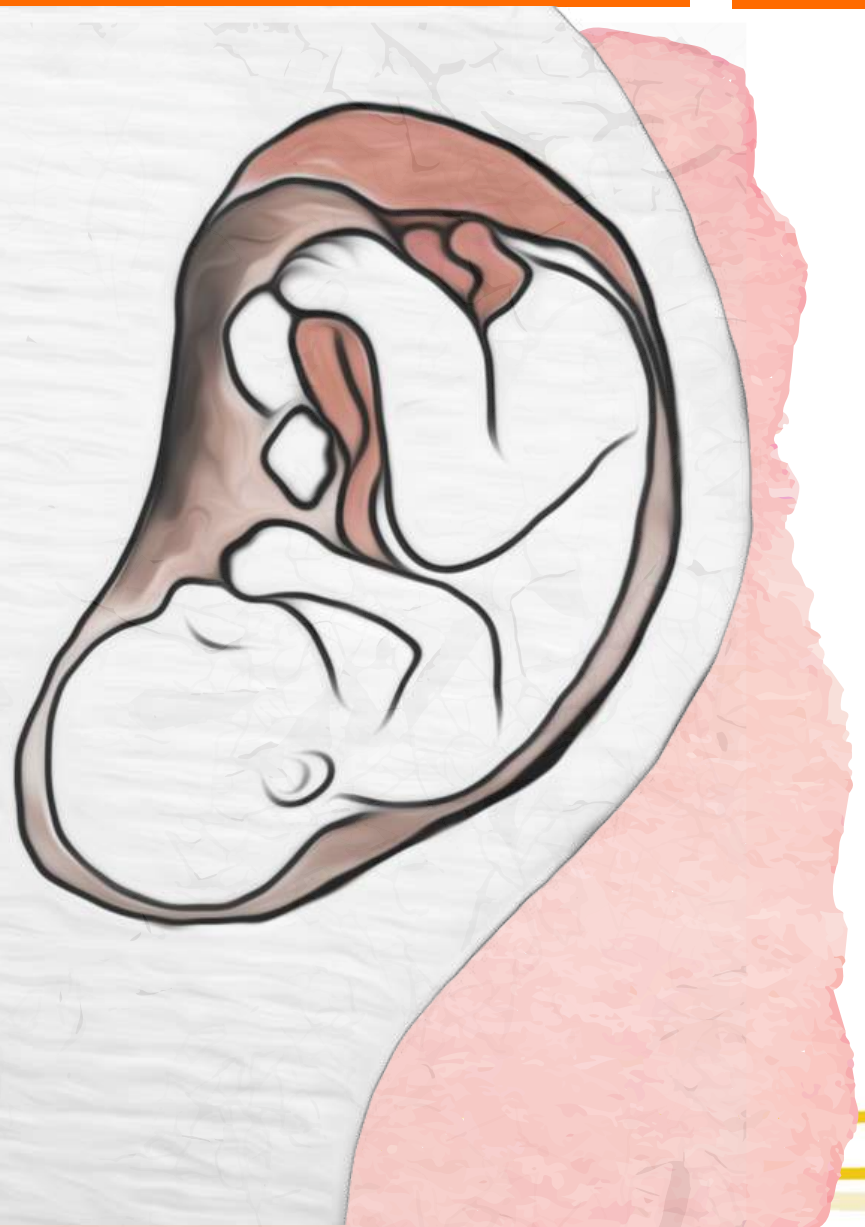
PTSD: Therapeutic intervention



www.nctsn.org/sites/default/files/resources//is_it_adhd_or_child_traumatic_stress.pdf

Co-morbid Difficulties

Foetal Alcohol Syndrome Disorder (FASD)



Alcohol drunk during pregnancy directly impacts the way the child's brain develops

Have Developmental Trauma and in addition show signs of:

- Abnormal growth
- Characteristic facial features

Co-morbid Difficulties

Foetal Alcohol Syndrome Disorder (FASD)

FASD is a spectrum: A range of difficulties are experienced and are likely to change as the child develops

Physical Health Complications

- Epilepsy
- Hearing and ear problems
- Height and weight issues
- Hormonal difficulties
- Liver, kidney and heart difficulties
- Weakened immune symptoms

Co-morbid Difficulties

Foetal Alcohol Syndrome Disorder (FASD)

A **specialist assessment is important** with FASD due to the intervention required and the physical complexities that accompany FASD

A brain affected by FASD is likely to have **permanent organic changes** to the brain functioning: the brain may have **less plasticity** and can **influence** a child's outcomes and how they **respond** to the intervention.

Risk

- Harm to Self
- Trauma Re-enactment

Risk

Potential Risks (non exhaustive list):

- Risk of harm to self
- Risk of harm to others
- Sexual and criminal exploitation
- Risk of ongoing or new sexual, physical or emotional abuse
- Intergenerational trauma or secondary trauma in parents and carers
- Risk of family breakdown

Risk

Children use attachment strategies to reduce the likelihood of danger

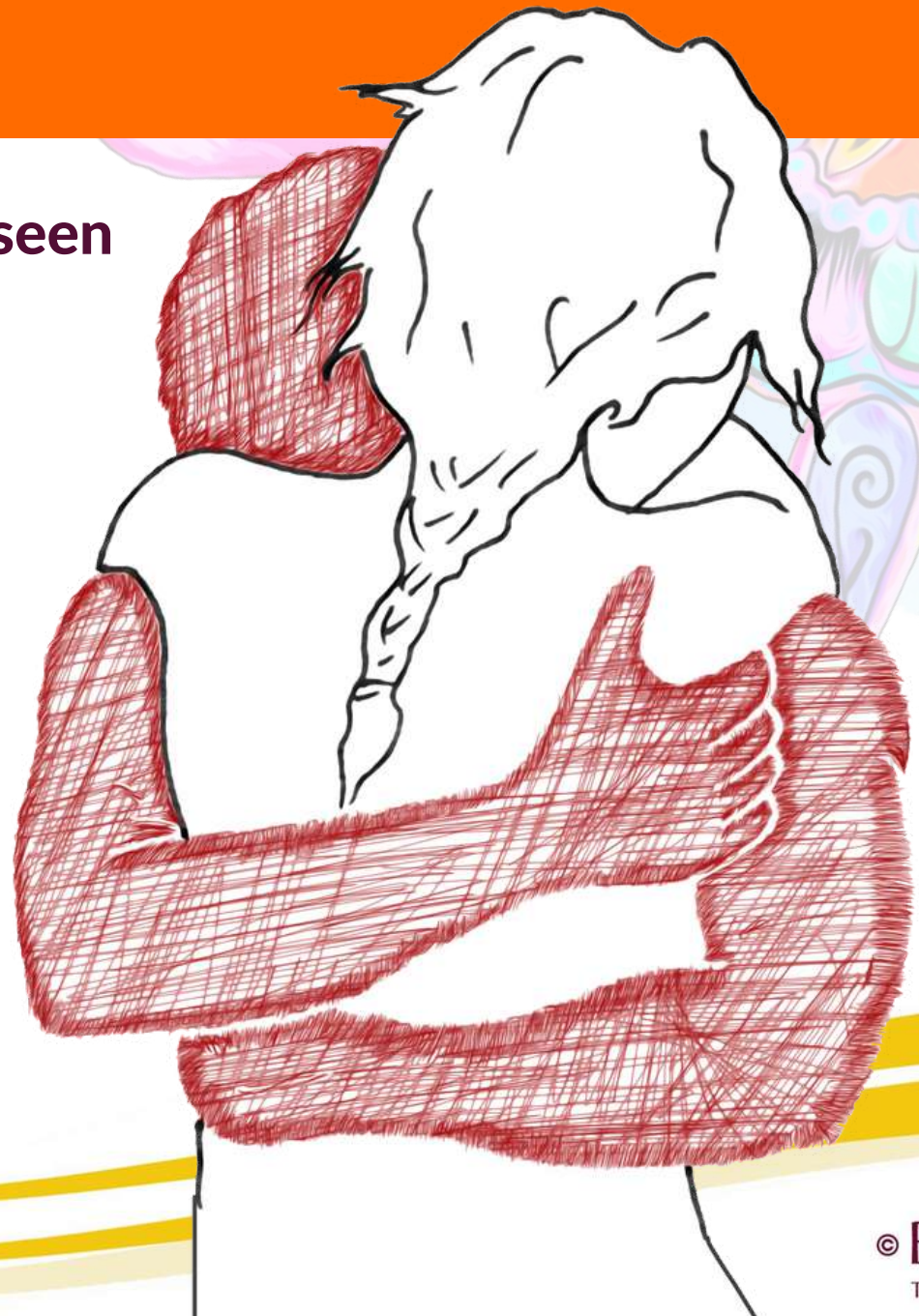
It is critical that we work explicitly to identify and directly address danger

Risk

Self Harm

Self harm can be broad and not always seen as self harm, examples include:

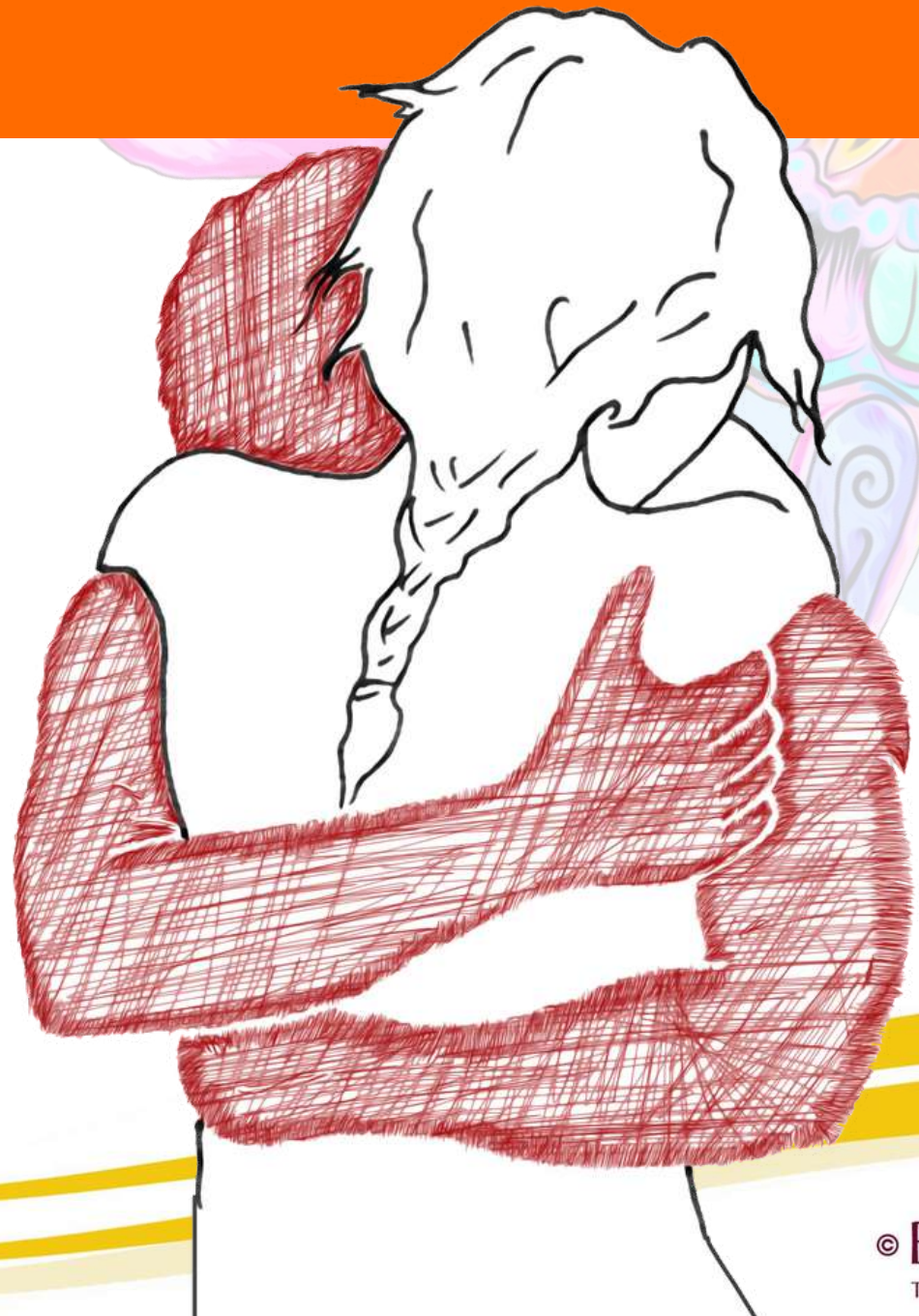
- Cutting
- Head banging
- Skin picking
- Self-poisoning
- Controlling food - starving/binging
- Punching and hitting themselves
- Using drugs and alcohol



Risk

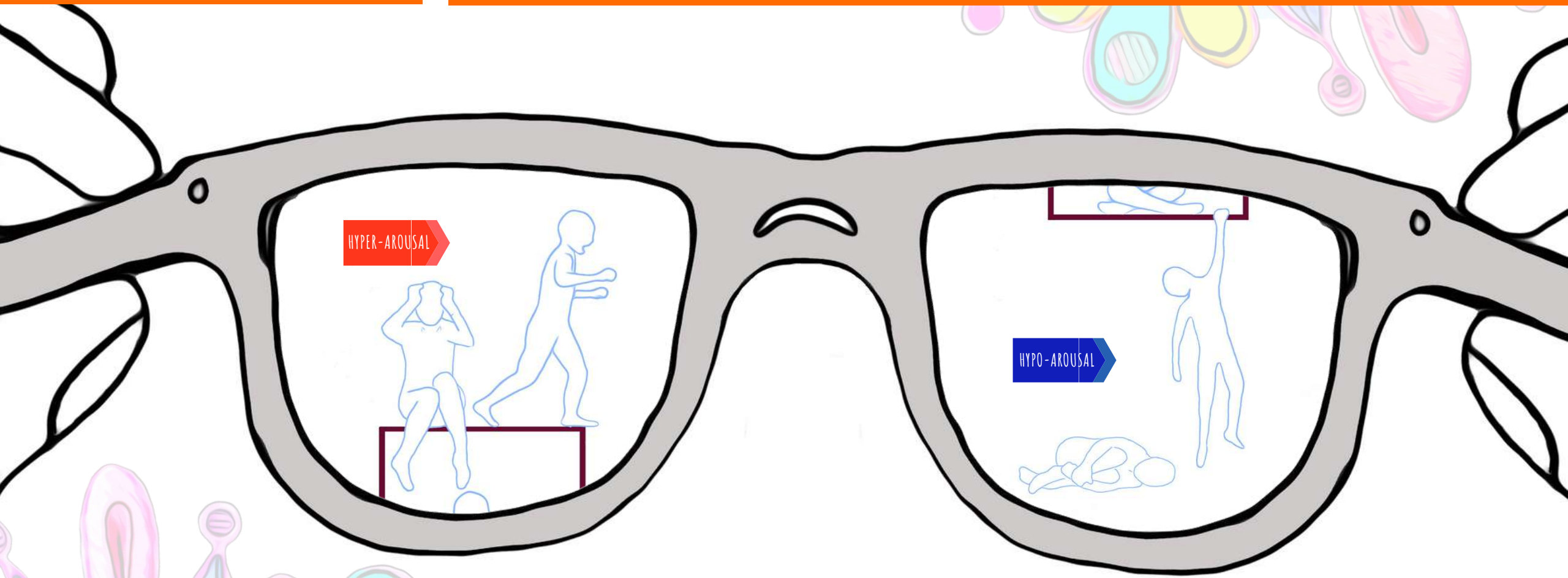
Self Harm

Self harm is often seen as a behaviour problem or a stand alone mental health problem

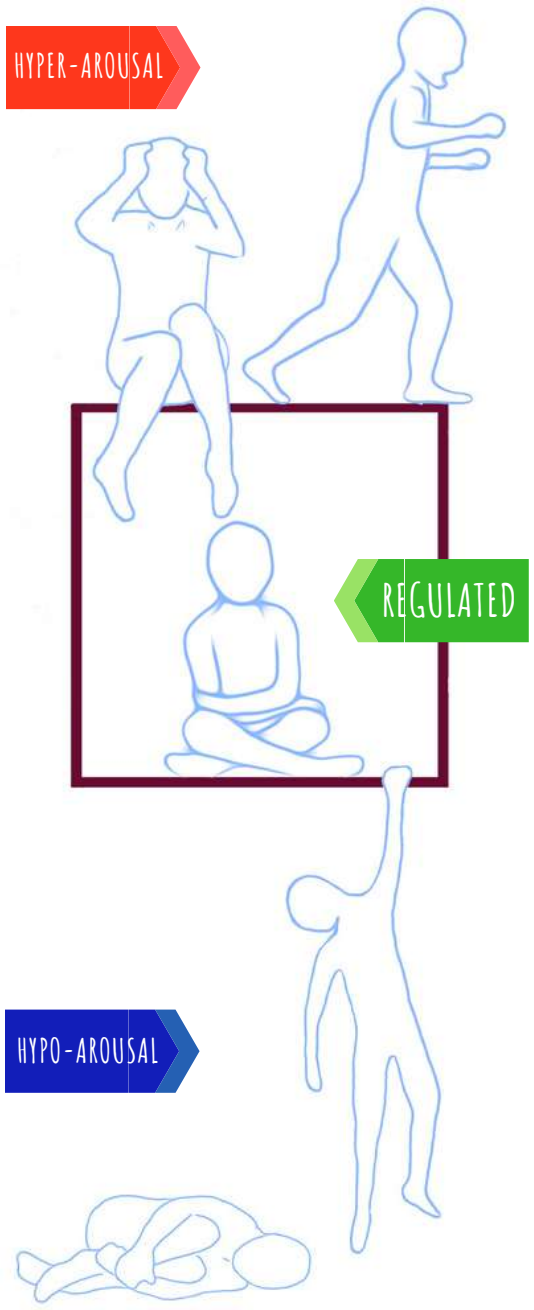


Risk

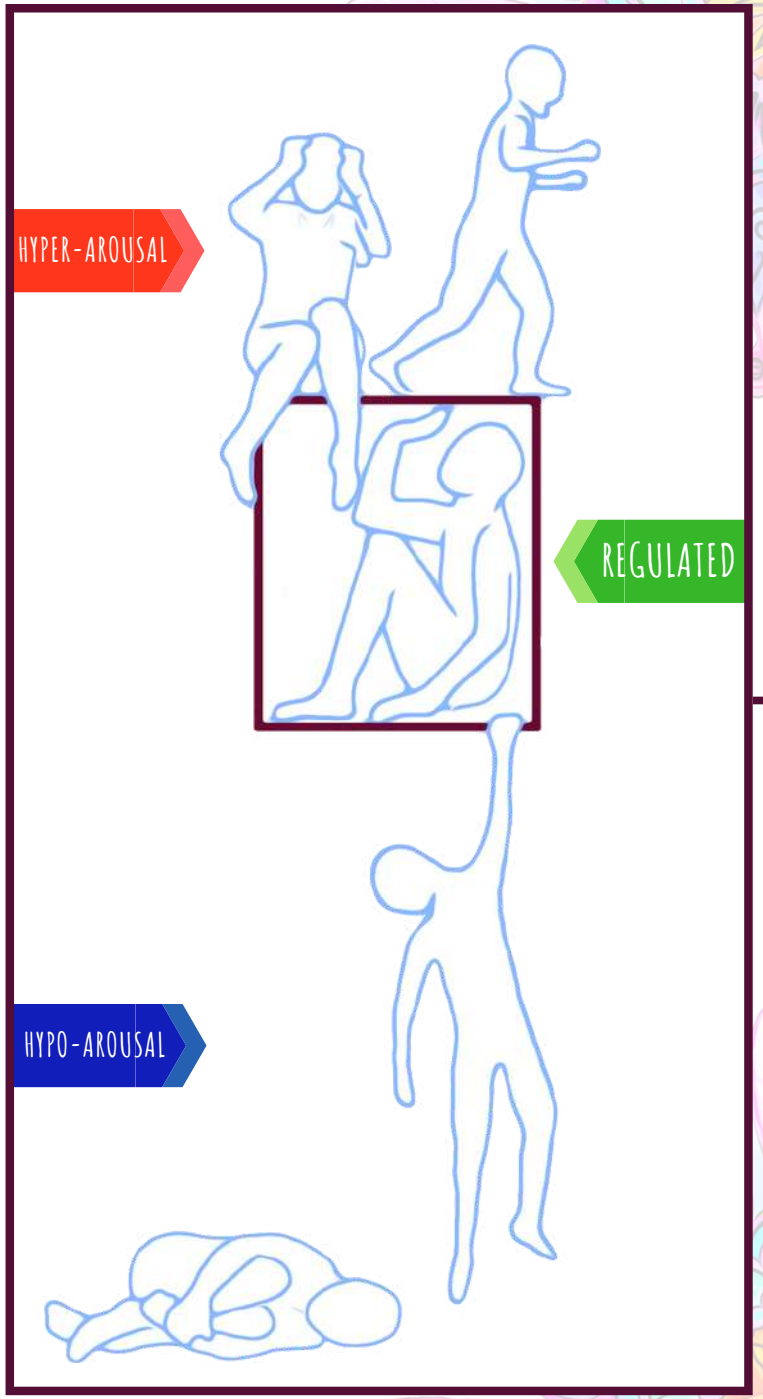
Self Harm



Self harm is a solution to the problem of emotional regulation



Every individual has a unique window of tolerance

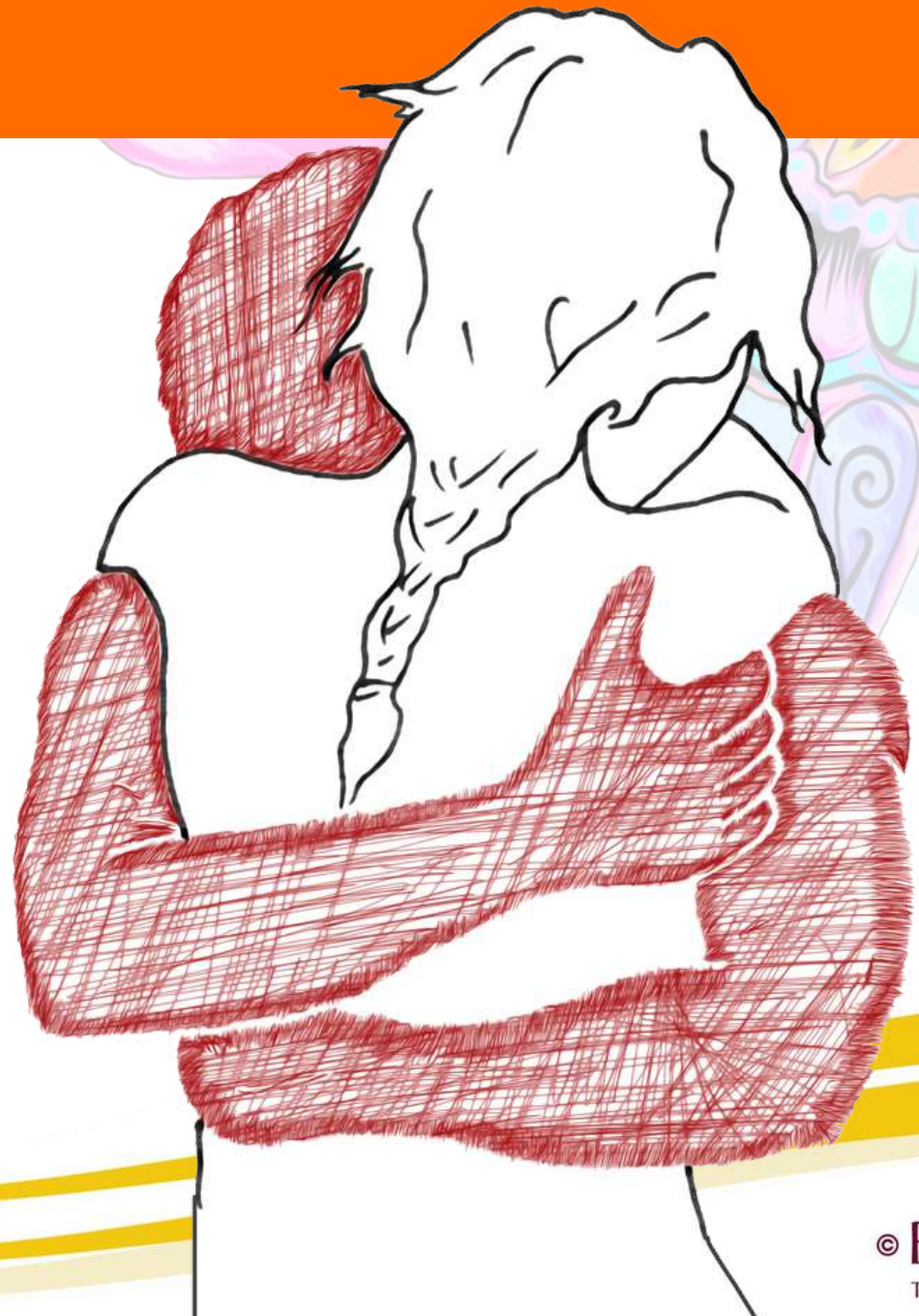


Traumatised children have a narrow window of tolerance

Risk

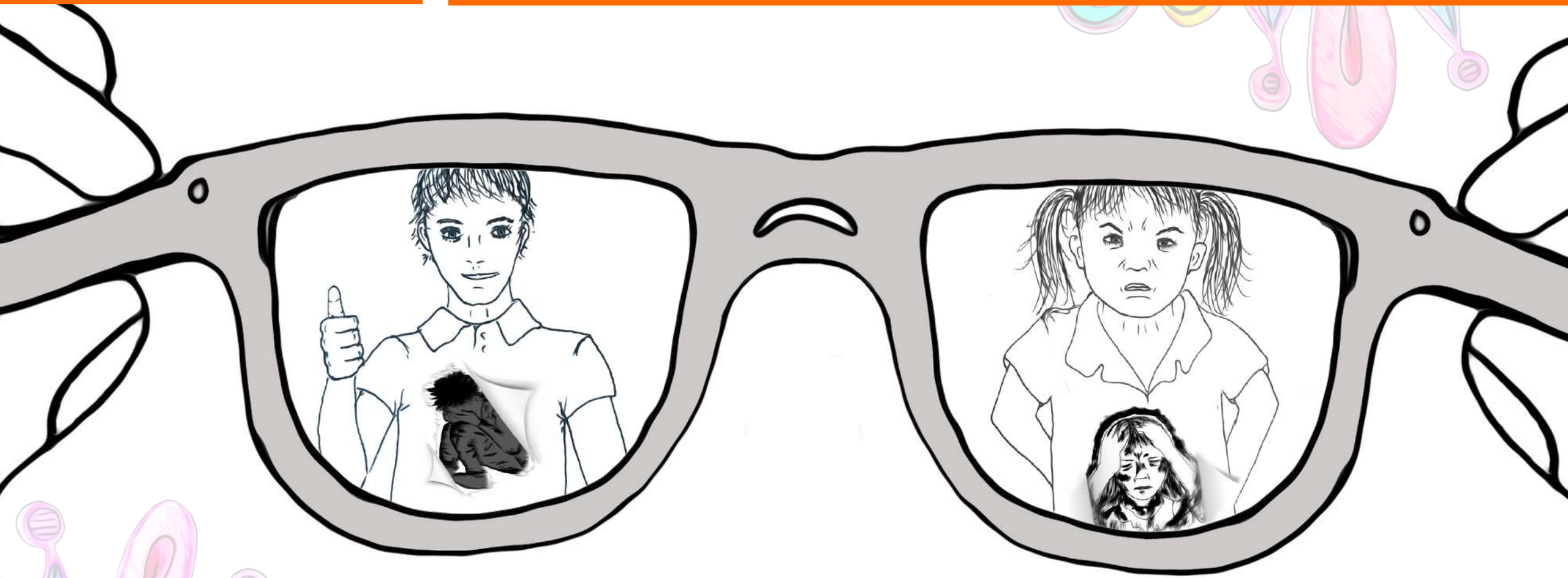
Self Harm

"Attention Seeking"



Risk

Self Harm



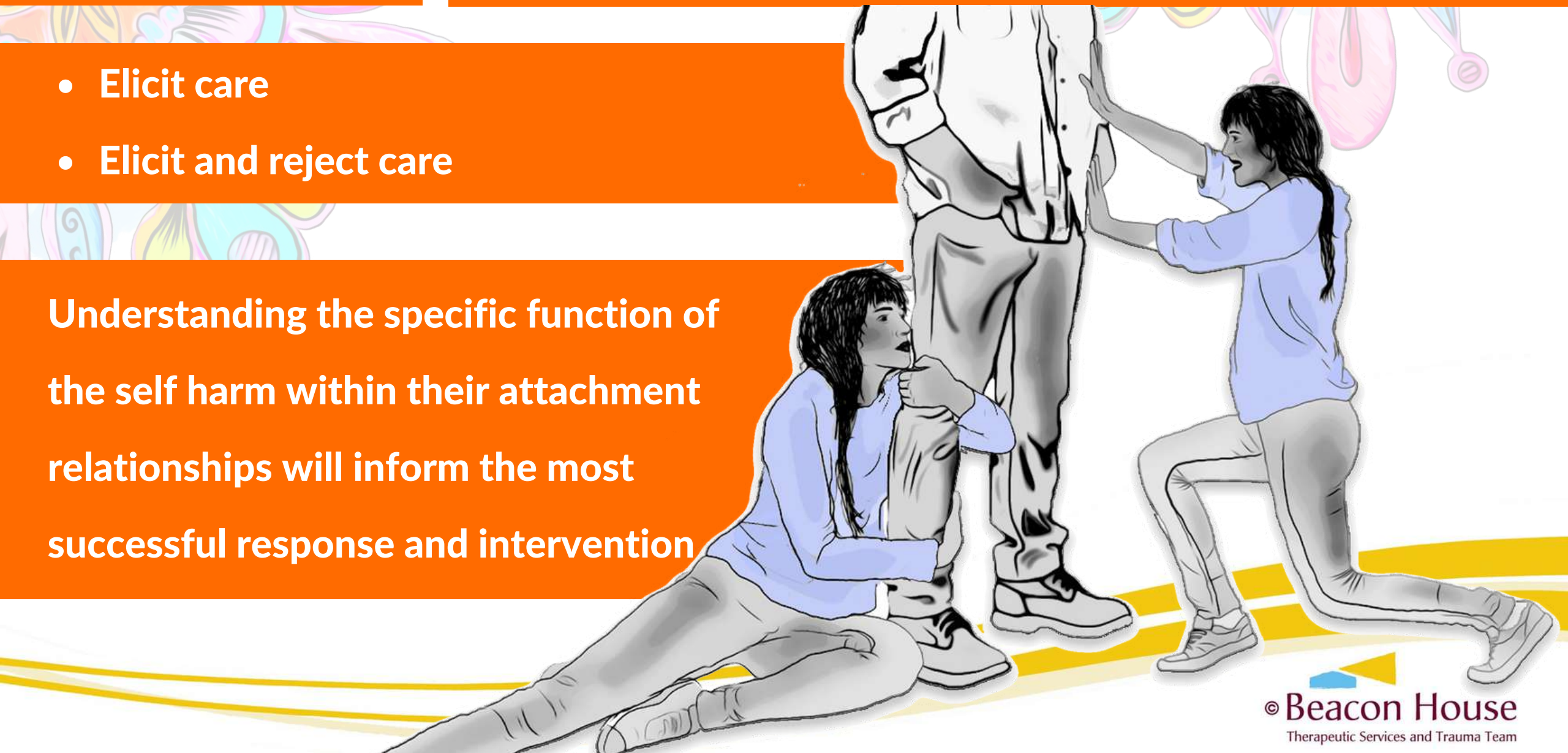
"Attachment Seeking"

Risk

Self Harm

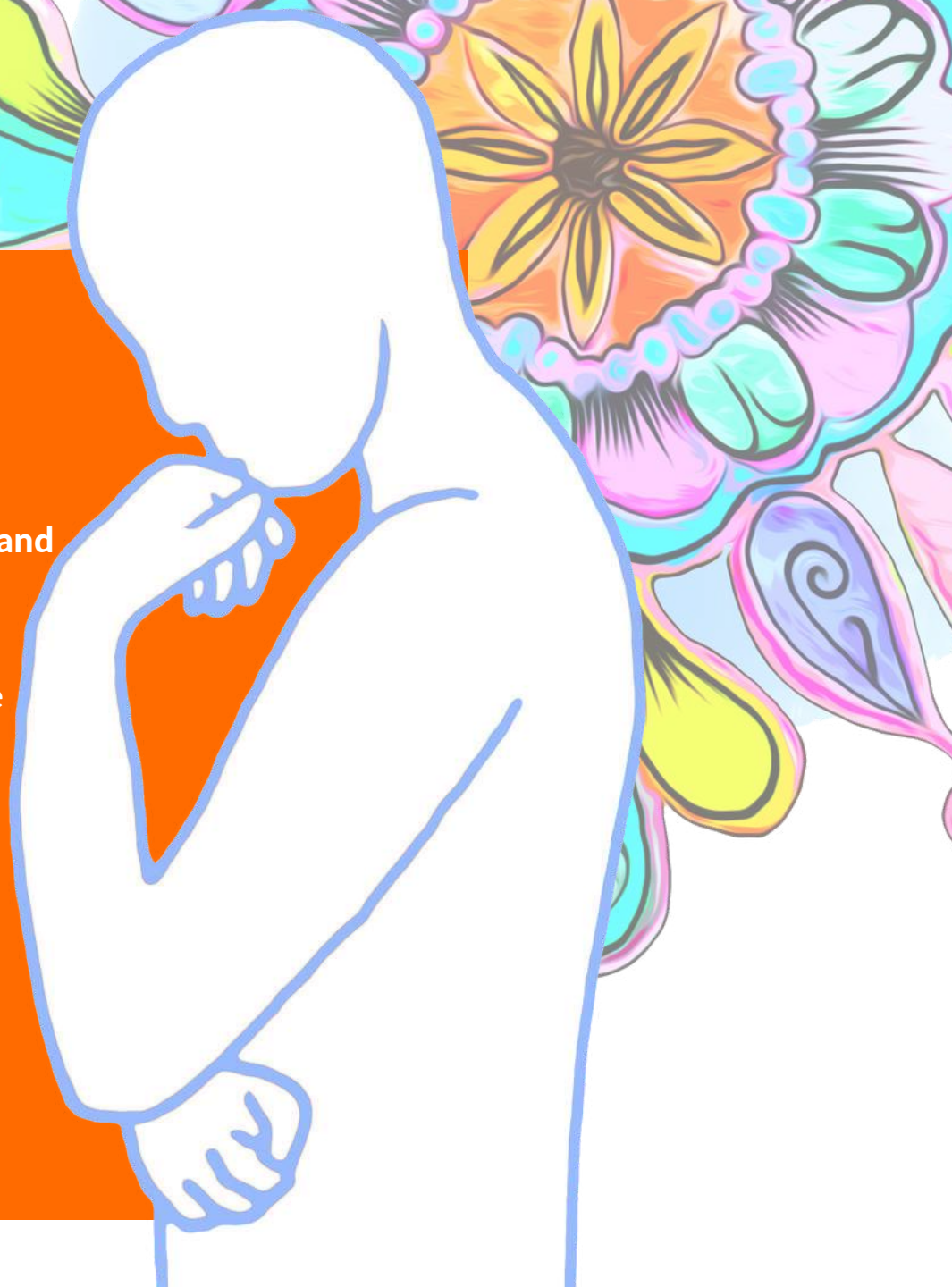
- Elicit care
- Elicit and reject care

Understanding the specific function of the self harm within their attachment relationships will inform the most successful response and intervention



Reflections & Lessons in Practice

- What is the **meaning** of the self-harm for the client?
- What is the **function** of the self-harm for the client?
- What is the **impact** of professional anxiety and punitive responses?
- How can **exploring** the client's narrative of self-harm support them to **understand** its meaning and function?
- How can **exploring** the different parts of the client help you to **understand** the function and meaning of the self-harm?
- What **alternatives** to self-harm can you and the client offer the parts?
- How can you **support** the client with damage limitation when they are using self-harm to regulate?
- What would happen if you and the client became **friends** with self-harm?



General Implications For Practice

Importance of re-framing the self-harm behaviour as a problem in emotional regulation which is the child's best solution to an internal experience which is overwhelming

The role of co-regulation to potentially reduce the child's likelihood and risk of ongoing self-harm

Increase the child's capacity for emotional regulation, helping the child to tolerate big feelings