Using an attachment and trauma perspective in social work with children

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Training aims

- Outline the different understandings and concepts of attachment and trauma
- Understand the impact of trauma on the developing brain
- Linking attachment and trauma
- Exploring the impact of child abuse and neglect on children's development
- Recognising and identifying developmental trauma
- Responding to trauma in residential care settings
- Explore the development of trauma informed practice in your workplace

Trauma and children

" Being harmed by the people who are supposed to love you, being abandoned by them, being robbed of the one-on-one relationships that allow you to feel safe and valued and to become humane – these are profoundly destructive experiences. Because humans are inescapably social beings, the worst catastrophies that can befall us inevitably involve relational loss. As a result, recovery from trauma and neglect is also about relationships – rebuilding trust, regaining confidence, returning to a sense of security and reconnecting to love. Of course, medication can help relieve symptoms and talking to a therapist can be incredibly useful. But healing and recovery are impossible – even with the best medications and therapy in the world – without lasting, caring connections to others"

Bruce Perry

Early concepts of trauma

- Bowlby identified that our primary relationship helped us develop our capacity to focus, identify feelings and manage our arousal (regulation)
- Erikson (1965) advised that if one stage of development had not been resolved due to neglect in childhood (e.g. trust v mistrust) it hindered the development of the next stages and into adulthood
- Concept of 'failure to thrive' and child abuse (1980's)
- More recently attachment theory has long identified the disruptions in development; Fahlberg (1991) linked attachment problems with cognitive, emotional, behavioural and developmental problems.
- Iwaniec (1995) linked developmental tasks to the attachment relationship

Neurobiology

- The infant brain is designed to adapt to it's environment. Over the first three years of life it undergoes a process of 'pruning and priming'.
- Experiences allow the brain to create pathways from the the instinctual parts of the brain to the areas that control emotion, prediction and regulation. 'Neuron's that fire together, wire together'
- Babies who have experienced abuse and neglect show different brain patterns than those with secure attachment experiences.
- Impact on development: Children who experienced attachment difficulties in infancy often have cognitive delays; sensory, motor, linguistic, memory-making and recognising patterns/routines.
- Equally important is supporting their parent's or carers in understanding the context for these delays
- Brain architecture https://youtu.be/VNNsN9IJkws

Child Development

0-2 months

- Physiological regulation. Babies primarily use crying to communicate discomfort and distress and can be calmed by different care takers.
- As they move towards three months they develop a preference for a carer. They can be soothed by the sound of his/her voice and touch.
- Despite the child's lack of preference for a caregiver in the early weeks, this is a significant bonding period for the primary caregiver, and any separation can impact on their attachment relationship, thus impacting on the child's as they develop.

3-6 months

- Babies smile and babble more to those they are familiar with.
- They turn to their primary attachment when in distress.
- The baby's mood can be 'held' by the carer, and their response – verbal, visual and physical, can all help the child regulate their emotions. Babies can begin to contribute more to the attachment relationship.

7-12 months

- Children develop a clear preference for their attachment figures, and will begin to ‘make strange’.
- They begin to physically move around, thus developing the ability to control their distance from the carer. They can engage more fully in play, contributing to the intensity and length of activities and will alter their behaviour to optimise a response from the carer.
- Due to these developments, children can begin the process of relying on certain attachment strategies, and discard others.

1-3 years

- The toddler’s primary task during this period is to psychologically separate from their primary attachment figure, and develop a sense of self and the formation of identity.
- Their capacity for exploration, both physically and socially, expands.
- Their ability to express and name a much wider range of emotions also develops.

Insecure attachment

Type A – Avoidant

This strategy focuses on cognitive/concrete information and dismisses negative arousal as this has been associated with physical or emotional danger in their lives

- Avoid negative arousal
- Seeks to please in interaction
- Minimises own negative experiences
- Seek to highlight/maximise positives in carers and own responsibility for behaviour

Type C – Resistant

This strategy ignores cognitive information and focuses on arousal, as feeling states have been a greater predictor of danger than cognitive ones

- Focus on arousal
- Seek to control interaction
- Maximises negative experiences
- Seeks to minimise own behaviours/responsibility and positives in carers

Why is this important?

Your interaction with the child may be impacted by their attachment style. Your use of self, appropriate self disclosure and empathic responses is likely to be interpreted by the child in the context of their attachment strategy.

Attachment and Developmental Trauma

- Developmental trauma arises out of relational trauma. The child does not receive the physical, emotional, social or cognitive input they require from their carers, or the input is done in a frightening or harmful way. As well as impacting the child's development, this also requires the child to develop strategies to reduce danger and increase safety. The strategies form a child's attachment style with that carer.

- Because the cause of the trauma is within relationships, interventions require not just a focus (both day to day and therapeutic) on returning to the developmental stage impacted and allowing the child to experience this safely and sensitively, it is likely to require psychoeducaitonal, dyadic and possibly individual work with the carer to allow them to respond to the child's maladaptive strategies that are formed around these traumas.

Attachment concepts and the link to trauma

Rupture and repair

- Contributes to development as much as pleasing interactions
- Impacts the parts of the brain linked to reward, interplay between cognition and emotion and
- Allows for development of psychological security, social intelligence, empathy and emotional awareness/ regulation
- Core in the development of the child's window of tolerance
  a) Excessive inhibition
  b) Excessive dysregulation
  c) Adaptive and flexible

Serve and return

- Required in all areas of development; eye contact, facial expression, gestures, touch, language, emotional expression, cognition development
- Requires carers to recognise and respond to infant signals
- Allows for the development of neural pathways
- Absence of this leads to toxic stress – prevents normative development
- Absence will weaken integration and interconnectivity with the brain. This will interfere with social, emotional and cognitive development

Developing an understanding of Trauma in an child abuse context

The DSM V recognises the symptoms of trauma within the diagnosis of Post Traumatic Stress Disorder (PTSD)

- Trauma survivors must have been exposed to actual or threatened (directly or indirectly): death, serious injury or sexual violence
- Symptoms include; Intrusive thoughts, nightmares, flashbacks, psychological and physical reactivity

This does not fit with the presentation of many abused and neglected children. However these children show a distinctive cohort of symptoms which appear to be due to repetitive traumatic events, or a cluster of traumas. These are known as 'little t' traumas or complex trauma.

Adverse Childhood Experiences Study (ACE)

Details ten different types of adverse types of childhood experiences

- Abuse
  - Emotional Abuse
  - Physical Abuse
  - Sexual Abuse
- Neglect
  - Absence of love and support from carers in childhood
  - Physical neglect
  - Family Dysfunction
  - Exposure to drug and alcohol use
  - Exposure to family violence
  - Separation or divorce
  - Carer with mental health issues
  - Carer in prison

US study of 17,000 people from 1995-1997 and found that those who scored higher on the ACE presented with a higher degree of physical, behavioural and mental health symptoms than those in the normative population

- Physical
- Obesity
- Physical injury
- Low level of physical activity
- Diabetes
- STDs
- Heart Disease
- Cancer
- Stroke
- Mental Health
- Depression
- Suicide attempts
- Anxiety
- Behaviour
- Smoking
- Drug/alcohol abuse
- Missed work/ unemployment

Mediated and reduced when there is a positive relationship in the child's life

Developmental Trauma

- Van der Kolk and the need for new diagnosis – Developmental Trauma
- Currently as this is not recognised by the DSM children with trauma histories tend to present with comorbidity (ADHD and ODD/ anxiety and ASD)
- Symptoms
  - Immature emotional and cognitive responses
  - Sensory issues
  - Hyper/hypo arousal
  - Lack of behavioural regulation and impulsivity
  - Relationship and social issues

Sensory Development and Emotional Regulation

- Children who have experienced relationship and developmental trauma in infancy and early childhood can exhibit severe sensory delays and difficulties managing their arousal and affect.
- Sensory integration is the ability of the central nervous system to respond to and process information coming into the body. In children who have been abused their experience is that information coming in may not be predictable or safe, and so they cannot access this system easily. Over time they can develop hypersensitivity (over arousal) or hyposensitivity (under arousal)

Signs of sensory delay

- Issues around food (unable to recognise hunger/fullness) and food textures
- Not being aware of climate – hot/cold
- Not noticing or dismissing pain/illness (for some children they may also make a huge deal out of minor injuries where there is clear evidence – paper cut for example, while not having noticed a severe abscess or tooth decay)
- Doesn't seem to notice bad smells (personal hygiene or environmental)
- Can't remember landmarks or familiar items at home/in school
- Can't follow sequential requests (one thing at a time) or remember day to day routines

Signs of emotional dysregulation

- Hypervigilance
- Hypovigilance
- Anxiety
- Avoidance
- Ractive aggression/anger
- Poor impulse control
- Poor attention/concentration
- Dissociation
- Decreased social competence
- Misunderstanding or misinterpreting social cues

Responding to Developmental Trauma

Requires a therapeutic model of care that addresses

1)Developmental trauma

2)Relationship trauma

3)Regulation and integration

Trauma informed model of care: Recognising and responding

- No one behaviour or symptom or experience can be correlated with developmental trauma.
- Developmental trauma is a cluster of symptoms that can be linked to the developmental experiences of a child in the early months and years of life.
- Child protection teams work with a trauma population so always need to hold this in mind, and when children are struggling or there are indicators of cognitive, emotional or behavioural issues professionals need to consider this within the model of care they providing

Responding to Developmental Trauma

It is essential that any professional working with the child is aware of the impact of trauma on emotional, social and cognitive development. Without this awareness carers and professionals are likely to treat the behaviour, not the symptoms of trauma.

- Behavioural approaches or child-led therapies are unlikely to be beneficial due to children's hypo- or hyper arousal
- Children who have experienced trauma require a holistic approach; Nurture, structure, empathy, developmentally appropriate challenges
- Multidisciplinary
- Multi-disciplinary assessment where possible
  - Social Care Workers
  - Social Workers
  - PHN
  - GP
  - Family Support Worker
  - CAMHS
  - OT
  - Speech and Language
  - Physiotherapist
  - School

Assessing and reviewing interventions

- Interventions can seem to have a dramatic impact initially but can stagnate quickly and children can regress
- Review of intervention needs to look at all areas of the child's development; sensory, emotional, cognitive and social.
- Review of intervention also needs to consider what areas the workers and carers are most responsive in terms of the above – requires open and constructive supervision for workers.
- If there are areas of delay that remain despite therapeutic intervention and an increase in sensitivity and responsiveness, a referral to CAMHS/neuropsychology is required