

Childhood Trauma: A Trauma Informed Systems Approach

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National Child Traumatic Stress Network Mission Statement

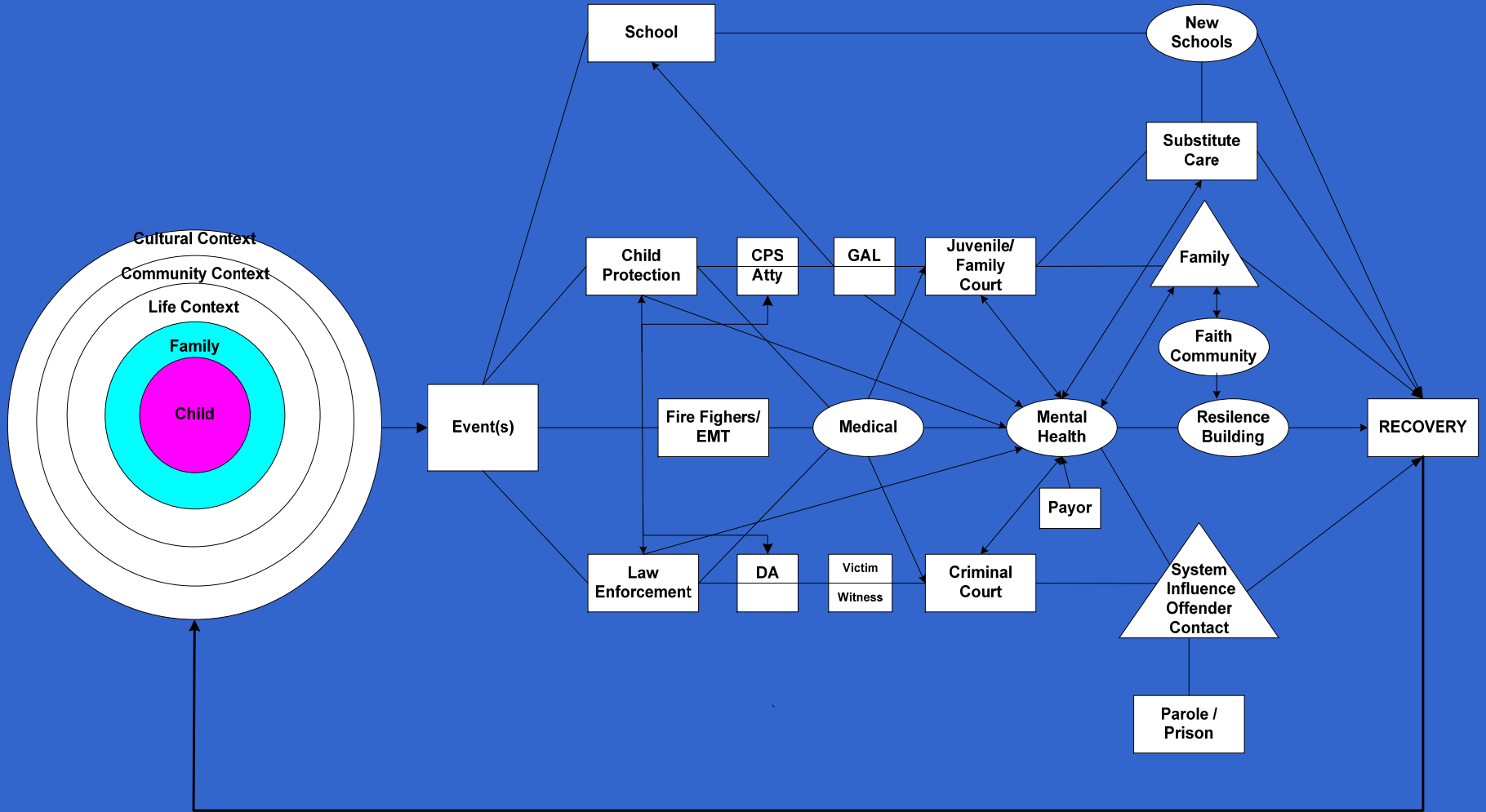
The mission of the National Child Traumatic Stress Network (NCTSN) is to *raise the standard of care* and *improve access* to services for traumatized children, their families and communities throughout the United States.

What is a Trauma Informed Child Serving System?

A Trauma Informed System understands:

- 1) The potential impact of childhood traumatic stress on the children served by the child serving system
- 2) How the system can either help mitigate the impact of trauma or inadvertently add new traumatic experiences;

Emotional Chain of Custody



Experience shapes response to future trauma

What is a Trauma Informed System?

- 4) how to promote factors related to child and family resiliency after trauma;
- 5) the potential impact of the current and past trauma on the families with whom we interact;
- 6) how adult trauma may interfere with adult caregivers' ability to care and support their child;
- 7) the impact of vicarious trauma on the child-serving workforce;
- 8) that exposure to trauma is part of the job of protecting kids

What Is Child Traumatic Stress?



Artwork courtesy of the International Child Art Foundation (www.icaf.org)

What Is Child Traumatic Stress?

- Child traumatic stress refers to the *physical and emotional responses* of a child to events that threaten the life or physical integrity of the child or of someone critically important to the child (such as a parent or sibling).
- Traumatic events overwhelm a child's capacity to cope and elicit feelings of terror, powerlessness, and out-of-control physiological arousal.
- Trauma is experienced as a series of traumatic moments each penetrating deep in the child's psyche.

Trauma Occurs as a Series of Traumatic Moments and Ripples Throughout the Child's Life



What Is Child Traumatic Stress

- Trauma is cumulative-one insult adds upon the last.
- A child's response to a traumatic event may have a profound effect on his or her perception of self, the world, and the future.
- Traumatic events may affect a child's:
 - Ability to trust others
 - Sense of personal safety
 - Effectiveness in navigating life changes

Acute Impact of Trauma

- Brain Development
- Capacity to Learn
- Educational Performance
- Social Relationships
- Behavior

Types of Traumatic Stress

- **Acute trauma** is a single traumatic event that is limited in time.
- **Chronic trauma** refers to the experience of multiple traumatic events.
- **Complex trauma** describes both exposure to chronic trauma—usually caused by adults entrusted with the child’s care—and the impact of such exposure on the child.

Proposed Criteria for Posttraumatic Stress Disorder in Preschool Children DSM5

Exposure

- A. The child (less than 6 years old) was exposed to the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation, in one or more of the following ways:
 - 1. Experiencing the event(s) him/herself
 - 2. Witnessing the event(s) as it (they) occurred to others, especially primary caregivers
 - 3. *Learning that the event(s) occurred to a close relative or close friend**
- NOTE: *Witnessing* does not include events that are witnessed only in electronic media, television, movies or pictures.

Intrusion symptoms

- Intrusion symptoms that are associated with the traumatic event (that began after the traumatic event), as evidenced by 1 or more of the following:
 - 1. Spontaneous or cued recurrent, involuntary, and **intrusive distressing memories** of the traumatic event. **Note:** spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.
 - 2. **Recurrent distressing dreams** related to the traumatic event (Note: it may not be possible to ascertain that the content is related to the traumatic event).
 - 3. **Dissociative reactions** in which the individual feels or acts as if the traumatic event(s) were recurring (such reactions may occur on a continuum with the most extreme expression being a complete loss of awareness of present surroundings).
 - 4. Intense or prolonged psychological **distress at exposure to internal or external cues** that symbolize or resemble an aspect of the traumatic event(s).
 - 5. Marked physiological reactions to **reminders** of the traumatic event(s).

One item from C. or D. below:

- C. Persistent avoidance of stimuli associated with the traumatic event (that began after the traumatic event), as evidenced by efforts to avoid:
 - 1. Activities, places or physical reminders, that arouse recollections of the traumatic event.
 - 2. People, conversations, or interpersonal situations that arouse recollections of the traumatic event
- D. Negative alterations in cognitions and mood that are associated with the traumatic event (that began or worsened after the traumatic event), as evidenced by 1 or more of the following:
 - 1. *Substantially increased frequency of negative emotional states -- for example, fear, guilt, sadness, shame or confusion.**
 - 2. Markedly diminished interest or participation in significant activities, including constriction of play.
 - 3. Socially withdrawn behavior.
 - 4. Persistent reduction in expression of positive emotions.

Arousal and Reactivity

- Alterations in arousal and reactivity that are associated with the traumatic event (that began or worsened after the traumatic event), as evidenced by 2 or more of the following:
 - 1. Irritable, angry, or aggressive behavior, including extreme temper tantrums.
 - 2. *Reckless or self-destructive behavior.**
 - 3. Hypervigilance
 - 4. Exaggerated startle response
 - 5. Problems with concentration
 - 6. Sleep disturbance – for example, difficulty falling or staying asleep, or restless sleep.

- Duration of the disturbance (symptoms in Criteria B, C, D and E) is more than one month.
- G. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings peers or other caregivers or school behavior.

Proposed Criteria for Developmental Trauma Disorder DSM5

Proposed Criteria for Developmental Trauma Disorder

- A. Exposure. The child or adolescent has experienced or witnessed multiple or prolonged adverse events over a period of at least one year beginning in childhood or early adolescence, including:
 - A. 1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence; and
 - A. 2. Significant **disruptions of protective caregiving** as the result of repeated changes in primary caregiver; repeated separation from the primary caregiver; or exposure to severe and persistent emotional abuse

Proposed Criteria for Developmental Trauma Disorder

- B. Affective and Physiological Dysregulation. The child exhibits impaired normative developmental competencies related to **arousal regulation**, including at least two of the following:
 - B. 1. Inability to modulate, tolerate, or recover from extreme affect states (e.g., fear, anger, shame), including prolonged and extreme tantrums, or immobilization
 - B. 2. Disturbances in regulation in bodily functions (e.g. persistent disturbances in sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions)
 - B. 3. Diminished awareness/dissociation of sensations, emotions and bodily states
 - B. 4. Impaired capacity to describe emotions or bodily states

- **D. Self and Relational Dysregulation.** The child exhibits impaired normative developmental competencies in their sense of personal identity and involvement in relationships, including at least three of the following:
 - D. 1. Intense **preoccupation with safety of the caregiver** or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation
 - D. 2. Persistent **negative sense of self**, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness
 - D. 3. Extreme and **persistent distrust, defiance or lack of reciprocal behavior in close relationships** with adults or peers
 - D. 4. Reactive physical or verbal **aggression** toward peers, caregivers, or other adults
 - D. 5. **Inappropriate** (excessive or promiscuous) attempts to get **intimate contact** (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance
 - D. 6. **Impaired capacity to regulate empathic arousal** as evidenced by **lack of empathy** for, or intolerance of, expressions of distress of others, or excessive responsiveness to the distress of others

- E. Posttraumatic Spectrum Symptoms. The child exhibits at least one symptom in at least two of the three PTSD symptom clusters B, C, & D.
- F. Duration of disturbance (symptoms in DTD Criteria B, C, D, and E) at least 6 months.
- G. Functional Impairment. The disturbance causes clinically significant distress or impairment in at least two of the following areas of functioning:
 - • Scholastic
 - • Familial
 - • Peer Group
 - • Legal
 - • Health
 - Vocation

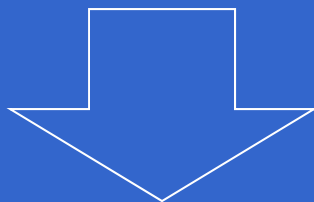
Adverse Childhood Experiences

- Abuse and Neglect (e.g., psychological, physical, sexual)
- Household Dysfunction (e.g., domestic violence, substance abuse, mental illness)



Impact on Child Development

- Neurobiologic Effects (e.g., brain abnormalities, stress hormone dysregulation)
- Psychosocial Effects (e.g., poor attachment, poor socialization, poor self-efficacy)
- Health Risk Behaviors (e.g., smoking, obesity, substance abuse, promiscuity)



Long-Term Consequences

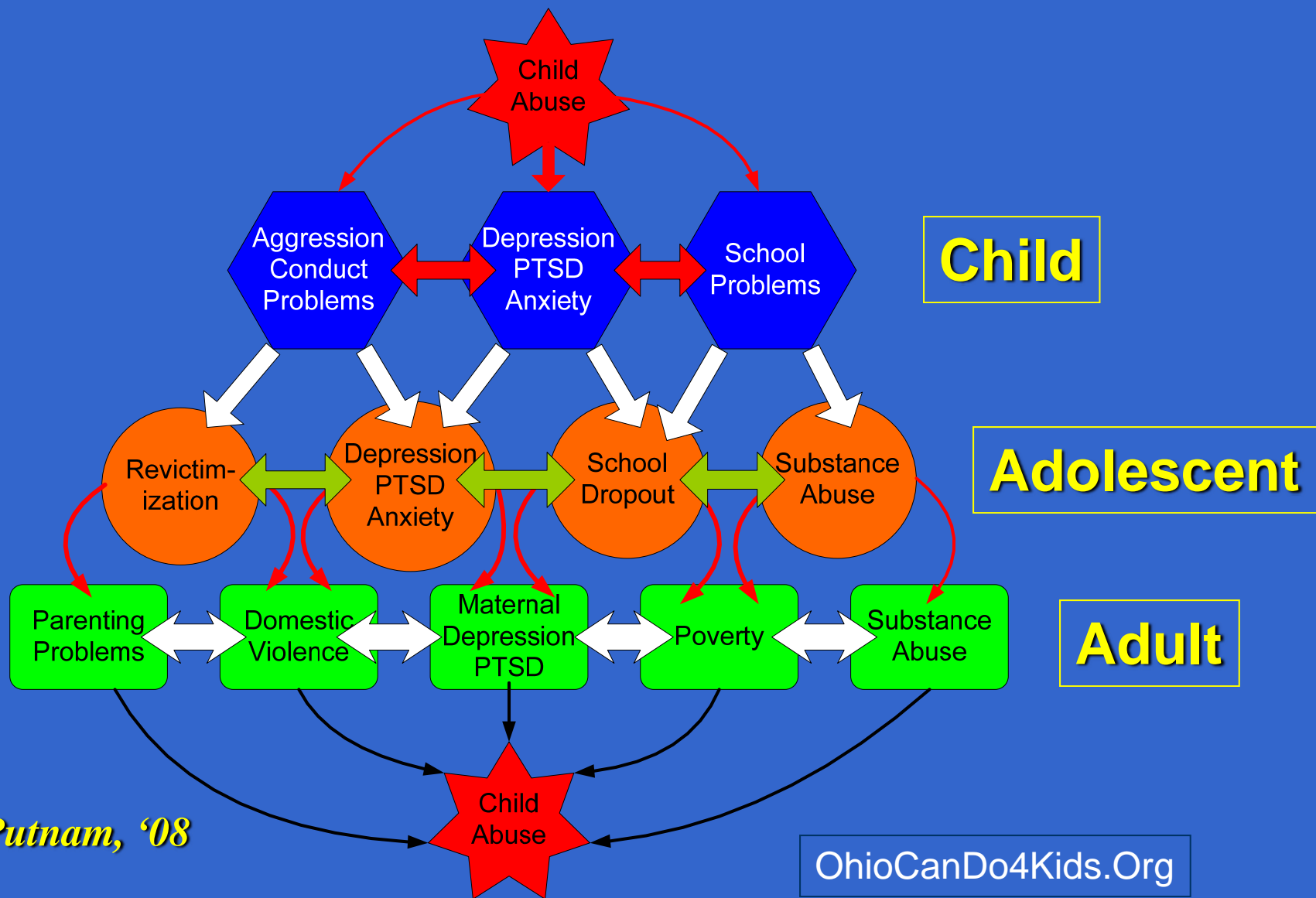
Disease and Disability

- Major Depression, Suicide, PTSD
- Drug and Alcohol Abuse
- Heart Disease
- Cancer
- Chronic Lung Disease
- Sexually Transmitted Diseases
- Intergenerational transmission of abuse

Social Problems

- Homelessness
- Prostitution
- Criminal Behavior
- Unemployment
- Parenting problems
- Family violence
- High utilization of health and social services

Developmental Cascade of Transgenerational Child Maltreatment Risk



-- F. Putnam, '08

Call for Trauma Informed Child Serving Systems



Artwork courtesy of the International Child Art Foundation (www.icaf.org)

What realistic and practical actions can be taken at all levels of the system to make meaningful use of that understanding to make it better for the children, families, and workforce.

Essential Elements of Trauma-Informed Practice

1. Maximize the child's sense of safety.
 - Concept of triggers
2. Utilize comprehensive assessment of the child's trauma experiences and their impact on the child's development and behavior to guide services when appropriate.
3. Assist children in reducing overwhelming emotion.
4. Address any impact of trauma and subsequent changes in the child's behavior, development, and relationships
5. Help children make new meaning of their trauma history and current experiences.

Essential Elements of Trauma-Informed Practice

6. Coordinate services with other agencies.
7. How and when to apply the right evidence based treatments
8. Support and promote positive and stable relationships in the life of the child.
9. Provide support and guidance to child's family and caregivers.
10. Recognize many of the adults caregivers you interact with are trauma victims as well-trauma in childhood, trauma last week
11. Manage professional and personal stress.

Trauma Informed Treatment Lessons form Evidence Based Practice:



Artwork courtesy of the International Child Art Foundation (www.icaf.org)

Resources

- www.cebc4cw.org (Online Evidence Based Practice Resource Designed for Child Welfare Professionals- With Support from California Department of Social Services)
- www.nctsn.net (National Child Traumatic Stress Network)
- www.ChadwickCenter.org (Chadwick)
- www.musc.edu/cvc/ (TF-CBT on-line and OVC guidelines)

What Is Assessment Based Treatment (ABT)?

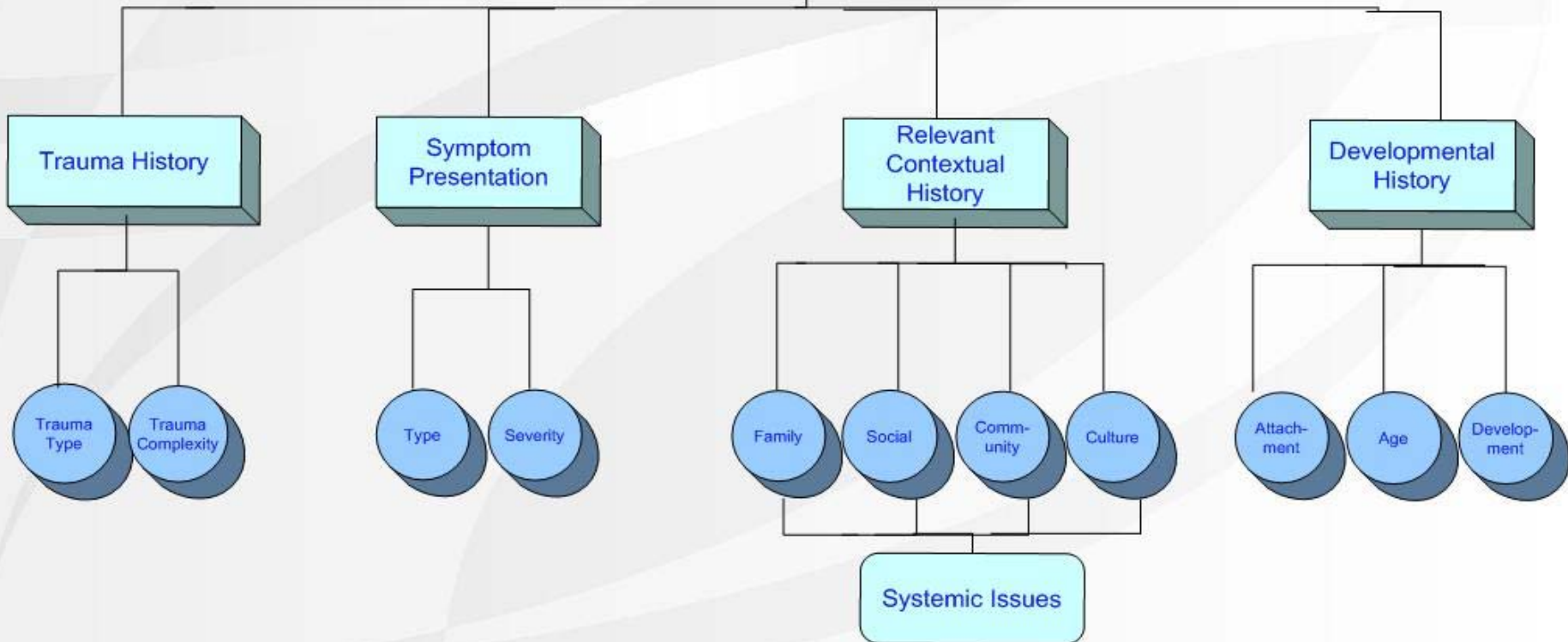
Development of clinical assessment-based treatment refers to the “development of an integrated plan of prioritized interventions, that is based on the diagnosis and psychosocial assessment of the client, to address mental, emotional, behavioral, developmental and addictive disorders, impairments and disabilities, reactions to illnesses, injuries, and social problems.” (Social work, consolidated laws, effective Sept. 1, 2004)

Chadwick's Philosophy of Trauma Treatment

- The therapeutic goal is to resolve the impact of a single or series of traumatic experiences to the child and their family.
- Therapeutic decisions emerge from clinical and standardized assessment.

Unique Client Picture

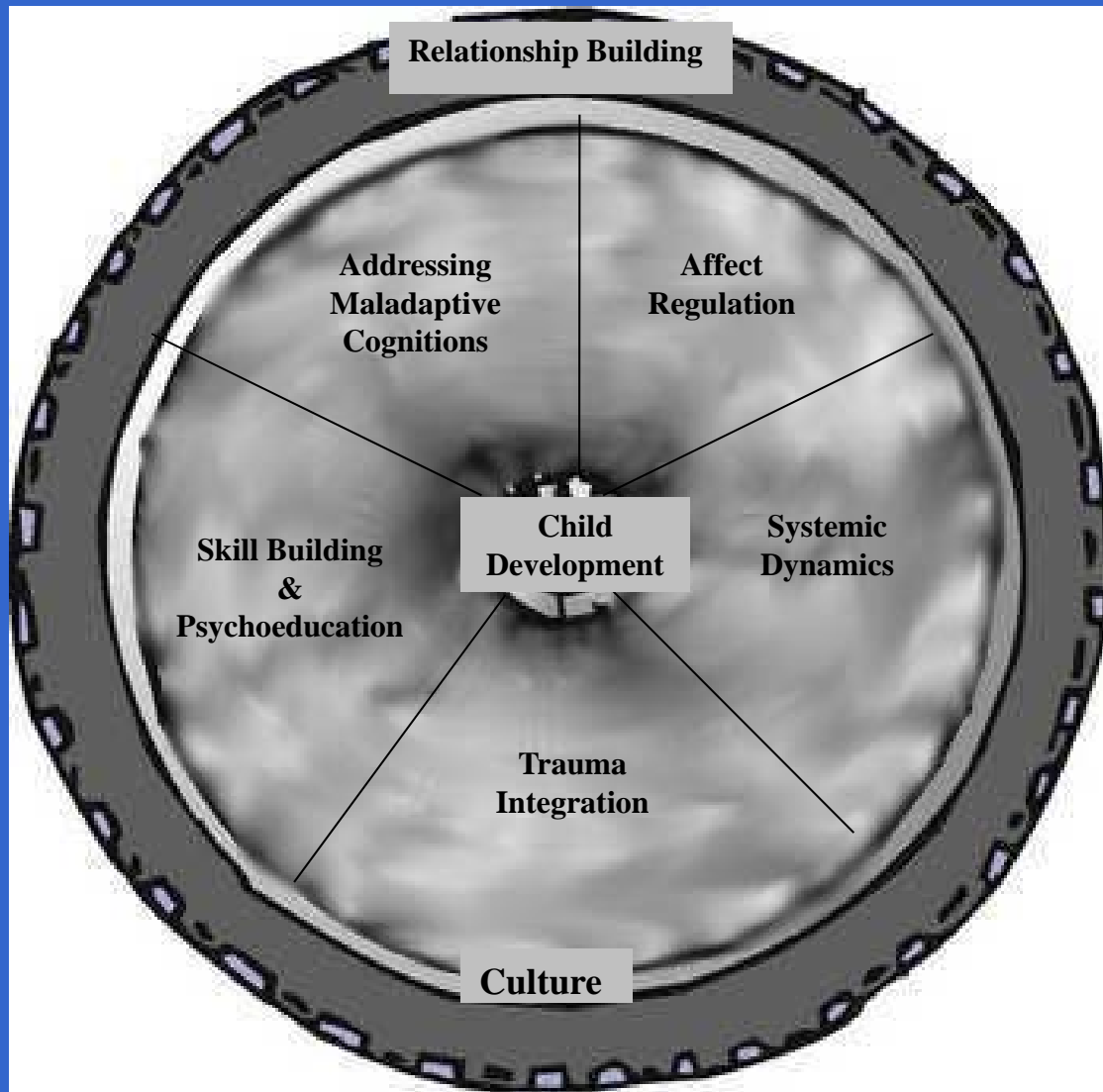
Completion of Standardized
Measures and Clinical Interview



Assessment Based Treatment at Chadwick Center

- All clients are assessed with standardized assessment instruments prior to entering treatment.
- The treating therapist develops a treatment plan based on the problems and needs identified by the assessment.
- Specific psychological problems and symptoms are paired with the most effective therapies, which contributes to successful outcomes in treatment.
- Continued assessment is an integral part of the family's ongoing treatment at the Chadwick Center and allows the therapists to evaluate the child's progress in treatment over time.

The Trauma Wheel



Core Components of Trauma-Informed, Evidence-Based Treatment

- Building a strong therapeutic relationship
- Psychoeducation about normal responses to trauma
- Parent support, conjoint therapy, or parent training
- Emotional expression and regulation skills
- Anxiety management and relaxation skills
- Cognitive coping or reframing
 - Cognitive Triangle- Thoughts, Feelings, Behavior

Core Components of Trauma-Informed, Evidence-Based Treatment, cont'd

- Construction of a coherent trauma narrative
- Mastery of trauma reminders -Strategies that allow exposure to traumatic memories, reminders, and feelings in tolerable doses so that they can be mastered and integrated into the child's experience
- Personal safety training and other important empowerment activities
- Resilience and closure

**Interventions such as the Evidence Based "Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)" utilize these components as a standard part of treatment*

Questions to Ask Therapists/ Agencies That Provide Services

- Do you provide trauma-specific or trauma-informed therapy? If so, how do you determine if the child needs a trauma-specific therapy?
- How familiar are you with evidence-based treatment models designed and tested for treatment of child trauma-related symptoms?
- How do you approach therapy with traumatized children and their families (regardless of whether they indicate or request trauma-informed treatment)?
- Describe a typical course of therapy (e.g., can you describe the core components of your treatment approach?).

Come Together in 2011

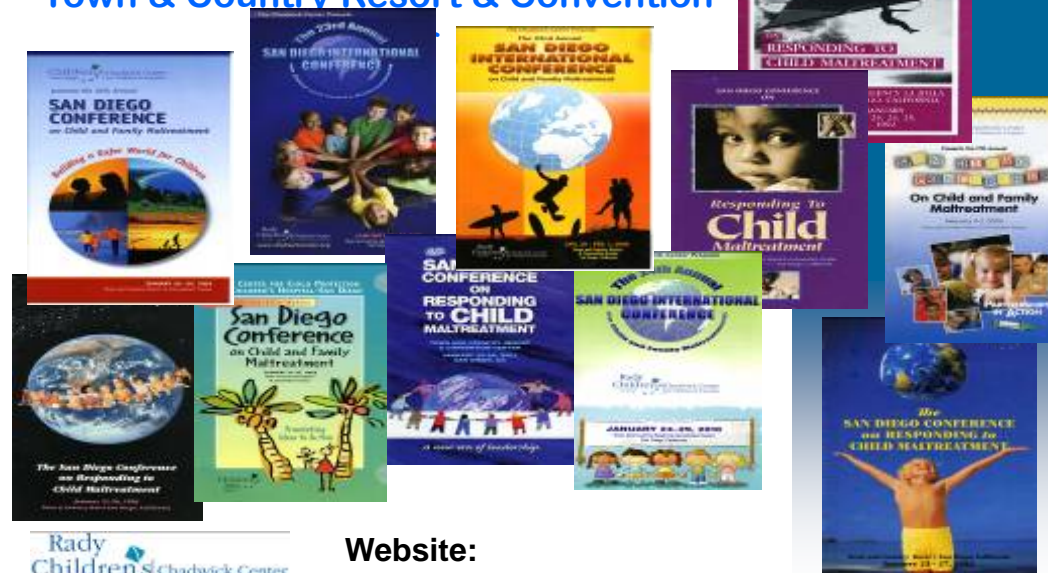
San Diego International Conference

**ON CHILD & FAMILY
MALTREATMENT**

January 23 - 28, 2011

Town & Country Resort & Convention

Celebrate
our
Anniversaries-
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& 35th year of
the Chadwick
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