Child Traumatic Stress and Trauma Informed Care

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Overview

• What is trauma & child traumatic stress?

• How can I identify child traumatic stress through Mobile Crisis?

• What can I do through Mobile Crisis for a traumatized child?
What is a “Trauma”

The person has directly experienced, witnessed, or learned that the event occurred to a close family member/ friend that involve actual or threatened death or serious injury, or sexual violence. Repeated exposure to aversive details or the event(s) been confronted with an event or events

(DSM-5)

• Overwhelming experience that cannot be mediated/processed utilizing existing coping mechanisms.
Range of Traumatic Events

- Physical abuse
- Sexual abuse
- Domestic violence
- Dating Violence
- Community violence and criminal victimization
- Bullying
- Sudden separation from a caregiver
Range of Traumatic Events

- Traumatic death of a loved one
- Accidents/fires
- Painful Medical Procedure
- Natural Disasters
- War/terrorism
- Historical Trauma
- Chronic/ Pervasive Trauma

- 78% of children age 14-17 have experienced at least one trauma
- 60-80% of children seeking treatment have been exposed to at least one trauma
Trauma Exposure in CT Mobile Crisis

PIC Annual Report / Statewide data

- Any history of trauma exposure: 67%
- Witness to violence: 24%
- History of sexual victimization: 12%
- Victim of violence: 16%
- Other: 21%
- Disrupted attachment/multiple placements: 27%
Timeline of Trauma Aftermath

- Traumatic Event
  - Immediate
- Short Term Effects
  - Hours, days, and weeks
- Long Term Effects
  - Months to years

Time after traumatic event
Immediate Reactions to Trauma

- Automatic survival mode
- Fight or Flight or Freeze
- Physiological changes
- Results in loss of internal control
- Reduced ability to think, feel, act
Short Term Reactions to Trauma

- **Normal reactions** to an abnormal event
- Children respond differently to same event
- Caregiver support
- Symptoms usually dissipate quickly (80%)
- Event-related & individual factors
Short-Term Reactions to Trauma (hours to days after)

- **Thinking**
  - Distractibility/inattention
  - Hypervigilance
  - Intrusive thoughts

- **Emotions**
  - Irritability
  - Emotional upset
  - Blunted emotions

- **Relationships**
  - Separation anxiety
  - Withdrawal
  - Social functioning

- **Behavior**
  - Changes in play
  - Regressive behaviors
  - Outbursts/fights
  - Risk taking

- **Physiological**
  - Sleep disturbances
  - Physical complaints
  - Appetite changes
Secondary stresses following a trauma

- Changes in Family Living Circumstances, Resources
- Change in Community Resources
- Change in School
- Change in Peers
- Change in Family Constellation and Function
Secondary stresses following a trauma

- Change in Availability and Utilization of Social Support
- Need to Assume New Responsibilities
- Medical / Surgical Care, Rehabilitation
- Legal proceedings

**EMPS role:** Minimizing/Mitigating effects
Young Children and Trauma

• Loss of trust in adults

• Emotional instability

• Behavior Changes

• Return to earlier behavior

• Can derail the normal developmental trajectory
Consequences of Child Maltreatment

• 30% of abused children have chronic health problems

• Over 50% have trouble in school

• 30% have some type of language or cognitive impairment

• 25% of traumatized children with PTSD became substance abusers (vs. 4% of non-traumatized children)

• Women with sexual abuse histories are more likely to suffer from gastrointestinal problems, chronic pelvic pain, and neurological problems such as headaches and backaches

• Intergenerational trauma is common
Long-Term Consequences

- PTSD can be a chronic condition
- If untreated, can persist for years and into adulthood
- Can result in a variety of emotional, behavioral, social and psychiatric consequences
- Adverse Childhood Experiences (ACE) Study: Collaboration with CDC and Kaiser Permanente in San Diego
Long-Term Consequences

Examples of long-term consequences:

- Attachment problems
- Eating disorders
- Depression
- Suicidal behavior
- Anxiety
- Mood disorders
- Substance abuse
- Violent/Abusive behaviors
- Somatic problems
- School problems
- Relationship problems
DSM-5 Diagnostic Criteria

• Exposure to a **traumatic event**
  - Direct experience/ witness in person/ actual or threatened death of a family member/ repeated exposure to aversive details of events

• **Symptoms**
  - re-experiencing
  - avoidance
  - hyperarousal
  - negative alterations in cognition/ mood

• Distress/ impairment/symptoms for > 1 month
DSM-5 Diagnostic Criteria for PTSD

Re-experiencing

• Persistent re-experiencing (1+):
  – recurrent distressing memories of event
  – recurrent distressing dreams of event
  – Flashbacks/ acting or feeling that the event was recurring
  – distress at internal or external cues resembling event/ aspects of the event
  – physiological reactivity to cues resembling event
DSM-5 Diagnostic Criteria for PTSD

Avoidance

• Avoidance of stimuli of (1+):
  – avoid thoughts, feelings, or conversations
  – avoid activities, places, or people
  – less interest in activities
  – estrangement from others
Persistent symptoms of increased arousal (2+):
- sleep disturbance (DFA/ MNA/ restless)
- irritability or outbursts of anger with little provocation
- difficulty concentrating
- hypervigilance
- exaggerated startle response
- reckless or self-destructive behavior
DSM-5 Change

• Negative alteration in cognition and mood associated with the traumatic event
  – Inability to remember an important aspect of the traumatic event (not due to medical/substances)
  – Persistent and exaggerated negative beliefs
  – Distorted cognition that results in self-blame
  – Persistent inability to experience positive emotions
  – Diminished interest in significant activities
DSM-5 Change

• With Dissociative Symptoms– Persistent or recurrent symptoms of either:
  – Depersonalization: feeling detached from as if an outsider (in a dream/ time moving slowly)
  – Derealization: unreality of surroundings (the world is unreal/ distant/ distorted)

* Note: not related to substance use or other medical condition
DSM-5 Change

• In Children 6 years or younger
  – Includes learning a traumatic event occurred to a parent or caregiving figure
  – Intrusive memories may not appear distressing and may be expressed as play reenactment
  – Dissociative reactions (flashbacks) may occur on a continuum with the most extreme being a loss of awareness of surroundings
PTSD in Children:
Risk for Misdiagnosis

Children presenting with PTSD symptoms are at risk of being misdiagnosed for what other disorders

BUT they might also have PTSD and other disorders

Onset of symptoms/timeline can be helpful
PTSD Card Sort

• Groups of 4-6 people – one set of cards

• Spread the cards out and mix them up

• Find the 4 PTSD cluster cards – these are the categories

• Sort other cards under one of the headings
What Lens Are You Looking Through?
Call for a 14yo girl fighting with mother

**MOM SAYS:**
- Anger/irritable
- Can’t pay attention
- School grades & attendance
- Getting into fights
- Scared of the dark
- Withdrawn
- Disobeys mom
- Restricted affect
- Sleep problems

*Thoughts? Diagnosis?*
Call for a 14 yo girl- fighting with mother

MOM SAYS:
- Anger/irritable
- Can’t pay attention
- School grades & attendance
- Getting into fights
- Scared of the dark
- Withdrawn
- Disobeys mom
- Restricted affect
- Sleep problems

CONDUCT DISORDER?

So you follow-up with:
- Has she destroyed property?
- Stolen?
- Hurt anybody?
Call for a 14yo girl fighting with mother

MOM SAYS:
• Anger/irritable
• Can’t pay attention
• School grades & attendance
• Getting into fights
• Scared of the dark
• Withdrawn
• Disobeys mom
• Restricted affect
• Sleep problems

Disruptive Mood Dysregulation D/O?
So you follow-up with:
• Mood lately?
• Less interest in activities?
• Appetite/weight change
Call for a 14yo girl fighting with mother

MOM SAYS:
- Anger/irritable
- Can’t pay attention
- School grades & attendance
- Getting into fights
- Scared of the dark
- Withdrawn
- Disobeys mom
- Restricted affect
- Sleep problems

ANXIETY DISORDER?

So you follow-up with:
- Worry a lot?
- Hard to control worry?
- Other fears?
Call for a 14yo girl fighting with mother

MOM SAYS:
• Anger/irritable
• Can’t pay attention
• School grades & attendance
• Getting into fights
• Scared of the dark
• Withdrawn
• Disobeys mom
• Restricted affect
• Sleep problems

Traumatic stress/PTSD?
So you follow-up with:
• Traumatic event?
• Avoid thinking/talking about it?
• Flashbacks/nightmares?
• Upset by reminders?
• Hypervigilant/jumpy?
Complex Trauma

• Long standing exposure to DV, abuse, and other community violence

• Problems in multiple areas

• Many children in child welfare system have complex trauma
Areas Impacted by Complex Trauma

- **Biological** changes in the brain
- **Impaired thinking/analytic ability**
- Become **disorganized** when stressed
- **Attachment** problems
- **Affect Regulation** - problems managing emotions
- Difficulty managing **anger** (short fuse, easily triggered)
Areas Impacted by Complex Trauma

- Inability to differentiate between emotional states
- Dissociation
- Behavioral dysregulation
- Poor self-concept (shame or guilt)
- Child may think that danger/violence is the norm
Key Points

• Trauma is common; so is resiliency

• **Avoidance**: If you don’t ask about trauma, they often won’t tell

• Looking through a “**trauma lens**”

• **Developmental differences** in symptoms

• **Support** following a traumatic event is critical
Screening for Traumatic Stress
Screening for Trauma Exposure

- If you don’t ask…
- Easiest if following a written form (e.g. “these are some questions we ask all kids about upsetting things that might have happened.”
- Has the child experienced [each type of trauma]?
- Ask the hard questions (sexual abuse, DV)
- How they respond vs. what they say
Screening for Trauma Exposure

- Unreported trauma?
- Is further assessment needed?
- Universal
- Quick but specific
- Ask child & caregiver separately if possible
Range of Traumatic Events

In EMPS PIE:

- Physical abuse
- Sexual abuse
- Domestic violence
- Community violence and criminal victimization
- Separation from a caregiver
- Incarceration of a loved one

History of traumatic experience? If yes, then:
- Been a victim of violence?
- Been a witness to violence?
- History of sexual victimization?
- Disrupted attachment/multiple placements?
- History of other traumatic experience - please specify..
Range of Traumatic Events

MISSING:

- Dating violence
- Traumatic death of a loved one
- Accidents/fires
- Natural Disasters/war/terrorism
- Painful medical procedures
Symptom Screening

- Positive trauma exposure AND
- Some possible/definite symptoms based on eval
  → but how much is it affecting the child?
- Screen for PTSD, depression, anxiety sxs
- Use standardized measures when possible (brief!)

*UCLA Posttraumatic stress disorder reaction index
Symptom Screening

- Makes it easier to ask the hard questions
- Don’t have to memorize everything
- Example:
  - UCLA PTSD-RI (Reaction Index)
  - TESI- (Traumatic Events Screening Inventory)
  - CPSS (Child PTSD Symptom Scale)
- Integrate standardized scores w/other information
Things to Consider

• Look through a trauma lens – does it fit?

• Is the child/family avoiding?

• Have you asked the right questions?

• Don’t need all the details

• Is there enough evidence to warrant a referral for trauma specific treatment?
Intervention for Traumatic Stress

**Acute Intervention**

*(immediately to weeks following a traumatic event)*
Acute Intervention
Responding Immediately after Trauma

• When you show up not long after a traumatic event happened

• Examples:
  – Child distressed at school after witnessing a violent fight
  – Teenager aggressive /out of control at home after witnessing DV between mom and stepfather that day

• Your job:
  – Support, stabilize, reduce distress, assess, monitor, (refer)
Maslow’s Hierarchy of Needs

- **Physiological**
  - Breathing, food, water, sex, sleep, homeostasis, excretion

- **Safety**
  - Security of body, of employment, of resources, of morality, of the family, of health, of property

- **Love/Belonging**
  - Friendship, family, sexual intimacy

- **Esteem**
  - Self-esteem, confidence, achievement, respect of others, respect by others

- **Self-actualization**
  - Morality, creativity, spontaneity, problem solving, lack of prejudice, acceptance of facts
Acute Intervention
Responding after Trauma

- Empathize
- Be aware of cultural differences related to trauma
- Restore sense of safety and sense of protection
- Plan for future safety & security
- Help children express their thoughts/feelings/concerns
- Explain to child in developmentally appropriate terms
Acute Intervention
Responding after Trauma

• Guide existing caregivers to support the child

• Psychoeducation for child and caregivers

• Encourage and support help-seeking/coping behaviors

• Create a supportive environment for the spectrum of reactions and different courses of recovery
Acute Intervention
Responding Immediately after Trauma

• Physical safety of you and others first
• Establish human connections without being intrusive
• Speak slowly and be concrete
• Identify immediate needs
• Reduce unnecessary secondary exposures & separations
• Listen - focus on what they say & want
Acute Intervention
Responding Immediately after Trauma

Responding with police
• Police departments are hierarchical - introduce yourself to the highest ranking officer present (ask who is in charge).
• You are on police turf, but you are the mental health expert; respectfully advocate.
• Police who take an interest in the family may want to join in your intervention; weigh the benefit of police perspective and including them as partners against managing their input.
Acute Intervention

Days and weeks after a traumatic event

• Return to healthy routines

• Identify trauma triggers

• Re-assess symptoms & monitor

• Relaxation/stress management

• Problem solving

• Instilling hope & optimism

• Referrals (if needed)
Referrals for Trauma-Focused Treatment in CT
Trauma-focused Treatments for Children in CT

- TF-CBT
- TI- CPP
- CFTSI
- MATCH— ADTC
- CBITS/ Bounce Back! (schools)
- EMDR
What is TF-CBT?

• Evidence-based Treatment (5+ studies)
• Developed as an outpatient intervention for child trauma victims
• Improves child PTSD, depression, anxiety, shame, behavior problem
• Improves parent depression, distress, parenting
• Manualized/Flexible
What is TF-CBT?

- Short-term (often 16-24 sessions)
- Goals: Improve child (& parent) symptoms by helping them manage powerful emotions related to traumatic event(s)
- Emphasis on caregiver involvement when possible
- Teaching of relaxation & coping skills
- Gradual exposure to trauma reminders – “working through” trauma
Who is appropriate for TF-CBT

• Youth age 4-18
• Comprehensive evaluation/assessment
• One or more specific identified traumas
• PTSD/child traumatic stress symptoms
• Best with a caregiver; effective with child alone
What is TI- CPP?

- Ages 0-6
- Emphasis on the way the trauma has affected the child-caregiver relationship
- Dyadic attachment-based approach
- Focus on safety, affect regulation and improving the child-caregiver relationship
- Joint construction of a trauma narrative
- Goal: return child to normal developmental trajectory
What is CFTSI

• Short term (often 4-6 sessions)

• Ages 7-18; within 30 days of the event

• Primary goal of preventing PTSD

• Theoretical Basis: the role of family support as a primary protective factor for children exposed to violence
Goals of CFTSI

- Improve screening and identification of children impacted by traumatic stress
- Reduce traumatic stress symptoms
- Increase communication between caregiver and child about child’s traumatic stress reactions
- Provide skills to help master trauma reactions
- Assess child’s need for longer-term treatment
- Reduce concrete external stressors
MATCH- ADTC

- **MATCH- ADTC**: Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems

- Ages 6-15

- 33 modules
CBITS/ Bounce Back!

- CBITS: Cognitive Behavioral Intervention for Trauma in the Schools
- Students in grades 5-12
- Uses CBT based techniques in a skill-based group format
- 10 group sessions
- Includes parent educations session/ teacher education session and individual sessions
CBITS/ Bounce Back!

- Bounce Back is a CBT/ skills based group
- Elementary students in grades K-4
- 10 group sessions
- 2-3 individual sessions; parent education and teacher education sessions
EMDR

• EMDR: Eye Movement Desensitization and Reprocessing

• Originally designed to treat adults; now adapted to work with children

• Eight Phases- each with its own intention
Want to Learn More?

• National Child Traumatic Stress Network (lots of resources, handouts, etc.): [www.nctsn.org](http://www.nctsn.org)

• Excellent, free in-depth TF-CBT training: [www.tfcbt.musc.edu](http://www.tfcbt.musc.edu)

• Contact Info:
What Interferes with our ability to be Trauma-Informed?

- Emotions
- Behaviors
- Need for control
- Past interactions with clients
- Personal Stress and Life experiences
Vicarious Trauma/ Transformation

- Results from empathic engagement with a traumatized client
- Cumulative exposure to another person’s traumatic material
- Process of transforming VT
- Spiritual growth
- A greater appreciation of the gifts in one’s own life
- Knowledge that people can endure
Prevention and Coping

• Personal assessment and balance
  – Know your triggers, your history, your needs
  – Address your stress throughout the day
  – Use of Supervision
  – Peer Support

• Brainstorming
Reminder-

• As we remain committed to taking care of children and families– remember to take care of YOU.
Evaluation

www.playingforchange.com