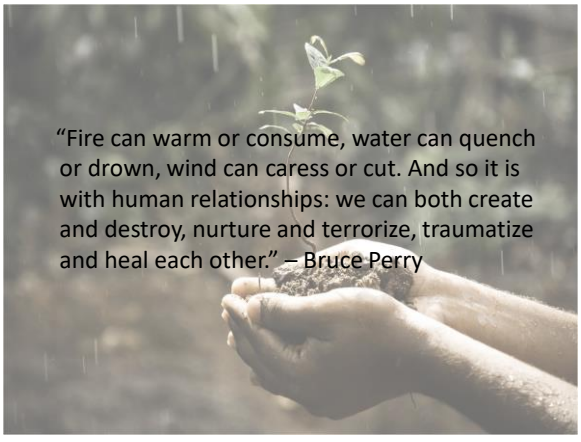
Child Development

Effects of Maltreatment and Trauma

Stacey Hoksbergen, MA, LPC



Reasons Children Come Into Care

- Neglect – physical, educational, medical
- Abuse – physical, sexual, emotional
- Abandonment
- Physical or mental illness – of child or parent
- Death of a parent
- Poverty/homelessness
- Criminal charges for parents
- Theses issues continue to have an impact on a child during placement and when the child is adopted.

Perspective

- The definition of what is "traumatic" is different for every person
- Resiliency factors
  - How was the situation communicated to them?
  - Was this situation a one time occurrence or pervasive?
  - What is the level of family and friend support?
  - How many times have they been removed?
  - If they got removed did they get placed with strangers or people they knew?
- Example- Firefighters

"Removed"

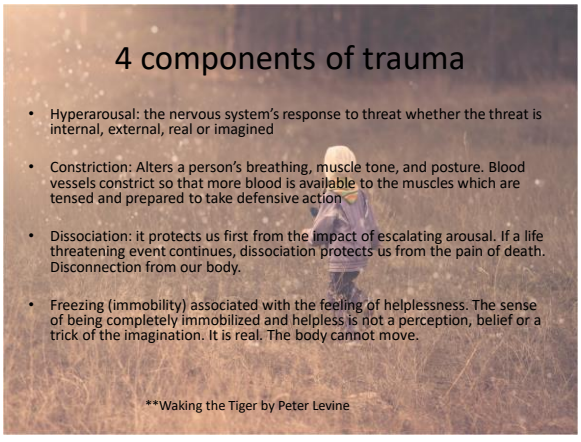
- https://vimeo.com/73172036

Video Reflections

- What was it like for you to watch this video?
- Can you identify at least three situations where her level of trauma was increasing?
- How does it change the way you think about advocating for the children on your caseload?
- What are questions that she will probably struggle to answer about her situation?

Differentiation of trauma vs. stress

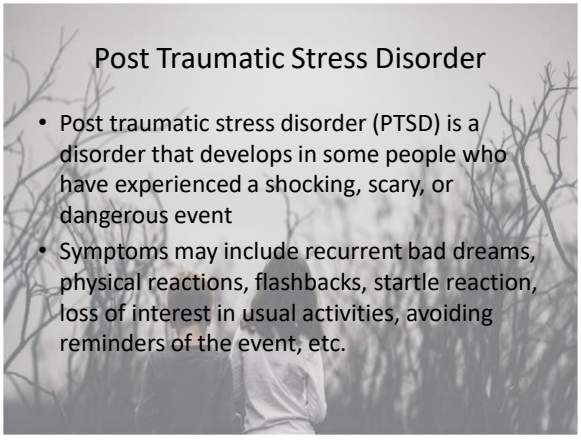
- Stress
  - Children are able to adjust back to day to day life with little disruption after the situation has ended
- Trauma
  - If signs and symptoms of traumatic stress last longer than a month
  - And if symptoms are…..
    - disrupting daily life
    - impacting their social and emotional health
    - meet specific diagnostic criteria



4 components of trauma

- Hyperarousal: the nervous system's response to threat whether the threat is internal, external, real or imagined
- Constriction: Alters a person's breathing, muscle tone, and posture. Blood vessels constrict so that more blood is available to the muscles which are tensed and prepared to take defensive action
- Dissociation: it protects us first from the impact of escalating arousal. If a life threatening event continues, dissociation protects us from the pain of death. Disconnection from our body.
- Freezing (immobility) associated with the feeling of helplessness. The sense of being completely immobilized and helpless is not a perception, belief or a trick of the imagination. It is real. The body cannot move.

**Waking the Tiger by Peter Levine



Post Traumatic Stress Disorder

- Post traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event
- Symptoms may include recurrent bad dreams, physical reactions, flashbacks, startle reaction, loss of interest in usual activities, avoiding reminders of the event, etc.

Complex PTSD

- This diagnosis captures the significant psychological harm that occurs with prolonged, repeated trauma
- This can cause changes in their self concept, the way they view themselves in relationship with others, emotional regulation, distorted perceptions of the perpetrator

What is bonding?

- A relationship that usually begins at the time of birth between a parent and child that establishes the basis for an ongoing mutual attachment
- It does not equal attachment
- Trauma bonds- we bond with people over shared experiences and trauma can be one of those shared experiences
- Parents may stay in unhealthy relationships because of trauma bonds and children can be bonded with parents but not trust them to provide consistently for their needs

What is attachment?

- Attachment is a reciprocal process by which an emotional connection develops between an infant and his/her primary caregiver.
  - Influences the child's physical, neurological, cognitive and psychological development
  - It becomes the basis for development of basic trust or mistrust, and shapes how the child will relate to the world, learn and form relationships throughout life.

How does trauma impact attachment?

- Intensifies questions
  - Can I trust people?
  - Am I valuable?
  - Do people love me?
- Parents are children's mirror of what is reality, how relationships work and how they view themselves. What kind of mirror is this parent reflecting back to the child?
- After repeated disappointment of not providing or continued harm that is caused from the parent the brain tries to keep that child safe by emotionally distancing from that caregiver

Questions

- What questions do you think Joey is trying to answer about his situation?
- How do you think mother's response to Joey's questions about her "papers" impacted their attachment?
- How do you think all of Joey's moves impacted his relationship with mother and with biological father?
- As their GAL what questions would you have for their parents and caregivers?

Trauma in the Context of Relationships

- Mirroring
  - –Regulating stress
  - –Understanding who they are in relationship to others
  - –Synergy between two people that helps children understand how to handle emotions
- Angels and ghosts in the nursery
- Attachment
  - –Higher stress levels in children who have disrupted attachment
  - –Stranger danger
  - –Lose their sense of basic security if they don't have attachment figures

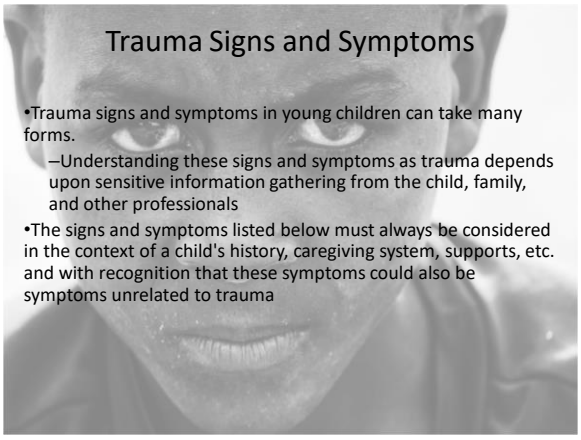
Roadblocks to healthy parent child relationships

- Abrupt loss of a parent through death or illness
- Multiple Caregivers
- Invasive or painful procedures
- Hospitalization
- Abuse and or/Neglect
- Mother's poor prenatal care or prenatal alcohol or drug exposure.
- Neurological problems
- Incarceration

Impacts of Abuse and Neglect on a Child's Development

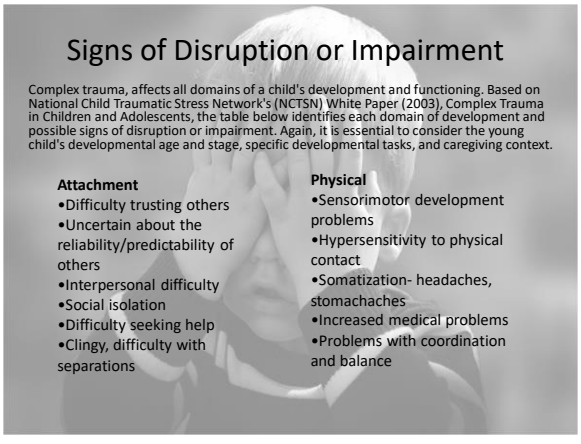
- Child may have missed key developmental tasks. They can have cognitive, emotional and social delays.
- Strategies and habits learned by children to survive in a chaotic home environment are maladaptive in other settings.
  - However, they are survival strategies so we have to honor them for the child and teach them ways to find healthy, more adaptive coping mechanisms
  - Asking yourself the question- "I wonder how this behavior kept them safe?"
- Medical procedures also cause children to have developmental setbacks

There are ongoing effects from abuse/neglect and drug exposure that require special kinds of parenting and continuing, long term parental patience. Every traumatized child must be parented individually



Trauma Signs and Symptoms

- Trauma signs and symptoms in young children can take many forms.
  - Understanding these signs and symptoms as trauma depends upon sensitive information gathering from the child, family, and other professionals
- The signs and symptoms listed below must always be considered in the context of a child's history, caregiving system, supports, etc. and with recognition that these symptoms could also be symptoms unrelated to trauma

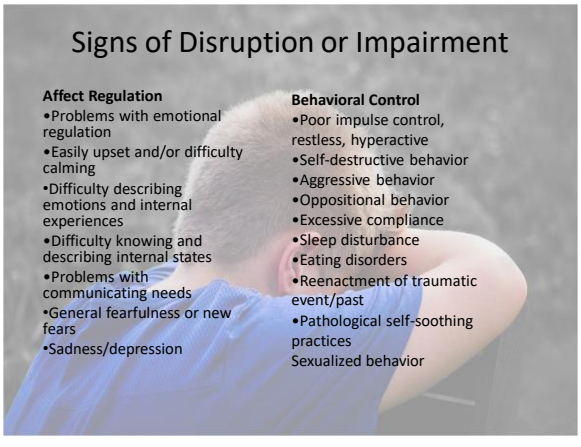


Signs of Disruption or Impairment

Complex trauma, affects all domains of a child's development and functioning. Based on National Child Traumatic Stress Network's (NCTSN) White Paper (2003), Complex Trauma in Children and Adolescents, the table below identifies each domain of development and possible signs of disruption or impairment. Again, it is essential to consider the young child's developmental age and stage, specific developmental tasks, and caregiving context.

Attachment
- Difficulty trusting others
- Uncertain about the reliability/predictability of others
- Interpersonal difficulty
- Social isolation
- Difficulty seeking help
- Clingy, difficulty with separations

Physical
- Sensorimotor development problems
- Hypersensitivity to physical contact
- Somatization- headaches, stomachaches
- Increased medical problems
- Problems with coordination and balance



Signs of Disruption or Impairment

Affect Regulation
- Problems with emotional regulation
- Easily upset and/or difficulty calming
- Difficulty describing emotions and internal experiences
- Difficulty knowing and describing internal states
- Problems with communicating needs
- General fearfulness or new fears
- Sadness/depression

Behavioral Control
- Poor impulse control, restless, hyperactive
- Self-destructive behavior
- Aggressive behavior
- Oppositional behavior
- Excessive compliance
- Sleep disturbance
- Eating disorders
- Reenactment of traumatic event/past
- Pathological self-soothing practices

Sexualized behavior

Signs of Disruption or Impairment

Cognition
- Difficulty paying attention
- Lack of sustained curiosity
- Problems processing information
- Problems focusing on/completing tasks
- Difficulty planning and anticipating consequences
- Learning difficulties, developmental delays
- Problems with language development
- Daydreaming or dissociation
- Talking about the traumatic event all the time and in appropriate situations

Self-Concept
- Lack of continuous/predictable sense of self
- Poor sense of separateness

Disturbance of body image
- Low self-esteem-helplessness, passive, low frustration
- Shame and guilt

No stranger danger

Sensitive Inquiry and Observation

- The following should be considered when gathering trauma specific information:
  - Observable signs, symptoms, behavioral concerns
  - Child and family circumstances
  - Family and staff perceptions/explanations of the child's behavior
  - Any recent change or event that may have contributed to the child's behavior
  - Any upsetting or traumatic event or history, if so describe who, what, when, where and what happened immediately after and since the traumatic event
  - The child's "story" about any recent change, traumatic event, or history
  - How the client and family perceive the trauma and its effects from a cultural perspective
  - Level of concern about the child's response to trauma
  - Level of disruption in the child's functioning (social, emotional, behavior, etc.)
  - How the child is coping and the child's strengths
  - Safety of the child, family, and their environment
  - Openness to consultation or additional therapy services that might be helpful

Stages of Child Development

- Trust vs. mistrust- infancy (0 to 1 ½)
  - If the child does not experience trust, they may develop insecurity, worthlessness and a mistrust of the world
  - Can I trust caregivers? Can my needs be met consistently?
- Autonomy vs. shame- early childhood (1 ½ to 3)
  - Children can be vulnerable in this stage and can feel shame and low self esteem if they struggle to learn a task
  - Can I do it all by myself?
- Initiative vs. guilt- play age (3 to 5)
  - Children play out their trial universe of what it means to be an adult and they begin to socially identify with roles
  - What is my purpose and how do I understand it in the context of relationships?

Stages of Development

- Industry vs. inferiority- school age (5 to 12)
  - This is a very social stage and if children have unresolved feelings of inadequacy and inferiority there can be serious problems in regards to competence and self esteem
  - Am I competent? Do my relationships affirm this?
- Ego identity vs. role confusion-adolescence (12 to 18)
  - The struggle to find their own identify while also negotiating social interactions and also working develop a sense of morality
  - Can I be myself and still feel connected in my relationships?
- Intimacy vs. isolation-young adult (18 to 35)
  - If satisfying relationships are unsuccessful isolation may occur
  - Do I have meaningful relationships?

Trauma's impact
Infants, Toddlers and Pre-school

- Attachment is critical at this age and it has most likely been disrupted by being involved with the system. Children tend to have a primary attachment, but can bond to several people
- A Child Find shall be recommended in efforts to access and identify any development barriers a child may have due to the trauma they have experienced
- In addition and if appropriate, a trauma screen shall be requested by your county DHS case worker to identify appropriate trauma services for your child
- Regardless of the specific trauma, the child needs a stable caregiver that can provide routine, boundaries and affection even if it is temporary while the parent works to resolve the areas of concern
- Longer placements allow children to learn how to at least connect to caregivers and receive their care even if they are not with them permanently. Shorter placements make that more difficult due to the amount of time it takes to build trust in order to be able to receive the benefits that a caregiver can provide

Parenting time

- Children of this age group have difficulty separating for long periods of time from primary caregiver, which is why establishing parenting time as soon as possible is critical if appropriate and shall include more frequent shorter periods of time with parent/parents

Trauma's impact
School Aged (4-11 years)

- Children will potentially struggle being separated from caregivers depending on their level of attachment
- Children of this age need an emotional foundation that provides confidence and self-worth.
- Therapeutic services are important to help them integrate their story to prevent further trauma symptoms
- At this age an (IEP) Individual Education Plan shall be requested by the child educational decision maker, should there be any academic, social/emotional or mental health concerns as a result of the child's trauma.
- In addition a trauma screen shall be requested by your county DHS case worker to identify appropriate trauma services for your child

Parenting time

- Parenting time needs a schedule that allows the child to focus on school, and shall be after school hours in efforts to keep the child's mind distracted from the family issues and focused on school. The same is to be said for therapy and or other services
- Visits should be on a consistent day and time to minimize trauma reactions and children should be made aware of transitions as much as possible

Trauma's Impact
Pre-Adolescent (12-15 years)

- Children at this age need help with school, peer problems and disruption of family
- Therapeutic services are critical in helping the child understand how to integrate their situation, develop coping skills and giving them a safe environment to discuss their worries
- Identify if your child has an IEP and review the current services and or request a review due to the change in circumstances in efforts to identify if the current service plan is still appropriate in supporting the child's needs
- A trauma screen shall be requested by your county DHS case worker to identify appropriate trauma services for your child.
- Children at this age need time to have organized activities and time with friends in efforts to maintain a sense of normalcy. Extracurricular activities are extremely important in giving the child a normal outlet due to the trauma they may have experience outside of therapeutic services.

Parenting time
- It should incorporate the flexibility to work around the activities they are involved in

Trauma's Impact
Adolescents (15-18 years)

- It is critical at this age you include the child in decisions that are being made for them
  - If applicable, have discussions with the child as to what an emancipation plan looks like for them if an identified permanent home is not available for them. It is critical by the age of 16 that an independent living plan is identified and the child is being referred for IL services and Chafee.
- Children this age should be attending court hearings
- At this age, children are very private and do not want others to know their business. They may prefer to have home base services. It is important we meet the child where they are at and we use our relationship with the child to encourage them to participate in appropriate services
- Adolescent children need consistent rules by all caregivers. They can be very manipulative and challenge the caregiver if consistency is not maintained

Parenting time
- The adolescent may want to spend time with peers vs parents so the team needs to discuss what this looks like for each child

Trauma Screens

- Trauma screening is used to determine whether a child has experienced trauma, displays symptoms related to trauma exposure, and/or should be referred for a comprehensive trauma-informed mental health assessment. It should include:
  - Exposure to potentially traumatic events/experiences
  - Traumatic stress symptoms/reactions

*From The National Child Traumatic Stress Network

Types of Trauma Screens

•Trauma Symptom Checklist for Children (TSCC): A 54-item caretaker report instrument developed for the assessment of trauma related symptoms in children ages 8-16.

•Trauma Symptom Checklist for Young Children (TSCYC): A 90 item caretaker-report instrument that can be used to assess trauma symptoms in children between 3-12 years old

•Traumatic Events Screening Inventory — Parent Report Revised (TESI-PRR): This parent report inventory is available for children under 7 and inquires about a variety of traumatic events, including current and previous injuries, hospitalizations, domestic violence, community violence, disasters, accidents, physical, and sexual abuse. Each form takes 20 - 30 minutes to complete.
https://www.ptsd.va.gov/professional/assessment/documents/tesi-parent.pdf

•Parenting Stress Index: Available in two forms, this screening instrument measures stress in the parent-child relationship, identifies dysfunctional parenting and predicts the potential for parental behavior problems and child adjustment difficulties within the family system. While its primary focus is on the preschool child, the PSI can be used with parents whose children are 12 years of age or younger. The 101-item format takes 20-25 minutes for the parent to complete. The 36 item Short Form (PSI/SF) takes 10 minutes.

(Chadwick Center for Children and Families, 2009)

Finding Qualified Therapists and Effective Therapy

- Does the therapist provide trauma specific or informed therapy, especially focused on young children and families?
- Does the individual/agency that provides therapy conduct an age appropriate comprehensive trauma assessment?
  - What specific standardized measures appropriate for young children are given?
  - What does your assessment show about the young child and the family?
  - What are some of the major strengths and/or areas of concern for the child and family?
- Is the clinician/agency familiar with evidenced-based treatment models for young children and are they trained in any?
- How are cultural competency and special needs issues addressed?
- Does the therapist do in home therapy or just office based sessions?
  - If the trauma occurred in the home you want to be hesitant about the child receiving therapy there. Ideally the child would have a space to process the trauma outside of the initial event

- Which approach(es) does the clinician/agency use with young children and families?
- How are parent support, conjoint therapy, parent training, and/or psychoeducation offered?
- Which techniques are used for assisting with the following:
  - Building a strong collaborative and therapeutic relationship with parents or caregivers and the young child
  - Identifying feelings and supporting emotional expression and regulation
  - Identifying strategies to help calm the child when feeling overwhelmed
  - Establishing routines and helping the child feel secure (including at home/and Head Start)
  - Cognitive processing/reframing in language appropriate to the child's development; linking feelings, thoughts, and memories
  - Construction of a trauma narrative through age appropriate conversation and observing the child's play and interaction
  - Developmentally appropriate strategies that allow exposure to trauma reminders/memories and feelings in tolerable doses so that they can be mastered and integrated into the child's experience
  - Assuring safety, encouraging self- control, and allowing age-appropriate choices
  - Supporting developmental progress, building resiliency, and closure

Treatment modalities

- TF-CBT- Trauma Focused Cognitive Behavioral Therapy
- DBT- Dialetical Behavioral Therapy
- EMDR- Eye Movement Desensitization and Reprocessing
- CBT- Cognitive Behavioral Therapy
- CPP- Child Parent Psychotherapy
- FFT- Functional Family Therapy
- MST- Multisystemic therapy
- MST-PSB- Multisystemic therapy with Problem Sexual Behaviors
- Safe Care
- TBRI- Trust Based Relational Intervention
- Animal Assisted Therapy

Evidence based treatment modalities

- http://www.nctsnet.org/resources/topics/treatments-that-work/promising-practices

Psychotropic and Over the counter Medication

- ***Psychiatric medication should not be used alone.*** **The use of medication should be based on a comprehensive psychiatric evaluation and be one part of a comprehensive treatment plan.**
- Before recommending any medication, the child and adolescent psychiatrist interviews the youngster and makes a thorough diagnostic evaluation. In some cases, the evaluation may include a physical exam, psychological testing, laboratory tests, other medical tests such as an electrocardiogram (EKG) or electroencephalogram (EEG), and consultation with other medical specialists.
- Medications which have beneficial effects may also have side effects, ranging from just annoying to very serious.
- Psychiatric medication should be used as part of a comprehensive plan of treatment, with ongoing medical assessment and, in most cases, individual and/or family psychotherapy.
- When prescribed appropriately by a psychiatrist (preferably a child and adolescent psychiatrist), and taken as prescribed, medication may reduce or eliminate troubling symptoms and improve the daily functioning of children and adolescents with psychiatric disorders.

Moving Past The Trauma

- Early identification and intervention has the capacity to modify and influence development in many positive ways
- The elements of successful intervention must be guided by the core principals of brain development
- Therapeutic interventions that restore a sense of safety and control are very important for the acutely traumatized
- In cases of chronic abuse and neglect, the very act of intervening can add to the child's catalogue of fearful situations
- Our systems, placement and therapeutic activities can diminish the fearful nature of these children's lives by providing consistency, reputation (familiarity), nurturance, predictability and control(returned to the child)
- There is hope. Children need a tribe of people that fighting for them.