Effects of trauma on Child Development

Moving Towards a Systems Based Approach

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Learner objectives

- Participants will become familiar with how trauma effects children at different stages of development
- Participants will learn the role and steps of trauma informed screening
- Participants will learn components of comprehensive trauma assessment and how this informs evidence based intervention

Child Welfare Trauma Training Toolkit

- **Module 1: Introduction – The Essential Elements of a Trauma-Informed Child Welfare System**
- **Module 2: What is Child Trauma and Child Traumatic Stress?**
- **Module 3: How Does Trauma Affect Children?**
- **Module 4: What is the Impact of Trauma on the Brain and Body?**
- **Module 5: What is the Influence of Developmental Stage?**
- **Module 6: What is the Influence of Culture?**
- **Module 7: Essential Element 1 – Maximize Physical and Psychological Safety for Children and Families**

Child Welfare Trauma Training Toolkit

- Module 8: Essential Element 2 – Identify Trauma-Related Needs of Children and Families
- Module 9: Essential Element 3 – Enhance Child Well-Being and Resilience
- Module 10: Essential Element 4 – Enhance Family Well-Being and Resilience
- Module 11: Essential Element 5 – Enhance the Well-Being and Resilience of those Working in the System
- Module 12: Essential Element 6 – Partner with Youth and Families
- Module 13: Essential Element 7 – Partner with Agencies and Systems that Interact with Children and Families
- Module 14: Summary

What is Trauma Informed Care?

A trauma-informed child welfare system is one in which:

- ***All parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers, families, and those who have contact with the system.***
- ***Programs and organizations within the system infuse this knowledge, awareness, and skills into their organizational cultures, policies, and practices.***
- ***They act in collaboration, using the best available science, to facilitate and support resiliency and recovery.***

- Source: Chadwick Trauma-Informed Systems Project National Advisory Committee. (2011). *Chadwick Trauma-Informed Systems Project*. Retrieved from www.ctisp.org

Why do we Need it?

- 25% of children in child welfare will be incarcerated within two years of aging out
- More than 20% will become homeless
- Only 58% have high school diploma
- Less than 3% have a college education by age 25
- Approximately 40% of infants and toddlers and 50% of preschoolers involved in child welfare have serious developmental and/or behavioral problems (Stahmer, Collings, & Palinkas, 2005). These rates are much higher than in the general population, which range from 10-12%

Principles of a Trauma Informed System

- Childhood traumatic stress impacts children.
- The system can either help mitigate the impact of trauma OR inadvertently add new traumatic experiences.
- The culture of the child and family influences the child's response to trauma.
- Child and family resiliency after trauma can be enhanced.
- Current and past trauma impacts the families with whom child welfare workers interact.
- Adult trauma interferes with adult caregivers' ability to care and support their children.
- Vicarious trauma (Secondary Stress) impacts the child welfare workforce. Exposure to trauma is part of the child welfare job.
- Trauma has shaped the culture of the child welfare system, the same way trauma shapes the world view of child victims.
- Trauma-informed systems will integrate a range of evidence-based and trauma-specific treatments and practices.

Chadwick Trauma-Informed Systems Project. (2013). *Creating trauma-informed child welfare systems: A guide for administrators* (2nd ed.). San Diego, CA: Chadwick Center for Children and Families.

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Elements of Trauma Informed System

Element Definitions

- Maximize Physical and Psychological Safety for Children and Families
  - Psychological Safety is ability to feel safe within oneself and from external harm. Lack of psychological safety leads to maladaptive coping strategies, poor interactions with others, high risk behaviors. Even if safety is restored, triggers can cause relapse/regression. Trauma Informed System recognizes these triggers and incorporates strategies to manage triggers and help them to feel safe.
- Enhance Child Wellbeing and Resilience:
  - Involves evidence based mental health practice AND the support of caring adults. Planning must focus on giving the child/family the tools to manage lingering effects of trauma exposure, build supportive relationships – all of which enhances resilience (ability to overcome adversity)

Element Definitions

- Enhance Family Well being and Resilience: Provision of Trauma informed education and services to parents enhances their protective capacities →enhancing resilience, safety and permanency of the child. Also refers to assisting caregivers (birth and other resources) manage secondary stress.
- Enhance the Well-being and Resilience of those working in the system. Childhood providers who work with Trauma exposed children and families experience secondary stress – including feelings of helplessness, fear and anger. Refers to development of organizational strategies to address.

Element Definitions

- Partner with Youth and Families: Allow children and families a voice in their care, tap into their own resilience
- Partner with Agencies and Systems that Interact with Children and Families: Coordinate assessments, for example coordinating with Law Enforcement and DCF to minimize number of front end interviews of child; working with mental health systems to improve training of interventionists in specialized trauma care and coordinating with schools, courts/legal system.

Develop partnerships across agencies serving children

- **Child welfare agencies need to establish strong partnerships with other child and family-serving systems.**
- **Service providers should develop common protocols and frameworks.**
- **Cross-system collaboration enables all helping professionals to see the child as a whole person, thus preventing potentially competing priorities and messages.**
- **Collaboration between the child welfare and mental health systems promotes cohesive care and better outcomes**

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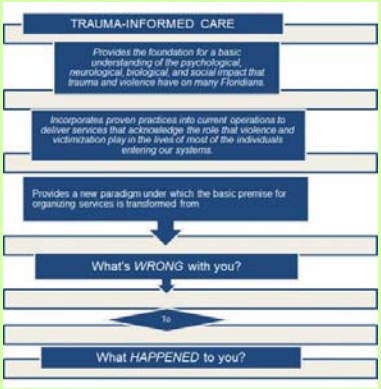
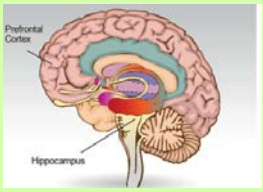
Looking Through the Trauma Informed Lens



Impact on brain Development

There is an increasing body of literature affirming that trauma, including neglect, has a significant impact on brain development, particularly during sensitive periods, such as infancy or adolescence. Recent brain research has established a foundation for many of the physical, cognitive, social, and emotional difficulties exhibited by children who experienced maltreatment in their early years. Maltreatment (e.g., child abuse or neglect) during infancy and early childhood has been shown to negatively affect early brain development and can have lasting effects into adolescence and adulthood (Child Welfare Information Gateway, 2011). Children involved in the child welfare system are usually not exposed to a single traumatic event. Rather, they experience multiple chronic and additive types of trauma that negatively impact their brain development. For families where there is intergenerational involvement in the system, the birth parents may also have been impacted in the same way. This chapter will provide a brief description of the impact of trauma on the brain.

Impact on brain Development



- Two areas of brain process cognitive info/learning and are affected by trauma
  - Hippocampus: affects memory processing, storage and retrieval
  - Prefrontal cortex: affects attention, executive function (planning, organizing, goal setting, problem solving/strategizing)

Impact on brain Development

- Cortisol directly damages the brain when secreted at levels caused by stress (especially over time)
- Depressive/Moody symptoms decrease activity in the Pre-frontal cortex – impacting executive function
- Anxiety symptoms increase activity in the limbic system (Hippocampus) resulting in poor working memory, difficulty focusing at will

ACE: Adverse Childhood Experiences

Key Concepts

- **Risk is additive**
- **Most families experience multiple risk factors**
- **Outcomes are generally related to:**
  - **Age at onset**
  - **Number of risk factors**
  - **Number of Protective Factors**
  - **Early Intervention**

ADVERSE CHILDHOOD EXPERIENCES STUDY FINDINGS

- **INCREASED RISK FOUND IN STRONG AND GRADED FASHION**
  - alcoholism and alcohol abuse
  - chronic obstructive pulmonary disease (COPD)
  - depression
  - fetal death
  - health-related quality of life
  - illicit drug use
  - ischemic heart disease (IHD)
  - liver disease
  - risk for intimate partner violence
  - multiple sexual partners
  - sexually transmitted diseases (STDs)
  - smoking
  - suicide attempts
  - unintended pregnancies

DEFINITION OF CHILD TRAUMATIC STRESS

- Physical and Emotional Response of a Child to events that threaten the life or physical integrity of the child or someone critically important to the child.
  - Acute Trauma refers to exposure to a single event such as a car accident
  - Chronic Trauma refers to repeated assaults on child's body or mind such as ongoing domestic violence, neglect, physical or sexual abuse.
  - Complex Trauma refers to the exposure to chronic , often multiple types of trauma as well as both immediate and long term impact on the child.

FACTORS INFLUENCING CHILDREN'S RESPONSE TO TRAUMA

- **Number and Severity of Episodes**
- Proximity to Event
- **Extent of Disruption of Support Systems**
- **Age and Developmental Stage of Child**
- Pre existing psychopathology
- Individual Perception of the danger or threat
- Victim or Witness
- Relationship of Child to Victim or Perpetrator
- Parental psycho-pathology/distress
- Adversities faced in the aftermath of trauma
- **Presence of adults who can offer help/protection**
- **Interactions with first responders/helping professionals**
- Genetics

TRAUMA AND DEVELOPMENT

- Prenatal Exposures: A CHAIN REACTION
  - Substances: direct neurotoxic effects
  - Effects of prenatal stress on developing HPA (Hypothalamus, Pituitary, Adrenal) axis; and other brain systems.
  - Impact of Cocaine on early maternal child interactions.
  - Impaired development including: poor attention & emotional regulation

TRAUMA AND DEVELOPMENT

- Infants and Toddlers:
  - Difficult to identify specifics of loss or poor coping (due to lack of communication skills)
  - Young children can remember traumatic events, but not explicit details: memory is physiological – and can be triggered even if does not have conscious memories of experience. (Child does not relate physical/emotional response to event as they do not understand it.)
  - Infants and young children are learning emotional regulation and may be more easily overwhelmed because skills have not developed yet.
  - Infants and young children are more dependent upon caregivers for protection. If they are verbal, they may become more easily dys-regulated when reminded of the event – shift activities, become clingy or aggressive.

TRAUMA AND DEVELOPMENT

- Preschoolers: More independent but still developing skills needed to cope with stress.
- Remains heavily dependent upon caregivers for protection and support.
- Strongly effected by the way caregivers react to a stressful event. Research supports that preschoolers exposed to IPV has greater risk of mental health sequalae than older children, who have already developed some coping skills.
- Symptoms of stress in preschoolers involve: regressive behaviors (loss of skills), revert to immature behaviors, increased clinginess, resistance to change in routines (perceived remove from safe place/routine to something unknown); changes in eating, sleeping or other routines based habits, somatic complaints begin.

TRAUMA AND DEVELOPMENT

- Preschoolers

- Crying, whimpering, screaming
- Appearing to be frozen
- Moving aimlessly
- Trembling
- Speech difficulties
- Irritability
- Repetitive reenactment of trauma themes in play or other activities
- Fearful avoidance and phobic reactions
- Magical thinking related to trauma (e.g., "...and then I jumped out the window and flew away.")

TRAUMA AND DEVELOPMENT

Figure 5: "A Man Being Shot"
Drawing of what happened by 7 year old

- Elementary Age:
  - Regression, somatic symptoms.
  - Improved understanding of traumatic event – increases feelings of depression, anxiety, anger, guilt. This may result in withdrawal from friends, attention seeking, refusals to go to school, and aggression. .
  - Frequent behaviors seen include; crying, poor concentration, irritability, fear of personal harm, nightmares, bedwetting, eating difficulties and re enactment of trauma themes in play or art

TRAUMA AND DEVELOPMENT

- Adolescents;
  - Better understanding of traumatic event, including why it may have happened
  - Somatic complaints, attention seeking from parents/caregivers, withdrawal from friends, sleep difficulties, school avoidance, poor task performance
  - Adolescents place more importance on peers, rebel more often against authority and have poor impulse control resulting in increasing high risk behaviors – including delinquent/self destructive behaviors.
  - Adolescents often feel extreme guilt about their inability prevent event, have revenge fantasies, deny or refuse to discuss emotions due to need to fit in, and demonstrate responses seen in adults – flashbacks, depression, suicidal thoughts and poor peer relationships

Developmental Delays and Trauma

- Rates of DD in out of home care 13-60% compared with 4-10% in general population
- Maltreated children reach milestones in all areas of development later (walking, talking), more frequently are difficult to soothe and have poorer growth rates. (Wulczyn, 2011)
- Disabled children have higher rates of abuse
- Disabled children have more difficulty articulating experience

Developmental Delays and Trauma risk

- Increased emotional, physical, economic and social demands on family (stress)
- Children with DD do not respond to traditional reinforcement/communication strategies – increases caregiver stress
- Intellectual limitations interfere with child's understanding of abusive situations/what to avoid & may prevent them from disclosing

Mental health diagnostic accuracy

- Insufficient research and mental health definitions related to presentation of PTSD, Reactive Attachment disorder in younger children – who are often diagnosed with OTHER developmental disabilities.
  - Example: PDD and Trauma Related symptoms may look similar and may not be sorted out until after treatment has already started

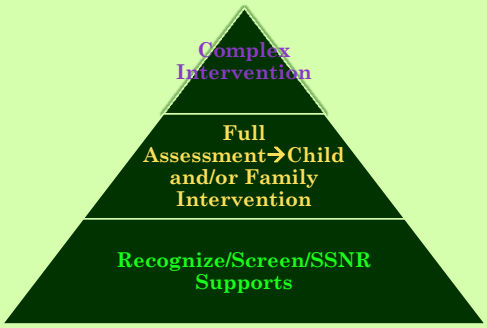
TRAUMA AND ATTACHMENT

- Secure attachment ----Safe Haven – child knows they will be comforted and safe when needed. Allows the child to develop secure base behavior - increases exploration and learning
- Critical periods for attachment are in the first year of life – and translate to ability to form positive relationships with caregivers.
- Disruptions in attachment impact child development – Traumatic events may threaten secure attachment as child cannot trust that caregiver can/will protect them. If caregiver has trauma, can also effect child as they may be absent emotionally.

TRAUMA AND ATTACHMENT

- Clinical signs of attachment problems in maltreated children include:
  - Developmental delays
  - Poor feeding
  - Difficulty soothing
  - Limited or impaired social-emotional functioning
  - Inappropriate modeling
  - Aggression

TIERED APPROACH



SCREENING

"...all children who have been exposed to traumatic events should be properly screened to determine their level and type of trauma exposure and symptoms…"

SCREENING

- Use of tools to identify if symptoms **and/or** events/experiences are present – not intended for diagnosis
  - Events: Physical Abuse, Sexual Abuse, Emotional Abuse, Neglect, Exposure to DV, War Trauma, Community Violence, Disaster
  - Symptoms: PTSD, Hypervigalence, Dissociation, emotional dysregulation, sleep-eating difficulty, poor concentration
- Self report, parent/caregiver report or administered by professional
- GOAL OF SCREEN IS TO DETERMINE IF COMPREHENSIVE TRAUMA ASSESSMENT REFERRAL IS NEEDED

SCREENING

- Caregiver reporting (children ages 0-8):
- Child Report (>8 years)
- Professional Screening using Integration Tool (Integrates reporting of parent/child and other information from courts, health providers etc)

Tools used for Screening & Assessment

- Trauma Symptom Checklist for Children
- Trauma Symptom Checklist for Young Children

Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005) The TSCYC is a 90-item caregiver-report instrument developed for the assessment of trauma-related symptoms in children ages 3-12. The scoring gives a detailed evaluation of posttraumatic stress symptoms and a tentative PTSD diagnosis. It also provides information on other symptoms such as anxiety, depression, anger, and abnormal sexual behavior. This tool may be used as a screening tool on its own, or part of a larger trauma-informed assessment or psychological evaluation.

- UCLA PTSD Reaction Index for DSMIV

The UCLA PTSD Reaction Index for DSM-IV (parent, child, and adolescent versions) (UPID; Steinberg, Brymer, Decker, & Pynoos, 2004) The UPID is a revision of the Child PTSD Reaction Index: CPTS-RI (Pynoos, et al., 1998). It is a 48-item semi-structured interview that assesses a child's exposure to 26 types of traumatic events and assesses PTSD. It includes 19 items to assess the 17 symptoms of PTSD as well as 2 associated symptoms, guilt and fear of events recurring. This tool may be used as a screening tool on its own, or part of a larger trauma-informed assessment or psychological evaluation.

- Child and Adolescent Needs and Strengths (CANS)

Screening Checklist: Identifying Children at Risk Ages 0-5

Please check each area where the item is known or suspected. If history is positive for exposure and concerns are present in one or more areas, a comprehensive assessment may be helpful in understanding the child's functioning and needs.

1. Are you aware of or do you suspect the child has experienced any of the following:

_____ Physical abuse
_____ Suspected neglectful home environment
_____ Emotional abuse
_____ Exposure to domestic violence
_____ Known or suspected exposure to drug activity *aside from parental use*
_____ Known or suspected exposure to any other violence *not already identified*
_____ Parental drug use/substance abuse
_____ Multiple separations from parent or caregiver
_____ Frequent and multiple moves or homelessness
_____ Sexual abuse or exposure
_____ Other _____

Screening Checklist: Identifying Children at Risk Ages 0-5

- **If you are not aware of a trauma history, but multiple concerns are present in questions 2, 3, and 4, then there may be a trauma history that has not come to your attention.**
- **Note: Concerns in the following areas do not necessarily indicate trauma; however, there is a strong relationship.**
- **2. Does the child show any of these behaviors:**

- **_____ Excessive aggression or violence towards self or others**
- **_____ Repetitive violent and/or sexual play (or maltreatment themes)**
- **_____ Explosive behavior (excessive and prolonged tantruming)**
- **_____ Disorganized behavioral states (i.e. attention, play)**
- **_____ Very withdrawn or excessively shy**
- **_____ Bossy and demanding behavior with adults and peers**
- **_____ Sexual behaviors not typical for child's age**
- **_____ Difficulty with sleeping or eating**
- **_____ Regressed behaviors (i.e. toileting, play)**
- **_____ Other _____**
- **3. Does the child exhibit any of the following emotions or moods:**

- **_____ Chronic sadness, doesn't seem to enjoy any activities.**
- **_____ Very flat affect or withdrawn behavior**
- **_____ Quick, explosive anger**
- **_____ Other _____**
- **4. Is the child having relational and/or attachment difficulties?**

- **_____ Lack of eye contact**
- **_____ Sad or empty eyed appearance**
- **_____ Overly friendly with strangers (lack of appropriate stranger anxiety)**
- **_____ Vacillation between clinginess and disengagement and/or aggression**
- **_____ Failure to reciprocate (i.e. hugs, smiles, vocalizations, play)**
- **_____ Failure to seek comfort when hurt or frightened**
- **_____ Other _____**

When to refer?

- Has the child experienced early and repeated exposure to overwhelming events in the context of a caregiver/family setting or in the community?
- Is the child having difficulty regulating or controlling behavior, sometimes appearing hyperactive, engaging in risk behaviors, or having difficulties with complying with rules? (There may be a diagnosis of ADHD treated with limited success).
- Is the child having difficulty with sustaining attention, concentration or learning?
- Is the child showing persistent difficulties in his/her relationships with others?
- Does the child have difficulty regulating bodily states and emotions, including problems with sleep, eating, sensory processing, and/or difficulties with regulating or identifying/expressing feelings?
- Does the child have multiple mental health diagnoses without any one sufficient diagnosis explaining his/her problems?

Trauma-focused mental health assessment

- Diagnostic process conducted by trained mental health provider or clinician.
- Goal is to determine whether traumatic stress is present, characterize severity of symptoms and determine the impact on functioning.
- Detailed and includes multiples sources of information
- Includes evaluation of both child and caregiver functioning and
- Addresses Needs and Strengths

Assessment Tools 0-5 years

- Child Behavior Checklist (CBCL)14—aged 1½–5
- Posttraumatic Stress Disorder Semi-Structured Interview and Observation Record15— aged 0–4 years of age
- Posttraumatic Symptom Inventory for Children (PT-SIC) 16—aged 4–8 years
- Preschool Age Psychiatric Assessment (PAPA) 17—aged 2–5
- PTSD Symptoms in Preschool Aged Children (PTSD-PAC) 18—aged 3–518
- Traumatic Events Screening Inventory-Parent Report Revised (TESI-PRR) 19—aged 0–6
- Trauma Symptom Checklist for Young Children (TSCYC) 20—aged 3–12
- Trauma Symptom Checklist for Young Children (TSCYC) 20—aged 3–12

Assessment Tools: Parent Stress Assessment

- Life Stressor Checklist—Revised (LSC-R) 21
- Parenting Stress Index (PSI) 22
- Davidson Trauma Scale (DTS) 23

Assessment: Role of Early Childhood Providers

- Diagnostic evaluation (Trauma and DD/PDD overlapping symptoms)
- **Need to know developmental abilities of child**
  - **What is language ability of child? Receptive and Expressive Skills?**
  - **Educate DCF and Legal System about Developmental Disabilities – related to interpretation of child behavior and function.**
  - **Educate DCF related to developmental needs of child; what should be included in case plan for caregivers (parents, kinship (family) care or foster parents.**
  - **Ensure that both Developmental issues and Mental Health Issues are incorporated into Individualized Family Support Planning.**
  -

Core components of Evidence Based, Trauma focused treatment

- **Building a strong therapeutic relationship**
- **Psycho-education about normal responses to trauma**
- **Parent support, conjoint therapy, or parent training**
- **Emotional expression and regulation skills**
- **Anxiety management and relaxation skills**
- **Trauma processing and integration**
- **Personal safety training and other important empowerment activities**
- **Resilience and closure**

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