CHILDREN AND TRAUMA:
LOOKING BENEATH THE SURFACE

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Overview

• Trauma
• Responses to trauma and the brain
• Symptoms – what are we looking for?
• Resilience and therapy
• Identifying the effects of trauma – the relational learning framework
• Trauma-informed care
Maltreatment and mental health

45% of child mental health problems would not exist if there was no child maltreatment

(Teicher & Samson, 2016)
Stress and fear

• Babies and young children can’t manage their own stress
• Parents acts as a buffer against high stress levels through physical contact and emotional communication.
• When trauma occurs within early parent child relationships if parent arouses fear or doesn’t respond to child’s fear – leaves child in a state of fear without a way of calming down.
• If there is too much stress or fear, the child’s biological systems are flooded and become hard to regulate (control).
• Cortisol patterns are altered.
• Fight, flight or freeze reactions and adrenaline are easily triggered.
• The child may be in a state of fear which can be hard to tell.
• Fright without solution – disorganised attachment.
HPA Axis

- Hypothalamus
  - CRH
  - Corticotropin Releasing Hormone

- Anterior Pituitary
  - ACTH
  - Adrenocorticotropic Hormone

- Adrenal Cortex
  - CORT
  - Cortisol

Negative Feedback
Cortisol, maltreatment and foster care

- Cortisol typically peaks in the morning and lowest level about midnight.
- Maltreated children and children in foster care have different patterns of cortisol release:
  - Blunted levels of cortisol - externalising problems.
  - High cortisol – internalising problems.¹
- Increasing carer sensitivity restores typical cortical rhythm and reduces behaviour problems.²

¹Laurent, Gillam, Bruce, & Fisher (2014); ²Dozier et al., 2006
What is trauma?

- **DSM-5**
  - exposure to actual or threatened death, serious injury, sexual violence (includes witnessing violence).

- **Briere and Scott (2015)**
  - Extremely upsetting event
  - Overwhelm individual’s internal resources
  - Produces lasting psychological symptoms.

- Recent writing includes attachment disruption and neglect.
Multiple trauma

• Physical sexual and emotional abuse, witnessing violence, neglect and attachment disruptions.

• Most maltreated children experience more than one type of trauma.

• 6 – 8% of children in NZ experience severe maltreatment. ¹,²

• Occurs across generations.³

¹ Breslau et al. (2014); ² McLeod, Fergusson, & Horwood (2014); ³ Connolly, Wells, & Field (2007).
Main effects of trauma

• Traumatic stress reactions
  • Over-arousal – watchful, startle, highly reactive (survival mode).
  • Under-arousal – dissociation, numbing, shut down.
  • Can’t manage emotions (emotion dysregulation).

• Disruption of future development
  • Brain development affected
  • Includes insecure or disorganised attachment from impaired caregiving/ multiple placements.
Types of responses to trauma

- Posttraumatic stress disorder (1/3 to a 1/2 of maltreated children).
- Complex trauma and developmental trauma disorder.
- Depression and anxiety.
- Conduct and attention problems, aggression (over 1/3 children in foster care).
- Substance misuse.
- Resilience.
- Posttraumatic growth.
Effects on brain

• Brain **adapts** to a high stress environment.

• “Biologic systems shift from a focus on learning to a focus on survival.”\(^1\)

• Depends on the part of the brain developing at the time of the abuse.

• Effects can be seen within a month but worse if maltreatment prolonged.

(Kliethermes et al., 2014, p. 342)
Main structures of brain affected\textsuperscript{1,2}

- **Hippocampus** – where memories are processed.
- **Amygdala** – where emotions are processed.
- **Pre-frontal cortex** – where verbal memories are stored and rational/logical information processed.
- **Corpus callosum** – communication between the two hemispheres of the brain.

Changes in the brain from child maltreatment map onto brain changes found in psychiatric problems.

\textsuperscript{1}Teicher & Samson (2014); \textsuperscript{2}McCrory, Gerin, & Viding (2017)
Brain changes associated with
• hypervigilance or avoidance in threat detection.
• lowered reward processing.
• more effortful emotion regulation and executive control.
• Symptoms are related to structural changes in the brain such as flashbacks, emotional dysregulation and dissociation.

¹McCrorry, Gerin, & Viding (2017)
Posttraumatic stress disorder

- **Exposure** to traumatic event
- **Intrusions** such as repetitive play, flashbacks.
- **Avoidance** of reminders of trauma
- Negative alteration in **cognition and mood**: fear, anger, horror, self-blame.
- Negative alteration in **arousal and reactivity**: irritable, reckless or self-destructive behaviour.
- More than 1 month, clinically significant.
Developmental Trauma Disorder
(van der Kolk, 2006)

• Multiple or chronic interpersonal trauma.
• Repeated pattern of dysregulation
  • **Feelings** - shame, betrayal and fear.
  • **Behaviours** - rage, re-enactment, cutting.
  • **Cognitive** - confusion, dissociation.
  • **Relational** – distrust, clinging, oppositional.
  • **Expectations** – won’t be cared for or protected
• Functional impairment
The children who need love the most, ask for it in the most unloving ways

Children’s best attempts to cope with their experiences put them at risk for future trauma.
Dissociation

• “Dissociation occurs when individuals unintentionally find themselves shutting down and disconnecting from experiences and from the world...” (Shemmings & Shemmings, 2011).

• Blank, trance-like state affecting consciousness and memory.

• Can occur in a hyper-aroused (rage) and hypo-aroused (shut down) state (Struik, 2014).
Repetitive play

- Some children play out their trauma through repetitive play such as a house burning down.
- Some children re-enact the situation e.g. jumping off the roof, joining a gang.
- Quality of behaviour or play -
  - Relentlessness and repetitive.
  - Doesn’t get resolved.
  - Makes people uncomfortable.
  - Not easy to shift.
How do we recognise trauma behaviours?

• Take note of child who dissociates, shuts down or withdraws (people think nothing is wrong).
• Rage may be triggered by trauma reminder.
• Recklessness and endangering self or others.
• Take note of re-enacting trauma and trauma play.
• Self-medicating.
• Avoidance including losing control to avoid activities or scary people or in residential care getting into secure.
Conceptualising severe symptoms
(See Tarren-Sweeney, 2007)

Examples include:
• Self-injury e.g. hitting or biting self
• Sexualised behaviour
• Soiling and smearing
• Desperation for food, gorging
• Not showing pain
• Obvious lying
• Cruelty, including laughing at the pain of people or animals (lack of empathy or guilt).
• Not genuine – charming, changing for different people and situations.
Trauma affects relationships

• Affects trust and ability to be close to others.
• Trauma threatens the security of the child’s attachment.
• Complex trauma experiences threaten the primary attachment relationship – child does not feel safe in relationships
• Through attachment relationships children develop an **Internal Working Model** of what relationships are, what other people are like and how to be in relationships.
Support by parents or caregivers crucial

- Believe and validate the child’s experience.
- Tolerate the child’s affect.
- Caregiver regulates own emotional response.
- Secure attachment lessens the impact of overwhelming stressors and supports recovery and healing.
- For foster children, development of a secure attachment is crucial.
Post-traumatic growth  
(Tedeschi & Calhoun, 2004)

Ways that people are positively transformed by experiences of significant adversity

• Personal strength
• Explore new life possibilities
• Form meaningful interpersonal relationships
• Gain appreciation of life
• Develop spirituality
• Making meaning of experiences
• Passion for preventing abuse or supporting others going through it.
Resilience and recovery
Resilience

- Abuse does not determine a child’s fate due to human ability to adapt and grow and brain plasticity (Cicchetti, 2016).

  Resilience includes strengths and protective factors, coping strategies and recovery processes.

  Children and adolescents (Kearney & Day, 2016)

- Sense of optimism, adaptability and relatedness to others associated with fewer PTSD symptoms
- Emotional reactivity related to more PTSD symptoms.
Maltreated adolescents

- Recognising and applying strengths associated with better anger control and fewer conduct problems. \(^1\)
- Higher educational support and having talent or interests protective. \(^1\)
- Moderate to high resilience when transitioning out of foster care with 15% competence in all domains. \(^2\)
- Adults abused as children and physical health \(^3\)
  - emotional regulation, making meaning, forgiveness and social support important.

\(^1\) Go Chu, Barlas, & Chng, 2017; \(^2\) Shpiegel, 2016; \(^3\) Banyard, Hamby, & Grych, 2017
Children in foster care

• Less evidence of resilience
• Up to 50 do not have mental health problems
• Example: only 16% of children seen as “positive exceptions” - good mental health, expected level of literacy and 85% school attendance. ¹
• Example: 30% in average range for emotional, behavioural and prosocial behaviour but only 7% also had positive academic performance and peer relationships. ²

¹ Rees (2013); ² Bell, Romano, & Flynn (2013)
• Internal factors
  • sense of mastery
  • self-control
  • ability to regulate emotions
  • cooperation and problem solving ability

• External factors
  • secure attachment
  • family support
  • social support

These factors also affect ability to benefit from resilience programmes in the community and therapy.
Culture and resilience

• Young people have less anxiety and depression when placed with foster parents of the same culture (US). ¹

• Phillip Rhodes (Māori opera singer)

• “I hoped the people who were coming would be more like us. Not only in colour but have a better understanding of us”. ²

• Youth with foster parents who helped them develop their ethnic identity in the US were 1.6 times less likely to be depressed. ³

¹ Anderson & Linares (2012); ² Livingstone (2016); White et al. (2009)³
Therapy

• Over 160 studies show therapy is effective for child trauma, especially sexual abuse.

• Two studies – therapy with youth in residential care with complex trauma is as effective as in the community BUT
  • They have more traumatic stress before and after therapy but improve at the same rate.
  • They need longer (25 – 30 sessions compared to 12 – 16 sessions).
  • Need more focus on safety and emotion regulation.
  • Need therapeutic environment
Approaches to therapy for trauma

- Trauma-focused cognitive behaviour therapy (TF-CBT) strongest evidence.
- Eye movement desensitisation and reprocessing (EMDR).
- Don’t let sleeping dogs lie (Struik).
- Psychodynamic play therapy.
- Neuro-sequential Model of Therapeutics (Bruce Perry). (www.childtrauma.org)
- Training by Pieter Rossouw (Australasia and online) and Dan Siegel (US and online).
Approaches to therapy

• Importance of exposure work.
• Window of tolerance (Siegal), therapeutic window (Briere).

Trauma and recovery (Herman, 1992)

• Phase 1: Safety and stability
• Phase 2: Remembering and mourning – putting words to what occurred, emotions, meaning.
• Phase 3: Reconnection and integration
Therapeutic tasks for children in care

• Stabilisation and basic skills – safety, rules and routines, practical skills e.g. taking turns, eating.
• Secure base – child begins to trust parent, approaches parent for help when upset or ill. Relationships with birth family stable if possible.
• Longer term skills – managing emotions, putting things into words, concentrating at school, interactions with peers.
• Addressing trauma – if child is ready and able and the child’s life is stable.
Components of TF-CBT

- Psychoeducation and parenting skills.
- Relaxation and mindfulness.
- Emotion regulation – naming feelings, helping parent to reflect child’s feelings, positive self talk.
- Cognitive processing – examining conclusions child has drawn from the event such as “I deserved it”.
- Trauma narrative – child writes about the trauma in a book. For children in care, may need to be a life narrative.
- Parent child sessions and parallel work.
Avoidance

• Vital that neither social workers nor therapists avoid trauma
• What we may say to ourselves!
  • It’s ADHD. It’s behavioural.
  • The child is too vulnerable to address trauma.
  • It will make it worse.
• We need to go there with the child in a gradual and safe way.
• Be aware of and don’t ignore secondary trauma.
Trauma-informed care
Trauma-informed care

• Cultural change in an organisation to focus on the role of violence and trauma in children’s lives.
• Considers the impact of trauma on children, birth parents, foster parents and staff.
• Safe, non-violent culture, policy and practice.
• Makes link between disruptive behaviour and trauma.
• Aims to prevent re-traumatisation and minimise system generated trauma e.g. seclusion, multiple placements.
A new way of working

Administrators and managers

• Fully trained in the impact of trauma on clients and staff.

• Support a culture change with a focus on decreasing re-traumatising practices.

• View decisions through a trauma lens e.g. changing social worker for policy reasons, moving placement due to behavioural problems.

• Enable staff to be trauma-focused through time allocation and funding.
Front-line staff

• Screen children for traumatic stress.
• Change practice to focus on trauma e.g. re-triggering through access visits, changing schools.
• Decrease re-traumatisation e.g. multiple placements, lockdowns and secure.
• Form teams with mental health agencies.
• Refer children for therapy and resilience programmes.
• Look after self – culture of recognising effect of working with trauma and supporting staff.
Small groups – what can I do?

• Administration, management and policy
  • What resources do staff need to become trauma-focused?

• Care and protection/Youth justice
  • How could processes become trauma-informed? (investigation, placement, recovery processes).

• Caregivers and residential staff
  • What practices are potentially re-traumatising?
  • How can trauma be addressed?
References


• Siegel, D.J. (2012). *The developing mind: How relationships and the brain interact to shape who we are*. NY: Guilford.
