Talking to Children and Their Caregivers About Trauma

Part 1: Assessment, Case Conceptualization and Treatment Planning
April 25, 9-12:15
Presenter: Ashleigh Kraft, LPC, IMH-E®

Introductions

- Name
- Setting
- Population
- What you hope to get from the class
- Something that brings you intense joy

Orient to Google Drive

- https://drive.google.com/drive/folders/1faCWlE6rP4WSt7CnGeZ8blYHEfaouBml?usp=sharing

- Everyone try this and troubleshoot any problems

We can’t talk effectively about or treat trauma until we understand it…

Macro/Theory

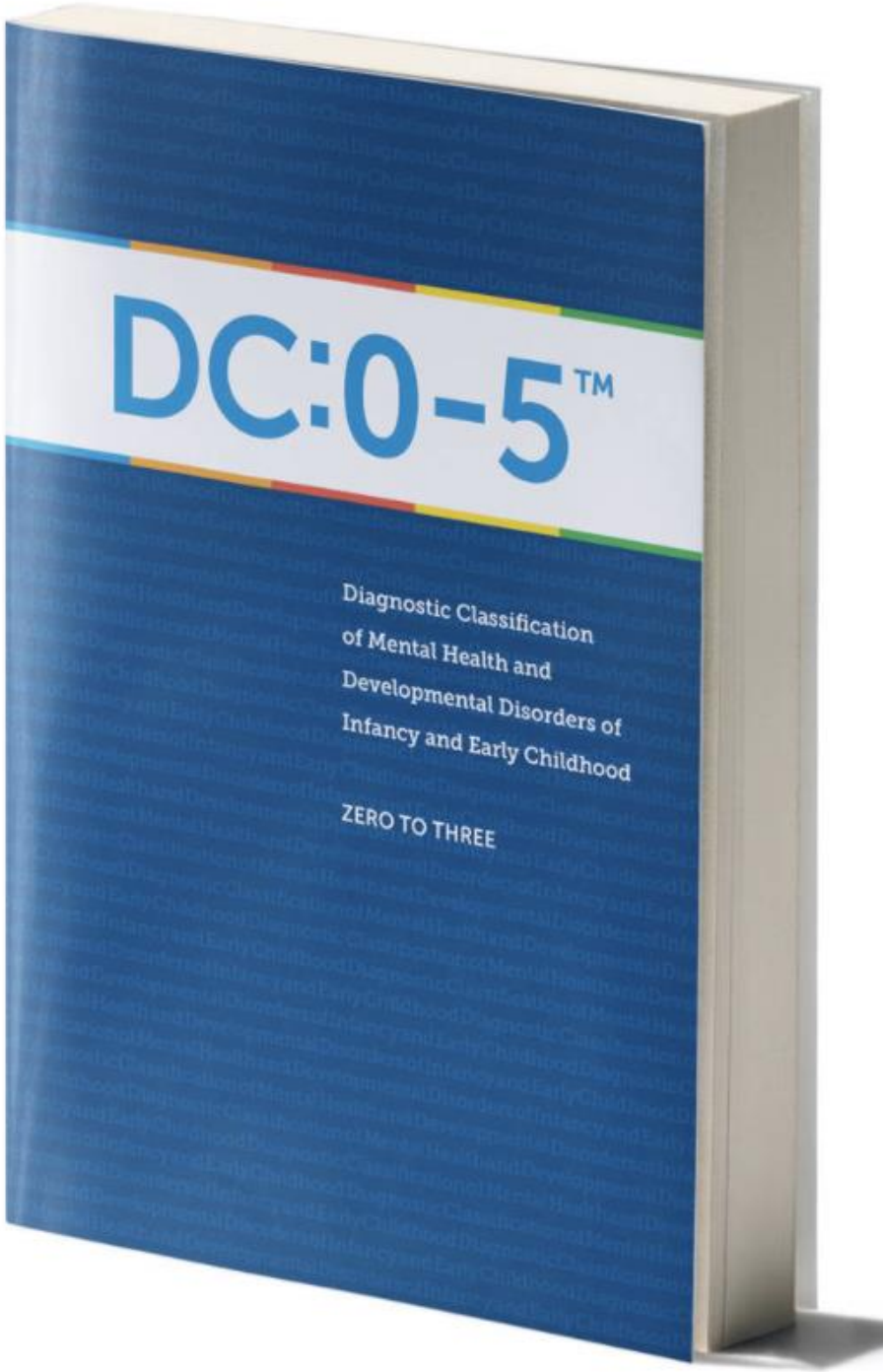
- Diagnosis, Symptoms, Exposure types, Prevalence

Micro/Individual

- What happened to this child and how did impact how they see the world, how they interact with the world, the important people around them, and how others experience them?

Diagnostic Systems

DC:0-5
Best practice diagnostic manual for children 0-5
5 Axes
Axis I: Clinical Disorders
Axis II: Relational Context
Axis III: Physical Health Conditions and Considerations
Axis IV: Psychosocial Stressors
Axis V: Developmental Competence



Trauma, Stress, and Deprivation Disorders

(DC:0-5)

- Posstraumatic Stress Disorder
- Adjustment Disorder
- Complicated Grief Disorder of Infancy/Early Childhood
- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Other Trauma, Stress, and Deprivation Disorder of Infancy/Early Childhood

Posttraumatic Stress Disorder-DC: 0-5

Criterion A (Exposure)

- The infant/young child was exposed to significant threat of or actual serious injury, accident, illness, medical trauma, significant loss, disaster, violence (e.g., partner violence, community violence, war or terrorism), or physical/sexual abuse in one or more of the following ways:
  - Directly experiencing the traumatic event
  - Hearing or seeing, in person, the event as it occurred to others
  - Learning that the traumatic event occurred to a significant person in the infant's/young child's life.

(DC: 0-5 2016, p.115)

Posttraumatic Stress Disorder-DC:0-5

Criterion B (*at least on symptom*)-The infant shows evidence of re-experiencing the traumatic event(s) by demonstrating at least one of the following:

1. Play or behavior that reenacts some aspect of the trauma(s).
2. Preoccupation with the traumatic event(s) conveyed by repeated statements or questions about some aspect of the event(s). Distress is not necessarily apparent.
3. Repeated nightmares, the content of which may or may not be linked to the traumatic event(s), which increase in frequency after the traumatic event(s).
4. Significant distress at reminders of the traumatic event(s).
5. Marked physiological reactions (e.g., sweating, agitated breathing, changes in color) at reminders of the traumatic event(s).
6. Dissociative episodes, beginning after the traumatic event(s), in which the infant/young child freezes, stills, or stares and is unresponsive to environmental stimuli for seconds to minutes in response to reminders of the traumatic event(s).

(DC: 0-5 2016, p115-116)

Posttraumatic Stress Disorder-DC:0-5

One Symptom from C OR D

Criterion C-The infant/young child persistently attempts to avoid trauma-related stimuli through efforts to avoid people, places, activities, conversations, or interpersonal situations that are reminders of the trauma(s).

Criterion D-The infant/young child experiences a dampening of positive emotional responsiveness that appears or intensifies after the trauma(s) and is revealed by at least one of the following:

1. Increased Social Withdrawal.
2. Reduced expression of positive emotions.
3. Markedly diminished interest or participation in activities such as play and social interactions.
4. Increased fearfulness or sadness.

(DC: 0-5 2016, p116)

Posttraumatic Stress Disorder-DC:0-5

Criterion E (*at least 2 symptoms*)-After a traumatic event, an infant/young child may exhibit onset or intensification of signs of increased arousal, as revealed by at least two of the following:

Difficulty going to sleep, evidenced by strong bedtime protest, difficulty falling asleep, or repeated night waking unrelated to nightmares.

1. Difficulty concentrating.
2. Hypervigilance.
3. Exaggerated startle response.
4. Increased irritability, outbursts of anger or extreme fussiness, or temper tantrums.

(DC: 0-5 2016, p116)

Posttraumatic Stress Disorder-DC:0-5

Criterion F (*1 or more areas of functional impairment*)-Symptoms of the disosrder, or caregiver accommodations in response to the symptoms, significantly affect the infant's/young child's and family's functioning in one or more of the following ways:

1. Cause distress to the infant/young child;
2. Interfere with the infant's/young child's relationships;
3. Limit the infant's/young child's participation in developmentally expected activities or routines; or
4. Limit the infant's/young child's ability to learn and develop new skills or interfere with developmental progress.

(DC: 0-5 2016, p116)

Additional Information DC: 0-5

Age-Use caution in diagnosing under 12 mos.

Duration-Symptoms in B-E must be present for at leat 1 month following exposure

Diagnostic Features-

- Symptom clusters the same as older children and adults but manifest differently.
- Re-experiencing seen in play rather than self report
- Avoidance less common, and some become preoccupied instead
- Negative thoughts/emotions may look like irritability, withdrawal, detachment.

Associated Features Supporting Diagnosis (DC: 0-6 2016, p115-116 **-**

- New onset of fears, fearfulness, angry behaviors, aggressive behaviors.
- Increased oppositional behavior and separation anxiety.
- Developmental regression (ie toilet training)
- Expressive language retained but regression specific to referencing the trauma.

Additional Information DC: 0-5

Developmental Features-

Infants less than 12 mo old, less likely to re-experience and express re-experiencing, therefore less likely to quality for diagnosis.

Prevalence-

- Rates are low in community samples and a minority of those exposed to a traumatic event develop PTSD
- Likely under-recognized

Course-

Limited evidence suggests if PTSD is present, likely to continue to be symptomatic for at least 2 years after exposure.

Risk and Prognostic Features-

- If caregivers exposed to same trauma, may be more likely
- Pre-existing anxious diathesis may increase risk

Culture-Related Diagnostic Issues-

No cultural differences with regard to clinical picture

Cultural beliefs may impact help-seeking, risk of onset, and severity.

Significant barrier=common belief that babies aren't impacted by trauma, or will outgrow symptoms.

Additional Information DC: 0-5

Gender-Related Diagnostic Issues-

None identified

Differential Diagnosis-

- Symptoms must begin following exposure to a traumatic event OR intensify
- If duration of 3 months hasn't been met, Adjustment Disorder is appropriate
- If have been exposed and symptoms exist but are subthreshold and extend beyond 3 months, use *Other Trauma, Stress, and Deprivation Disorder of Infancy/Early Childhood*

Comorbidity-

Oppositional behavior, separation anxiety common.

For maltreated infants/young children, cognitive, language, and motor delays common.

DC: 0-5 vs DSM-5 Comparison

DC:0-5 **Trauma, Stress, & Deprivation Disorders**	**DSM-5** **Trauma & Stressor Related Disorders**
Posttraumatic Stress Disorder	Posttraumatic Stress Disorder
Adjustment Disorder	Adjustment Disorder Acute Stress Disorder
Complicated Grief Disorder of Infancy and Early Childhood	N/A
Reactive Attachment Disorder	Reactive Attachment Disorder
Disinhibited Social Engagement Disorder	Disinhibited Social Engagement Disorder
Other Trauma, Stress, and Deprivation Disorder of Infancy/Early Childhood	Other Specified Trauma- and Stressor- Related Disorder

DC: 0-5 vs DSM-5 Comparison

DC: 0-5	DSM-V
Criterion A Direct Experiencing Witnessing, in person (hearing or seeing) Learning the event happened to significant person in infant's life.	Criterion A-6 and under Direct Experiencing Witnessing, in person can't be witnessed only via electronic media, television, movies or pictures, esp. primary caregivers. Learning the event occurred to parent or caregiving figure.
NA	Criterion A-over 6 Direct Experiencing Witnessing, in person (no specifier re. how) Learning traumatic event happened to close family member or close friend. In cases of actual or threatened death of family member/friend must be violent or accidental. Repeated or extreme exposure to aversive details of the event-can't be electronic, pictures unless work related.
PTSD Symptom Clusters • Re-experiencing-at least 1 • Avoidance (must be present, but before 12 months not likely; can't diagnose without) • Dampening of positive emotional responsiveness • Increased Arousal	PTSD Symptom Clusters • Intrusion Symptoms-at least one • Avoidance (one or both of 2) • Negative alterations in cognitions and mood For 6 and under, either avoidance or arousal • Marked alterations in arousal and reactivity
Functional Impairment Required	Functional Impairment Required

Alternate Definition of Trauma

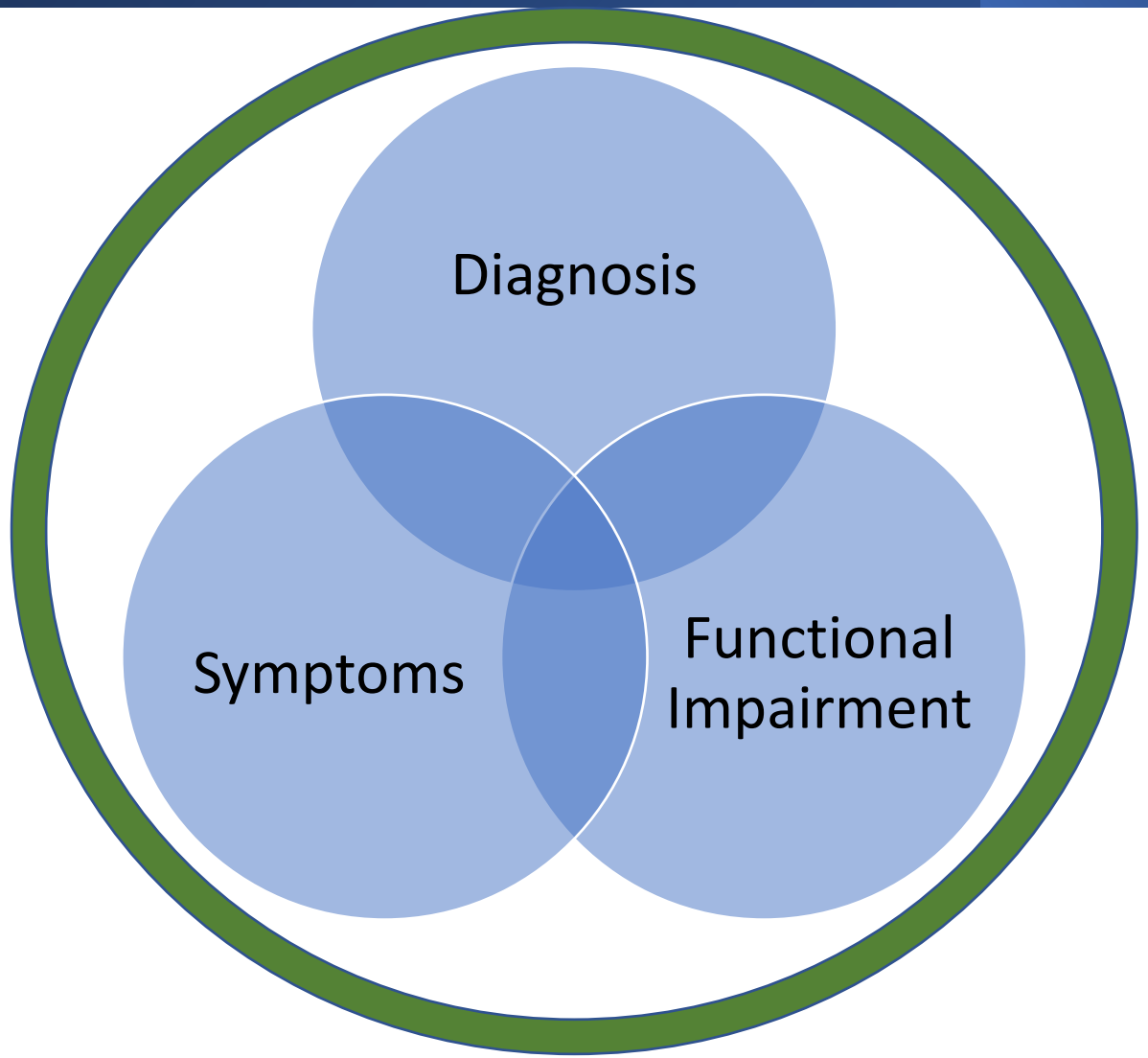
Trauma is the response to a deeply distressing or disturbing event that *overwhelms an individual's ability to cope*, causes feelings of helplessness, diminishes their sense of self and their ability to feel a full range of emotions and experiences.

https://integratedlistening.com/what-is-trauma/

For children, caregivers' presence and capacity to assist with comfort, organizing feelings and providing reassurance, safety and security very important to child's experience after the event.

Recentering: Alleviation of Distress

Factors that influence the decision to treat or not and how



Prevalence of Trauma Exposure

Exposure to traumatic life events is common

- About 2/3 of children report experiencing a traumatic event by age 16 in community samples
- 15-43% of girls and 14-43% of boys exposed according to National Center for PTSD at the VA https://www.ptsd.va.gov/understand/common/common_children_teens.asp
- Witnessing community violence 35-85%
- Victim of community violcence up to 65%
- Boys more likely to be exposed to community violence than girls
- Exposure to sexual abuse 25-43%
- Serious injury-increased risk for boys, living in poverty, Native American

(APA, 2008 Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents)

Prevalence of Child Maltreatment

- In 2021, the CDC said that 1 in 7 children have experienced child abuse and/or neglect. § https://www.cdc.gov/violenceprevention/pdf/can/CAN-factsheet_508.pdf Pg 67
- 5.5 million reports each year and about 30% substantiated.
  - 65% neglect
  - 18% physical abuse
  - 10% sexual abuse
  - 7% psychological (mental) abuse

  https://www.ptsd.va.gov/understand/common/common_children_teens.asp
- The national estimated number of child victims in 2020 was 618,000, (consider that children have been largely at home for school during the pandemic and away from education personnel who submit 17% of referrals, so likely underreported) https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2020.pdf pg 25 pg 38 pg 39

Prevalence of Child Maltreatment

- Oklahoma Human Services lists 6934 children currently in custody. https://okfosters.org/
- 8,306 Oklahoma children living in, entering, and exiting fostercare services in 2019.
- 37.32% White
- 17.91% Hispanic
- 8.53% were Black
- 0.06% were Asian/native Hawaiian or other pacific islander
- 9.05% were American or alaska natives
- 27.11% were two or more races https://www.childrensdefense.org/wp-content/uploads/2021/04/The-State-of-Americas-Children-2021.pdf pg 68 &69

Prevalence of Child Maltreatment

Race	Percent of Population	Percent of Child Welfare Population
White	50	44
Black	14	23
Am. Indian and Alaskan Native	1	2
Hispanic	Historically underrepresented, but most recent data shows overrepresentation in 20 states.	

Whites
More likely to experience trauma, learn of trauma to someone close, learn of unexpected death
Blacks
Higher risk of maltreatment, esp. witnessing domestic violence
More likely to have PTSD
Asians, Black men, Hispanic women
Higher risk of war-related events
Asians
Less likely to have PTSD
All minorities-less likely to seek treatment for PTSD

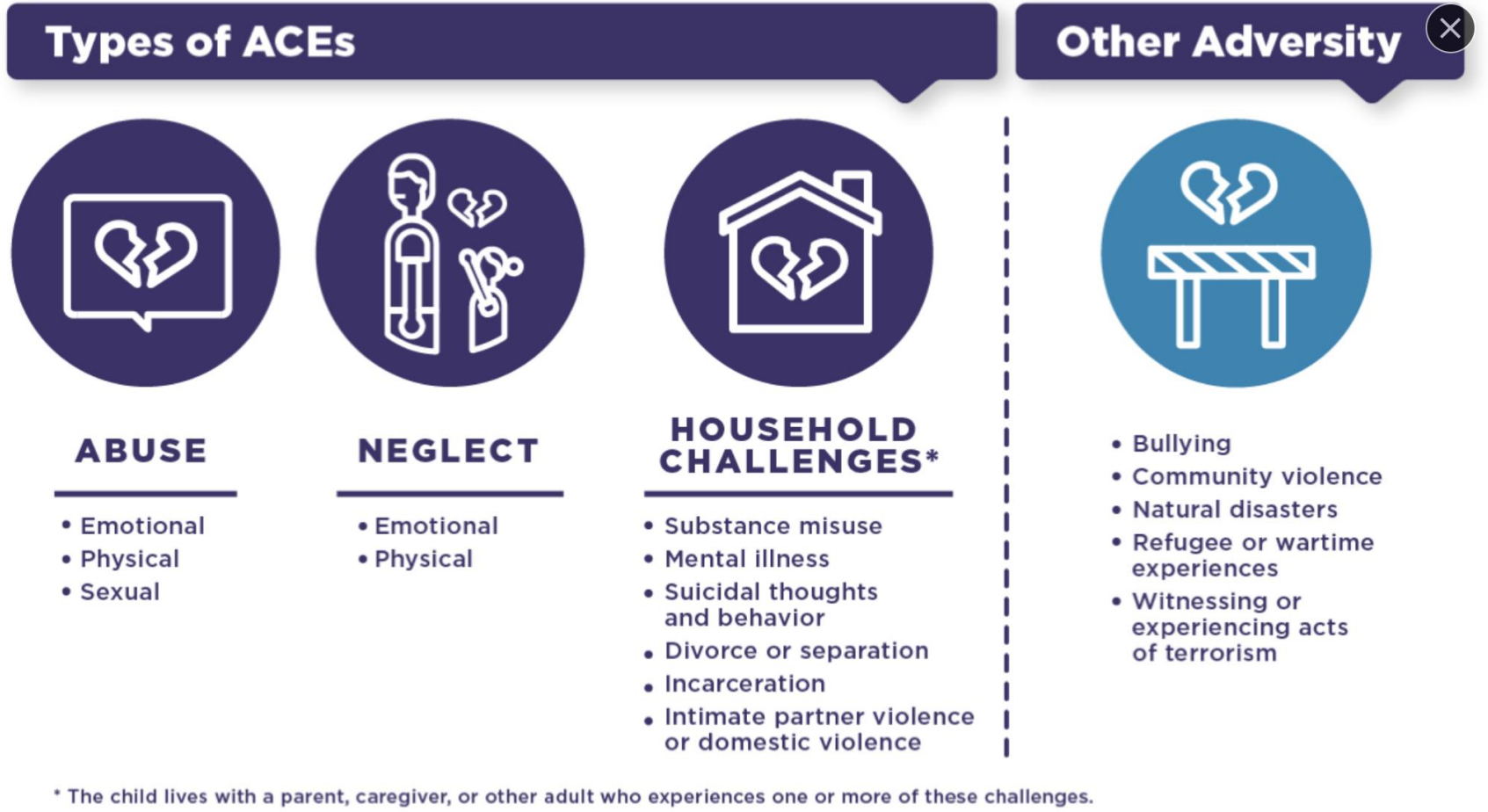
Prevalence of PTSD

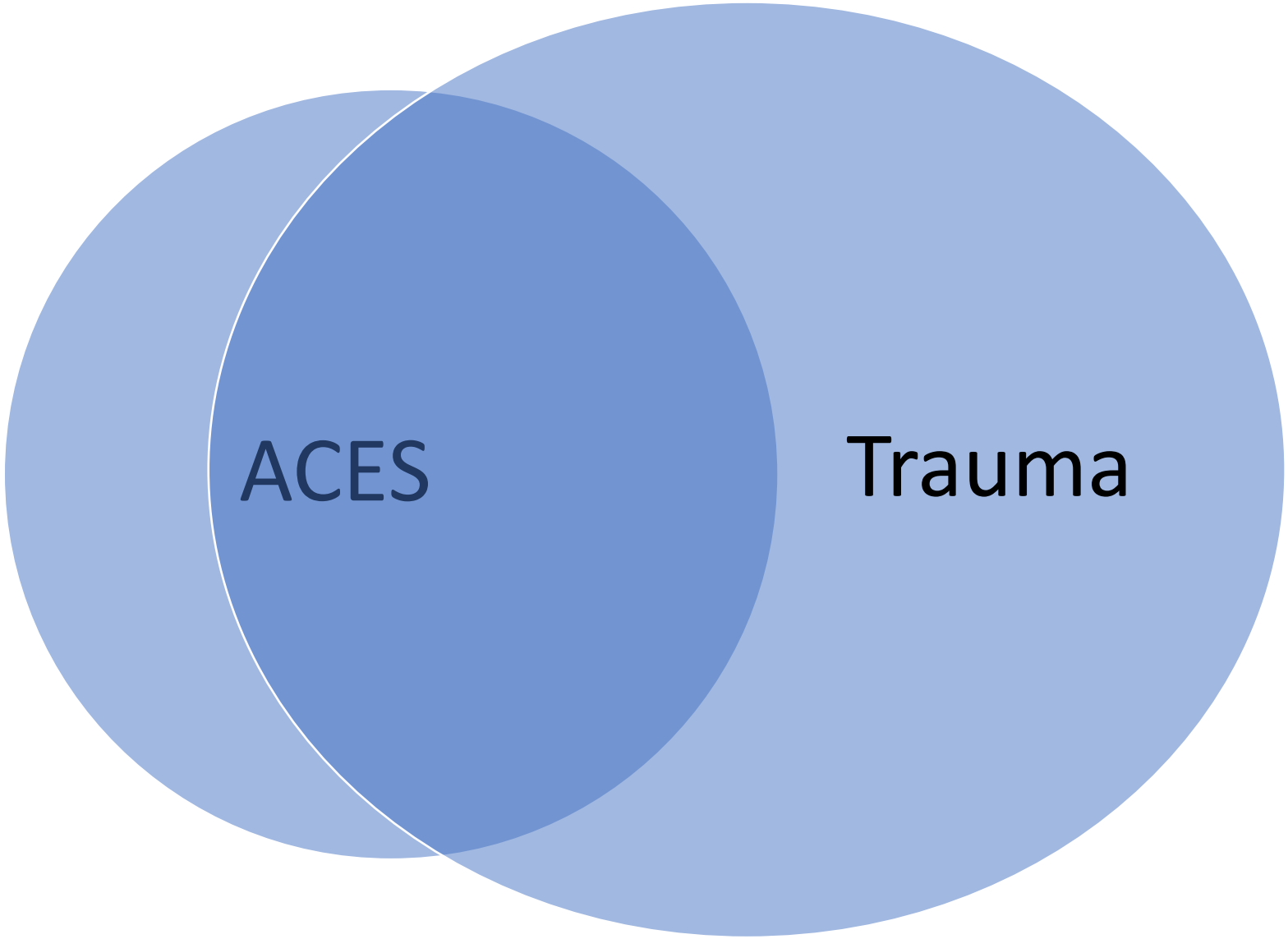
Development of PTSD after traumatic life events is infrequent

- 3-15% of girls and 1-6% of boys develop PTSD https://www.ptsd.va.gov/understand/common/common_children_teens.asp
- Most children experience distress immediately following exposure
- Most children return to typical functioning within a few weeks/month
- Risk factors for developing PTSD
  - Multiple traumas
  - History of anxiety disorders
  - Family adversity
- Recovery can be impeded by:
  - Individual and family factors
  - Severity of ongoing life stressors
  - Community stress
  - Prior trauma exposure
  - Psychiatric comorbidities
  - Ongoing safety concerns
  - Poverty and racism can make this recovery much more difficult

(APA, 2008 Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents)

Adverse Childhood Experiences




ACES
Trauma

Domains of Assessment

0-5	6 and Older
Trauma Exposure	Trauma Exposure
Trauma Symptoms	Trauma Symptoms
Parent Exposure	Generally not assessed, but related data may help inform clinical picture; consider a referral
Parent Symptoms	Generally not assessed, but related data may help inform clinical picture; consider a referral
Developmental Functioning	Less common, but may inform treatment options; if child developmentally delayed below age 6, consider other column.
Relationship Quality-young children highly dependent on caregiver to get needs met	Not typically formally assessed
Other common related areas: depression, anxiety	Other common related areas: depression, anxiety

Resource

Oklahoma Infant Mental Health Assessment Guide

https://drive.google.com/file/d/1z-kCQYNYxpsKc5t-zwZtyw-P3ERW1IJz/view?usp=sharing

Trauma Assessment Activity

1. Explore your assigned tool with your partner(s) in breakout rooms.
2. Review the resources in the Google Drive related to your instrument as well as any other resources you find during the activity.
3. Complete a Trauma Assessment Activity Form
4. Email completed form to akraft@ou.edu
5. Briefly report out about what you learned

Assessments

- CATS
- YCPC
- TESI
- PCL-5
- LSC-R

Why Assess Parent Trauma

- Mothers who were survivors of child sexual abuse (CSA). Low income, rural sample. Moms and their children under age 5.
  - More harsh and intrusive in parenting than parents not exposed to CSA (NCSA)
  - Both CSA moms and NCSA moms more harsh and intrusive toward their sons than their daughters
  - CSA moms more sensitive in parenting their daughters than their sons
  - Theorized that propensity of boys toward externalizing behaviors places them at more risk of child directed aggression.
  - Theorized that propensity of girls toward internalizing (pacifying, not being a problem) may place daughters at increased risk for anxiety/depression over time.

Interpersonal Trauma- Impacts on Parenting

Families led by caregivers with history of interpersonal trauma struggle to engage in traditional treatment methodologies (ie. TF-CBT)

Barriers to effective engagement

- Poor adult self-regulation
- Poor interpersonal relationships
- Disorganization in daily life and family patterns
- Negative Caregiver attributions toward the child
- Lack of confidence they can positively impact child's behavior
- Unable to form and sustain a recovery-oriented mindset

Negative outcomes of Interpersonal Trauma

- Difficulty regulating emotions
- Challenges with maintaining stable self-concept
- Impaired ability to trust others
- Difficulty attributing meaning to events in a coherent and adaptive manner
- Impaired ‘‘mentalizing,’’ -thinking and feeling with compassion about one’s own and others’ thoughts and feelings
- Impaired ‘‘Parental Reflective Function’’ is defined as the parent’s capacity to hold the child’s mental states in mind, even in the face of strong emotions

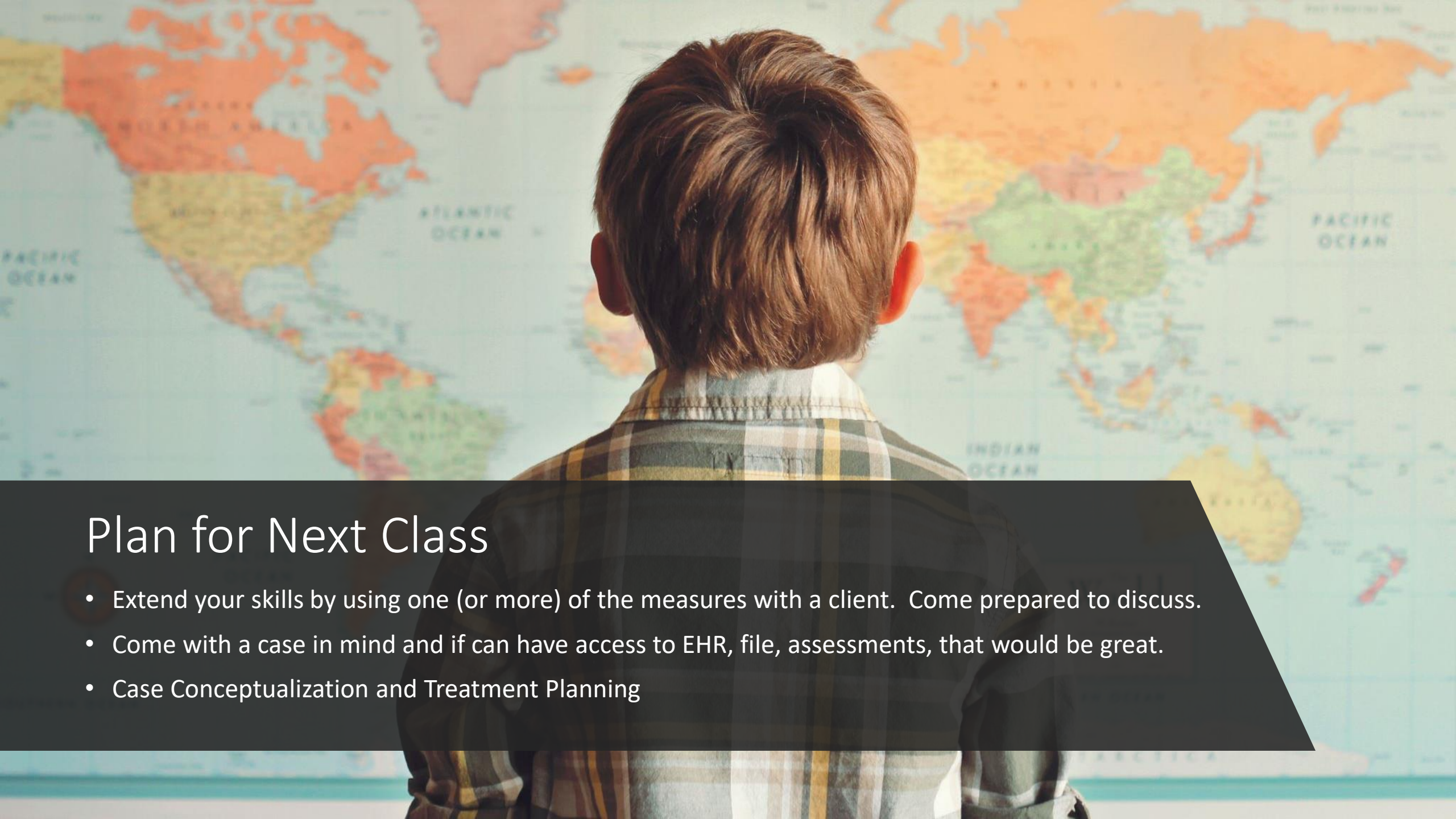
Implications of Poor Mentalizing and Parental Reflective Functioning

- Effective, safe parents utilize mentalizing and parental reflective functioning to think about their child's and their own behavior and select ways to respond that are safe and helpful.
- Deficits limit caregivers' ability to
  - Carry out parenting tasks
  - Help children learn to manage emotions
  - Benefit from therapy interventions

Male Caregivers

(Browne, Maye, Lieberman 2020)

- Less research on male caregivers, though increasing recently
  - Both male and female caregivers reported the same number of child events, but male caregivers
  - No relationship between caregiver stress and number of events caregiver experienced for males, but there was for females
  - Relationship between number of events caregiver experienced and caregiver's symptoms of trauma was weaker for men than for women.



Plan for Next Class

- Extend your skills by using one (or more) of the measures with a client. Come prepared to discuss.
- Come with a case in mind and if can have access to EHR, file, assessments, that would be great.
- Case Conceptualization and Treatment Planning