CHILDHOOD TRAUMA

University of Oregon, Substance Abuse Prevention Program
Weekend Seminar
with
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Treating Trauma is Not Simple

• No single treatment is appropriate for all individuals
• Effective treatment attends to multiple needs of the individual, not just trauma
• Treatment must address medical, cognitive, psychological, social, vocational, and legal problems, as well as substance abuse, among others
Overview of Diagnosing and Treating Infants and Young Children

(Many thanks to: Karen Frankel, Ph.D., Director, Harris Program in Child Development and Infant Mental Health, Director, Kempe Therapeutic Preschool, Associate Professor, Department of Psychiatry, UCSM, NCTSN)
Definition of “Infant Mental Health”

- The *developing capacity* of the child from birth to five to experience, regulate, and express emotions

*Source: Sameroff & Fiese, 2000*

*Slide courtesy of A. Talmi Ph.D., 2005*
Arc of State Regulation

“Gleam in the Eye”
Attentive, Interested, Engaged, Joyful

Alert Processing

“dampened down”
flat
alert, not processing
daydreaming
indifferent
withdrawn
dampened
depressed
terror

“revved up”

excited
nervous
shouting
angry
panicked
rageful

flooded

Stressor

(Constance M. Lillas, Ph.D.; 1999 Slide courtesy of A. Pinto, Ph.D. 2005)
Definition of Infant Mental Health

• The ability of the child to form close and secure interpersonal relationships
• The drive of the child to explore the environment and learn
Definition of Infant Mental Health

- All within the context of family, community, and cultural expectations for young children
- Synonymous with healthy social and emotional development

ZERO TO THREE: National Center for Infants, Toddlers and Families
What does good infant mental health look like?
“Problem behavior” is…

- Unusual for the child
- Causes parents & others to see child as “difficult”
- Makes satisfying interactions difficult
- Is seen in multiple settings by a number of people
- Persistent problems

Definition of Infant Mental Health in Practice

“Infant mental health clinicians work to enhance the development of very young children and alleviate their suffering”

Charles Zeanah, M.D., & Paula Doyle Zeanah, Ph.D. Zero to Three Bulletin
Assessment and Intervention Philosophy

Infancy is complex. Practice should reflect complexity. Assessments should include:

– Multiple areas of development
– Individual differences and regulatory patterns
– The quality of the relationship that develops between infants and caregivers
– The context of the infant
Infant’s Psychological and Developmental Status

• Temperament
• Progress to developmental milestones
• Socio-emotional milestones
• Medical problems, neuropsychological deficits
• Resiliency, strengths, talents
Assess the Quality of Relationships

- Affective tone
- Rhythms, expectancies, contingencies
- Flow, efficacy, coordination
- Comfort seeking, secure base, exploration
- Social referencing, relating to others
The Infant in Context

• Parent’s psychologies
  – psychiatric diagnoses, personality issues, substance abuse history

• Family as a care-giving system

• Cultural, community, and ethnicity influences
Challenges of Assessment with Infants and Young Children

- There are rapid changes in development
- The “developmental appropriateness” of behaviors changes over time
- The environmental context influences the child’s developmental progress
Challenges of Diagnosing

• Complexity of early childhood development
• “Labeling”
• Experience of the assessor
• Assess individuals; diagnose disorders
Purpose of the DC:0-3R

- To focus on the first 3-4 years
- To provide a developmentally sensitive diagnostic tool for young children
- To consider the impact of relationships
- To consider problems/behaviors not captured by other classification systems
- To complement other systems (e.g., DSM, ICD)
The 5 Axes of the DSM-IV and DC: 0-3R

**DSM-IV**
- **AXIS I:**
  - Clinical disorders
- **AXIS II:**
  - Personality disorders
  - Mental retardation
- **AXIS III:**
  - General medical conditions
- **AXIS IV:**
  - Psychosocial problems
- **AXIS V:**
  - Global assessment of functioning

**DC:0-3R**
- **AXIS I:**
  - Clinical disorders
- **AXIS II:**
  - Relationship classification
- **AXIS III:**
  - Medical & developmental disorders and conditions
- **AXIS IV:**
  - Psychosocial stressors
- **AXIS V:**
  - Emotional and social functioning

Revised from work of B. Wise, M.D., 2005
Diagnostic Classification: 0-3R

• The goal of diagnosis is to obtain a complete understanding of the infant, in the context of his/her family

• Diagnosis is an ongoing process

• The diagnostic process leads to the development of a comprehensive prevention and/or treatment plan
Culture and Community
Axis I: Clinical Disorders

- 100  Posttraumatic Stress Disorder
- 150  Deprivation / Maltreatment Disorder
- 200  Disorders of Affect
- 300  Adjustment Disorder
- 400  Regulation Disorders of Sensory Processing
- 500  Sleep Behavior Disorder
- 600  Feeding Behavior Disorder
- 700  Disorders of Relating & Communicating
- 800  Other Disorders (DSM or ICD)
AXIS I: 100. Posttraumatic Stress Disorder

• Various symptoms resulting from a single event, connected series of traumatic events, or chronic, lasting stress

• Child may directly experience or witness an event(s) that involve actual or threatened death, serious injury, or threat to the psychological or physical integrity of the child or others
AXIS I: 100. Posttraumatic Stress Disorder

- Need to take into consideration child’s developmental level, temperament, and caregiver’s ability to help the child cope
- In cases of severe trauma, important to make diagnosis and start providing treatment immediately if child’s symptoms interfere with daily functioning and have persisted for at least 1 month
AXIS I: 100. Posttraumatic Stress Disorder

• Must meet all 5 criteria:
  1. Exposure to a traumatic event
  2. Re-experiencing traumatic event(s) (at least 1)
     • Post-traumatic play
     • Recurrent /intrusive recollections of the traumatic event besides play
     • Repeated nightmares, content may or may not be associated trauma
     • Physiological distress at exposure to trauma reminders
     • Recurrent episodes of flashbacks or dissociation
AXIS I: 100. Posttraumatic Stress Disorder

3. Numbing of responsiveness or interference with development (at least 1):
   • Increased social withdrawal
   • Restricted range of affect
   • Markedly diminished interest or participation (i.e., play, social interactions, daily routines)
   • Efforts to avoid activities, places or people that are reminders of the trauma
AXIS I: 100. Posttraumatic Stress Disorder

4. Symptoms of increased arousal (at least 1):
   - Sleep problems
   - Reduced concentration
   - Hypervigilance
   - Exaggerated startle response
   - Increased irritability, angry outbursts, extreme fussiness, temper tantrums

5. Symptom pattern persists for at least one month
AXIS I: 210. Prolonged Bereavement/Grief Reaction

Requires meeting the following 3 criteria:

- Child’s functioning changes subsequent to the loss
- Symptoms must be present for most of the day, more days than not, over a period of at least 2 weeks
AXIS I: 210. Prolonged Bereavement/Grief Reaction

• And at least 3 symptoms:
  – Cries, calls, searches for the absent caregiver
  – Refuses comfort
  – Withdraws emotionally, with lethargy, sad expression, lack of interest
  – Disrupted eating patterns
  – Disrupted sleeping patterns
  – Developmental regression
  – Diminished range of affect
  – Show marked disturbance to loss reminders,
Axis II: Relationship Classification

• Three aspects of a relationship:
  – Behavioral quality of the interaction
  – Affective tone
  – Psychological involvement

• All relationships are rated using the above three aspects
Axis III: Medical and Developmental Disorders and Conditions

• Indicate any coexisting:
  – physical (including medical and neurological)
  – developmental disorders

• Made using other diagnostic and classification systems, such as ICD-9 or ICD-10, classifications from other specialties
Axis III: Medical and Developmental Disorders and Conditions

Important to note because:

– Symptoms of mood disorder may be due to endocrine disorders
– Irritability, frustration, behavioral dysregulation may be due to hearing / speech / language problems
– Abrupt onset irritability, restlessness or motor coordination difficulties may be due to heavy metal toxicity
– Abrupt onset obsessions or compulsions may be due to PANDAS (associated with strep)
Axis IV: Psychosocial Stressors

• Identify stressors that influence symptoms and disorders in children

• Impact of a Stressor:
  – Severity = intensity, duration, suddenness stress, frequency, unpredictability
  – Developmental level of child = chronological age, endowment, and ego strength
  – Availability and capacity of caregiving adults to serve as protective buffer to help child understand and cope with the stressor
Axis V: Emotional and Social Functioning

• Reflects child’s emotional and social functioning with important caregivers, in relation to expectable patterns of development

• Capacities for Emotional and Social Functioning Rating Scale:
  – Attention and regulation (birth – 3 mos.)
  – Mutual engagement (3 – 6 mos.)
  – Intentional two-way communication (4 – 10 mos.)
  – Complex gestures & problem solving (10 – 18 mos.)
  – Symbols express thoughts & feelings (18 – 30 mos.)
  – Connecting symbols, abstract thinking (30 – 48 mos.)
What about teens????

- Adolescents go through many of the stages that young children do
- They may also be using substances to mask pain
- They may be diagnosed with other mental health issues
- Their behavior may be more dangerous to themselves and others
Definition of Addiction

Addiction is a chronic, episodic, progressive disease of the brain and body characterized by periods of substance use followed by periods of abstinence. It may involve physical and/or psychological dependence on continued use, with negative impacts over a variety of areas of life. Recovery from the condition is possible, but it requires ongoing care and lifestyle change.

---National Institute of Drug Abuse
What Is Effective For Treating Youth?

• Effective programs for youth must be delivered in a comprehensive manner, within a greater cultural environment that supports a non-substance using society.

• Youth are positively affected by adult outcomes.

• Decrease Risk Factors and Increase Protective Factors
Adolescent Development & Impacts of Chemical Dependency

- Separation/identity formation
- Cognitive development
- Academic development
- Emotional development
- Social development
- Psychosexual development
Counseling and Other Behavioral Therapies

- Drug Resistance Skills
- Problem Solving Skills
- Interpersonal Relationships
- Motivation
- Replace Drug Using Activities
Healing Therapies Must Be Integrated

• Co-occurring disorders require multiple interventions for MH and SA
• Integrated Trauma and Substance Abuse therapies helpful
• Family members should be addressed together if possible
• The Ecological model can be a map to healing
Theoretical Underpinnings of Trauma Focused-CBT

• A hybrid model incorporating CBT, attachment, family, psychodynamic and empowerment principles

• Goals: resolve PTSD, depressive, anxiety and other trauma-related symptoms in children and adolescents; optimize adaptive functioning; and enhance safety, family communication and future developmental trajectory
TF-CBT Or Not?

- Target symptoms: PTSD, depression, anxiety, and behavioral symptoms secondary to trauma.
- Children presenting with predominance of behavioral problems may benefit more from a different treatment.
- TF-CBT has been used for all types of traumas.
- TF-CBT has been used for children ages 3-18, with and without parental participation, in schools, group home, foster home and in-home settings but is most commonly provided individually to child and parent in clinical settings.
• **TF-CBT Components: PRACTICE**

- Psychoeducation
- Parent Component includes parenting skills
- Relaxation
- Affect identification and regulation
- Cognitive coping
- Trauma narration and cognitive processing of these experiences
- In vivo desensitization to trauma reminders
- Conjoint child-parents sessions
- Enhancing safety and future development
TF-CBT Components

• **Psychoeducation**: About TF-CBT model, about abuse, typical reactions, normalizing reactions, safety skills, healthy sexuality
• **Parenting Skills**: responding to behavior, (praise, active ignoring, quiet time, etc.) effective communication
• **Relaxation skills**: focused & deep breathing, mindfulness, muscle relaxation
TF-CBT Components

• **Affective Expression & Regulation**: Feelings vocabulary, identification, expression and management.

• **Cognitive Coping & Processing**: Cog. Δ, skills for (+) v (-) focus on events, ID and correct inaccurate attributions, self / world view, (+) self-talk, learned optimism, distraction techniques, coping with feelings
TF-CBT Components

- **Trauma Narrative**: Gradual exposure via verbal, written or symbolic retelling of abusive events, rehearse coping / relaxation

- **In Vivo exposure**: direct exploration of traumatic event /triggers over several repetitions focusing on details, thoughts, feelings, correcting inaccurate /unhelpful cognitions emphasizing progressive logical questioning, employ play therapy tools
TF-CBT Components

• **Conjoint Parent/child sessions**: Assess parent support, share info about the child’s experience, correct distortions, improve communications, questions between parent and child, education, support & praise

• **Enhanced safety skills**: family safety plans, teach/practice touching rules / safety skills, responding to inappropriate behavior, developmental issues, prep for trauma reminders
TF-CBT Components

- Other relevant treatment / session issues; e.g.
- daily crises, medical, developmental, cultural, legal or other specialized case needs, behavioral / discipline issues, additional referrals needed, preparation for termination, ongoing follow up care when needed.
The Trauma Narrative

- A helpful part of treatment
- Should be done after coping skills are mastered
- Can be done orally, or through art, or music, poetry, a script, or journal
- Can be shared with a counselor, family member, or others, but concern is needed for sharing with appropriate persons
PTSD and Brief Therapy

• Brief psychodynamic psychotherapy focuses on the emotional conflicts caused by the traumatic event, particularly as they relate to early life experiences. Through the retelling of the traumatic event to a calm, understanding, kindhearted, and nonjudgmental therapist, the survivor feels better about him or herself, develops effective ways of thinking and coping, and learns to deal more successfully with strong emotions.

• The therapist helps the survivor identify current life situations that set off traumatic memories and worsen PTSD symptoms.
Treatment Can Be Lengthy

• For some people, treatment for PTSD can last 3 to 6 months.
• Others, especially those with additional on-going psychiatric problems, may require ongoing treatment for continued symptoms of PTSD, including professional counseling, medicines, and stress management.
• In these cases, treatment for PTSD may last for 1 to 2 years or longer.
Severe Trauma and PTSD

- Never go completely away
- Coping skills and stress management are techniques that never stop working either
- Learning to manage symptoms is the key to recovery from these conditions
- Family education and community understanding are needed as well.
Substance Abuse Treatment

- Treatment is targeted to abstinence from substances
- Cognitive-Behavioral models most common
- Relapse Prevention
- Rehabilitation
- Reinforcement, cue extinction, removal from triggers and using environment.
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