Treating Childhood Trauma

Presentation by Lisa Rochford, PhD, LCP

Slides and handouts available under "Resources" at www.connectedchild.info
Contact Dr. Rochford at 540-430-0235or email at lisa@connectedchild.info

Resources for clinicians:

- National Child Traumatic Stress Network: www.NCTSN.org
- Research and resources from Dr. Bessel van der Kolk at the Trauma Center in Boston: www.traumacenter.org/
  - - for papers specifically on Developmental Trauma, see www.traumacenter.org/announcements/DTD_papers.php
- *Free online training program* to learn Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): http://tfcbt.musc.edu/register.php. Treatment manual: for this program is found at http://www.nctsn.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf
- Psychiatric Annals 35:5, May 2005 (issue devoted to effects of complex trauma & its treatment)
- The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are by Daniel J. Siegel
- Books by Beverly James including Handbook for Treatment of Attachment-Trauma Problems in Children
- Books by Eliana Gil
- Helping Children Cope with Separation and Loss by Claudia Jewett Jarratt
- Facilitating Developmental Attachment: The Road to Emotional Recovery and Behavioral Change in Foster and Adopted Children by Daniel A. Hughes

Books for parents and children:

- To recommend to **parents** of children who were adopted, who experienced early abuse/neglect, or who have problems with emotion and behavioral regulation: The Connected Child: For Parents Who Have Welcomed Children by Purvis, Cross and Sunshine
- To recommend to **parents** struggling with attachment and their own histories (explains the neurological research, too): Parenting from the Inside Out: How a Deeper Self-Understanding Can Help You Raise Children Who Thrive by Daniel J. Siegel and Mary Hartzell
- For situations with separation of **siblings**: Siblings in Adoption and Foster Care: Traumatic Separations and Honored Connections by Silverstein and Smith.
- Books for **children** include:
  - About being in **foster care**:
    - Maybe Days: A Book for Children in Foster Care by Wilgocki, Wright, & Geis
    - The Star: A Story to Help Young Children Understand Foster Care by Lovell
    - Finding the Right Spot: When Kids Can't Live With Their Parents by Levy
    - Murphy's Three Homes: A Story for Children in Foster Care by Gilman
  - About being **adopted**: Welcome Home, Forever Child: A Celebration of Children Adopted as Toddlers, Preschoolers, and Beyond by Mitchell
  - About having been **sexually abused** (all for preschool through early school-age):
    - Something Happened and I'm Scared to Tell by Kehoe
    - The Right Touch by Kleven and Bergsma
    - My Body Is Private by Girard and Pate
    - It's My Body by Freeman
    - Uncle Willy's Tickles by Aboff and Gartner

Chronic trauma interferes with neurobiological development

- brain structure may be altered and brain function impaired in two self-regulatory domains
  - Attention and information processing
  - Affect regulation
- dysregulation in HPA axis stress response systems & associated neurotransmitters and neuropeptides

"Results of both animal and human studies suggest that (developmentally adverse interpersonal trauma) such as maltreatment may alter brain structure and function in childhood by requiring survival-adaptive changes such as avoidance of or over-reliance on relationships, vigilant threat detection and expectations, and impulsive reward-seeking. Decades later, those changes appear to lead to problems with attention, learning, and memory when one is confronted with cues or contexts that are associated with the abuse…. Even when trauma is neither present nor likely, abuse survivors may be so biologically over-prepared to seek, find and avoid threats that the CNS pathways necessary for somatic and affective self-regulation and information processing may be displaced by less consciously accessible survival-based pathways."

--- Julian Ford (2005), Psychiatric Annals 35:5, p. 417.

Findings in studies of abuse-related PTSD in women

Abuse was associated with an impaired ability to focus attention and categorize information as well as reduced capacity in the cerebellum and left hippocampus (shown by functional and volumetric studies)

- Impaired access to verbal language due to reduced activation in key brain areas when encoding neutral memories or reacting to neutral stimuli (inferior frontal, inferior and superior temporal cortices)
- With a difficult task there was increased activation in areas associated with automatic detection of threats (amygdala) and less in areas that would have helped with task.
- Appeared that attention and memory encoding were impaired as these women focused on detecting threats rather than becoming oriented perceptually and emotionally in response to neutral stimuli.
- Automatic scanning for threats in response to emotion stimuli
- Increased brain activation in areas related to vigilant visual scanning (precuneus), when emotional stimuli presented during perceptual task.
- Reduced brain activation in areas involving short-term, working, episodic, and autobiographical memory (left hemisphere hippocampus, fusiform gyrus, anterior cingulate, medial prefrontal cortex), when emotionally-encoded words presented

Findings in studies involving children

- Elevated excitatory brain chemical messenger levels proportional to the duration of PTSD in maltreated children
- Altered sleep-wake cycles of stress hormones, and either hyperglucocorticoid receptor activity in the HPA axis if abuse is in the past or hypoglucocorticoid receptor activity if abuse is ongoing
- Neuronal loss in the corpos callosum, anterior cingulate, and frontal cortex, particularly for boys, with maltreatment, and may exhibit reduced maturation and differentiation of the brain's left hemisphere.

Findings in studies involving animals

- Somatic dysregulation in animals with disrupted caregiving, with HPA activity increasing until reunion occurs
- With prolonged early maternal separation in rats, stress reactivity in adulthood appears due to HPA axis internal dysregulation associated with inadequate external inhibition along neural pathways to the HPA axis from the hippocampus, anterior cingulate, and prefrontal cortex

More than 60 years of attachment research findings

Attachment: Biosocial behavioral system first evident in infancy and continuing through the lifespan that has as its goals maintaining proximity, reducing distance, and/or engaging in social interchange with an important other. First evident at about 7 months of age. Deviation from the distance specified by the system's "set-goal" of proximity is likely to activate attachment behaviors until the preferred distance is restored. These genetically encoded behaviors help to reduce anxiety and increase felt security so that children can more effectively explore the world around them. By the end of the first year, the infant's behavior is purposeful and apparently based on specific expectations. Past experiences with the caregiver are aggregated into representational systems which Bowlby (1973) termed "internal working models." These working models are thought to shape an individual's attachment behaviors and social expectations throughout life. The attachment system is most highly activated and most visible during stressful occasions, which could include when the child is upset, nervous, frightened, intensely frustrated, sick, or hurt.

Secure attachment

- approximately two-thirds of all attachment relationships.
- Securely attached infants seek proximity and contact with their caregiver in situations that provoke uncertainty or fear
- the caregiver is able to soothe and reassure the infant in an effective manner, participating in the child's process of learning self-regulation skills

Avoidant

- tend to evade physical contact with their caregiver
- have learned that bids for affection or contact may result in rejecting reactions from the caregiver
- avoidant infants are thought to protect themselves through excessive self-reliance and emotionally detached play
- minimize attachment behavior toward the caregiver

Resistant (Ambivalent)

- seek to elicit their caregiver's attention through heightened vigilance and indicators of distress
- heighten their attachment behavior toward the caregiver

Disorganized

- exhibit behavioral disorganization or disorientation in the presence of the caregiver
- e.g. failing to approach the caregiver when distressed, or exhibiting contradictory behavior patterns such seeking proximity with the caregiver then freezing or stilling, or avoiding the caregiver (e.g., by averting gaze) while simultaneously maintaining contact with her (Main & Solomon, 1986, 1990)
- others exhibit cognitive disorientation or affective dysregulation, such as appearing dazed or depressed while with the caregiver or showing apprehension of the caregiver on reunion.

DSM-IV-TR Diagnoses Often Used With Trauma

PTSD (first introduced into DSM-III, 1980): **Patient must have experienced an event in which the life, physical safety, or physical integrity of the patient or another person was threatened or actually damaged; and the patient must have experienced intense fear, helplessness, or horror in response; continue to re-experience the traumatic event after it is over** (e.g., flashbacks, nightmares, intrusive thoughts, and emotional and physiological distress in the face of reminders of the event); **seek to avoid reminders of the event** (e.g., avoidance of thoughts, feelings, and conversations about the event; avoidance of people, places, and activities that are associated with the event; difficulty recalling aspects of, or the totality of the event; diminished interest in formerly pleasurable activities; feelings of detachment; and a sense of a foreshortened future); **exhibit signs of persistent arousal** (e.g., difficulty with sleep, increased irritability, concentration problems, scanning of environment for danger, and heightened startle responses).While the symptomatology of victims of single-incident traumas are fairly well captured in the DSM-IV diagnosis of PTSD, victims of interpersonal trauma present with a more complex picture.

Reactive Attachment Disorder (first introduced in DSM-III, 1980): Involves a severe disruption in protective care-giving/pathogenic care. Characterized by markedly disturbed and developmentally inappropriate ways of relating socially in most contexts, evidenced by either excessively inhibited, hypervigilant or highly ambivalent and contradictory responses (e.g., approach, avoidance and resistance to comforting, or frozen watchfulness) OR diffuse attachments with marked inability to exhibit appropriate selective attachments. Not accounted for by developmental delay/PDD.

A New Framework for Understanding: "Developmental Trauma Disorder"

National Child Traumatic Stress Network

Bessel A. van der Kolk, MD & Robert S. Pynoos, MD, et. al.

www.traumacenter.org

A. Exposure. The child or adolescent has experienced or witnessed multiple or prolonged adverse events over a period of at least one year beginning in childhood or early adolescence, including:

A. 1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence; and

A. 2. Significant disruptions of protective caregiving as the result of repeated changes in primary caregiver; repeated separation from the primary caregiver; or exposure to severe and persistent emotional abuse

B. Affective and Physiological Dysregulation. The child exhibits impaired normative developmental competencies related to arousal regulation, including at least two of the following:

B. 1. Inability to modulate, tolerate, or recover from extreme affect states (e.g., fear, anger, shame), including prolonged and extreme tantrums, or immobilization

B. 2. Disturbances in regulation in bodily functions (e.g. persistent disturbances in sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions)

B. 3. Diminished awareness/dissociation of sensations, emotions and bodily states

B. 4. Impaired capacity to describe emotions or bodily states

C. Attentional and Behavioral Dysregulation: The child exhibits impaired normative developmental competencies related to sustained attention, learning, or coping with stress, including at least three of the following:

C. 1. Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues

C. 2. Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking

C. 3. Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation)

C. 4. Habitual (intentional or automatic) or reactive self-harm

C. 5. Inability to initiate or sustain goal-directed behavior

D. Self and Relational Dysregulation. The child exhibits impaired normative developmental competencies in their sense of personal identity and involvement in relationships, including at least three of the following:

D. 1. Intense preoccupation with safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation

D. 2. Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness

D. 3. Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults or peers

D. 4. Reactive physical or verbal aggression toward peers, caregivers, or other adults

D. 5. Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance

D. 6. Impaired capacity to regulate empathic arousal as evidenced by lack of empathy for, or intolerance of, expressions of distress of others, or excessive responsiveness to the distress of others

E. Posttraumatic Spectrum Symptoms. The child exhibits at least one symptom in at least two of the three PTSD symptom clusters (reexperiencing symptoms, avoidance symptoms, and hyperarousal symptoms).

F. Duration of disturbance (symptoms in DTD Criteria B, C, D, and E) at least 6 months.

G. Functional Impairment. The disturbance causes clinically significant distress or impairment in at two of the following areas of functioning:

Scholastic: under-performance, non-attendance, disciplinary problems, drop-out, failure to complete degree/credential(s), conflict with school personnel, learning disabilities or intellectual impairment that cannot be accounted for by neurological or other factors.

Familial: conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, non-fulfillment of responsibilities within the family.

Peer Group: isolation, deviant affiliations, persistent physical or emotional conflict, avoidance/passivity, involvement in violence or unsafe acts, age-inappropriate affiliations or style of interaction.

Legal: arrests/recidivism, detention, convictions, incarceration, violation of probation or other court orders, increasingly severe offenses, crimes against other persons, disregard or contempt for the law or for conventional moral standards.

Health: physical illness or problems that cannot be fully accounted for physical injury or degeneration, involving the digestive, neurological (including conversion symptoms and analgesia), sexual, immune, cardiopulmonary, proprioceptive, or sensory systems, or severe headaches (including migraine) or chronic pain or fatigue.

Domains of Impairment in Children Exposed to Complex Trauma

Cook et al., "Complex Trauma in Children and Adolescents," p. 392

I. Attachment

Problems with boundaries
Distrust and suspiciousness
Social isolation
Interpersonal difficulties
Difficulty attuning to other people's emotional states
Difficulty with perspective taking

II. Biology

Sensorimotor developmental problems
Analgesia
Problems with coordination, balance, body tone
Somatization
Increased medical problems across a wide span (eg, pelvic pain, asthma, skin problems, autoimmune disorders, pseudoseizures)

III. Affect Regulation

Difficulty with emotional self-regulation
Difficulty labeling and expressing feelings
Problems knowing and describing internal states
Difficulty communicating wishes and needs

IV. Dissociation

Distinct alterations in states of consciousness
Amnesia
Depersonalization and derealization
Two or more distinct states of consciousness
Impaired memory for state-based events

V. Behavioral Control

Poor modulation of impulses
Self-destructive behavior
Aggression toward others
Pathological self-soothing behaviors
Sleep disturbances
Eating disorders
Substance abuse
Excessive compliance
Oppositional behavior
Difficulty understanding and complying with rules
Reenactment of trauma in behavior or play (eg, sexual, aggressive)

VI. Cognition

Difficulties in attention regulation and executive functioning
Lack of sustained curiosity
Problems with processing novel information
Problems focusing on and completing tasks
Problems with object constancy
Difficulty planning and anticipating
Problems understanding responsibility
Learning difficulties
Problems with language development
Problems with orientation in time and space

VII. Self Concept

Lack of a continuous, predictable sense of self
Poor sense of separateness
Disturbances of body image
Low self-esteem
Shame and guilt

Six core components of complex trauma intervention

Cook et al., “Complex Trauma in Children and Adolescents,” p. 394
From Complex Trauma Workgroup, National Child Traumatic Stress Network, (expert consensus model)

1. **Safety**
   Installation and enhancement of internal and environmental safety.
2. **Self-regulation**
   Enhancement of the capacity to modulate arousal and restore equilibrium following dysregulation across domains of affect, behavior, physiology, cognition (including redirection of dissociative states of consciousness), interpersonal relatedness and self-attribution
3. **Self-reflective information processing**
   Development of the ability to effectively engage attentional processes and executive functioning in the service of construction of self-narratives, reflection on past and present experience, anticipation and planning, and decision making.
4. **Traumatic experiences integration**
   The transformation, incorporation, or resolution of traumatic memories, reminders and associated psychiatric sequelae into a nondebilitating, productive, and fulfilling existence through such therapeutic strategies as meaning-making, traumatic memory containment or processing, remembrance and mourning of the traumatic loss, symptom management and development of coping skills, and cultivation of present-oriented thinking and behavior.
5. **Relational engagement**
   The repair, restoration or creation of effective working models of attachment and the application of these models to current interpersonal relationships, including the therapeutic alliance, with emphasis on development of such critical interpersonal skills as assertiveness, cooperation, perspective-taking, boundaries and limit-setting, reciprocity, social empathy, and the capacity for physical and emotional intimacy.
6. **Positive affect enhancement**
   The enhancement of self-worth, esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, competence, mastery-seeking, community-building and the capacity to experience pleasure.