Trauma and Attachment Across the Lifespan

Presented by:
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Agenda and Learning Goals

• Overview of the ACEs Study and Impact on children’s physical and behavioral health across the lifespan
• Impact of attachment issues and trauma on development across the lifespan
• Resiliency informed care
• Trauma and Resiliency Informed case management
• Identify choice points where case managers can intervene with appropriate services for youth and families who have experienced trauma
Self-Care Alert!

• Step out and take a break
• Talk to someone you trust
• Do something relaxing
ACEs Primer

https://vimeo.com/139998006
Consequences of a Lifetime Exposure to Violence and Abuse

- 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
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy
Shift from an ACE Score of 0 to 4 Population Health

• 242% more likely to smoke
• 222% more likely to become obese
• 357% more likely to experience depression
• 443% more likely to use illicit drugs
• 1133% more likely to use injected drugs
• 298% more likely to contract an STD
• 1525% more likely to attempt suicide
• 555% more likely to develop alcoholism
Mechanisms by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
Screening for ACEs
Short Version of the ACEs Tool for adults 18 or older

http://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean
What’s important to know about the ACEs Tool

• Important to note that at this time, there are no psychometrically tested and validated ACEs screens for children

• ACEs measure was developed originally as a research tool to gather history from adults 18 years or older

• Dr. Anda and Laura Porter prefer to call it a history gathering tool versus a “screening” tool

• ACEs scores are not predictive at the individual level therefore it should not be used to determine eligibility or diagnosis independent of a comprehensive psychosocial assessment with the use of valid and reliable tools that are shown to help in predicting likelihood of mental health challenges in living

Laura Porter  (personal communication 10/16/2016)
Center for Youth Wellness
Adverse Childhood Experiences Questionnaire
CYW ACE-Q
So how do we measure children for adversity and use it to predict future physical and behavioral health risks?

“Research suggests that individual risk factors in childhood do not determine individual outcomes in adulthood, but that the accumulation of multiple risk factors in childhood greatly increases the odds of a range of poor outcomes”
(Marie-Mitchell & O’Connor, 2013, p.14)

So how do we then find a useful clinical tool to screen for ACEs in children so as to better engage in preventative care tailored towards risk factors?
“In a multisite study of children exposed to or at risk for maltreatment, it was found that by age 6 children had an average ACE score of 1.94. Between ages 6 and 12, on average they accumulated an additional 1.53 ACE, and then between ages 12 to 16 another 1.15 24. The gradual accumulation of ACEs suggests that there is an opportunity to identify children at risk for accumulating ACEs and the negative health outcomes associated with them.”

Burke Harris, N. and Renschler, T.  
(version 7/2015).  
Center for Youth Wellness ACE-Questionnaire  
(CYW ACE-Q Child, Teen, Teen SR). Center for  
Youth Wellness. San Francisco, CA.  
Pg.8
“In the American Academy of Pediatrics (AAP) policy statement, “Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science into Lifelong Health,” the AAP explicitly calls on pediatricians to “actively screen for precipitants of toxic stress that are common in their particular practices” 26.”

Burke Harris, N. and Renschler, T. (version 7/2015). Center for Youth Wellness ACE-Questionnaire (CYW ACE-Q Child, Teen, Teen SR). Center for Youth Wellness. San Francisco, CA. Pg.8

Dr. Nadine Harris and the Center for Youth Wellness

http://www.centerforyouthwellness.org/what-we-are-doing/overview/
CYW ACE-Q Versions

1. CYW Adverse Childhood Experiences Questionnaire for Children (CYW ACE-Q Child) 17 item instrument completed by the parent/caregiver for children age 0 to 12

2. CYW Adverse Childhood Experiences Questionnaire for Adolescents (CYW ACE-Q Teen) 19 item instrument completed by the parent/caregiver for youth age 13 to 19

3. CYW Adverse Childhood Experiences Questionnaire for Adolescents : Self Report (CYW ACE-Q Teen SR) 19 item instrument completed by youth age 13 to 19

Burke Harris, N. and Renschler, T. (version 7/2015). Center for Youth Wellness ACE-Questionnaire (CYW ACE-Q Child, Teen, Teen SR). Center for Youth Wellness. San Francisco, CA. Pg. 9
ACE-Q Toolkit

ACE-Q for Children

ACE-Q for Teens

ACE-Q Licensing Agreement

* Available in Spanish and English

CYW-ACE Q (continued)

SECTION 1 - Ten items assessing exposure to the original ten ACEs

* Population level data for disease risk in adults

SECTION 2 - Seven or nine items assessing for exposure to additional early life stressors relevant to children/youth served in community clinics

* Hypothesized to lead to disruption in neuro-endocrine-immune axis
* Not yet correlated with population level data about risk of disease

Pg. 10
Whole Child Assessment
Child – Adverse Childhood Experiences Only
WCS C-ACEs
Key Points of Measure Development

• Physicians designed this measure to explore ability to distinguish early child outcomes of lower and higher risk children

• Goal was to demonstrate association between ACEs and specific early child outcomes using a brief measure that was feasible to use in clinical practice

• If links between exposure to adversity and childhood onset health conditions and/or behavioral problems arose ... then this could shape their evidence based approaches to well-child care

• They could then look at if practice based interventions are effective in improving health and behavioral outcomes

Population Studied in Pilot

- Cross Sectional Data on 102 children between ages of 4-5
- Presented in a Urban federally Qualified Health Center serving lower income inner-city population
- Medicaid was providing 90% of coverage for the pediatric population in the health center
- 149 selected eligible (female primary caretakers), 102 participated
- 171 children presented for well child visits during 6 month period
- African American (57%)
- Hispanic/Latino (43%)
- 50% male children
- 12% low birth weight (less than 2500 grams)

Most prevalent ACEs factors in the Study

<table>
<thead>
<tr>
<th>Variable</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maltreatment Suspected</td>
<td>24%</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>9%</td>
</tr>
<tr>
<td>Substance Use</td>
<td>11%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>41%</td>
</tr>
<tr>
<td>Criminal Behavior</td>
<td>22%</td>
</tr>
<tr>
<td>Single Parent</td>
<td>76%</td>
</tr>
<tr>
<td>*Maternal Education (no HS diploma or GED)</td>
<td>57%</td>
</tr>
<tr>
<td>At least one of the above 6 risk factors</td>
<td>90%</td>
</tr>
<tr>
<td>At least 1 of the above 7 risk factors</td>
<td>94%</td>
</tr>
</tbody>
</table>

* Important predictor of vulnerability to developmental delay

“... prevalence of behavior problems and developmental delay was 2 to 4 times greater in the higher risk ACE group, and injury visits were 5 times more likely.” p. 16
Survey Work has Continued Since it Started in 2010

• We are having physicians review and counsel in response to the questions. I don't think you need someone with MD expertise, but I would recommend someone with clinical training (psychologist, social worker, or graduate student in same).

• What I sent you is a work in progress. We are currently collecting data on this tool which will be able to address the question of cut-offs, but at this point I don't have that information. However, in general the literature supports the use of 3 or 4 risk factors as an indicator that the child is at higher risk for chronic diseases, and therefore that child/family may benefit from a higher level of services.

Dr. Ariane Marie Mitchell, Personal Communication October 2016
Whole Child Assessment (C-ACEs Only) Supporting Article

WCA C-ACEs Tool
Impact of attachment issues and trauma on development across the lifespan
Child Welfare
Prevalence of Trauma – United States

- Each year in the United States, more than 1,400 children—nearly 2 children per 100,000—die of abuse or neglect.

- In 2005, 899,000 children were victims of child maltreatment. Of these:
  - 62.8% experienced neglect
  - 16.6% were physically abused
  - 9.3% were sexually abused
  - 7.1% endured emotional or psychological abuse
  - 14.3% experienced other forms of maltreatment (e.g., abandonment, threats of harm, congenital drug addiction)

U.S. Prevalence of Trauma (continued)

• One in four children/adolescents experience at least one potentially traumatic event before the age of 16.¹

• In a 1995 study, 41% of middle school students in urban school systems reported witnessing a stabbing or shooting in the previous year.²

• Four out of 10 U.S. children report witnessing violence; 8% report a lifetime prevalence of sexual assault, and 17% report having been physically assaulted.³

Prevalence of Trauma in the Child Welfare Population

• A national study of adult “foster care alumni” found higher rates of PTSD (21%) compared with the general population (4.5%). This was higher than rates of PTSD in American war veterans.¹

• Nearly 80% of abused children face at least one mental health challenge by age 21.²


Prevalence of Trauma in the Child Welfare Population (continued)

- A study of children in foster care revealed that PTSD was diagnosed in 60% of sexually abused children and in 42% of the physically abused children.¹

- The study also found that 18% of foster children who had not experienced either type of abuse had PTSD,¹ possibly as a result of exposure to domestic or community violence.²

**Mismanagement of Trauma**


- Reduces likelihood of reunification (1)
- Increases placement instability (2)
- Increase in restrictive placements (3)
- Increases likelihood of using stronger psychotropic medications (4)
- Increases child perpetuating intergenerational cycle of abuse and neglect when they become a parent (5)

1) Rubin, O'Reilly, Luan, & Localio (2007) *Pediatrics, 119* (2) 336-344
4) Raghavan et al. (2005) *Journal of Child and Adolescent Psychopathology, 15*(1), 97-106
Juvenile Justice
A growing body of research indicates that victims of violence are more likely than their peers to also be perpetrators of violence, and that individuals most likely to be victims of personal crime are those who report the greatest involvement in delinquent activities.

(ABA, 2000; Shaffer and Ruback, 2002; Wiebush et al., 2001).
Studies with antisocial youth have found self reported trauma exposure ranging from 70% to 92% (Greenwald, 2002)

Antisocial youth have high rates of Post Traumatic Stress Disorder (PTSD) ranging from 24% to 65% (Greenwald, 2002)

Research has indicated high levels of trauma in the experiences of conduct-disorder youth (Bowers, 1990; McMackin, Morissey, Newman, Erwin, & Daley, 1998; Rivera & Widom, 1990; and Steiner, Garcia, & Matthews, 1997)

Research suggests that anger and violent acting out often are symptoms of PTSD (Chemtob, Novaco, Hamada, Gross, & Smith, 1997)
Trauma and Juvenile Delinquency

Research shows that childhood exposure to domestic and community violence, for example, can cause children to engage in aggressive behavior, suffer from problems such as depression and anxiety, have lower levels of social competence and self-esteem, experience poor academic performance, and exhibit posttraumatic stress symptoms such as emotional numbing and increased arousal (Colley-Quille et al., 1995; ABA, 2000; Osofsky, 1999).
NCTSN and Resources for Learning Juvenile Justice

http://learn.nctsn.org/index.php

- Screening and Assessment in Juvenile Justice Settings
- Juvenile Justice Resource Site
- Think Trauma Toolkit: Training for Staff in Juvenile Justice Settings
Cross Over Youth
Child Welfare and Corrections

Systems Integration Initiative (SII) were launched at the Child Welfare League of America in 2000 through the support of the John D. and Catherine T. MacArthur Foundation.

Crossover Youth Practice Model (CYPM) by the Center for Juvenile Justice Reform (CJJR) in partnership with Casey Family Programs in 2009.

Cross-Over Youth

*Herz, Lee, Lutz, Stewart, Tuell, & Wiig, pp 2-3*

- Majority are male
- Disproportionate are female (third to almost one half)
- Disproportionate number are children of color
- Majority have special education needs, problems in school
- Majority have mental health diagnosis/substance abuse issues
- Significant number have witnessed interpersonal violence
- Need of more intense services
The Future for “Our Kids”

Being abused or neglected as a child increased the likelihood of arrest as a juvenile by 59 percent and as an adult by 28 percent, and for a violent crime by 30 percent. The abused and neglected cases were younger at first arrest, committed nearly twice as many offenses, and were arrested more frequently (Widom, 1995; Widom and Maxfield, 2001).
Types of Trauma and Impact
What is Child Traumatic Stress?

- Child traumatic stress refers to the *physical and emotional responses* of a child to events that threaten the life or physical integrity of the child or of someone critically important to the child (such as a parent or sibling).

- Traumatic events overwhelm a child’s capacity to cope and elicit feelings of terror, powerlessness, and out-of-control physiological arousal.
What is Child Traumatic Stress? (continued)

- A child’s response to a traumatic event may have a profound effect on his or her perception of self, the world, and the future.
- Traumatic events may affect a child’s:
  - Ability to trust others
  - Sense of personal safety
  - Effectiveness in navigating life changes
Types of Traumatic Stress

**Acute trauma** is a single traumatic event that is limited in time. Examples include:

- Serious accidents
- Community violence
- Natural disasters (earthquakes, wildfires, floods)
- Sudden or violent loss of a loved one
- Physical or sexual assault (e.g., being shot or raped)

During an acute event, children go through a variety of feelings, thoughts, and physical reactions that are frightening in and of themselves and contribute to a sense of being overwhelmed.
Types of Traumatic Stress (continued)

• **Chronic trauma** refers to the experience of multiple traumatic events.

• These may be multiple and varied events—such as a child who is exposed to domestic violence, is involved in a serious car accident, and then becomes a victim of community violence—or longstanding trauma such as physical abuse, neglect, or war.

• The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact.
Types of Traumatic Stress (continued)

- **Complex trauma** describes both exposure to chronic trauma—usually caused by adults entrusted with the child’s care—and the impact of such exposure on the child.

- Children who experienced complex trauma have endured multiple interpersonal traumatic events from a very young age.

- Complex trauma has profound effects on nearly every aspect of a child’s development and functioning.

Other Sources of Stress
Variables that Impact Trauma
Other Sources of Ongoing Stress

Children in the child welfare system frequently face other sources of ongoing stress that can challenge workers’ ability to intervene. Some of these sources of stress include:

- Poverty
- Discrimination
- Separations from parent/siblings
- Frequent moves
- School problems
- Traumatic grief and loss
- Refugee or immigrant experiences
Variability in Responses to Stressors and Traumatic Events

• The impact of a potentially traumatic event is determined by both:
  o The objective nature of the event
  o The child’s subjective response to it

• Something that is traumatic for one child may not be traumatic for another.

• The impact of a potentially traumatic event depends on several factors, including:
  o The child’s age and developmental stage
  o The child’s perception of the danger faced
  o Whether the child was the victim or a witness
  o The child’s relationship to the victim or perpetrator
  o The child’s past experience with trauma
  o The adversities the child faces following the trauma
  o The presence/availability of adults who can offer help and protection
Effects of Trauma Exposure on Children

• When trauma is associated with the failure of those who should be protecting and nurturing the child, it has profound and far-reaching effects on nearly every aspect of the child’s life.

• Children who have experienced the types of trauma that precipitate entry into the child welfare system typically suffer impairments in many areas of development and functioning, including:
  o **Attachment.** Traumatized children feel that the world is uncertain and unpredictable. They can become socially isolated and can have difficulty relating to and empathizing with others.
  o **Biology.** Traumatized children may experience problems with movement and sensation, including hypersensitivity to physical contact and insensitivity to pain. They may exhibit unexplained physical symptoms and increased medical problems.
  o **Mood regulation.** Children exposed to trauma can have difficulty regulating their emotions as well as difficulty knowing and describing their feelings and internal states.
Effects of Trauma Exposure on Children (continued)

• **Dissociation.** Some traumatized children experience a feeling of detachment or depersonalization, as if they are “observing” something happening to them that is unreal.

• **Behavioral control.** Traumatized children can show poor impulse control, self-destructive behavior, and aggression towards others.

• **Cognition.** Traumatized children can have problems focusing on and completing tasks, or planning for and anticipating future events. Some exhibit learning difficulties and problems with language development.

• **Self-concept.** Traumatized children frequently suffer from disturbed body image, low self-esteem, shame, and guilt.
Long Term Effects of Childhood Trauma

In the absence of more positive coping strategies, children who have experienced trauma may engage in high-risk or destructive coping behaviors.

- These behaviors place them at risk for a range of serious mental and physical health problems, including:
  - Alcoholism
  - Drug abuse
  - Depression
  - Suicide attempts
  - Sexually transmitted diseases (due to high risk activity with multiple partners)
  - Heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease
Trauma and the Brain
Understanding “Why”

http://www.lfcc.on.ca/mccain/perry.pdf
Brain and Stress

• When stress is predictable and moderate, stress can facilitate resiliency and enhance memory
• When stress is unpredictable and severe, stress can create vulnerability and memory impairment
• Severe and chronic stress in childhood via multiple traumas from caregivers can impact affect regulation, interpersonal relationship skills, and states become traits (fight/flight/freeze... disassociation or hyper arousal)
## Types of Stress

<table>
<thead>
<tr>
<th>Positive Stress</th>
<th>Tolerable Stress</th>
<th>Toxic Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal and essential part of healthy development</td>
<td>Body’s alert systems activated to a greater degree</td>
<td>Occurs with strong, frequent or prolonged adversity</td>
</tr>
<tr>
<td>Brief increases in heart rate and blood pressure</td>
<td>Activation is time limited and buffered by caring adult</td>
<td>Disrupts brain architecture and other organ systems</td>
</tr>
<tr>
<td>Mild elevations in hormonal levels</td>
<td>Brain and organs recover</td>
<td>Increased risk of stress-related disease and cognitive impairment</td>
</tr>
<tr>
<td>Example: Tough test at school or a playoff game</td>
<td>Example: Death of a loved one, divorce, natural disaster</td>
<td>Example: abuse, neglect, caregiver substance dependence or mental illness</td>
</tr>
</tbody>
</table>

### Interventions
- **Social-emotional buffering**
- **Parental Resilience**
- **Early Detection**
- **Effective Intervention**

### Stress Levels
- **Intense**
- **Prolonged**
- **Repeated**
- **Unaddressed**
Stress and the Brain

Model adapted by Allison Sampson from Ledoux (1996, page 164) and utilizing terms from van der Kolk’s work and Goldie Hawn’s Book (2011) *Mindful Minutes*
Stress and the Brain (continued)

Model adapted by Allison Sampson from Ledoux (1996, page 164) and utilizing terms from van der Kolk’s work and Goldie Hawn’s Book (2011) 10 Mindful Minutes.
Trauma and the Brain

- Trauma can have serious consequences for the normal development of children’s brains, brain chemistry, and nervous system.
- Trauma-induced alterations in biological stress systems can adversely effect brain development, cognitive and academic skills, and language acquisition.
- Traumatized children and adolescents display changes in the levels of stress hormones similar to those seen in combat veterans.
  - These changes may affect the way traumatized children and adolescents respond to future stress in their lives, and may also influence their long-term health.\(^1\)
Trauma and the Brain (continued)

• **In early childhood**, trauma can be associated with reduced size of the cortex.
  - The cortex is responsible for many complex functions, including memory, attention, perceptual awareness, thinking, language, and consciousness.
• Trauma may affect “cross-talk” between the brain’s hemispheres, including parts of the brain governing emotions.
  - These changes may affect IQ, the ability to regulate emotions, and can lead to increased fearfulness and a reduced sense of safety and protection.
In school-age children, trauma undermines the development of brain regions that would normally help children:
- Manage fears, anxieties, and aggression
- Sustain attention for learning and problem solving
- Control impulses and manage physical responses to danger, enabling the adolescent to consider and take protective actions

As a result, children may exhibit:
- Sleep disturbances
- New difficulties with learning
- Difficulties in controlling startle reactions
- Behavior that shifts between overly fearful and overly aggressive
Trauma and the Brain (continued)

- **In adolescents**, trauma can interfere with development of the prefrontal cortex, the region responsible for:
  - Consideration of the consequences of behavior
  - Realistic appraisal of danger and safety
  - Ability to govern behavior and meet longer-term goals
- As a result, adolescents who have experienced trauma are at increased risk for:
  - Reckless and risk-taking behavior
  - Underachievement and school failure
  - Poor choices
  - Aggressive or delinquent activity

Attachment
Attachment

Many argue that these early relationships (experiences) shape neuronal circuits which regulate emotional and social functioning.
Attachment’s Purpose
Siegel, 1999

Evolutionary Level – biological
• Infant Survival (Bowlby)

Mind Level – biological and social
• Caregiver’s brain helps child’s brain to organize regulation
• Caregiver’s brain teaches child self-soothing
• Child experience of safety allows for exploration

Experience of safety is encoded in child’s implicit memory and provides secure base from which to grow and access higher levels of information processing.
Impact of Secure Attachment

Associated with:

• Emotional Regulation
• Social Relatedness
• Access to autobiographical memory
  o Sense of self in time (presence)
• Development of Self-Reflection and Narrative

Other Impacts of Trauma

Culture and Development
The Influence of Culture on Trauma

- Social and cultural realities strongly influence children’s risk for, and experience of trauma.
- Children and adolescents from minority backgrounds are at increased risk for trauma exposure and subsequent development of PTSD.
- In addition, children, family and community responses to trauma vary by group.
The Influence of Development Stage

• Child traumatic stress reactions vary by developmental stage.

• Children who have been exposed to trauma expend a great deal of energy responding to, coping with, and coming to terms with the event.

• This may reduce children’s capacity to explore the environment and to master age-appropriate developmental tasks.

• The longer traumatic stress goes untreated, the farther children tend to stray from appropriate developmental pathways.
The Influence of Development Stage: Young Children

• **Young children** who have experienced trauma may:
  o Become passive, quiet, and easily alarmed
  o Become fearful, especially regarding separations and new situations
  o Experience confusion about assessing threat and finding protection, especially in cases where a parent or caretaker is the aggressor
  o Regress to recent behaviors (e.g., baby talk, bed-wetting, crying)
  o Experience strong startle reactions, night terrors, or aggressive outbursts
The Influence of Development Stage: School-age Children

- **School-age children** with a history of trauma may:
  - Experience unwanted and intrusive thoughts and images
  - Become preoccupied with frightening moments from the traumatic experience
  - Replay the traumatic event in their minds in order to figure out what could have been prevented or how it could have been different
  - Develop intense, specific new fears linking back to the original danger
  - Alternate between shy/withdrawn behavior and unusually aggressive behavior
  - Become so fearful of recurrence that they avoid previously enjoyable activities
  - Have thoughts of revenge
  - Experience sleep disturbances that may interfere with daytime concentration and attention
The Influence of Development Stage: Adolescents

• In response to trauma, adolescents may feel:
  o That they are weak, strange, childish, or “going crazy”
  o Embarrassed by their bouts of fear or exaggerated physical responses
  o That they are unique and alone in their pain and suffering
  o Anxiety and depression
  o Intense anger
  o Low self-esteem and helplessness
The Influence of Development Stage: Adolescents (cont’d)

• These trauma reactions may in turn lead to:
  o Aggressive or disruptive behavior
  o Sleep disturbances masked by late-night studying, television watching, or partying
  o Drug and alcohol use as a coping mechanism to deal with stress
  o Over- or under-estimation of danger
  o Expectations of maltreatment or abandonment
  o Difficulties with trust
  o Increased risk of re-victimization, especially if the adolescent has lived with chronic or complex trauma
The Influence of Development Stage: Adolescent, Trauma and Substance Abuse

- Adolescents who have experienced trauma may use alcohol or drugs in an attempt to avoid overwhelming emotional and physical responses. In these teens:
  - Reminders of past trauma may elicit cravings for drugs or alcohol.
  - Substance abuse further impairs their ability to cope with distressing and traumatic events.
  - Substance abuse increases the risk of engaging in risky activities that could lead to additional trauma.
- Child welfare workers must address the links between trauma and substance abuse and consider referrals for relevant treatment(s).
The Influence of Developmental Stage: Specific Adolescent Groups

• **Homeless youth** are at greater risk for experiencing trauma than other adolescents.
  o Many have run away to escape recurrent physical, sexual, and/or emotional abuse
  o Female homeless teens are particularly at risk for sexual trauma

• **Special needs adolescents** are 2 to 10 times more likely to be abused than their typically developing counterparts.

• **Lesbian, gay, bisexual, transgender or questioning (LGBTQ) adolescents** contend with violence directed at them in response to suspicion about or declaration of their sexual orientation and gender identity
Big Picture

- Many of the symptoms we are seeing in the children we work with are direct results of coping with trauma.

- When we try to take away their coping, families and children often withdraw and protect themselves from us.

- Be aware of the “invisible suitcase” that our children and parents bring with them as they move into the system and often away from everything they know.
Cross Generational Trauma

What about the caregivers?
Perspective of a Parent

Poem ...
https://pathwaysu.com/pluginfile.php/12642/mod_resource/content/1/I%20am%20a%20child.pdf

• Perspective on children of trauma who have now grown up to be parents
• Understanding how trauma may be impacting a birth parent
• Impact of trauma on communication and decision making of adult caregivers
• Data on caregivers needs
Cross- Generational Trauma Histories

Why does it matter to us?

• Affects the emotions and behaviors of the parents and thus their communication and decision-making
• All that we have learned about trauma, attachment, and the brain now applies to the parents
• Is an important consideration in kinship care and relative placements
• Not addressing parental trauma history decreases the parenting abilities of all caregivers in the child’s life, results in disrupted placements and client recidivism

Cross-Generational Trauma

If a parent has had chronic trauma in their own childhoods it impacts:

• Ability to engage in positive parent-child interactions
• Ability to protect their own children
• Ability to help their children recover from trauma
• Ability to cope and function with Child Welfare interventions (including removal) with their children

Cross-Generational Trauma (Continued)

- Women who have experienced trauma are more likely to self-medicate with a substance (55-99%) (1)
- Intergenerational transmission of trauma (Depression, PTSD) (2)
- Unresolved childhood trauma can lead to reenactments with partners in adult relationships and/or with their children (3)
- Unresolved childhood trauma can lead to difficulty forming secure attachments with their children (4)
- Childhood trauma can result in parenting styles that include threats & violence (2)
- Childhood sexual abuse survivors can miss “red flags” of sexual abuse with their own children due to avoidance of trauma memories themselves (2)

Using Trauma Informed Services to Increase Parental Protective Factors

2) Hendricks, A. (2012). Using Trauma-Informed Services to Increase Parental Factors (pp. 89-91)
4) Main & Hess (1990) In M. Greenberg, D. Cicchetti, & E. Cummings (Eds.), Attachment in the preschool years: Theory, research, and intervention
Cross-Generational Trauma (Continued)

Caregiver functioning following a child’s exposure to trauma is a major predictor of child’s functioning (1 & 2)

If we want to improve a child’s outcome, we must address parent’s trauma history. Failure to do so can result in (2):

- Failure to engage in treatment services
- An increase in symptoms
- An increase in management problems
- Re-traumatization
- An increase in relapse
- Withdrawal from service relationship
- Poor treatment outcomes

Using Trauma Informed Services to Increase Parental Protective Factors

Pro-Active Approaches with Parents

• Utilize trauma focused screening and assessment and treatment services with all family members including the birth family
• Don’t just make a referral to general mental health services, substance abuse services, or domestic violence services
• Advocate for better trained service providers
• Promote awareness of parent trauma across Child Welfare System

ACEs and Resilience
Case Planning Tools
Resilience Trumps ACEs

Children’s Resilience Initiative

Empowering community understanding of the forces that shape us and our children

Website: www.resiliencetrumpsaces.org

From Trish Mullen, Chesterfield Community Services Board
Children’s Resilience Initiative

SKILL BUILDING

Think: lack of skill not intentional misbehavior
Think: building missing skills not shaming for lack of skills
Think: nurture not criticize
Think: teach not blame
Think: discipline not punishment
Orientation to
Phase Oriented Treatment
Core Areas of Focus in Complex Trauma

Self-Regulation
• Affect Regulation
• Disassociation (difficulty in being “present”)
• Somatic Dysregulation

Positive Self-Identity
• Impaired Self-Concept
• Impaired Self-Development

Co-regulation
• Secure working model of caring relationship
• Disorganized Attachment Patterns

Courtois, C. & Ford, J. (2009), Introduction (p.2)
Phase Oriented Treatment “Gold Standard”

Phase I: Safety and Stabilization

Phase 2: Trauma Reprocessing

Phase 3: Reintegration

Courtois, C., Ford, J., & M. Cloitre (2009), pp.90-100
Phase Oriented Treatment (continued)

PHASE ONE: Safety and Stabilization

• Personal and Interpersonal Safety Established: Education/Support/Safety Planning
• Enhance Client’s ability to manage extreme arousal (hyper/hypo)
• Active engagement in positive/negative experiences (deal with automatic avoidance behaviors, self awareness of avoidance, increase coping skills and use of coping skills)
• Education (psychotherapy, trauma, skills to be learned)
• Assess and develop relationship capacity (decrease avoidance of relationships or negative thoughts about relationships, build support network, define client’s attachment network)

Courtois, C., Ford, J., & M. Cloitre (2009), pp.90-100
Making a Treatment or Case Plan
Trauma and Resilience Interview
Ask the Client to State what He or She Observes

Guide the client through this exercise by using statements like, “You seem to feel very scared/angry right now. You’re probably feeling things related to what happened in the past. Now, you’re in a safe situation. Let’s try to stay in the present. Take a slow deep breath, relax your shoulders, put your feet on the floor; let’s talk about what day and time it is, notice what’s on the wall, etc. What else can you do to feel okay in your body right now?”

Ask the Client to Use Breathing Techniques

Ask the client to inhale through the nose and exhale through the mouth. Have the client place his or her hands on his or her abdomen and then watch the hands go up and down while the belly expands and contracts.

Communicating Emotion: Validation

Six Levels by Marsha Linehan, Ph.D

Using the Top 3

Level One: Being Present (Deep Listening)

Level Two: Accurate Reflection (So if I hear you correctly ....)

Level Three: Mindreading (I am guessing that you are feeling ....)
Opening with Resilience
Opening with Resilience

• Show the resilience list

• Highlight 42 resilience factors vs. 10 adversity factors

• Normalize:
  ○ 50% of youth will have at least one ACE
  ○ 70% of adults will have at least one ACE
Resilience Skills

- Showing empathy
- Critical thinking skills
- Helping appreciate cultural & ethnic heritage
- Sense of belonging
- Learning to accept help
- Hope
- Trust
- Sense of Belonging
- Letting Child Know you are Available for Help
- Learning Responsibility
- Teach Self Discipline
- Establish Consequences
- Model Problem Solving
- Sharing Something Important
- Family Meetings
- Clear Rules and Expectations
- Help a Child Learn to Express Feelings
- Accept Ownership for Behavior
Resilience Skills (continued)

- Work as a team
- Learn to show appreciation
- Master a Skill
- Assign a Responsibility
- Sense Triggers that create negative behavior
- Develop Communication Skills
- Helping a Friend
- Allowing Experience of Success or Failure
- Respect ability to make decisions
- Model appropriate behavior
- Help child develop problem solving skills
- Learning to ask for help
- Acknowledge when you are wrong

- Learn to self advocate
- Give back to community
- Giving a choice
- Ability to Calm Self
- Verbally say “I love you”
- Express Feelings
- Experience Success
- Develop Friendships
- Develop Self Esteem
- Attach to Caring Adult
- Learn to Solve Problems
Talk to Me About Your Skills

• Get them to share 2-3 skills they have that they see on the table with the cards

• Give a story that they used one of those skills in
Bad Chapter Titles, not Book Contents
Talking About the Tough Stuff
Bad Chapter Titles

• Note that the transition is going to happen now to the “bad” chapter titles
• Present the ACEs information
• Offer options
  o Can be asked the questions
  o Can read the questions
  o Can take listen to a recording of the questions
• First give the number
• Identify events that have happened
• Remember the ground rules
Resilience and ACEs game

Bread Meat Bread

• Pick an ACE you experienced

• Pick 2-3 Resilience Skills/Cards you want to build

• For every adversity, there are resilient skills you can build

http://resiliencetrumpsaces.org
Understanding Our Coping Styles
Behavior Wheel

When tough stuff happens ....

• Your body and brain change to cope
• You choose coping skills that meet your needs then
• Sometimes these coping skills help in some ways and cause big problems in other ways
• These coping skills can be bad for our well-being
• We want to look at the coping behaviors that may be causing you a hard time
• Think about the needs behind those coping behaviors
• And figure out are there other ways you can practice coping that are more healthy
• We want to offload the negative coping skills and increase the positive skills
Interviewing Skills

Normalizing
Rationale: Normalizing is intended to communicate to clients that having difficulties while changing is not uncommon, that they are not alone in their experience, or in their ambivalence about changing. Normalizing is not intended to make clients feel comfortable with not changing; rather it is to help them understand that many people experience difficulty changing.

Examples of Normalizing

• “A lot of people are concerned about changing their [insert risky/problem behavior].”
• “Most people report both good and less good things about their [insert risky/problem behavior].”
• “Many people report feeling like you do. They want to change their [insert risky/problem behavior], but find it difficult.”
• “That is not unusual, many people report having made several previous quit attempts.”
• “A lot of people are concerned about gaining weight when quitting.”

Behavior Wheel Example

- Self mutilation
- Homicidal ideation
- Aggressive behavior

Control
Release of anxiety/aggression
Defense mechanism – using it as a barrier to keep people at a distance

A safe way of getting a message across, raising red flags to dig deeper, getting everyone’s attention

Gets her attention because she’s making poor decisions, at least someone is paying attention to her

Attention, fills something, releasing anxiety, self soothing

Gives her release, she get things off her chest
Process of Building a Behavior Wheel

• Interview your client and build a behavior wheel with them

• Now with the unhealthy behaviors

• Again with new behaviors they can select
Closing with “Good” Chapter Titles

• Talk about the best things that have ever happened to you
• Make the list of good things
  o Time you felt happy
  o Time you felt excited
  o Supportive Adult Story
• If possible get the age and SUD scale
Making a Plan
Making a Plan

• Look at the table in the Trauma/Resilience Case Planning Tool

• What Resilience Skills/Replacement Coping Strategies does your client want to build based on the ACEs/Resilience Table, their Behavior Wheel, and the “good stuff” they want to increase?

• What Resources will they need?

• What is their timeline?
Balancing

Positive Factors

Negative Factors
Expanding to Resilience

• Helps case planning
• Approach vs Avoidance Case Planning Goals
• Helps know services and activities to link to
Balancing

Negative Factors

Positive Factors
How Could this Look in CASE Planning?

http://www.healthygen.org/resources/nearhome-toolkit
Ongoing Resources for Trauma and Resiliency
Magellan Training Site
Course Objectives

Part One

Verbalize 5 of the 10 Adverse Childhood Experience categories and how they relate to risk factors for physical well-being.

Verbalize 3-4 key medical conditions that are more likely to exist among individuals with higher ACE scores.

Part Two

Verbalize how the CYW ACE-Q was developed and can be utilized with caregivers, children and teens.

Reflectively appraise 2 ways they might incorporate ACE understanding into their practices with members utilizing Resiliency Science.
Resiliency Toolkit – IOWA
http://www.iowaaces360.org/resiliency-toolkit.html
Be a **F.O.R.S.E. in your community**

**Focus**

**On**

**Resilience &**

**Social-Emotional**

(competence)

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Image by Lincoln High student Brendon Gilman
Thanks
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