BRIEF OVERVIEW: TRAUMA AND EVIDENCE-BASED INTERVENTION

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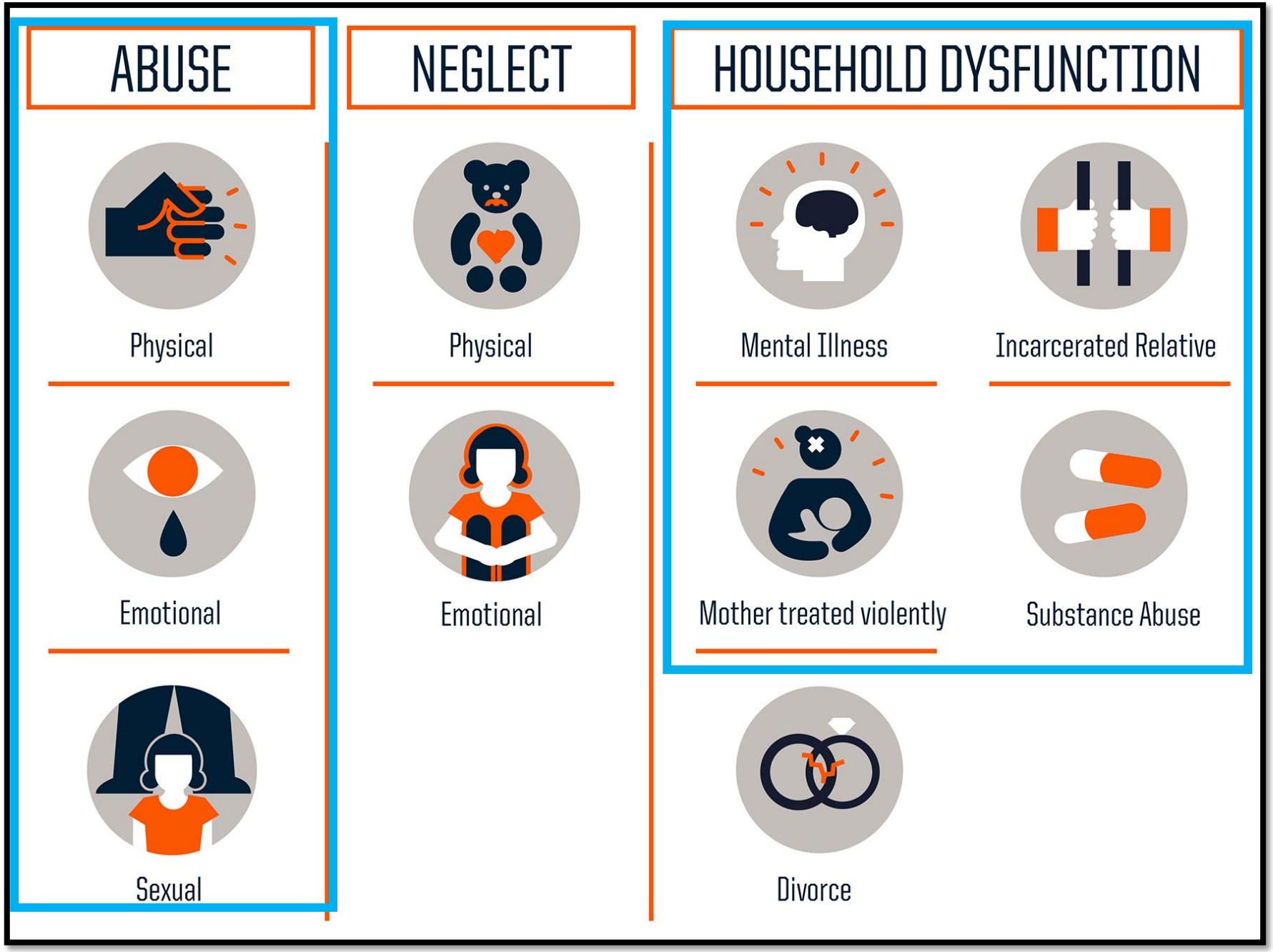
DISCLAIMER

- We will be discussing content that may be uncomfortable
- **Please take care of yourself**

ACE STUDY (ACEs)



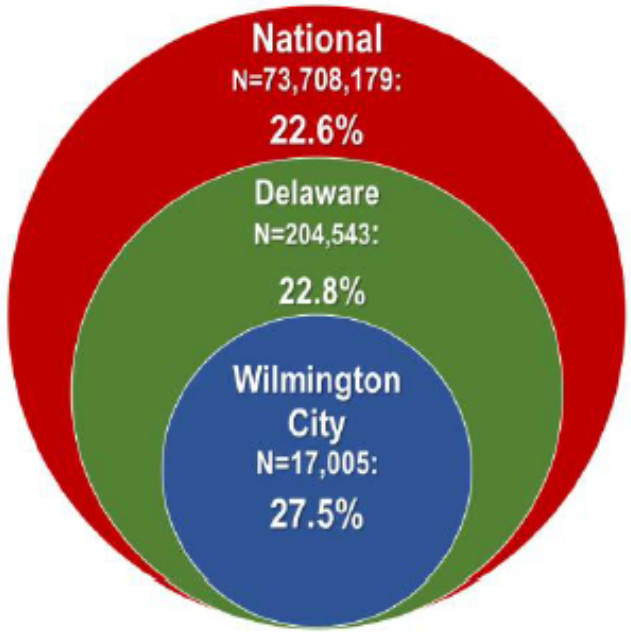
Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *14*(4), 245-258.

WHAT MAY CAUSE A POSTTRAUMATIC RESPONSE IN A CHILD?

PERCEPTION IS KEY!

- **An experience that includes:**
  - Serious harm/threat of death/injury to the child **or** loved one
  - Unexpected/violent death of a family member or friend
- **Examples:**
  - Physical/Sexual/Emotional Abuse
  - Online Child Abuse*
  - Exposure to DV
  - Neglect
  - Natural Disaster; **Pandemic**
  - Deportation of Family Member
  - Medical Trauma; Illness
  - Exposure to Abuse of Family Member
  - Bullying
  - Family Mental or Medical Illness
  - Refugee Trauma
  - Racial Trauma; Historical Trauma
  - Substance Abuse in Family
  - Death of Family Member/Friend
  - Incarceration of Caregiver
  - Foster Care Involvement
  - School Shooting or Violence
  - Peer-to-Peer Sexual Abuse*
  - Perceived Event*

WHAT IS HAPPENING IN DE?



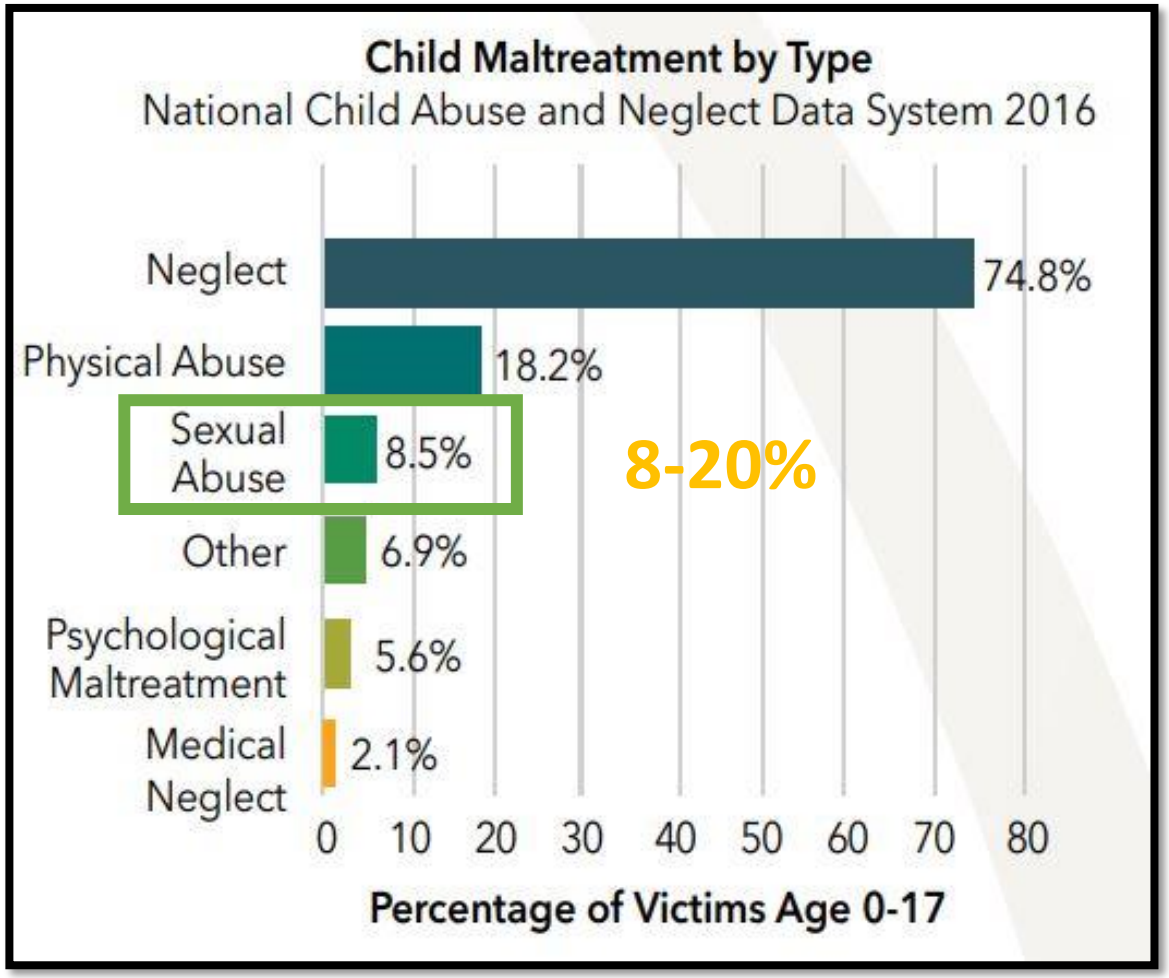
New Castle County: 22.2%; Kent County: 25.9%; Sussex County: 26.2%

Over one fourth of children in Wilmington City have 2 or more ACEs (n=~4,680)

Table 1. Local, State and National Level Prevalence of Adverse Childhood Experiences Items Among Children, Age 0-17 yrs.

Adverse Child or Family Experiences (ACEs) Items	Wilmington City	Delaware State	National
Extreme economic hardship	34.0%	24.8%	25.7%
Family disorder leading to divorce/separation	20.1%	20.6%	20.1%
Has lived with someone who had an alcohol/drug problem	9.0%	11.1%	10.7%
Has been a victim/witness of neighborhood violence	11.9%	11.6%	8.6%
Has lived with someone who was mentally ill/suicidal	7.0%	9.1%	8.6%
Witnessed domestic violence in the home	8.5%	8.0%	7.3%
Parent served time in jail	9.2%	7.5%	6.9%
Treated or judged unfairly due to race/ethnicity	6.7%	5.7%	4.1%
Death of parent	5.2%	3.5%	3.1%
Child had ≥1 ACEs *(1/more of above items)*	60.5%	50.4%	47.9%

BUILDING ON ACES: UPDATED RATES



- Incidence rates of child sexual abuse by adults has declined as child-on-child sexual abuse has increased (Jones, 2012; DeLago et al., 2020)
- 35-66% of youth who have experienced childhood maltreatment report child-on-child sexual abuse (Finkelhor, Ormrod, & Chaffin, 2009; Radford et al., 2011)
- 19% of children with medical injuries develop persistent posttraumatic stress (Kahana, Feeny, Youngstrom, & Drotar, 2006)
- 12% of youth will medical illnesses develop persistent posttraumatic stress* (Kahana, Feeny, Youngstrom, & Drotar, 2006)
- 28% of males and 41% of females who are bullied endorse significant PTSD symptoms (NCTSN Resource, 2018)
- ??% of youth are abused online (e.g., cyberbullying, grooming, child sexual exploitation)

RESPONSES TO POTENTIALLY TRAUMATIC EVENTS (PTEs)

1. No Significant Response ✗
2. Posttraumatic Stress Symptoms ✗
3. Anxiety/Depressive Symptoms ✗
4. Persistent Posttraumatic Stress Symptoms ✓
5. Posttraumatic Stress Disorder (PTSD) ✓

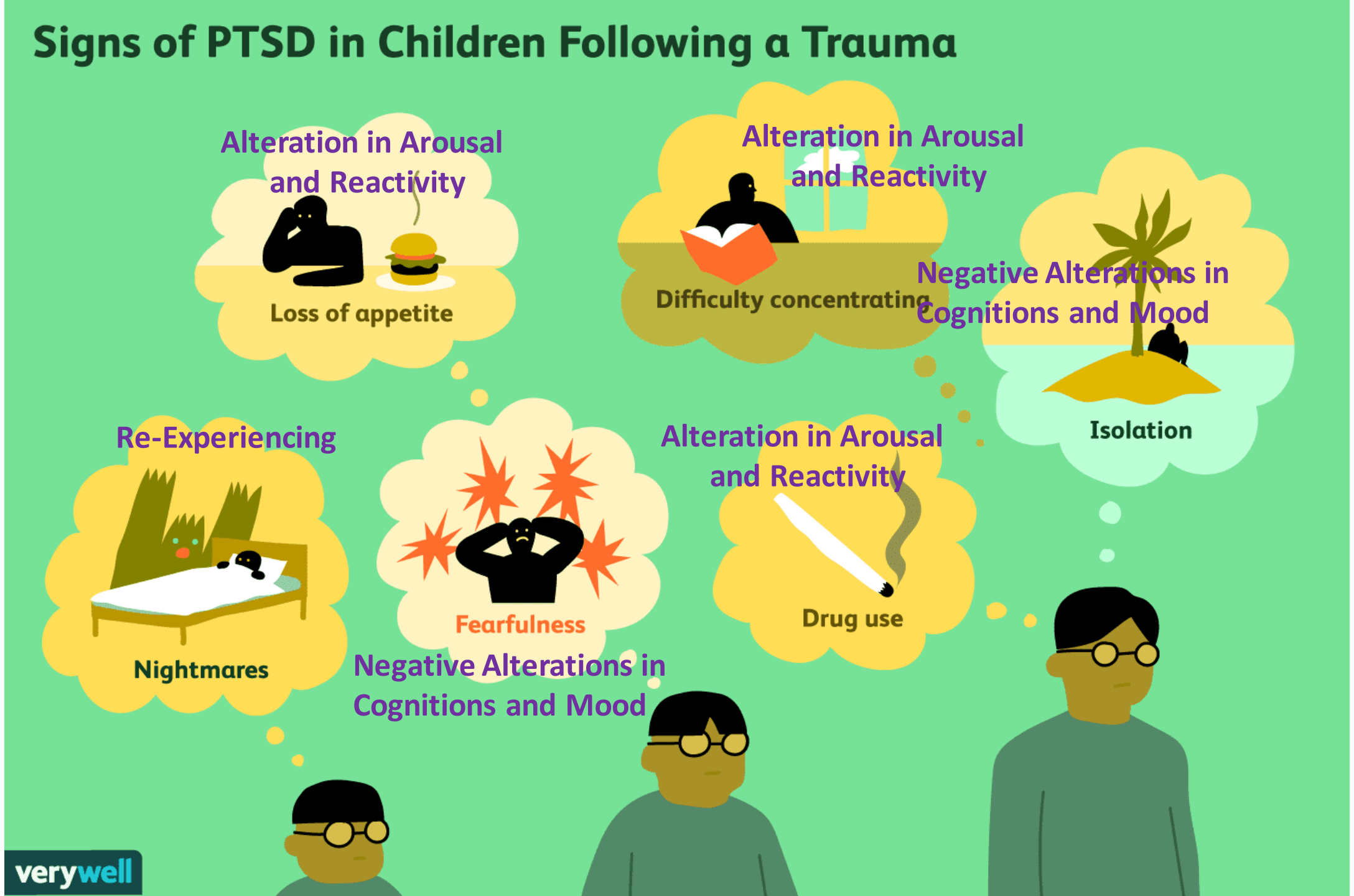
✓ *Good Candidate for Trauma-Specific Treatment*

POSTTRAUMATIC STRESS SYMPTOMS

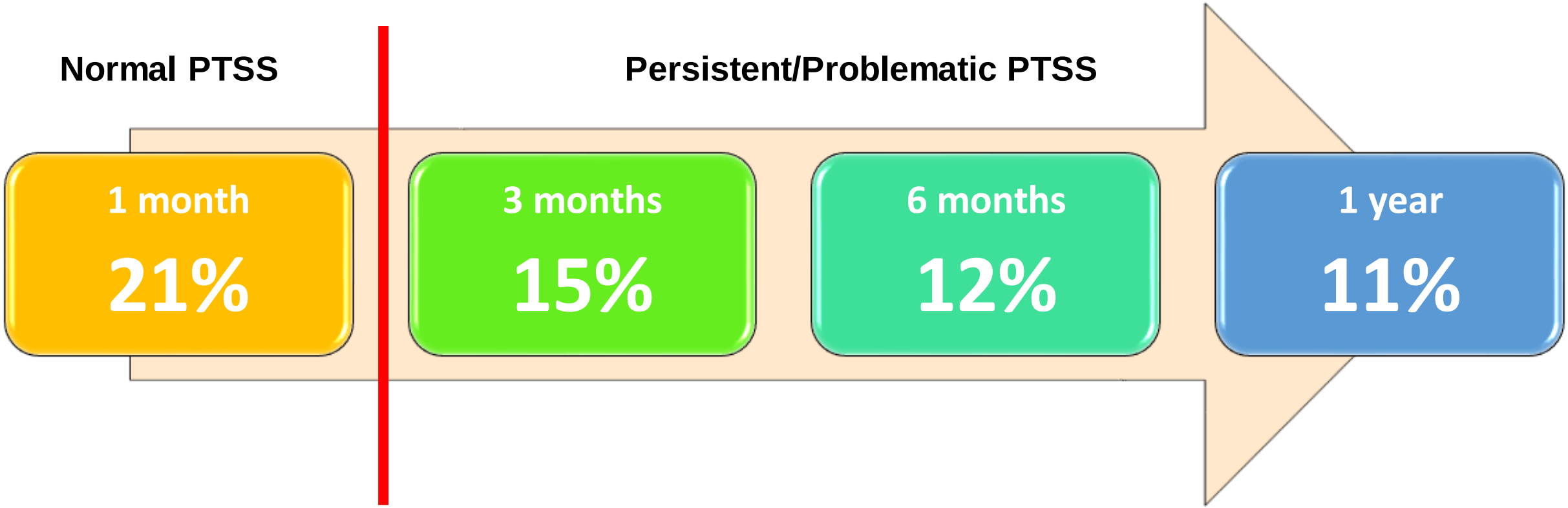
- **Re-experiencing:** Unwanted upsetting memories, nightmares, flashbacks, emotional distress after exposure to traumatic reminders, and physical reactivity after exposure to traumatic reminders.
- **Persistent Avoidance:** Youth actively avoids thoughts or feelings related to events, as well as external reminders (e.g., does not enter room sexual abuse occurred in).
- **Negative Alterations in Cognitions and Mood:** Difficulty recalling facts of trauma, overly negative thoughts about oneself, others, or the world, exaggerated blame of self or others for causing the trauma, negative affect, decreased interest in activities, and difficulty expressing happiness.
- **Alterations in Arousal and Reactivity:** Increased irritability and aggression, risky behavior, hypervigilance, difficulty concentrating and sleeping, and heightened startle reaction.
- **Significantly impairs functioning**

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

Signs of PTSD in Children Following a Trauma



WHO DEVELOPS PTSS/PTSD?



Hiller, R. M., Meiser-Stedman, R., Fearon, P., Lobo, S., McKinnon, A., Fraser, A., & Halligan, S. L. (2016). Research Review: Changes in the prevalence and symptom se verity of child post-traumatic stress disorder in the year following trauma–A meta-analytic study. *Journal of Child Psychology and Psychiatry*, *57*(8), 884-898.

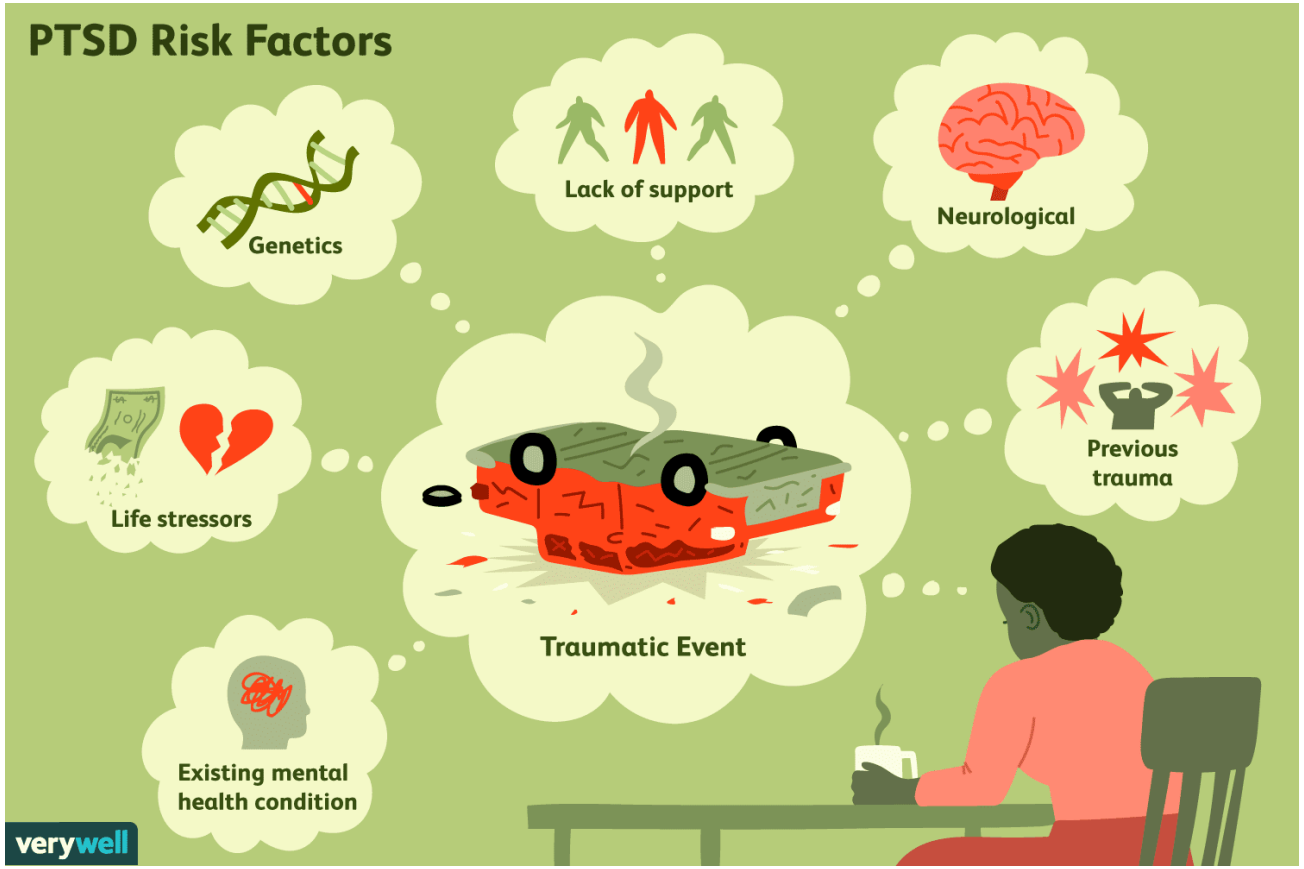
FACTORS THAT ENHANCE RESILIENCY

- Quality of social support
- Feeling safe at home, school, and in the community
- High self-esteem
- Self-efficacy
- Sense of meaning in one's life
- Having a talent or skill in a specific area
- Adaptive and flexible coping skills
- Caregivers' response to trauma*

http://www.nctsn.org/sites/default/files/assets/pdfs/resilience_and_child_traumatic_stress_0316.pdf

WHO IS AT GREATEST RISK?

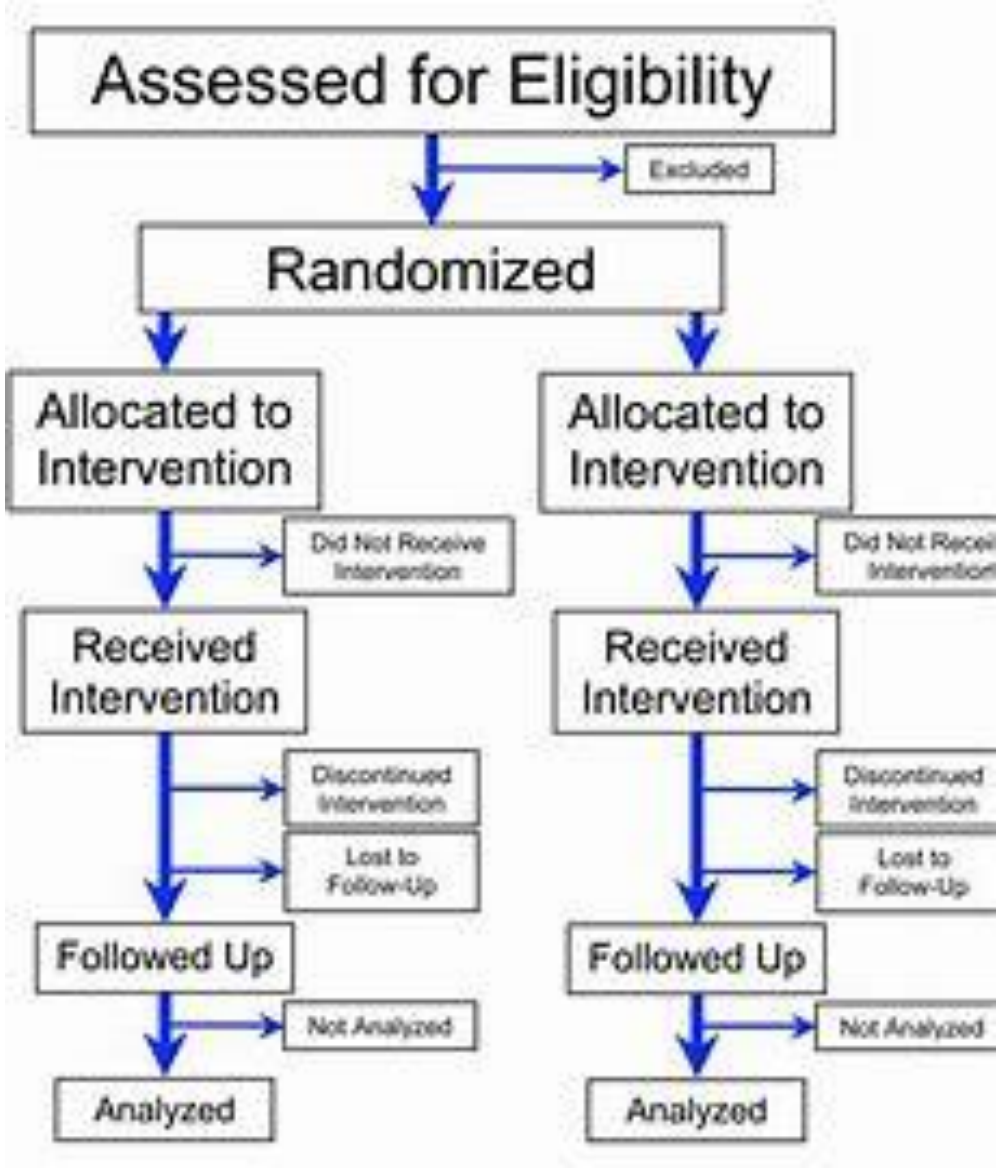
- Factors that place youth at higher risk to experiencing traumatic events:
  - Low socioeconomic status/poverty
  - Part of a marginalized or minority group
  - Youth:
    - who identify as LGBTQ
    - with developmental disabilities
    - with externalizing behaviors
    - who have experienced prior instances of abuse
  - Lack of supervision
  - Those with pre-existing mental health conditions



EVIDENCE-BASED TREATMENT FOR CHILDHOOD TRAUMA

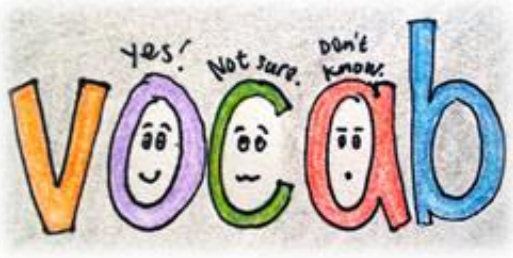
WHAT DOES EVIDENCE-BASED MEAN?

- Considered to be “best practice” in the field
- At least 3 randomized controlled trials have found that the treatment can help a specific population



For more information, visit: https://www.apa.org/ptsd-guideline/treatments

QUICK VOCABULARY LESSON



Trauma-Informed

Refers to interventions that have been specifically adapted (but may not have initially been designed) to treat symptoms associated with the adverse effects of exposure to traumatic events.

- *Focuses on understanding the impacts of trauma and creating safety.*

Trauma-Focused

Refers to treatment designed to infuse and sustain trauma awareness, knowledge, and skills into daily life designed to maximize physical and psychological safety, facilitate the recovery of the child and family, and support their ability to thrive.

- *Delivered by practitioners who have extensive knowledge and skills in trauma treatment.*
- *Focuses directly on the trauma and on trauma recovery.*

NCTSN Trauma Informed Systems (Retrieved 10/15/2018) https://www.nctsn.org/trauma-informed-care/creating-trauma-in formed-systems.
UCLA-Duke National Center for Child Traumatic Stress. Los Angeles, CA: Durham, NC

WHAT WORKS?: CORE COMPONENTS

- The most tested treatments for child traumatic stress include several core practice elements across treatments:
  1. Psychoeducation about trauma and goals of treatment
  2. Management of stress-related symptoms and trauma reminders
  3. Trauma narration and organization
  4. Cognitive and affective processing
  5. Problem solving regarding safety and relationships
  6. Parenting skills and behavioral management
  7. Addressing grief and loss *of life, innocence, etc.*
  8. Emotional regulation
  9. Supporting youth to resume developmental progression that may have been derailed due to trauma

https://www.nctsn.org/sites/default/files/resources/position-statement/position-statement-evidence-based-practice.pdf

EVIDENCE-BASED TRAUMA INTERVENTIONS*

1. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
2. CBT for Body Safety
3. Cognitive Processing Therapy (CPT)**
4. Parent-Child Interaction Therapy (PCIT)***
    - Trauma Lens
    - PSB adaptation

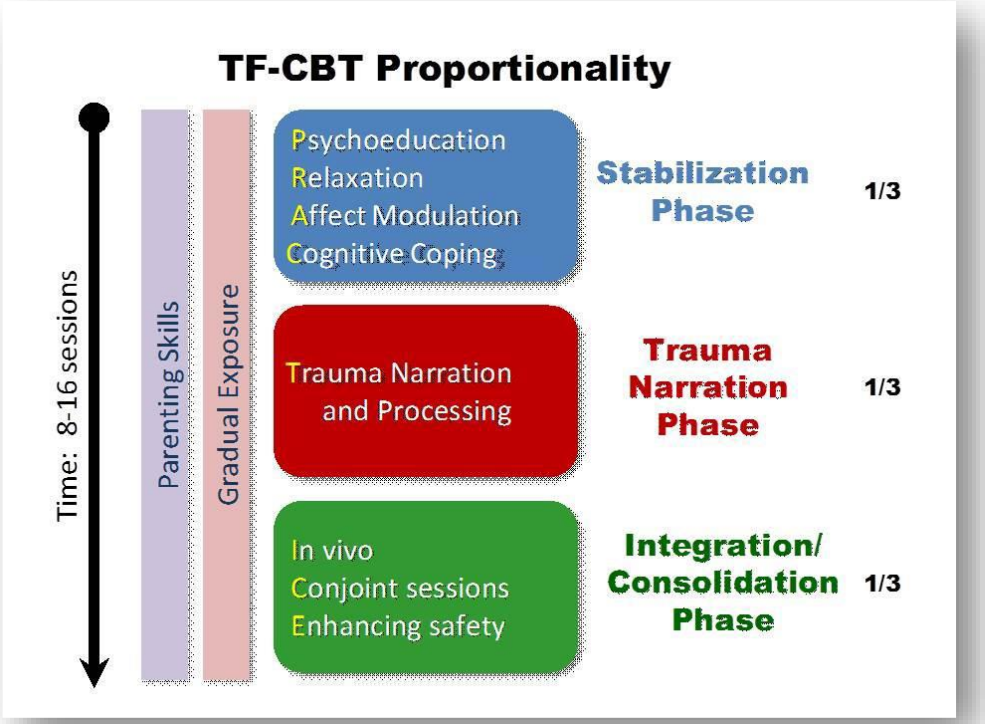
TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

- **Evidence-based treatment** for 3 to 21 year olds and their caregivers developed by Cohen, Mannarino, and Deblinger.
- Addresses multiple domains of trauma impact: PTSD, depression, anxiety, externalizing behavior problems, relationship and attachment problems, sleep hygiene, academic difficulties, poor peer relationships, and suicidal ideation/non suicidal self-injury.
- TF-CBT has been found to be effective in treating a variety of trauma types
- **Treatment Length:** 12 to 20 sessions (60 – 90 minutes)

(Cohen, Deblinger, Mannarino, & Steer, 2004; Deblinger, Pollio, Runyon, & Steer, 2017; Fitzgerald, & Cohen, 2012).

TF-CBT Components: *PRACTICE*

- **P**sychoeducation about child trauma & Parenting
- **R**elaxation skills
- **A**ffective modulation skills
- **C**ognitive coping: thoughts, feelings, & behavior
- **T**rauma narrative & processing
- **I**n vivo mastery of trauma reminders
- **C**onjoint child-parent sessions
- **E**nhancing safety & future developmental trajectory



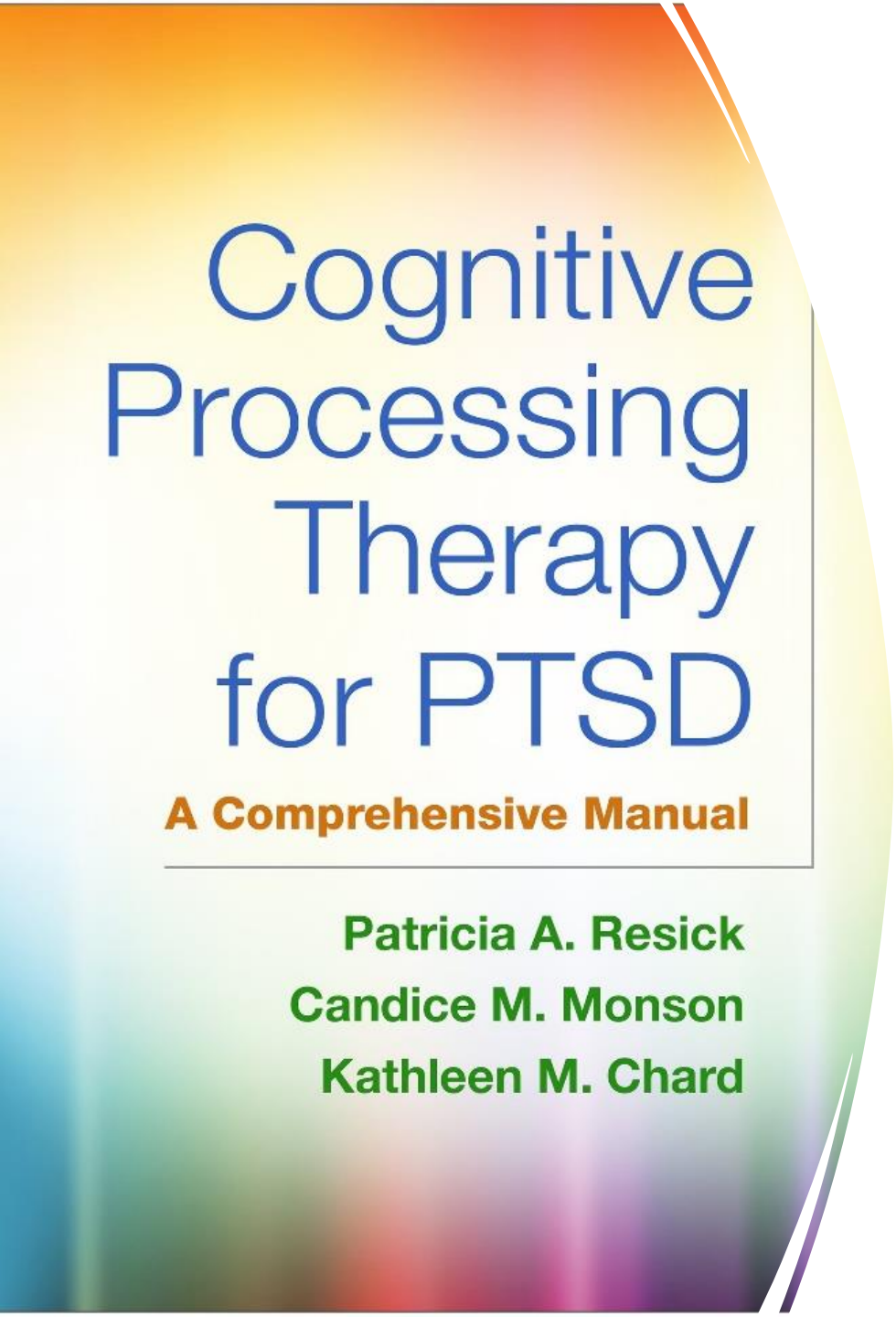
WHO IS A GOOD CANDIDATE FOR TF-CBT?

- **TF-CBT is most effective when:**
  1. Youth should not have contact with perpetrator!
  2. Child is able to benefit from a CBT approach (i.e., consider age, cognitive ability, communication skills)
  3. Child has significant PTSS
  4. Family can commit to attending sessions consistently
  5. Youth has a supportive caregiver who can regularly participate in treatment
  6. Behavioral problems are secondary to trauma
  7. Life is relatively stable
  8. Trauma has ended*
  9. Minimal legal involvement

Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: impact of the trauma narrative and treatment length. *Depression and anxiety*, *28*(1), 67-75.

CBT FOR BODY SAFETY

- **TF-CBT – Trauma Narrative = Body Safety**
- **Treatment Goals:**
  - Provide skills to youth and family to help manage day-to-day stressors
  - Improve family communication to promote future disclosures if needed
  - Learn and practice strategies to keep body safe
- **Treatment Length:** 6 to 8 sessions (60 minutes)
- **Who is a good candidate for Body Safety?**
  1. Child may have regular contact with alleged perpetrator
  2. Slight elevations of PTSS or parent-only reported PTSS
  3. Allegation was unfounded and emotional distress is present
  4. Child experiences chronic stressors



COGNITIVE PROCESSING THERAPY (CPT)

- **Unique Features:**
  - Heavily grounded in cognitive theory
  - Has been used in crisis situations (Nixon, 2012)
  - Includes ongoing assessment
  - SI is conceptualized as "passive avoidance behavior"
  - 7 pages of homework each session
  - Treatment starts with *Impact Statement*
- **Treatment Length:** ~12 sessions
- **Who is a good candidate for CPT?**
  - Willing to do homework
  - Highly motivated youth
  - >14 years old
  - Beautiful relationship with caregiver or unsupportive/unavailable caregiver

PCIT WITH TRAUMA LENS

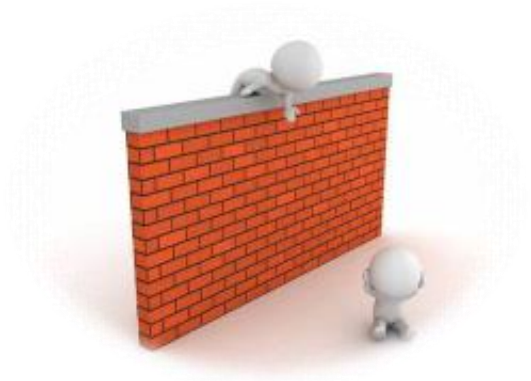
- PCIT is an **evidence-based treatment** designed to treat children 2 to 6 years, 11 months
  - Identified as trauma EBT by the National Child Traumatic Stress Network.
- Highly specified, step-by-step, live-coached sessions with both the caregiver and child
- **Treatment Goals:**
  - Improve quality of the parent-child relationship
  - Decrease child behavioral problems, while increasing prosocial behaviors
  - Increase parenting skills including use of positive discipline
  - Decrease parenting stress*
- **Who is a Good Candidate for PCIT with Trauma Lens:**
  - Child is within appropriate age range
  - Consistent caregiver participation
  - Primary concerns are behavioral
  - Family would benefit from stronger relationships

CULTURAL CONSIDERATIONS

- Key to gather culturally relevant information about families to inform engagement strategies
- *Sexual abuse/behavior/education* and *parenting strategies* are two of the most sensitive issues that can be addressed with families
- **Common cultural factors to consider:**
  - Conservatism about the topics
  - Openness regarding sexual matters and sexual preference
  - Beliefs about parenting (i.e., use of corporal punishment)
  - Family beliefs and practices regarding coming of age and sex education
  - Religion
  - Developmental level of youth and caregivers
  - **Be mindful of what you are bringing into the room**

BARRIERS TO EVIDENCE-BASED TX

- Attrition rates (27-77%) (Cohen et al., 2004; Cohen et al., 2004b; Scheeringa et al., 2011)
  - Caregivers' perception of symptoms (Tebbett, 2018)
    - Assessment and caregiver involvement is key!
  - Stigma
  - Caregivers' posttraumatic stress symptoms are triggered
  - An overwhelming amount of related appointments



- Access to providers/waitlists; provider burnout
- Distance, lack of reliable transportation, or inconvenient appointments
  - Telehealth
- Belief that immediate treatment is needed
- Unsure what evidence-based treatment is
  - Other treatments commonly recommended (e.g., play therapy, equine therapy, and art therapy; conditionally approved treatments)

THE JOURNEY CONTINUES…

State-wide Trauma Initiatives

- Child Protection Accountability Commission
- Project Thrive
- Trauma Matters Delaware
- …and more!

- *Networking and collaboration matters!*

Concluding Thoughts

- Keep learning
- Assessment is important
- RCTs are always occurring
- Take care of yourself and your colleagues

Your feedback is important!
If there is another trauma-related topic of interest, please type it in the chat!

Thank you for your time and attention!

If interested in further discussion, please contact:

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