

The Impact of Trauma on Child Development: Considerations for Infant/Early Childhood Mental Health

Katie Lingras, PhD, LP
University of Minnesota

Becca Starr, PhD
Early Childhood Development Consultant

Objectives

1. Define and distinguish types of stressful and/or traumatic experiences.
2. Understand basic early brain development concepts and how trauma impacts these processes.
3. Identify the role of protective factors in fostering resilience among young children who experience trauma.
4. Assessment/Treatment options for trauma

• Content Warning: Note, we will be talking about trauma and its impact on development, but we will also be asking you to reflect on your own experiences/reactions. Please take breaks/take care of yourself as needed!

Who are we and where are we from?
(Poll Everywhere: Map of MN, word cloud of professions)



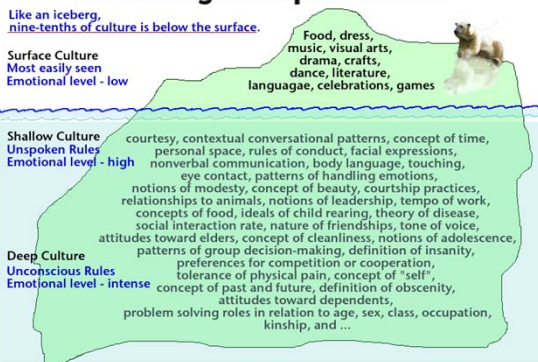
Context of Development




Cultural Context

- Greater variation within cultures than across
- How an individual parent/family influences and understands child development is a factor of combined identities
 - Any given individual has multiple identities
 - Male/female AND straight/LGBTQ AND white/non-white, etc.
- How do our own views/experiences affect how we as providers understand/influence families?
 - Expectations about child development, interactions within families, etc. are largely influenced by our own experiences and what we are exposed to!

The Iceberg Concept of Culture



Poll Everywhere:
Where is your car's blindspot?



Keeping our views in mind

- We aren't the car manufacturer, but we still have to check when operating a car
 - Our main job is not necessarily to solve every one, but to know to look for them!

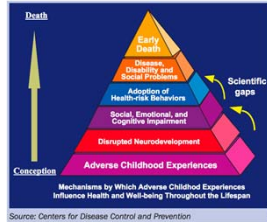


Blind spot mirror

Adverse Childhood Experiences
(ACEs)

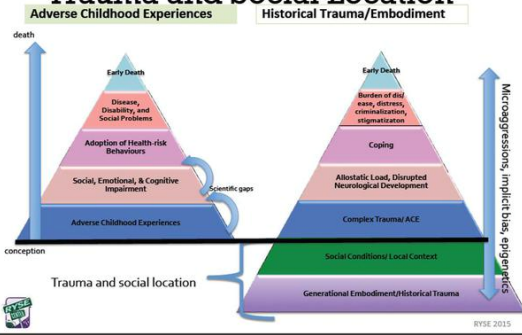
Adverse Childhood Experiences (ACEs)

- Abuse
 - Physical, emotional, sexual
- Neglect
 - Physical, emotional
- Household dysfunction
 - Mental illness
 - Incarcerated relative
 - Mother treated violently
 - Substance abuse
 - Divorce



Adverse Childhood Experiences (ACEs)

Trauma and Social Location



The ACEs measure (Before you were 18...)

1. Did a parent/other adult in the household often swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
2. Did a parent or other adult in the household often push, grab, slap, or throw something at you? Or Ever hit you so hard that you had marks or were injured?
3. Did an adult or person at least 5 years older than you ever touch/fondle you or have you touch their body in a sexual way, try/actually have oral, anal, or vaginal sex with you?
4. Did you often feel that no one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
5. Did you often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
6. Were your parents ever separated or divorced?
7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
9. Was a household member depressed or mentally ill or attempt suicide?
10. Did a household member go to prison?

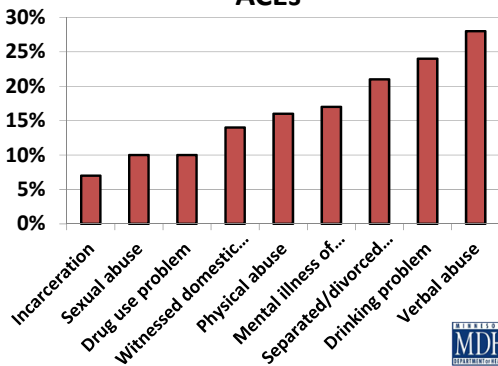
Reflecting on Our Own ACEs

- Poll Everywhere

What do we know about ACEs?

- ACEs are common
 - Landmark study with 17,000 participants found 28% of sample reported physical abuse, 21% reported sexual abuse
 - In Minnesota: 55% have one or more ACEs
- ACEs cluster
 - 40% of original sample experienced 2+
 - 12.5% experienced 4+
 - In Minnesota: of those with any ACEs, 87% have more than 1
- ACEs are cumulative
 - Dose-response relationship
 - Strong, graded relationship to health and behavior problems

Prevalence of Individual ACEs



Links to Later Outcomes

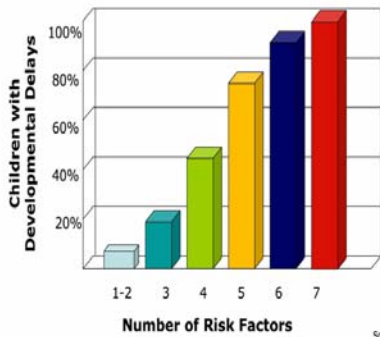
- ACEs increase risks for poor physical, mental health
 - Increased risk of lifetime suicide attempts (2-5x's)
 - Lifetime depressive episodes
 - Sleep disturbances
 - Fetal mortality
- Links to negative social consequences
 - Early initiation of alcohol use
 - Higher risk of alcohol use as adult
 - Increased prescription drug use
 - Life time illicit drug use, dependency, self-reported addiction (2-4x's more likely)
 - High-risk sexual behaviors

Cumulative Stress in Young Children

- 2-5 year olds from Durham pediatric public health clinic sample (n=307)
- Prevalence of High magnitude events:
 - Death of loved adult 20.9%
 - Grandparent (11%), Aunt/Uncle (3.7%),
 - Other (6.2%), Parent (.2%)
 - Child hospitalized 16.4%
 - Motor vehicle accident 9.9%
 - Serious fall 9.5%
 - Burned 7.9%
- 52.5% young children experienced at least 1 major stressor (no gender, race diff.)
 - 42% of 2-year-olds had experienced one major stressor



Significant Adversity Impairs Development in the First Three Years

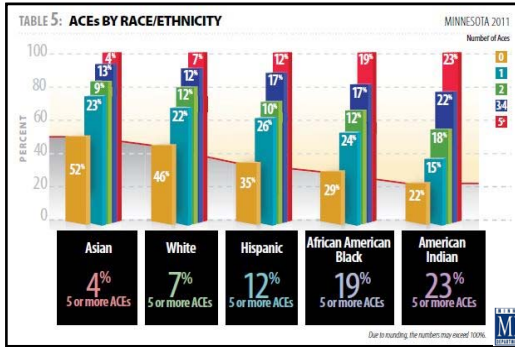


Child adversity and minority/non-white status

- Minority children more likely to be poor
 - Traumatic events cluster in poverty
- Cumulative impact of traumatic events
- Minority children may be more vulnerable to traumatic event due to...
 - Cumulative adversities
 - Less access to services
 - Compromised/ 'at-risk' protective figure

(Oser & Cohen, 2003; Flores et al., 2002; U.S. Surgeon General's Report, 2001 – cited in Lieberman, 2015)

ACEs by Race/Ethnicity



What doesn't ACEs score tell us?

- Guidance, not causal
- Doesn't tally positive/protective factors
- Details around the context of the experience
- Duration of experience
- Timing of experience
 - "first 18 years"
 - Other events occurring at the time

The Resiliency Puzzle

| | |
|---|--|
| Protective factors (Family/Community) | Protective factors (Child) |
| <ul style="list-style-type: none">• Availability of primary caretaker• Ties to extended family and/or supportive adults• High expectations of child• Consistent family rules• Well balanced discipline• Family routine , rituals and stability• Pre-traumatic level of stress and coping• Social support• Cultural identity• Safe, positive, nurturing school experience | <ul style="list-style-type: none">• Age of the Child• Flexible temperament• Secure attachment• Robustness• Regulatory capacity• Strong cognitive, problem solving and verbal skills (symbolic)• Positive self- esteem• Mastery motivation |

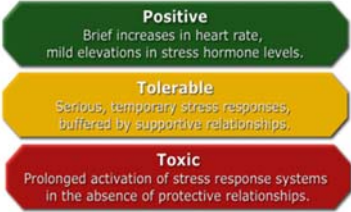
Consideration of Our Perspectives/Views/Experiences

- How does it feel to think about our own experiences (or lack of experiences) with adversity?
- How does it feel to consider our own protective factors?
 - Does anything surprise you? Anything on the list that you wouldn't have thought of as a protective factor?
- How do these reflections shape our views/ approaches as providers for children who have experienced trauma?

Childhood Trauma

Types of Stress

- Taking a test, first day with new caregiver
- Loss of loved one, natural disaster, frightening injury
- Recurrent abuse, chronic neglect, caregiver mental illness or substance abuse, and/or violence or repeated conflict.



What does trauma look like?

- Poll Everywhere

What can trauma look like?

| Children aged 0-2 exposed to trauma may | Children aged 3-6 exposed to trauma may |
|---|---|
| <ul style="list-style-type: none"> •Demonstrate poor verbal skills •Exhibit memory problems •Scream or cry excessively •Have poor appetite, low weight, or digestive problems | <ul style="list-style-type: none"> •Have difficulties focusing or learning in school •Develop learning disabilities •Show poor skill development •Act out in social situations •Imitate the abusive/traumatic event •Be verbally abusive •Be unable to trust others or make friends •Believe they are to blame for the traumatic event •Lack self-confidence •Experience stomach aches or headaches |

NCTSN, 2018

Defining Trauma

- A traumatic event is a frightening, dangerous, or violent event that poses a threat to a child’s life or bodily integrity.
- Witnessing a traumatic event that threatens life or physical security of a loved one can also be traumatic.
 - For young children , sense of safety depends on the perceived safety of their attachment figures.
- Causing an overwhelming sense of terror, helplessness, and horror;
 - Can produce intense physical effects such as a pounding heart, rapid breathing, trembling;
 - Can overwhelm child’s available coping strategies

Examples of traumatic events

- Physical, sexual, or psychological abuse and neglect (including trafficking)
- Natural and technological disasters or terrorism
- Family or community violence
- Sudden or violent loss of a loved one
- Prolonged or unexpected separation from a primary caregiver
- Substance use disorder (personal or familial)
- Refugee and war experiences (including torture)
- Serious accidents or life-threatening illness
- Medical trauma
- Military family-related stressors (e.g., deployment, parental loss/injury)
- Historical trauma

<https://www.nctsn.org/what-is-child-trauma/trauma-types>

Populations at greater risk

- Intergenerational and/or historical trauma
- Serious mental health concerns, substance use
- Economic stress
- Military and veteran families
- Children with intellectual or developmental disabilities
- Homeless youth
- LGBTQ youth
- Youth in foster care

<https://www.nctsn.org/what-is-child-trauma/populations-at-risk>

Child Traumatic Stress

- Symptoms often show up when reminded of event
- Reactions can include:
 - Intense and ongoing emotional upset
 - Depressive symptoms or anxiety
 - Behavioral changes,
 - Difficulties with self-regulation
 - Problems relating to others or forming attachments
 - Regression or loss of previously acquired skills
 - Attention and academic difficulties
 - Nightmares,
 - Difficulty sleeping and eating
 - Physical symptoms, such as aches and pains.

<https://www.nctsn.org/what-is-child-trauma/about-child-trauma>

Post-traumatic Stress Disorder

- PTSD Exposure to one or more traumas over the course of their lives **AND** reactions that persist and affect child’s daily life after event ends
- Reactions interfere with the child’s daily life and ability to function and interact with other
- The way that traumatic stress manifests will vary from child to child
 - Also based on the child’s age/developmental level

Risk (and protective) factors for PTSD

- Severity of the event
 - Severity of injury, separation from caregivers, etc.
- Proximity to the event
 - Witness vs. victim, directly witness vs. saw on TV
- Caregivers’ reaction/response/belief
- Prior history of trauma
- Family and community factors
 - Cultural ties/identities as protective
 - Experiences of racism/discrimination as risk factor

Impact of Trauma

Areas of Impact

- Multiple areas of impact
 - Brain development and cognitive skills
 - Interpersonal relationships
 - Emotion/behavior regulation
 - Educational outcomes
 - Caregivers/Parenting

A Caveat!

- Not all children who experience adversity go on to develop difficulties related to learning, memory and attention!
- Impact of adversity on brain development may depend on whether/when/how children experienced *deprivation* or *threat* during early years, which *can* result in either delayed cognitive development or dis-integration of cognitive skills, respectively (McLaughlin et al., 2014).

Impact on biology

- Stress/trauma affects functioning at any age, but in children it can affect the way the brain develops.
 - Brain structures and function (chemical activity)
 - The body stays activated to accommodate to *perceived* danger and fear.
- Trauma memories different than other kinds of memory: emotional/sensory states-not verbal.
 - Very young babies *remember* too
- Trauma triggers impact behavior.
 - Understanding the impact of trauma can help us interpret behavior & interactions and inform response.

Basic Concepts in Brain Development

- Rapid development of brain architecture
 - More than a million neural connections formed per second in early years (based on experiences)
 - Connections that are used a lot grow stronger and stronger
 - Those that are not used disappear (neural pruning)
- <https://youtu.be/VNNsN9Ikw>

Brain development and toxic stress


<http://developingchild.harvard.edu/resources/toxic-stress-derails-healthy-development/>



Setting the Alarm System

Acute episode of threat

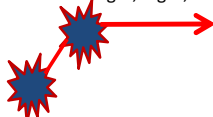
1) Brain releases hormones that help body respond to threat—fight, flight, freeze




2) If threat is removed everything returns to normal

Chronic or repeated threat

1) Brain releases hormones that help body respond to threat—fight, flight, freeze



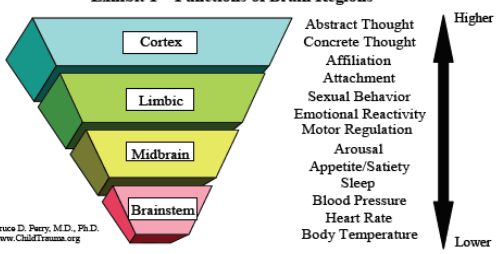
2) If the threat continues or is repeated, the alarm system stays on alert which interferes with brain development.

NCTSN 

Impact on cortisol (stress hormones)

- Cortisol shows natural variation during the day
- Variations help with regulation of bodily functions
- Maltreatment associated with cortisol levels that are either too low or too high (Body can react differently to stressors)
 - Lower cortisol can be associated with learning and socialization, externalizing disorders, vulnerability to autoimmune disorders
 - Higher cortisol levels can harm cognitive processes, decrease immune and inflammatory reactions, increase risk for mood/anxiety disorders

Exhibit 1 – Functions of Brain Regions



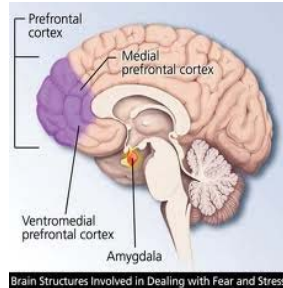
| | | |
|-----------|---|---------------------------|
| Cortex | Abstract Thought Concrete Thought Affiliation Attachment | Higher ↑ ↓ Lower |
| Limbic | Sexual Behavior Emotional Reactivity Motor Regulation | |
| Midbrain | Arousal Appetite/Satiety Sleep | |
| Brainstem | Blood Pressure Heart Rate Body Temperature | |

Bruce D. Perry, M.D., Ph.D.
www.ChildTrauma.org

Stress de-activates the problem-solving part of the brain and activates the part of the brain which activates automatic behavior.

And this can look like:

- **Fight**—dysregulated, aggressive efforts to manage
- **Flight**—withdrawal
- **Freeze**—dissociate
- **Tend or befriend**—cling, caretake



Impact on brain structure

- Some studies show reduced functioning of **prefrontal cortex**
 - Area related to behavior, cognition, and emotion regulation, social regulation
- **Amygdala** – no size change, but can be overactive
 - Identifies threats, triggers emotional responses
- **Brain connectivity**
 - Involved for integrating complex information

Impact on brain structure

- Reduced **hippocampus** volume
 - Related to learning and memory
 - Involved in returning cortisol (stress hormone) back to normal levels after stressful event
- Decreased **corpus callosum** volume
 - Responsible for communication across the brain
 - Involved in emotion, arousal, higher cognitive abilities
- Reduced **cerebellum** volume
 - Motor behavior and executive functioning

Impact on Cognitive Processes

- **Executive functioning** (working memory, inhibitory control, mental flexibility) can be reduced
 - These functions are based in the prefrontal cortex
 - For example, children may have trouble:
 - Paying attention, staying on task
 - Organizing, planning, and problem solving
 - Remembering and using information during an activity
 - for example: remembering teachers' instructions while completing an assignment

Impact on Memory

- There is evidence that traumatic events are remembered differently than non-traumatic events (effects on hippocampus and amygdala)
- Example: Tornado study (Ackil et al., 2003)
 - Children's narrative recollections of a devastating tornado were longer, more coherent, and more complete than those for non-traumatic events.



Impact on Memory - Recall: Cortisol

- Cortisol levels may also be related to memory foundation and arousal
 - Instead of helping the person's sympathetic nervous system (stress response) calm down, may strengthen the consolidation of memories
 - Could partially explain formation of traumatic memories, 'flashbacks' or triggers.



Impact on Early Behavioral Functioning

- Infants respond with sensorimotor disorganization and disruption of biological rhythms (e.g. sleep, eating)
- Toddlers and preschoolers engage in fight or flight mechanisms in response to the perception of danger:
 - Recklessness and accident proneness
 - Little focused exploration and/or hyperactivity
 - Precocious competence in self care—seem “grown”

(Lieberman and Van Horn)

Impact on Early Relationships

- Attachment/caregiving
 - Impact on serve-and-return interactions, and therefore brain development
 - More likely to have insecure attachment
- *PTSD is the only disorder that speaks to the social contract breakdown (big people take care of little people)*

Impact on behavioral, social, emotional functioning

- **Hyperarousal** – stress response triggered without conscious thought due to more sensitive ‘fear pathways’
 - Persistent **fear response/safety vs. threat** (even when no threatening stimuli)
 - May have increased **sensitivity to/misinterpretation of nonverbal cues** (e.g. eye contact, touch on arm, etc.)
 - Less likely to **recognize** own emotional state
- **Complicated social interactions**
 - Sensitivity to loss/fear of abandonment
 - Related to biases in social information processing

Bias in the processing of social/emotional information

- In children that have experienced abuse/traumatic environments:
 - Over-responsiveness to emotional stimuli (e.g., angry faces)
 - Able to identify angry faces more quickly than non-traumatized children ("primed" to detect threat)
 - Difficulty in recognizing other’s emotions
 - More likely to perceive a neutral face as angry
 - More likely to see anger where others see fear
- Related to *amygdala* functioning and potentially areas of the *prefrontal cortex* responsible for processing social information

(McCrary et al., 2011; McLaughlin et al., 2014; Pollak, Klorman, Thatcher, & Cicchetti, 2001; McLaughlin, et al., 2014; Pollak & Sinha, 2002; De Brito et al., 2013; Kelly et al., 2013; McLaughlin et al., 2014)

Impact on behavioral, social, emotional functioning

- Weakened **response to positive** feedback and reward cues
 - Basal ganglia: areas related to reward processing
- Links to lower **social competence**, empathy
 - Via amygdala and biases in social information processing
- Increased **anxiety, depression symptoms**
 - May be due t impact on brain connectivity and/or brain’s ability to use neurotransmitters
- Delayed developmental **milestones** (e.g. language)

Impact on Educational Outcomes

- Trauma can impact abilities to:
 - Self-regulate, manage/regulate emotions, focus/pay attention, persist, build trusting relationships with adults & peers
 - All of these areas are critical to learning in an educational environment!
- Trauma can also impact learning, academic performance, attendance, communication
 - Example: maltreatment associated with increased rates of special education, grade retention, lower grades
- Trauma is often overlooked and/or misdiagnosed as ADHD, Autism, depression, anxiety
 - Can impact learning similarly to trauma, but behaviors won't resolve unless trauma is correctly identified/addressed

Impact on Educational Outcomes – Trauma-Informed Care

- “Trauma-informed” approaches have been implemented in many fields including the medical profession and our judicial system.
- Not “What’s wrong with you?” but “What happened to you?” when children act out/disengage
- Trauma-informed care/systems can break the cycle of trauma, prevent re-traumatization, and engage a child in learning and finding success in school
- Schools/home visiting systems can provide important stability, safe space, connections to caring adults



7 Elements of Trauma-Informed Systems

1. Screen routinely for trauma exposure and symptoms.
2. Implement culturally appropriate, evidence-based assessments and treatments for traumatic stress and symptoms.
3. Provide resources to children, families, and providers on trauma, its impact, and treatment options.
4. Build on the strengths of children and families impacted by trauma.
5. Address parent and caregiver trauma.
6. Collaborate across child-serving systems to coordinate care.
7. Support staff by minimizing and treating secondary traumatic stress, which can lead to burnout.

(NCTSN)

Impact on Parenting

- When caregivers have their own history, it can impact their ability to...
- **Recognize what is safe** and what is unsafe, and keep himself/herself and the children from harm
 - Parents fighting for survival may experience their own child as a threat to their well-being
- **Stay in control of his/her emotions**, especially in stressful situations with the children;
- **Deal with stress** in healthy ways;
- **Trust other people**—more likely to respond consistent with past negative experiences

Considerations in Assessing and Diagnosing Trauma

Multiple lenses for understanding the child [and parent]/inform response

- **The developmental lens**
 - How old is this child? How old does she seem?
- **The attachment lens**
 - What does this child expect from relationships?
- **The stress/trauma lens**
 - What happened to this child? vs. What's wrong with this child?
- **The social and cultural lens.**
 - What is this child/family's social and cultural context
 - How might this impact observable behavior/emotional functioning?

Multiple lenses applied to trauma

- **The developmental lens.**
 - Trauma can make development go 'off track'.
 - The developmental stage of a child impacts how trauma impacts the child.
- **The attachment lens.**
 - Secure attachment relationships can buffer the effects of trauma.
 - Trauma can obstruct the relationship between a child and caregiver.
- **The stress/trauma lens.**
 - Behavior can be understood using a trauma lens.
 - Trauma impact neurobiology.
- **The social and cultural lens.**
 - Historical trauma has impact across generations.
 - Cultural strengths can support healing from trauma.

Key Components of a Trauma Lens

- Trauma impacts development.
- Trauma impacts the regulation of arousal, emotions, activity level and attention.
- Behavior can be understood using a trauma lens.
- Trauma and toxic stress impact bodily sensations.
- Trauma triggers: Memory of trauma is encoded differently.
- Rebuilding the Protective Shield: Healing from trauma needs to occur within the context of relationships.

Using A Trauma Lens

**Behavioral Lens:
External dimensions**

- Looks exclusively at the observable behavior.
- Considers external factors in the environment as the primary influence on behavior.
- Shapes behavior through reinforcement: antecedent-behavior-consequence

**Trauma Lens:
Internal dimensions**

- Specifically considers the effects of trauma on behavior and development
- Considers internal factors that influence behavior: bodily sensations, trauma triggers, hyper-arousal
- Addresses trauma effects through rebuilding the protective shield, integrating the trauma story and regulating the system

Sally is having a huge, aggressive tantrum and mom is ineffective

Behavioral explanation:

Sally has learned that when she has a huge tantrum she gets her way.

Intervention:

Teach mom to ignore and give no response to Sally's tantrums and to be more consistent in her discipline.

Trauma explanation:

Sally is highly dysregulated because of her trauma history and has just experienced a trauma trigger. She needs help.

Intervention:

Keep everyone safe while staying in relationship and helping Sally regulate. Teach mom to understand trauma triggers.

Principles for Understanding Trauma

- 1. If everything is trauma, nothing is trauma
- 2. It is the child's experience of the event, not just the event itself, that is traumatizing.
- 3. If we don't look for/acknowledge trauma, we end up chasing behaviors and limiting possibilities for change.
- 4. Behavioral and emotional adaptations that maltreated children make in order to survive are brilliant, creative solutions AND are personally costly.
- 5. Since trauma = chaos, structure = healing
- 6. If you don't ask, they won't tell.
- 7. What is not integrated is repeated. NCTSN, 2018

Talking to Parents About Trauma

- *You've both been through a lot.*
- *This hasn't been easy, has it?*
- *I'm guessing there have been hard things in your life that you've had to overcome to get to this point.*
- *Parents want to keep their child safe. I know that is important to you.*
- *Sometimes when kids have gone through really hard things they can behave like they are hyperactive.*
- *Sometimes it's hard to know what to do, when you want to do things differently than the way you grew up. We can try to figure it out together.*

Ways to talk about Trauma

***A Clingy Thing* story**

<https://www.youtube.com/watch?v=rnWkVpBWBrk>



***Inside Him* story**

<https://www.youtube.com/watch?v=g23V7lxoSn0>



Assessing for Trauma

- Targeted questions about domestic violence in families, accidents, loss of family members, and/or significant medical history
- Focus on the presenting problem in the context of the child's overall development.
- Gather information about:
 - Reactions of the child and parents/caregivers
 - Changes in the child's behavior
 - Resources in the environment to stabilize the child and family
 - Quality of the child's primary attachment relationships
 - Ability of parents/caregivers to facilitate the child's healthy socioemotional, psychological, and cognitive development
- If you're not sure, refer!

Instruments for Assessing Traumatic Stress in Young Children *(parent-report, interpreted by a mental health professional)*

- Child Behavior Checklist (CBCL): Achenbach, and Rescorla (2001). Ages 1½–5
- Posttraumatic Stress Disorder Semi-Structured Interview and Observation Record: Scheeringa and Zeanah (1994). Ages 0–4
- Posttraumatic Symptom Inventory for Children (PT-SIC): Eisen (1997). Ages 4–8
- Preschool Age Psychiatric Assessment (PAPA): Egger and Angold (1999). Ages 2–5
- PTSD Symptoms in Preschool Aged Children (PTSD-PAC): Levendosky, Huth-Bocks, Semel, and Shapiro (2002). Ages 3–5
- Traumatic Events Screening Inventory-Parent Report Revised (TESI-PRR): Ghosh et al. (2002). Ages 0–6
- Trauma Symptom Checklist for Young Children (TSCYC): Briere et al. (2001). Ages 3–12
- Violence Exposure Scale for Children-Preschool Version (VEX-PV): Shahinfar, Fox, and Leavitt (2000). Ages 4–10
- Violence Exposure Scale for Children-Revised Parent Report (VEX-RPR): Shahinfar, Fox, and Leavitt (2000). For parents of preschool-aged children aged 4–10
- <https://www.nctsn.org/what-is-child-trauma/trauma-types/early-childhood-trauma/screening-and-assessment>

Diagnosing Trauma

- Considerations:
 - Diagnosis by a trained mental health professional
 - PTSD does not take into account chronic, multiple, or on-going trauma
 - Not developmentally sensitive
 - Many traumatized children do not meet criteria
 - PTSD can look like ASD, ADHD, Anxiety, ODD
 - Can impact attention/activity/focus OR can impact ability to connect via attachment pathways
- DSM-5 vs. DC 0-5 Classification of Trauma
 - DC 0-5 considers developmental presentation (i.e. intrusion, avoidance, behavioral arousal)
 - https://www.ptsd.va.gov/professional/ptsd-overview/ptsd_children_6_and_younger.asp
 - Previous consideration of Developmental Trauma Disorder

Poll Everywhere: Cultural Considerations in Assessing/Diagnosing Trauma

Supporting children who experience trauma (this could be its own webinar!)

- Six principles for supporting children in care who have been traumatized
- 1) Provide safe environments and rich experiences that stimulate and enrich brain growth.
- 2) Support children and caregivers to understand the link between traumatic events and cognitive difficulties.
- 3) Develop and support positive relationships and connections in children's lives.
- 4) Maintain targeted interventions throughout childhood and adolescence.
- 5) Offer all children in care targeted and trauma-specific interventions.
- 6) Ensure that specific cognitive difficulties are addressed directly.

<https://aifs.gov.au/cfca/publications/effect-trauma-brain-development-children>

Treating Trauma

- Gold-standard, evidence-based treatments that focus on addressing trauma symptoms and making meaning of the experience (in order to integrate/move forward)
- Attachment and Biobehavioral Catch-Up (ABC) for infants and young children
 - In-home parent-child treatment
 - 10 sessions of coaching interactions, uses video feedback
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT)
 - Work with individual child, caregiver sessions along side
 - 12-25 sessions
 - Ages 3-18
- Child-Parent Psychotherapy
 - Dyadic parent-child therapy for children and their caregivers who have experienced trauma
 - 6-24 months (depends on child/caregiver)
 - Ages 0-6

What children need from adults when bad things happen

<https://www.youtube.com/watch?v=YRcevvjpLE8>



Secondary Traumatic Stress

A word for those working with children/families who experience(d) trauma...

(More words – 2 hours – are available on December 2017 webinar!)

Secondary Traumatic Stress

- Secondary Traumatic Stress: Emotional duress that results when an individual hears about the firsthand trauma experiences of another.
- Symptoms resemble post-traumatic stress disorder (PTSD)
 - Re-experiencing personal trauma, notice an increase in arousal, avoidance reactions related to the indirect trauma exposure.
- Broad (possible) symptoms:
 - Changes in memory and perception
 - Alterations in their sense of self-efficacy
 - Depletion of personal resources
 - Disruption in their perceptions of safety, trust, and independence

Self-care strategies for addressing STS

Child Trauma Academy (2002) http://www.childtraumacademy.com/cost_of_caring/

| Physical | Psychological | Emotional | Workplace |
|------------|--------------------|-----------------|-------------------|
| Sleep well | Self-reflect | See friends | Take breaks |
| Eat well | Read for pleasure | Cry | Set limits |
| Exercise | Say "No"! | Laugh/Humor | Get peer support |
| Walk/Jog | Smile | Praise yourself | Get supervision |
| Dance | Solitude | Meditate | Use vacation time |
| Others? | Gratitude | Mindfulness | Others? |
| | Leave work at work | Journal/blog | |
| | | Others? | |

Additional strategies for building individual resilience and addressing STS

- Use supervision to address STS
- Increase self-awareness of STS
- Maintain a healthy life-work balance
- Develop and implement plans to increase personal wellness and resilience
- Continue individual training on risk reduction and self-care
- Use employee assistance programs or counseling services as needed
- Participate in a self-care accountability 'buddy system'
- December 2017 webinar is focused on secondary trauma and self-care!

NCTSN.org

Summary

- Definition of ACEs, trauma, and stress
- Types of stress and trauma
- Impacts of trauma
 - Brain and cognitive development
 - Social, emotional, behavioral functioning
 - Parenting
- Assessment, diagnosis, and treatment of traumatic experiences/PTSD
- Self-care considerations for providers/caregivers

Additional Resources

- ACEs Too High: <http://acestoohigh.org/>
- Dr. Nadine Burke-Harris and talks on ACEs/trauma:
 - Center for Youth Wellness: <https://centerforyouthwellness.org/>
 - NPR/Forum: <http://www.westminsterforum.org/forum/the-health-effects-of-childhood-adversity-and-trauma/>
 - TedTalk: <https://youtu.be/95ovl3dsNk>
 - <https://www.cbsnews.com/news/oprah-winfrey-treating-childhood-trauma/>
- NCTSN
 - <https://www.nctsn.org/resources/all-nctsn-resources>
 - Learning Center (at bottom of page), lots of webinars
- Overview of brain development/impacts of trauma, including glossary of terms
 - https://www.childwelfare.gov/pubPDFs/brain_development.pdf
 - How brains are built: <https://youtu.be/LmVWOe1ky8s>
- Harvard Center for the Developing Child
 - <http://developingchild.harvard.edu/resources/toxic-stress-derails-healthy-development/>
- Trauma Informed Systems
 - <https://www.elc-pa.org/wp-content/uploads/2015/06/Trauma-Informed-in-Schools-Classrooms-FINAL-December2014-2.pdf>
- Bessel Van der Kolk: (Book) The Body Keeps the Score



Katie Lingras, PhD, LP
 Child Psychologist, University of Minnesota
klingras@umn.edu

Becca Starr, PhD;
 Early Childhood Development Consultant
starr28@gmail.com
