Helping Foster and Adoptive Families Cope With Trauma

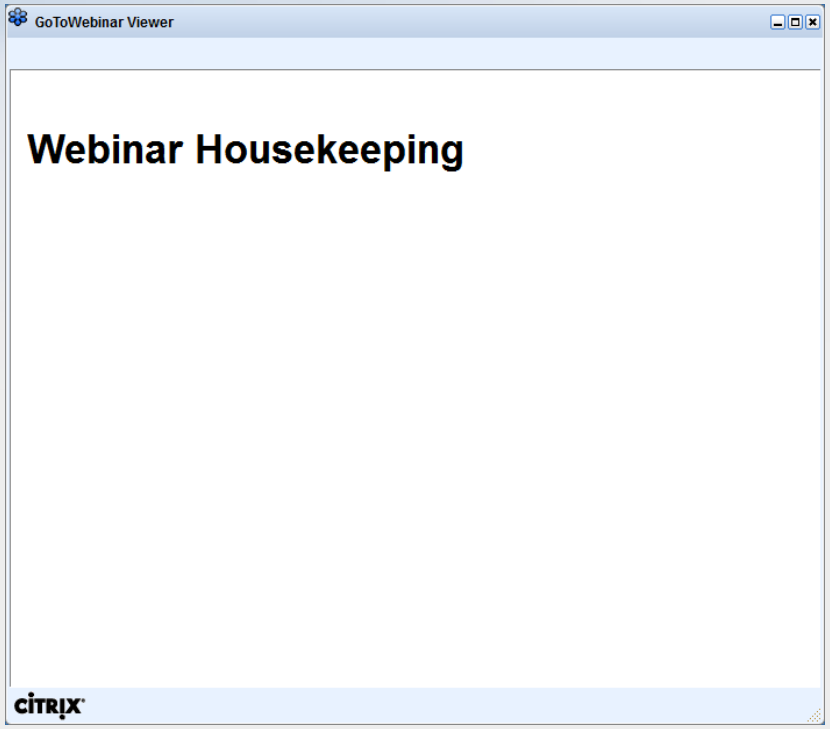
June 19, 2013

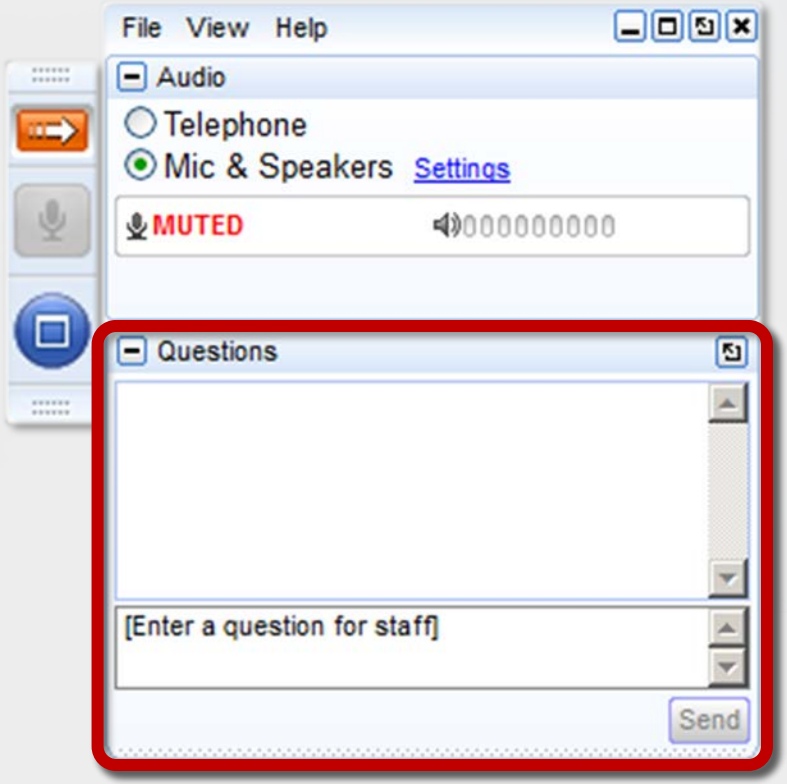
Dave Thomas Foundation For Adoption®

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

What You See





- To the left is the GoToWebinar Viewer through which you see the presentation.
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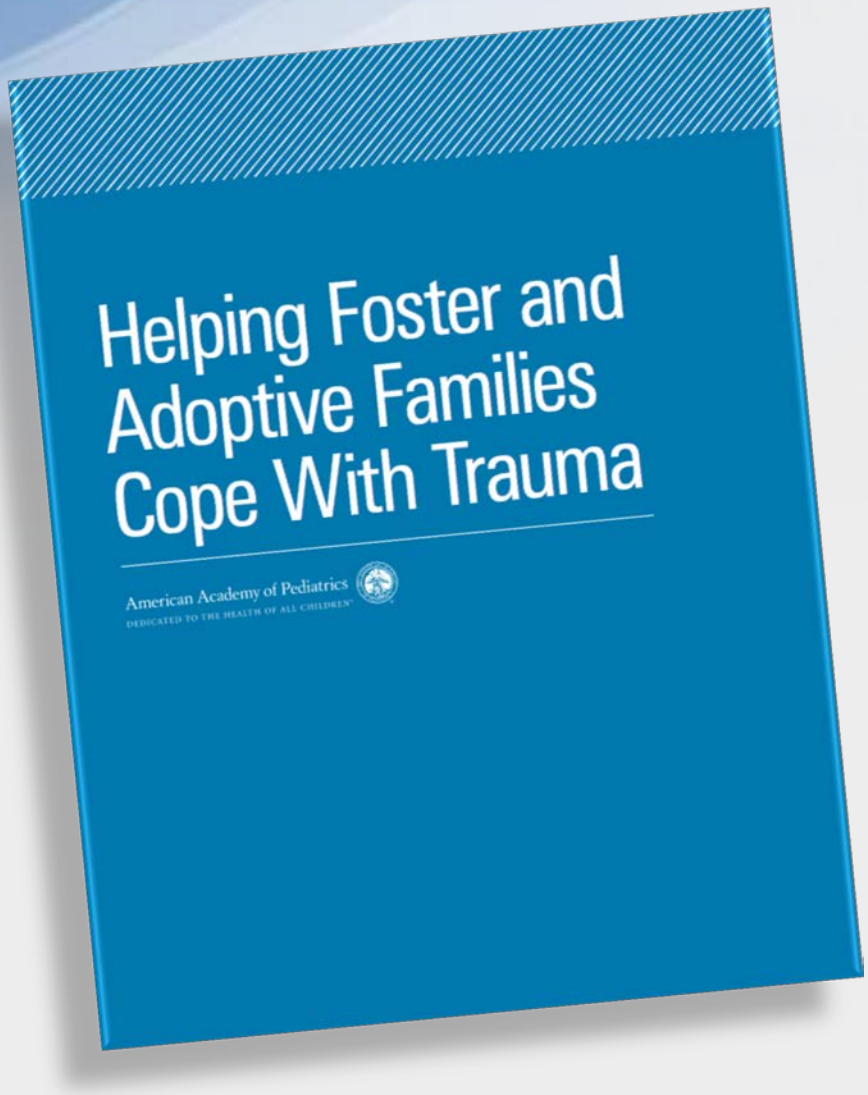
Questions

- To ask a question during the webinar, please type your question in the box on the right
- Questions will be answered at the end of the webinar, time permitting
- Today's webinar will be recorded and posted online at www.aap.org/fostercare
- Any other questions or comments, please email Jonathan Faletti jfaletti@aap.org



1. Childhood Adversity & Toxic Stress
   Andrew S. Garner, MD, PhD, FAAP
2. How to Identify Traumatized Children
   Heather C. Forkey, MD, FAAP
3. Anticipatory Guidance
   John Stirling, MD, FAAP

Thank You!

Dave Thomas Foundation for Adoption
Jockey Being Family

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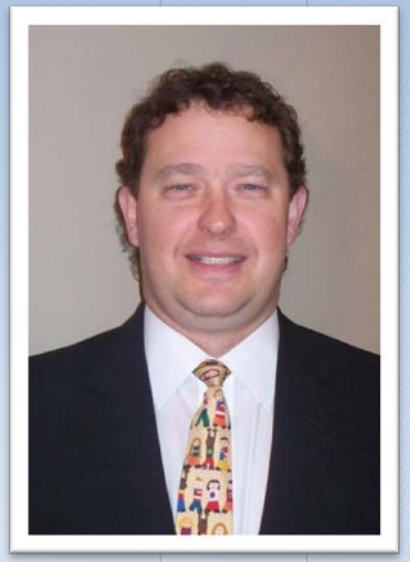


Childhood Adversity & Toxic Stress

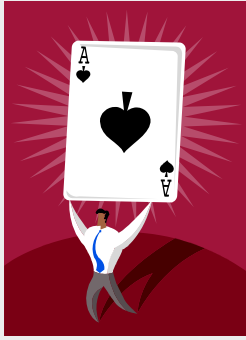
Andrew S. Garner, MD, PhD, FAAP

Children in Foster Care

- Significant early life trauma & adversity
  - Prenatal substance exposures
  - Inadequate parenting
    - Mental health conditions
    - Drug or alcohol addictions
    - Neglect
  - Being the victim of and/or witness to violence
    - Physical, sexual, emotional abuse
  - Multiple losses, separations, & major life changes
- Removal from home is traumatic
- What do we know about the impact?

ACE Study

- Adverse Childhood Experiences (ACE) Study
- 1995-1997
- > 17,000 middle-aged, middle class Americans in San Diego
- Retrospective assessment of childhood adversity
  (3 categories of abuse, 2 categories of neglect, 5 categories of household dysfunction)
- Associations with current physical, behavioral, and mental health status



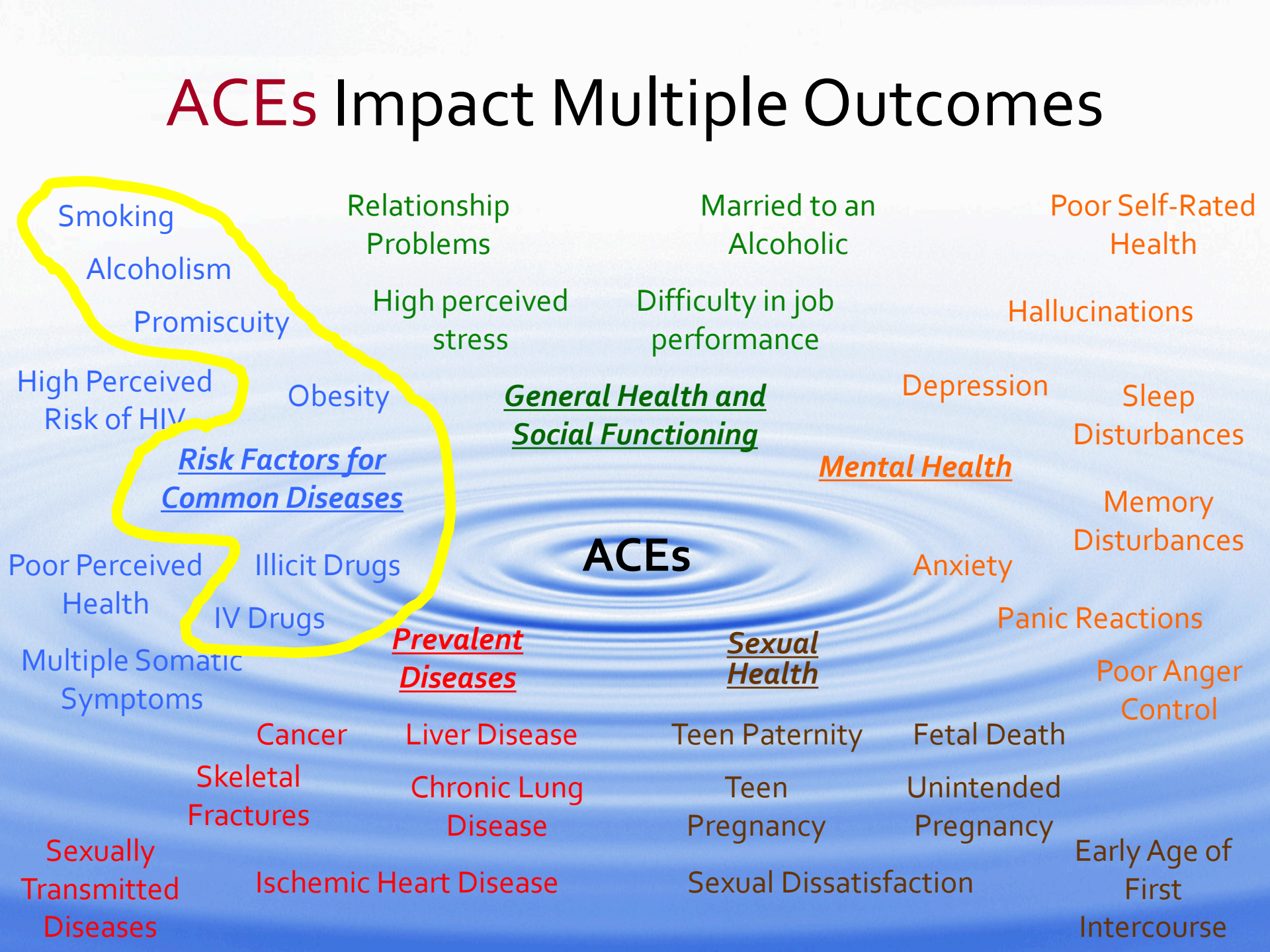
ACE Categories

	Women (n=9,367)	Men (n=7,970)	**Total** (17,337)	
• Abuse				
– Emotional	13.1%	7.6%	10.6%	
– Physical	27.0%	29.9%	28.3%	1:4!
– Sexual	24.7%	16.0%	20.7%	
• Household Dysfunction				
– Mother Treated Violently	13.7%	11.5%	12.7%	
– Household Substance Abuse	29.5%	23.8%	26.9%	1:4!
– Household Mental Illness	23.3%	14.8%	19.4%	
– Parental Separation or Divorce	24.5%	21.8%	23.3%	
– Incarcerated Household Member	5.2%	4.1%	4.7%	
• Neglect*				
– Emotional	16.7%	12.4%	14.8%	
– Physical	9.2%	10.7%	9.9%	

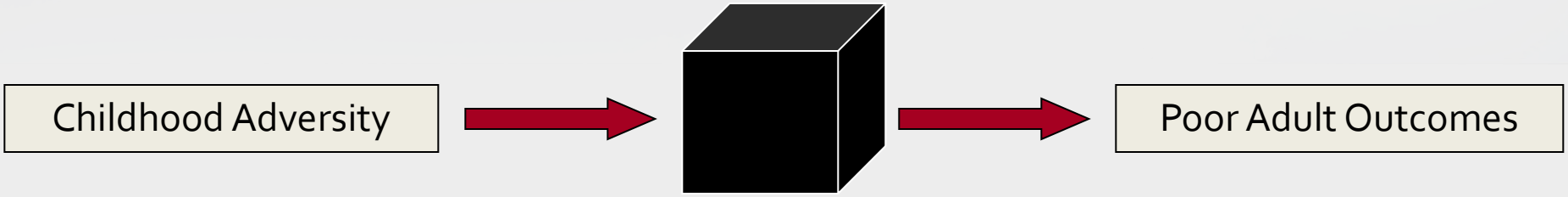
*** Wave 2 data only (n=8,667)**

Data from www.cdc.gov/nccdphp/ace/demographics

ACEs Impact Multiple Outcomes



Linking Childhood Experiences and Adult Outcomes



Defining Adversity or Stress

- How do you define/**measure** adversity?
- Huge **individual variability**
  - **Perception** of adversity or stress (subjective)
  - **Reaction** to adversity or stress (objective)
- National Scientific Council on the Developing Child (Dr. Jack Shonkoff and colleagues)
  - **Positive** Stress
  - **Tolerable** Stress
  - **Toxic** Stress

Based on the **REACTION**
(objective physiologic responses)

Defining Adversity or Stress

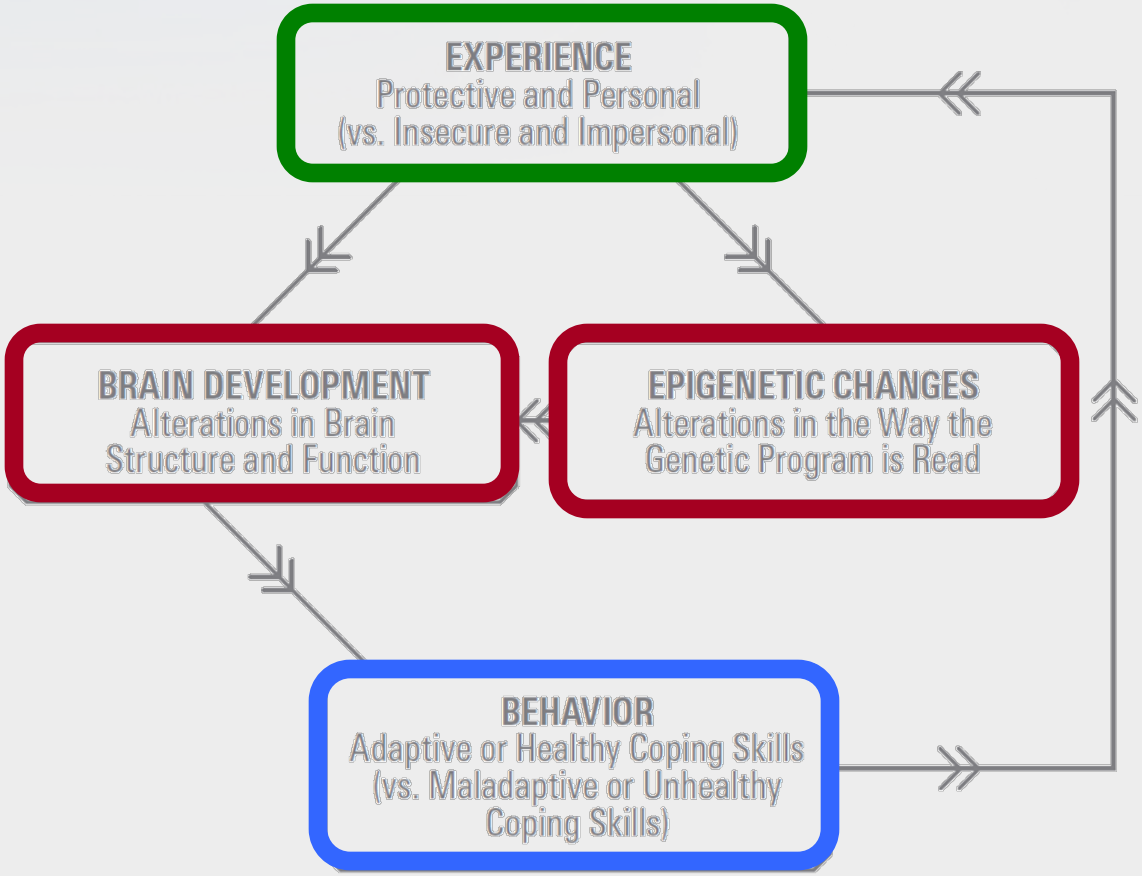
- **Positive** Stress
  - Brief, infrequent, mild to moderate intensity
  - Most normative childhood stress
    - Inability of the 15 month old to express their desires
    - The 2 year old who stumbles while running
    - Beginning school or daycare
    - The big project in middle school
  - **Social-emotional buffers** allow a return to ***baseline***

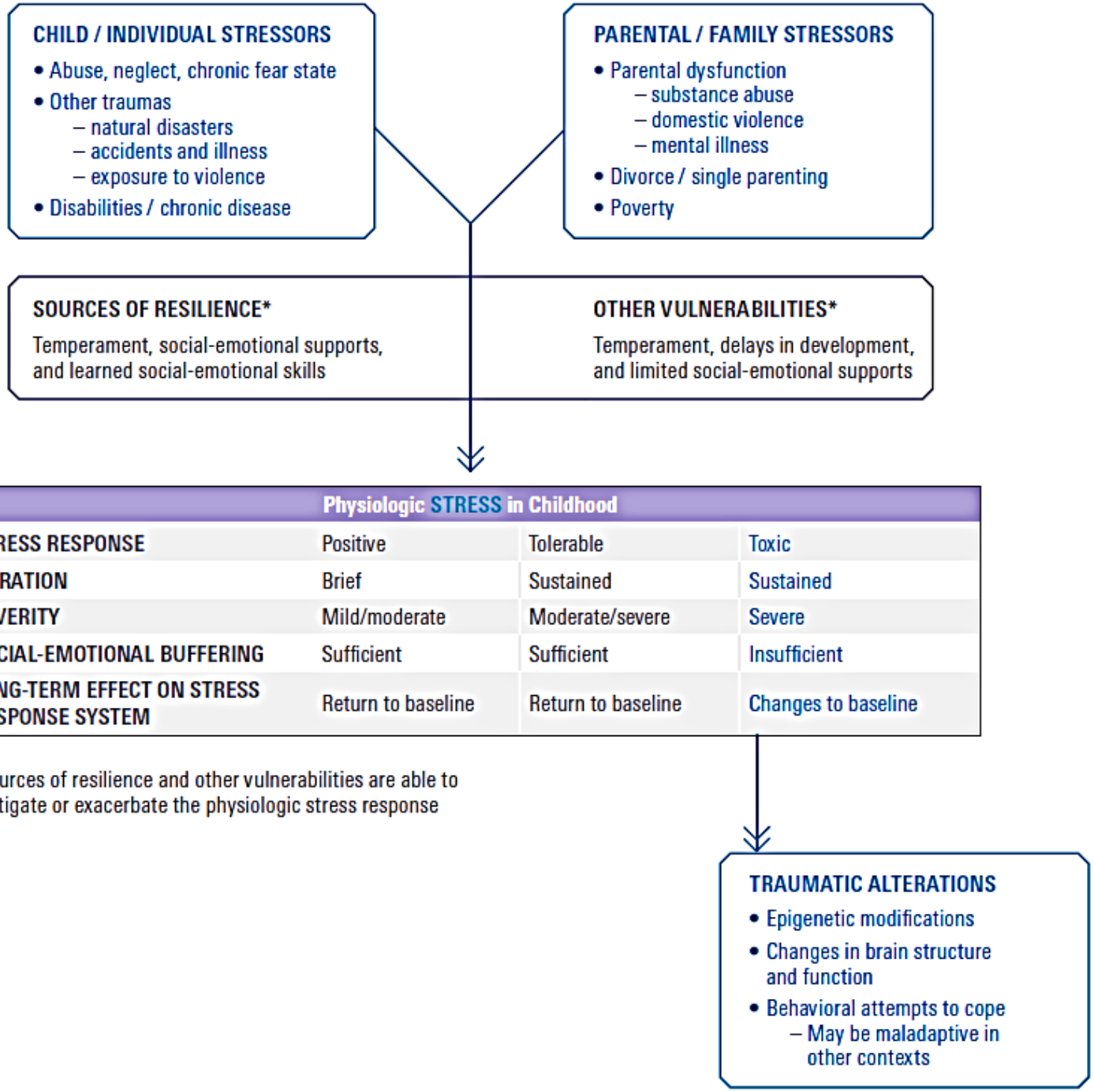
    (responding to non-verbal clues, consolation, reassurance, assistance in planning)
  - **Builds motivation and resiliency**
  - Positive Stress is **NOT** the **ABSENCE** of stress

Defining Adversity or Stress

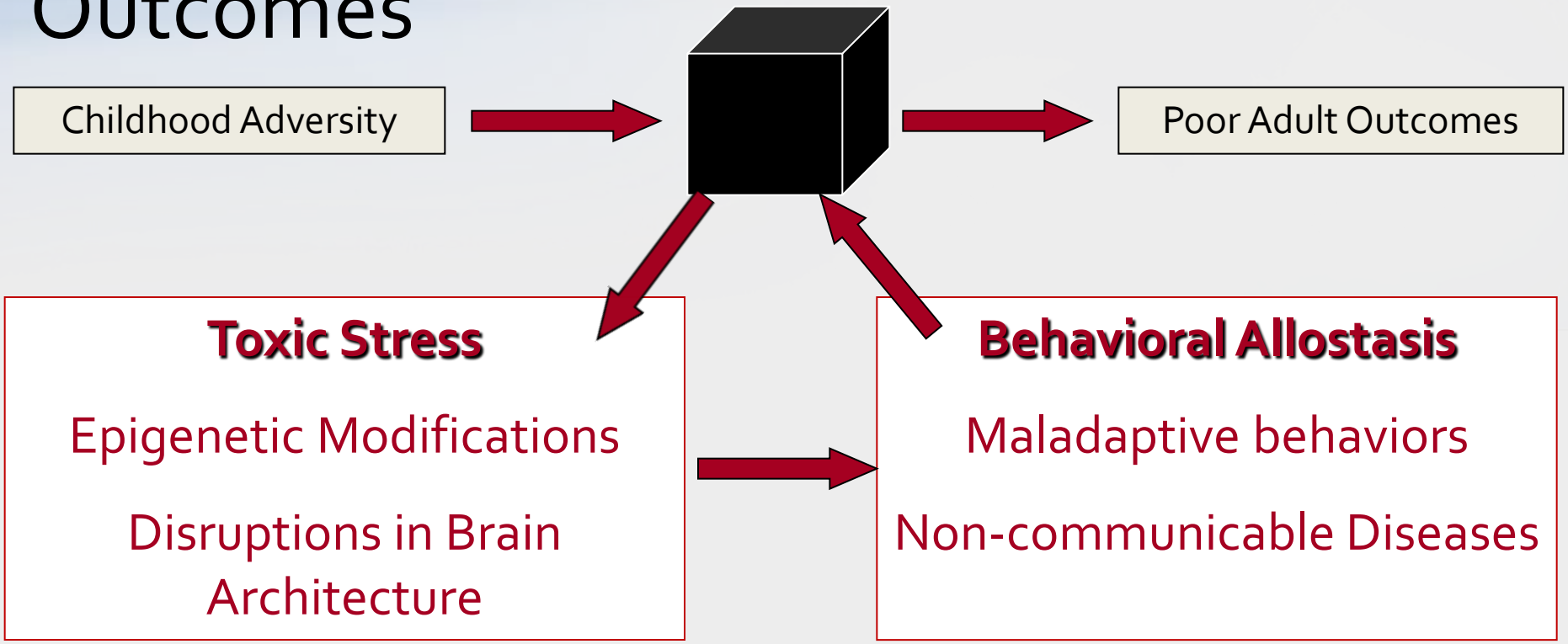
- **Toxic** Stress
  - Long lasting, frequent, or strong intensity
  - More extreme precipitants of childhood stress (**ACEs**)
    - Physical, sexual, emotional abuse
    - Physical, emotional neglect
    - Household dysfunction
  - **Insufficient social-emotional buffering**
    (Deficient levels of emotion coaching, re-processing, reassurance and support)
  - Potentially permanent changes and long-term effects
    - **Epigenetics** (there are life long / intergenerational changes in how the genetic program is turned **ON** or **OFF**)
    - **Brain architecture** (the mediators of stress impact upon the mechanisms of brain development / **connectivity**)

Development results from an on-going, re-iterative, and cumulative dance between nurture and nature




CHILD / INDIVIDUAL STRESSORS
• Abuse, neglect, chronic fear state
• Other traumas
– natural disasters
– accidents and illness
– exposure to violence
• Disabilities / chronic disease
PARENTAL / FAMILY STRESSORS
• Parental dysfunction
– substance abuse
– domestic violence
– mental illness
• Divorce / single parenting
• Poverty
SOURCES OF RESILIENCE*
Temperament, social-emotional supports, and learned social-emotional skills
OTHER VULNERABILITIES*
Temperament, delays in development, and limited social-emotional supports
Physiologic STRESS in Childhood
STRESS RESPONSE | Positive | Tolerable | Toxic
DURATION | Brief | Sustained | Sustained
SEVERITY | Mild/moderate | Moderate/severe | Severe
SOCIAL-EMOTIONAL BUFFERING | Sufficient | Sufficient | Insufficient
LONG-TERM EFFECT ON STRESS RESPONSE SYSTEM | Return to baseline | Return to baseline | Changes to baseline
* Sources of resilience and other vulnerabilities are able to mitigate or exacerbate the physiologic stress response
TRAUMATIC ALTERATIONS
• Epigenetic modifications
• Changes in brain structure and function
• Behavioral attempts to cope
– May be maladaptive in other contexts

Linking Childhood Experiences and Adult Outcomes



Improve caregiver/community capacity to prevent or minimize toxic stress (e.g. – efforts to promote the safe, stable and nurturing relationships that turn off the physiologic stress response)

Improve caregiver/community capacity to promote healthy, adaptive coping skills (e.g. - efforts to encourage rudimentary but foundational SE, language, and cognitive skills)

Pediatricians' Role

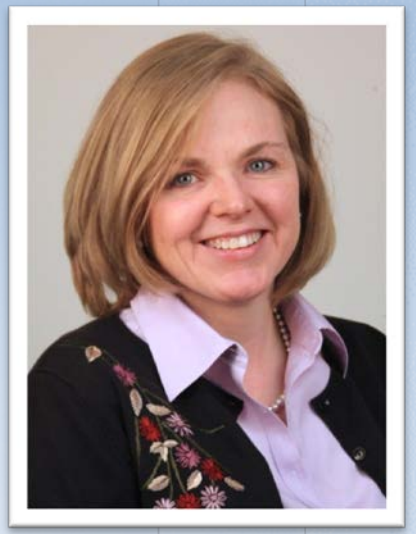
Pediatricians are uniquely positioned to intervene through their:

- Regular interactions.
- Appreciation for the important roles played by families and communities.
- Developmental approach to health.
- Understanding of the advantages of prevention over remediation.
- Connections with the local resources/service providers.
- Awareness of the critical importance of effective advocacy.

Asking Families

Asking families about exposure to stress and potential associated symptoms:

- Communicates that it is a common problem.
- Begins to reduce the isolation and frustration associated with troublesome behaviors.
- Communicates that there are solutions … but they may take time.
- Conveys that past trauma is threat to the healthy growth and development of children.

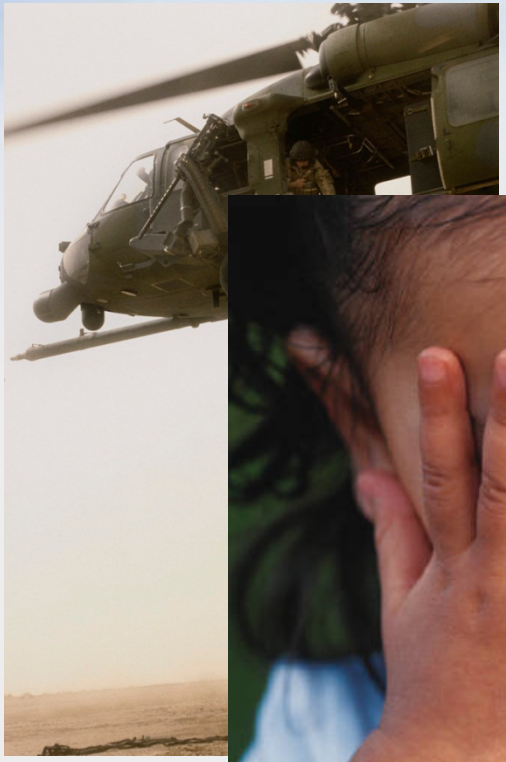


How to Identify Traumatized Children

Heather C. Forkey, MD, FAAP

What Trauma Looks Like

What Trauma Looks Like



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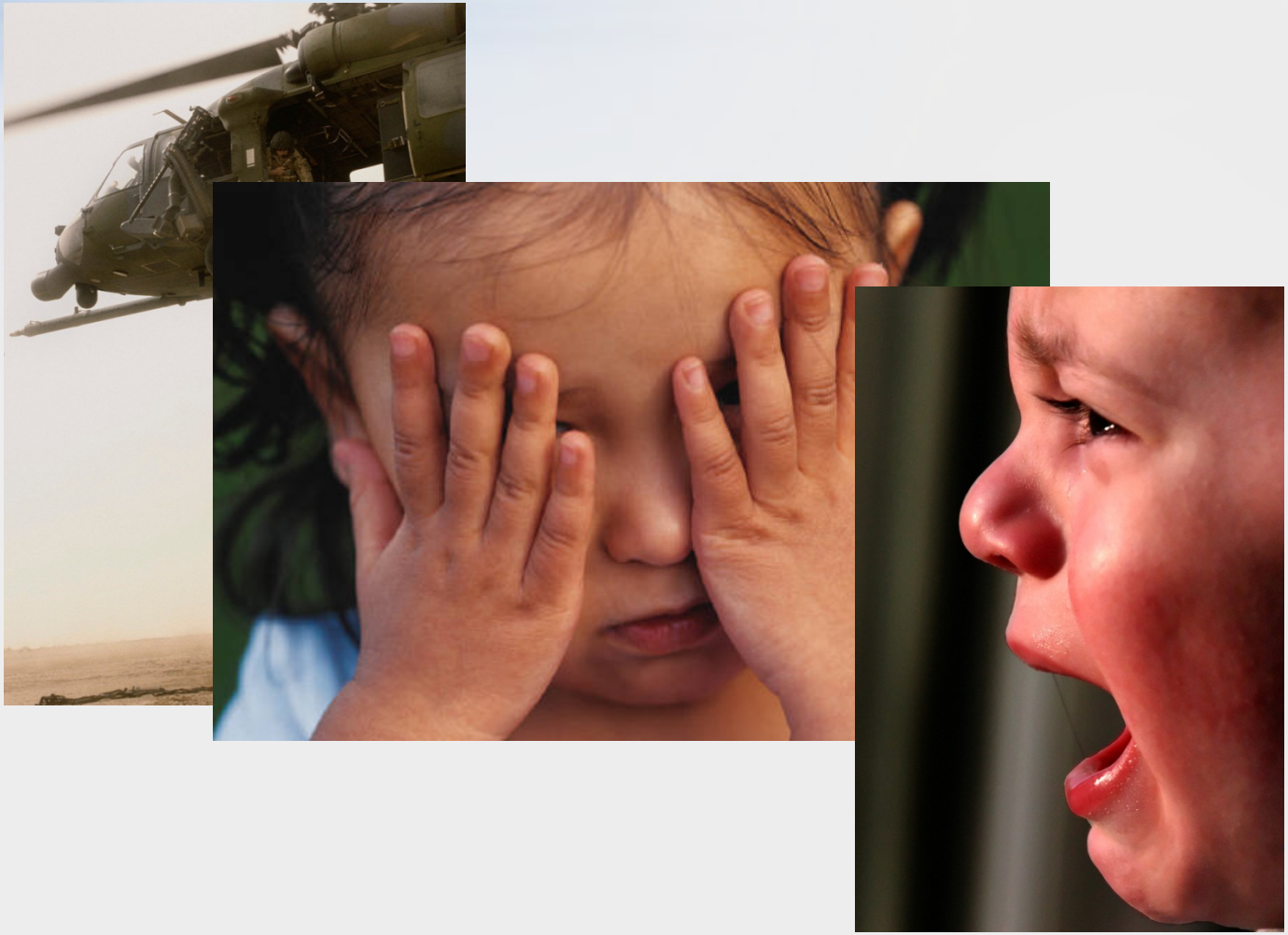

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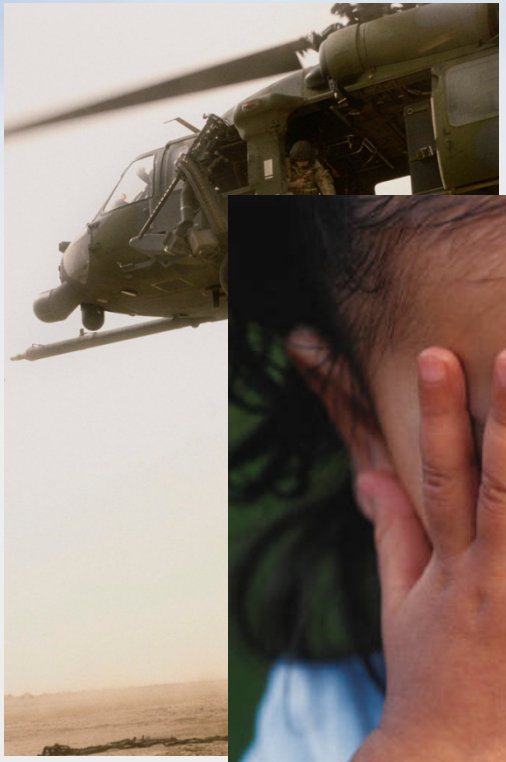
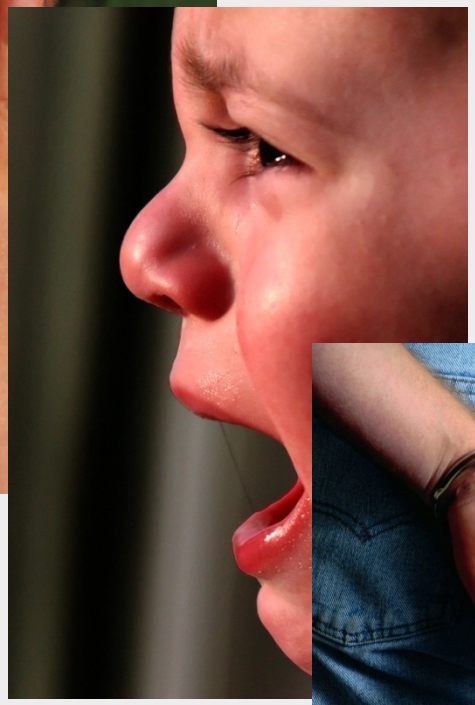


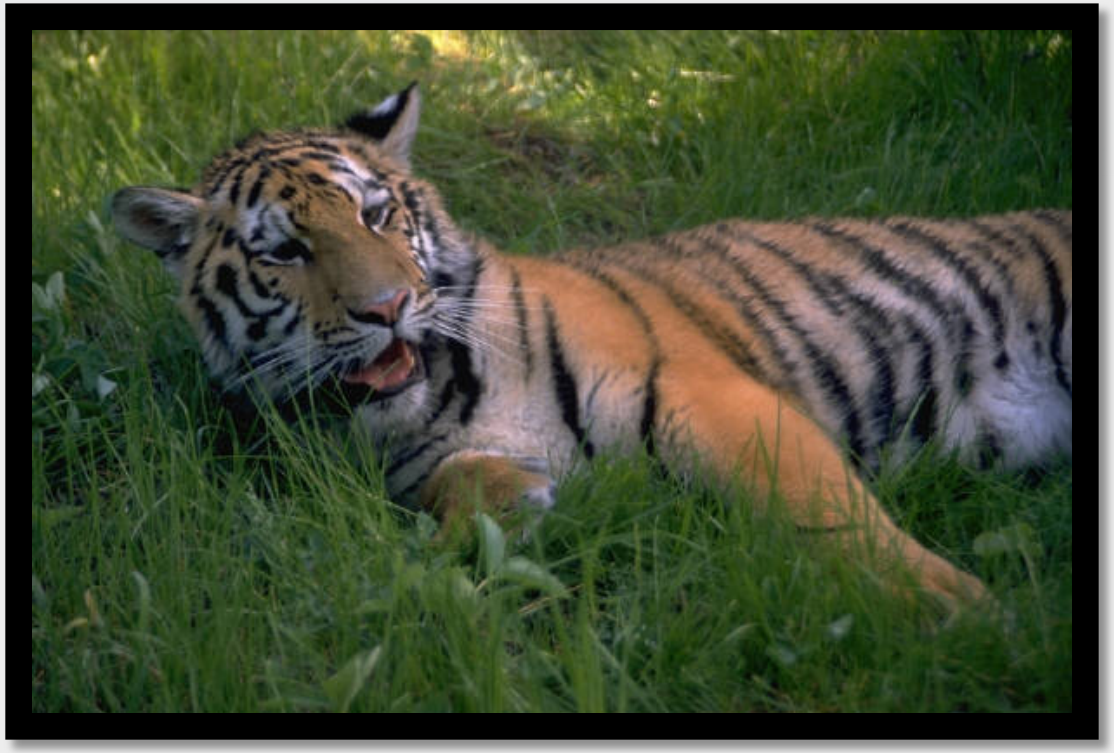


How Do You Identify a Child Impacted by Trauma?

Trauma

- Stress and the tiger
  - Bodies designed to respond to stress
  - Adrenaline and cortisol help us run from tiger or hide
  - Threat of short duration

Trauma happens when the tiger lives in your home, neighborhood, or life

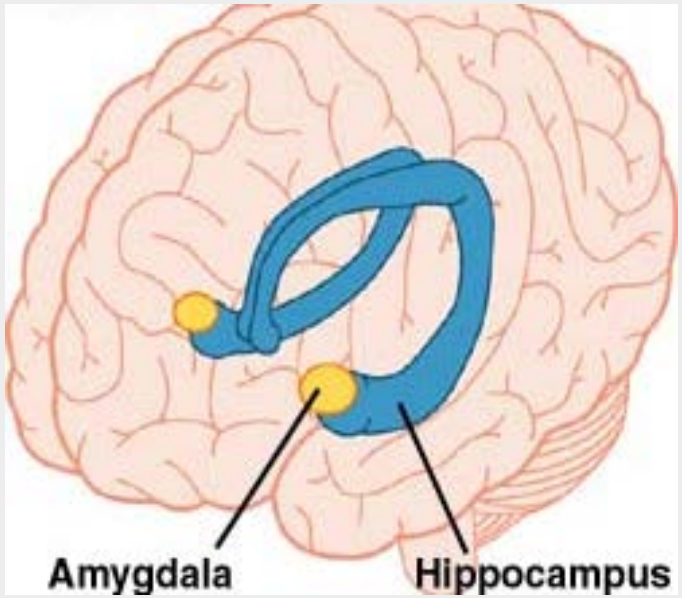


Assume that all children who have been adopted or fostered have experienced trauma.

Neurobiology of Trauma

Amygdala

- Input from sensory, memory and attention centers
  - Emotional memory system =The brain's alarm system



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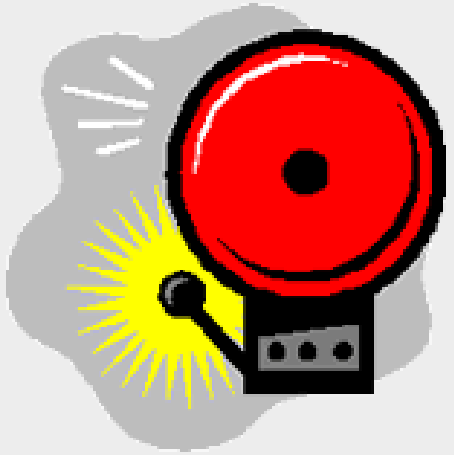
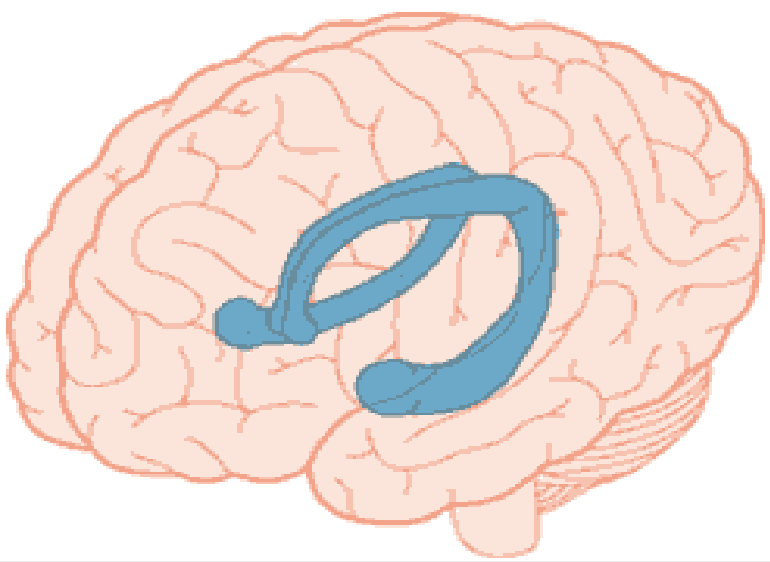


Neurobiology of Trauma

Hippocampus

- Interface between cortex and lower brain areas.
- Major role in memory and learning.
  - The brain's file cabinet or search engine.



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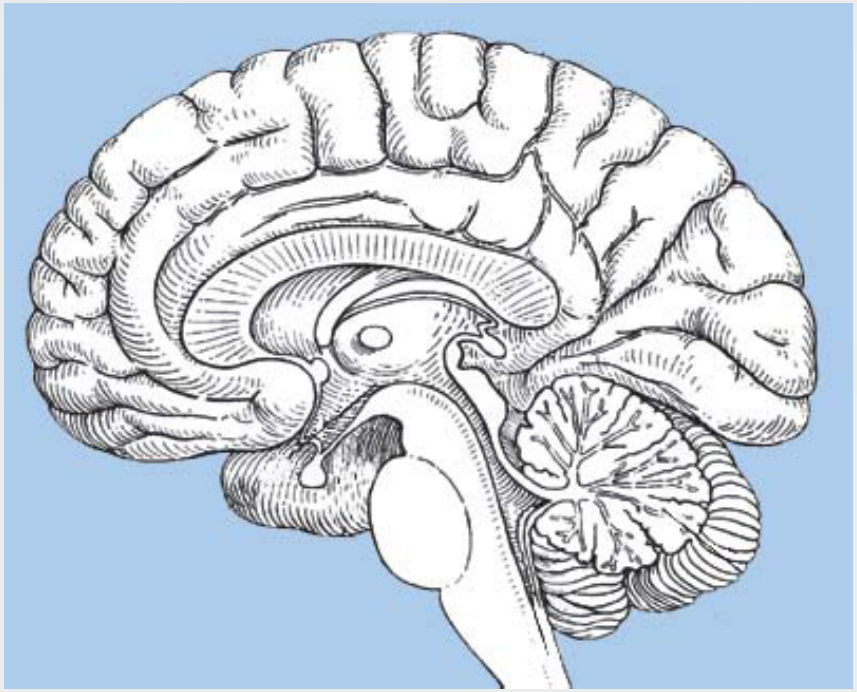
Neurobiology of Trauma

- Frontal cortex
  - Executive function
    - Impulse control
    - Working memory
    - Cognitive flexibility



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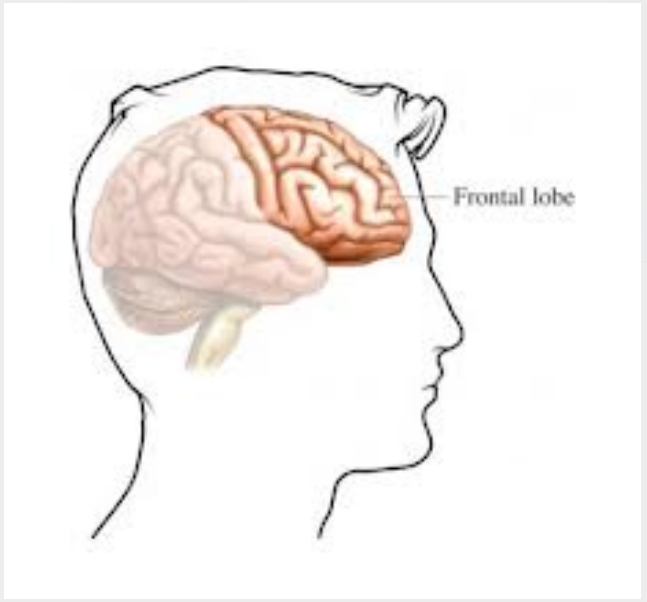

Frontal lobe

Response to Trauma: Behaviors[15,16]

CATEGORY	MORE COMMON WITH	RESPONSE	MISIDENTIFIED AS AND/OR COMORBID WITH
Dissociation (Dopaminergic)	• Females • Young children • Ongoing trauma/pain • Inability to defend self	• Detachment • Numbing • Compliance • Fantasy	• Depression • ADHD inattentive type • Developmental delay
Arousal (Adrenergic)	• Males • Older children • Witness to violence • Inability to fight or flee	• Hypervigilance • Aggression • Anxiety • Exaggerated response	• ADHD • ODD • Conduct disorder • Bipolar disorder • Anger management difficulties

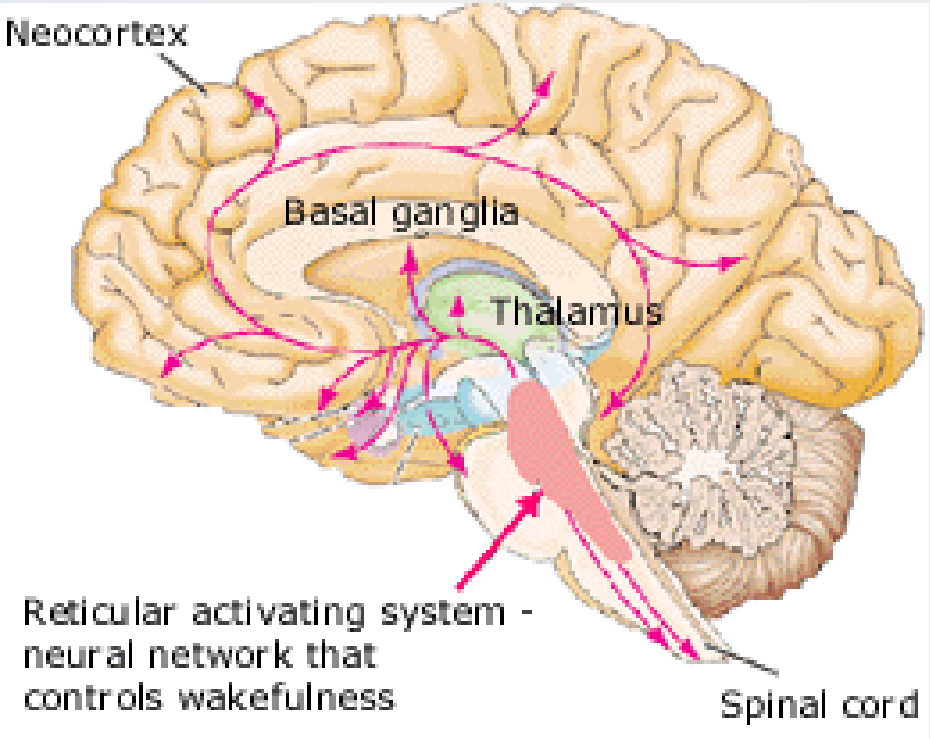
35 Month Old Was Kicked Out of Preschool

- Severe tantrums
- Hurts other kids, damages furniture
- Very short attention span
- BMI >95%
  - Eats all the time
  - Obese
- Not toilet trained
- Insomnia

Response to Trauma: Bodily Functions

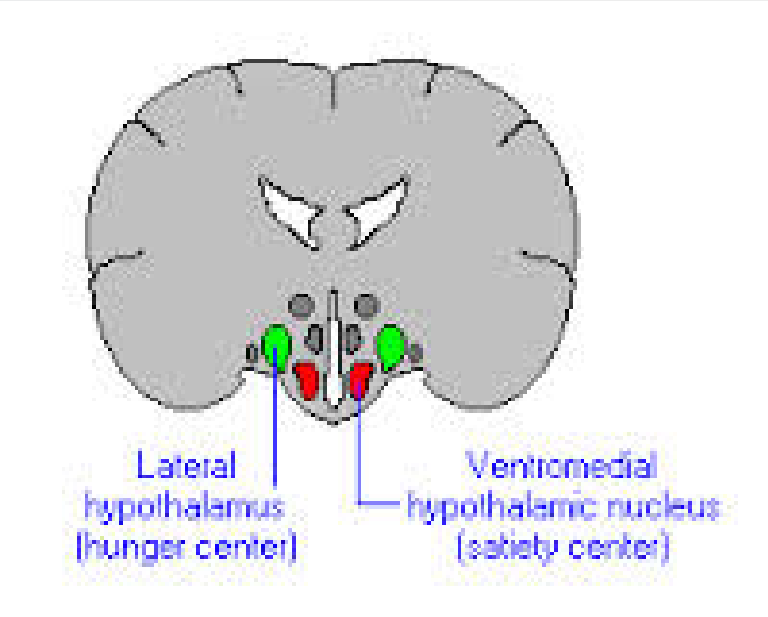
FUNCTION	CENTRAL CAUSE	SYMPTOM(S)
Sleep	Stimulation of reticular activating system	1. Difficulty falling asleep 2. Difficulty staying asleep 3. Nightmares
Eating	Inhibition of satiety center, anxiety	1. Rapid eating 2. Lack of satiety 3. Food hoarding 4. Loss of appetite
Toileting	Increased sympathetic tone, increased catecholamines	1. Constipation 2. Encopresis 3. Enuresis 4. Regression of toileting skills

Not Sleeping



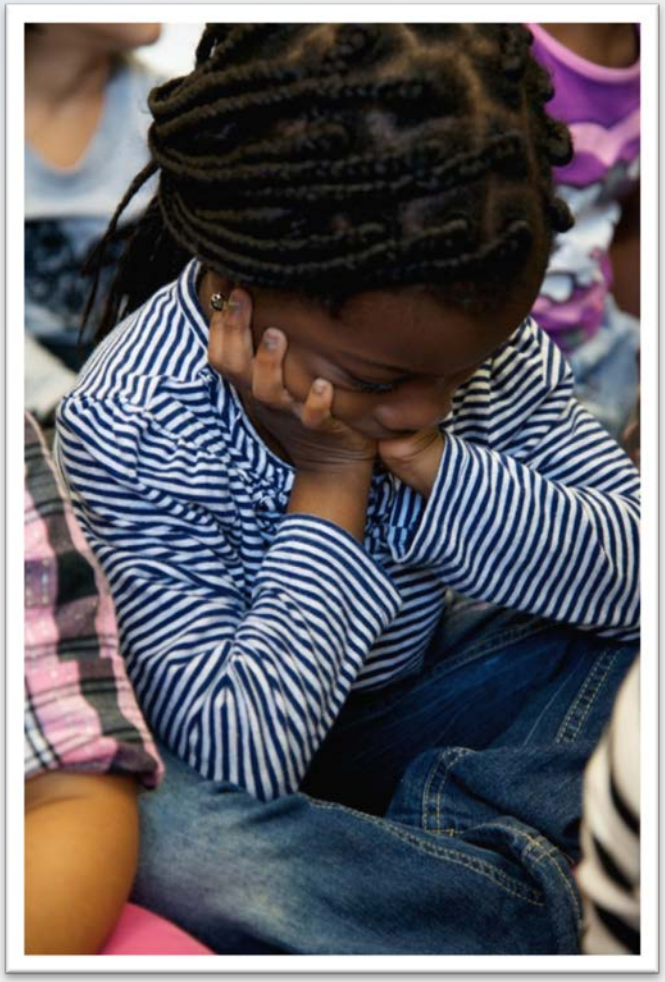
https://www.meducation.net/encyclopedia/reticular%20formation

Overeating

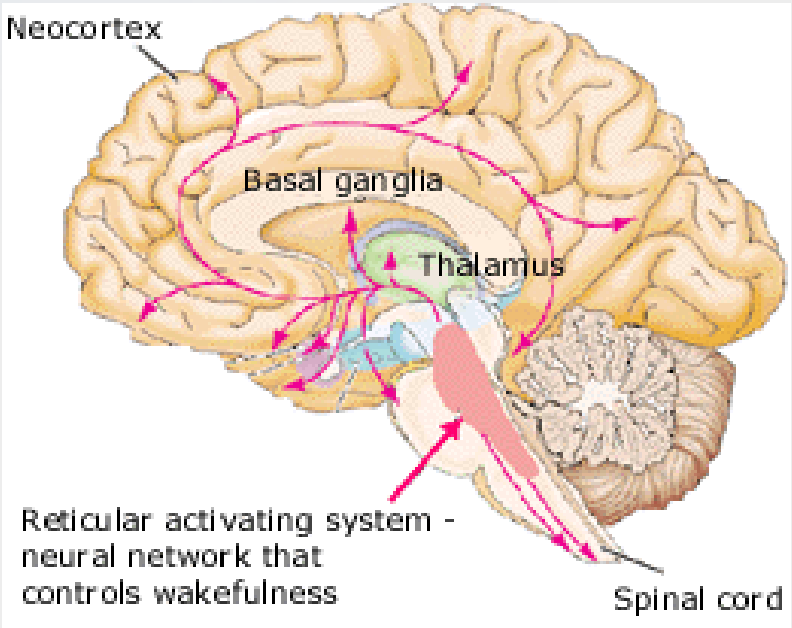


http://www.vivo.colostate.edu/hbooks/pathphys/digestion/pregastric/foodintake.html

Angie Just Can't Get to Sleep



Not Sleeping



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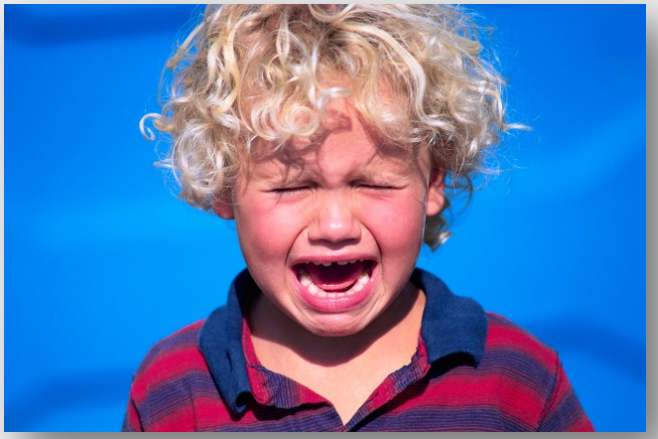
The Baby is Fine

- 22 month old
- Very quiet, never cries, hides in every corner during exam
- Stays where put – not getting into everything
- Serious looking baby

Dissociative Continuum

- Infants & young children not capable of fighting or fleeing
  - Early stress: infants manifest precursor form of hyperarousal
    - Limited way to express distress to caretaker



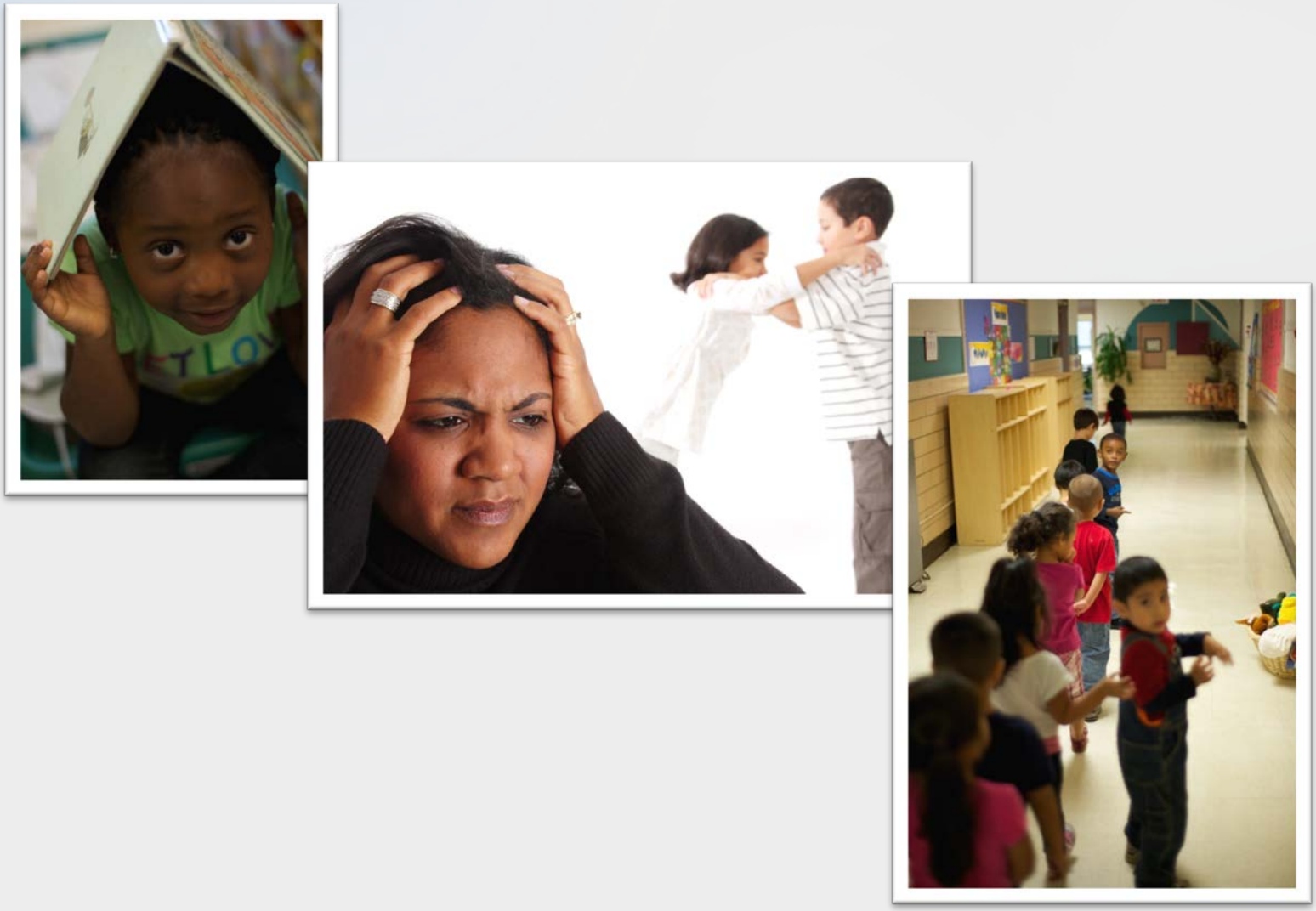
Dissociative Continuum

- Defeat response
  - Dissociation describes mental mechanisms of
    - disengaging from the external world
    - attending to stimuli of the internal world

Trauma Responses: Adaptive and Protective When in Threatening Situation

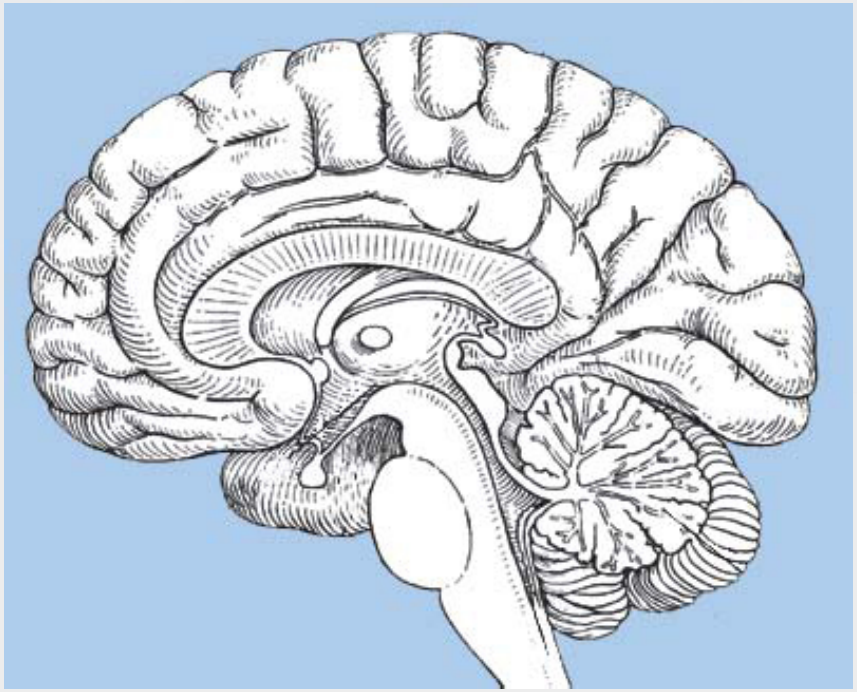
- Same bodily functions and behaviors may be maladaptive when children are removed from the stressor
- When not examined within the context of past traumas can be misinterpreted as pathologic

ADHD – Really??



Neurobiology of Trauma

- Frontal cortex
  - Executive function
    - Impulse control
    - Working memory
    - Cognitive flexibility



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Response to Trauma: Development and Learning[15,16]

AGE	IMPACT ON WORKING MEMORY	IMPACT ON INHIBITORY CONTROL	IMPACT ON COGNITIVE FLEXIBILITY
Infant / toddler / pre-schooler	Difficulty acquiring developmental milestones	Frequent severe tantrums Aggressive with other children Attachment may be impacted	Easily frustrated
School-aged child	Difficulty with school skill acquisition Losing details can lead to confabulation, viewed by others as lying	Frequently in trouble at school and with peers for fighting and disrupting	Organizational difficulties Can look like learning problems or ADHD
Adolescent	Difficulty keeping up with material as academics advance Trouble keeping school work and home life organized Confabulation increasingly interpreted by others as integrity issue	Impulsive actions which can threaten health and well-being Actions can lead to involvement with law enforcement and increasingly serious consequences	Difficulty assuming tasks of young adulthood which require rapid interpretation of information: ie, driving, functioning in workforce

Screening for Trauma

- Questions
  - Since the last time I saw you (your child) has anything really scary or upsetting happened to you (your child) or anyone in your family?

  - You have told me that your child is having difficulty with aggression, attention and sleep. Just as fever is an indication the body is dealing with an infection, when these behavioral symptoms are present, they indicate that the brain and body are responding to a stress or threat. Do you have any concerns that your child is being exposed to threat?"

Screening for Trauma

"The behaviors you describe and the trouble she is having with school and learning are often warning signs that the brain is trying to manage stress or threat. Sometimes children respond this way if they are being harmed, or if they are witnessing others they care about being harmed. Do you know of any violence exposure at school, with friends, or at home?"

Trauma Surveillance/Screening Tools

TOOL	DESCRIPTION	NUMBER OF ITEMS AND FORMAT	AGE GROUP	ADMIN AND SCORING TIME	CULTURAL CONSIDERATIONS	COST AND DEVELOPER
UCLA PTSD - RI: Post Traumatic Stress Disorder Reaction Index*	Assesses exposure to trauma and impact of events	20-22 items depending on child, parent, or youth version	Child and Parent: 7-12 years; Youth 13+	20-30 min to administer 5-10 min to score	English, Spanish	Available to International Society for Traumatic Stress Studies members
Abbreviated UCLA PTSD RI	Elicits trauma-related symptoms	9 items for child 6 items for adult	8-16 years 3-12 years	2-5 min	English, Spanish	Available to International Society for Traumatic Stress Studies members
TSC-C Trauma Symptom Checklist for Children	Elicits trauma-related symptoms	TSC-C: 54 items TSC-YC: 90 items, caregiver report for young children	8-16 years 3-12 years	15-20 min	English, Spanish	Proprietary ($172-$230 per kit)

Therapies for the Traumatized Child

AGE	THERAPY	GOALS
Young child 0-5 years	• PCIT – Parent Child Interactive Therapy • CPP – Child Parent Psychotherapy	Works with caregivers and children to address child behaviors observed during play. A dyadic intervention that targets the impact of trauma on the child-parent relationship and how the parent can provide emotional safety for the child.
Older children	• TF-CBT – Trauma Focused Cognitive Behavioral Therapy (for children 5 and older) • CBITS – Cognitive Behavioral Intervention for Trauma In Schools (for high school-aged youth)	Trains children and families in: • relaxation techniques • skills and language to access emotion • psychoeducation Then, child is guided to create a trauma narrative. Child develops/writes a story about what happened to him or her. When the child is able to tell or read this story to the caregiver, it indicates the trauma no longer defines the child, but is instead a story of what happened, having lost its power to continue to harm.
Both older and younger children with complex trauma/ attachment concerns	• ARC – Attachment, Self-Regulation, and Competency	To support healthy relationships between children and their caregiving systems to: • support resources and safety for adult members of the family • build all family members' ability to manage feelings, body sensations, and behaviors • improve problem solving skills • support healthy development of identity • support the child in processing/integrating stressful life experiences

Trauma Treatments

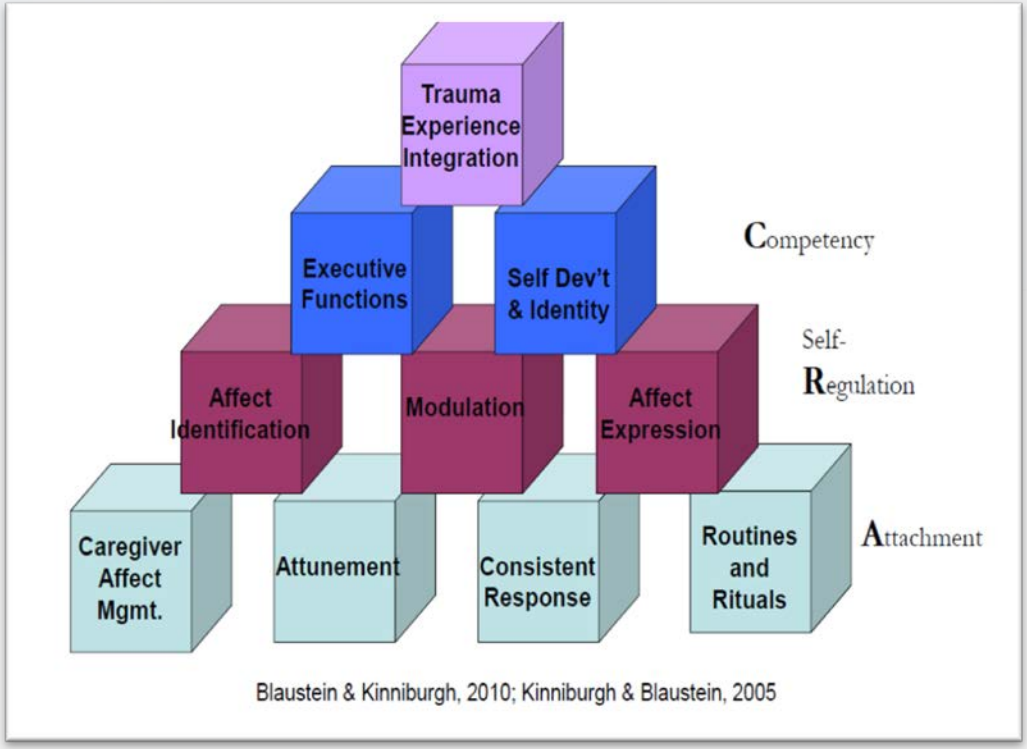
- Child Parent Psychotherapy (CPP)
  - Observing child behavior or play with therapist
  - Facilitates interactions/understanding behaviors
  - Caregiver guided to identify trauma narrative and triggers for caregiver and child

Therapy for Older Children

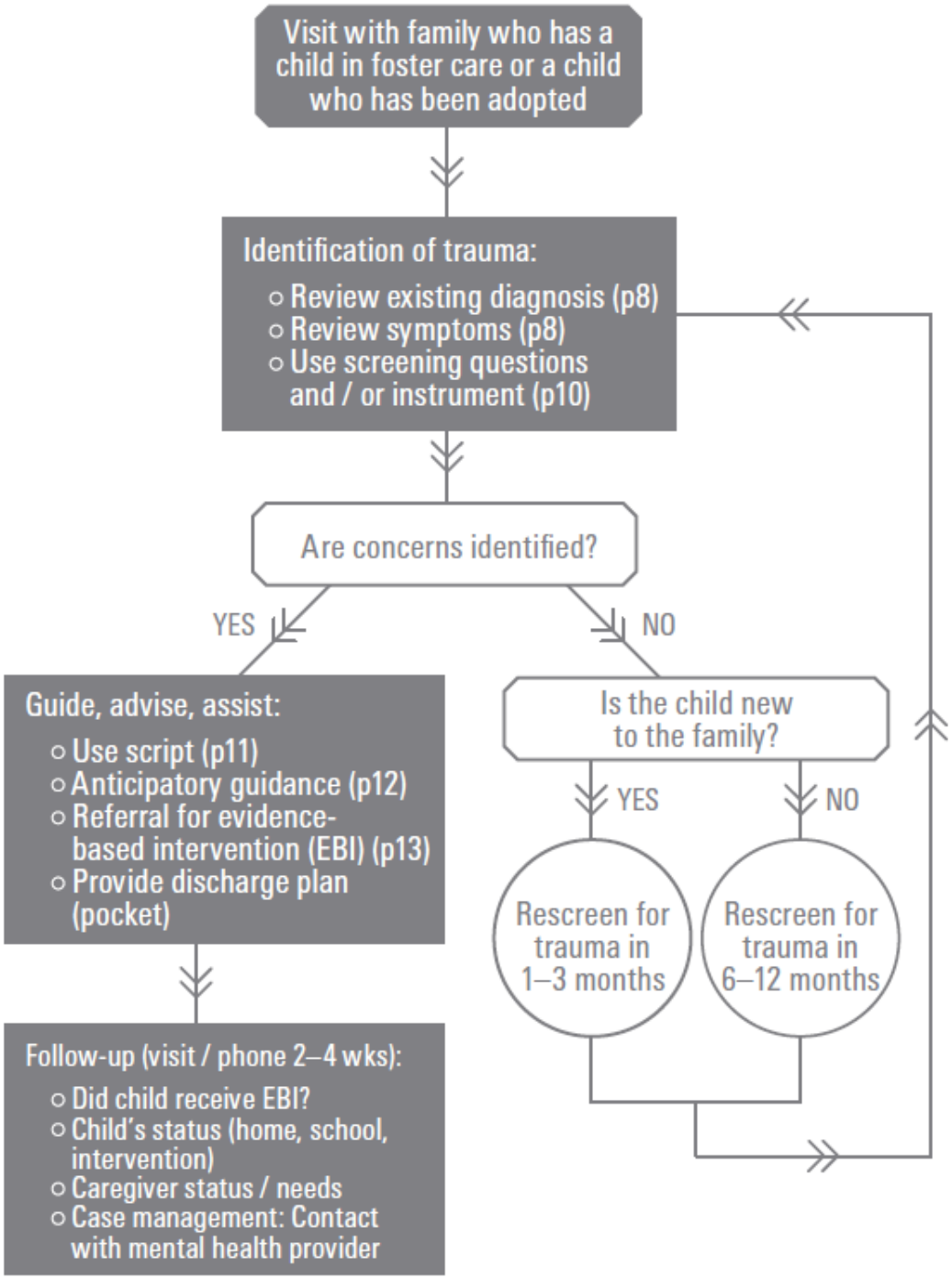
- Trains children and families in:
  - Relaxation techniques.
  - Skills and language to access emotion.
  - Psychoeducation.
- Child is guided to create a trauma narrative.
  - Child develops a story about what happened to them.
- Final goal: Child is able to tell or read story
  - Trauma no longer has capacity to hurt child

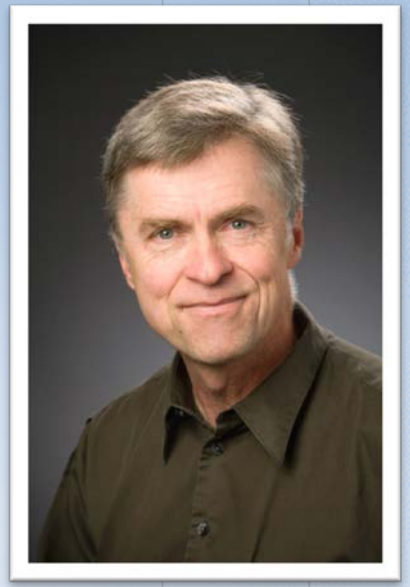
Attachment, Self Regulation and Competency (ARC)

- ***Attachment:***
  - Caregiver Affect Mgt
  - Attunement
  - Consistent Response
  - Routines and Rituals
- ***Self-Regulation***
  - Affect Identification
  - Modulation
  - Expression
- ***Competency:***
  - Executive Functions
  - Self and Identity
- **Trauma Experience Integration**



For more info on ARC see:
http://nctsn.org/sites/default/files/assets/pdfs/arc_general.pdf


Visit with family who has a child in foster care or a child who has been adopted
Identification of trauma:
Review existing diagnosis (p8)
Review symptoms (p8)
Use screening questions and / or instrument (p10)
Are concerns identified?
YES
NO
Guide, advise, assist:
Use script (p11)
Anticipatory guidance (p12)
Referral for evidence-based intervention (EBI) (p13)
Provide discharge plan (pocket)
Follow-up (visit / phone 2–4 wks):
Did child receive EBI?
Child's status (home, school, intervention)
Caregiver status / needs
Case management: Contact with mental health provider
Is the child new to the family?
YES
NO
Rescreen for trauma in 1–3 months
Rescreen for trauma in 6–12 months



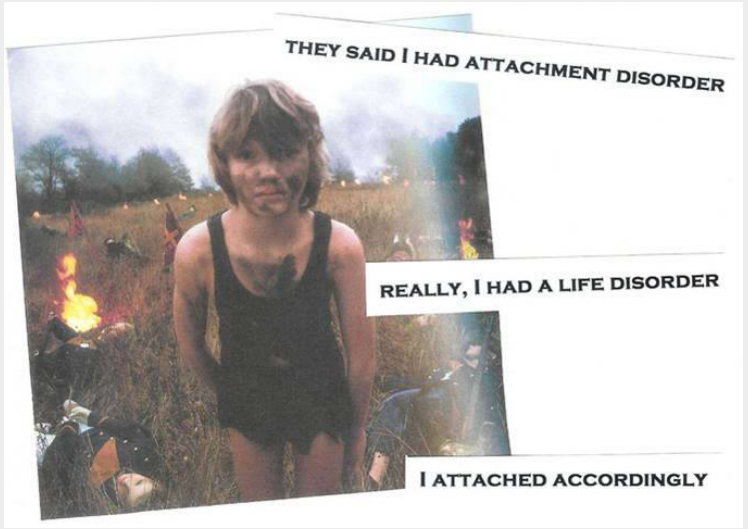
Anticipatory Guidance

John Stirling, MD, FAAP

What's Our Job?

Children in Foster Care Are Children With Special Health Care Needs

- Medical needs
- Developmental delays
- History of toxic stress: trauma, neglect, grief
- Attachment difficulties
- Maladaptive behaviors



What's a Maladaptive Behavior?

- One that brings about negative results,
- Usually learned in a different setting, where it worked, and
- Which persists because of some gain.
- AKA: "mental health needs," diagnosed as:
  - Attention Deficit Hyperactivity Disorder
  - Oppositional Defiant Disorder
  - Bipolar disorder

What Do Parents Need to Know?

Kids who have lived with toxic stress may have:

- "Hair trigger" emotional responses
- Difficulty regulating their arousal
- Reluctance to turn to others for help (trust)
- Inability to discuss their emotional feelings
- Insecurity over food, safety, or relationships

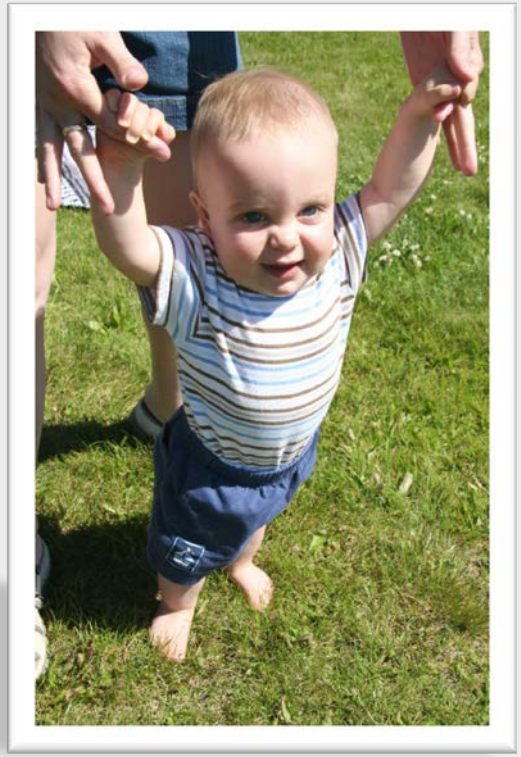
What Do You Need to Know?

- What do the parents see as the problem?
  - Preconceptions, fears
- What kind of experiences have they had?
  - Strengths, weaknesses
- Who will be there to help them?
  - Sources of support

Begin by listening!

What's a Parent's Job?

- Parents are teachers
  - Show the kids what's important
  - Show them what works
- Good teachers are:
  - Responsive
  - Consistent
  - Predictable

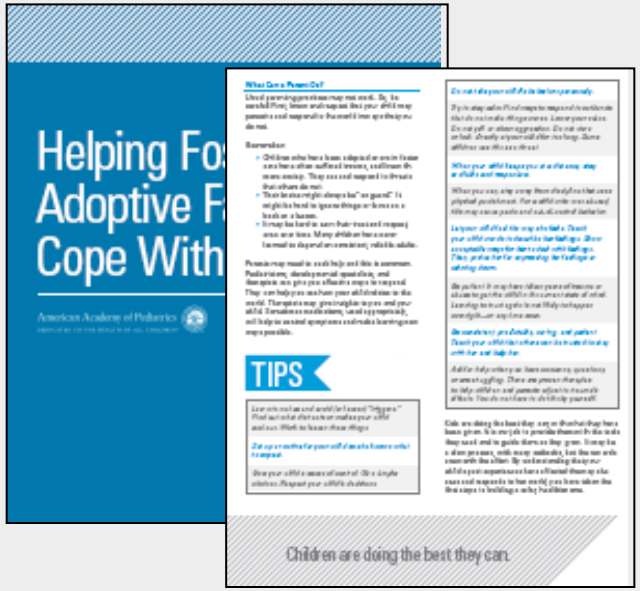


Changing Behavior

- Changing learned behaviors takes time
  - The more the child sees a behavior as protective, the harder it is to change
- Keep the lesson simple, and logical
- Discipline is not the same as punishment
- Anger
  - Can trigger the threat/safety response
  - Which makes learning difficult

Tips to Teach

- Learn to notice and avoid emotional "triggers"
- Allow control: Keep to a routine, give choices
- Don't take behaviors personally
- Remain as calm, patient, logical as possible
- Acknowledge (and respect) the child's feelings
- Don't expect quick results!



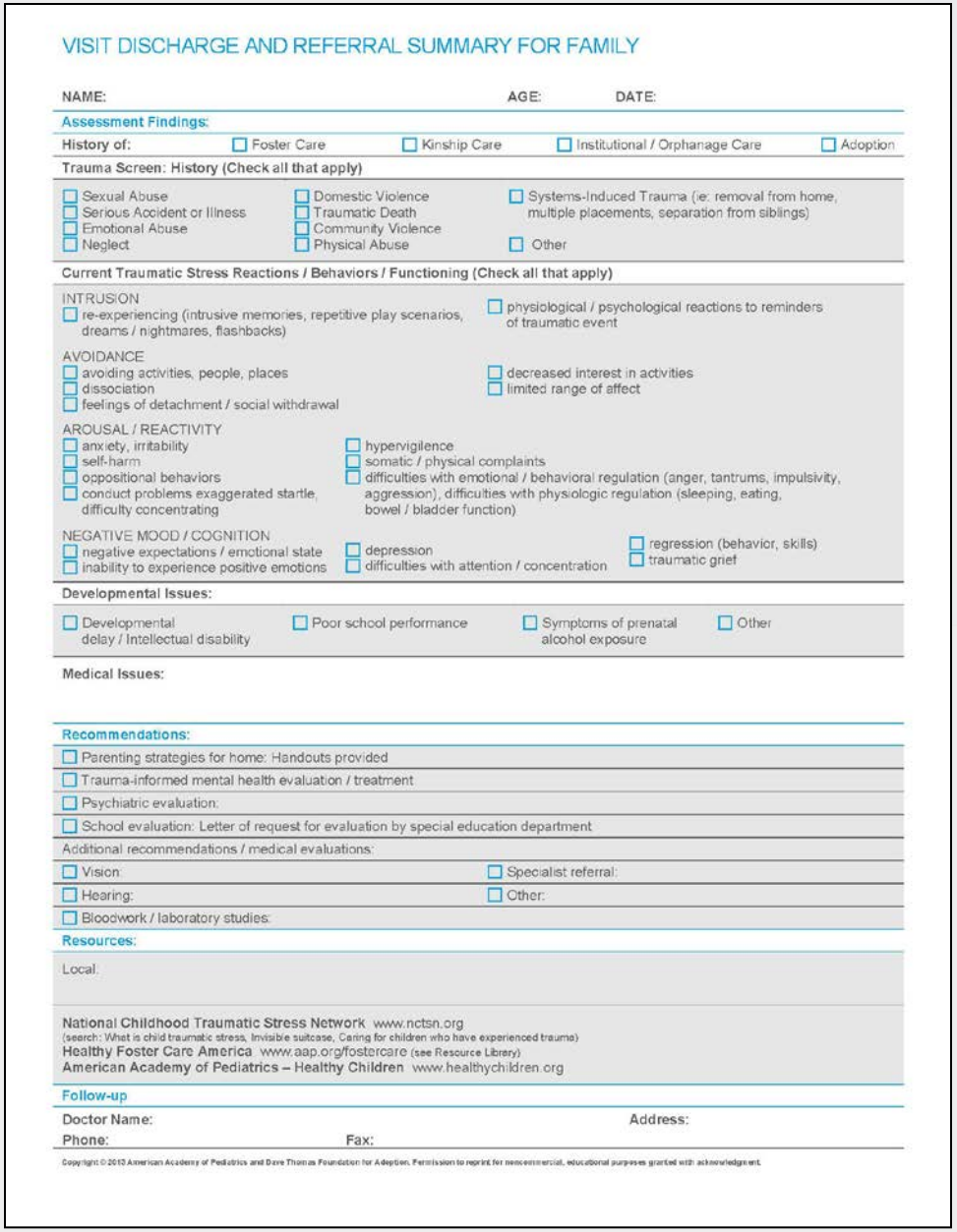
Children Are Doing the Best They Can!

- Parents' job is to teach them how to adapt to our world
- Our job is to support them as teachers
- If we're both patient and persistent, and listen to each other, we can help make the transition successful.

can I have the life I always dreamed of ?

Using the Discharge Form

- Summarizes findings
  - Trauma reactions
  - Developmental, medical issues
- Directs next steps



VISIT DISCHARGE AND REFERRAL SUMMARY FOR FAMILY

NAME: AGE: DATE:

Assessment Findings:

History of: ☐ Foster Care ☐ Kinship Care ☐ Institutional / Orphanage Care ☐ Adoption

Trauma Screen: History (Check all that apply)

☐ Sexual Abuse
☐ Serious Accident or Illness
☐ Emotional Abuse
☐ Neglect
☐ Domestic Violence
☐ Traumatic Death
☐ Community Violence
☐ Physical Abuse
☐ Systems-Induced Trauma (ie: removal from home, multiple placements, separation from siblings)
☐ Other

Current Traumatic Stress Reactions / Behaviors / Functioning (Check all that apply)

INTRUSION
☐ re-experiencing (intrusive memories, repetitive play scenarios, dreams / nightmares, flashbacks)
☐ physiological / psychological reactions to reminders of traumatic event

AVOIDANCE
☐ avoiding activities, people, places
☐ dissociation
☐ feelings of detachment / social withdrawal
☐ decreased interest in activities
☐ limited range of affect

AROUSAL / REACTIVITY
☐ anxiety, irritability
☐ self-harm
☐ oppositional behaviors
☐ conduct problems exaggerated startle, difficulty concentrating
☐ hypervigilence
☐ somatic / physical complaints
☐ difficulties with emotional / behavioral regulation (anger, tantrums, impulsivity, aggression), difficulties with physiologic regulation (sleeping, eating, bowel / bladder function)

NEGATIVE MOOD / COGNITION
☐ negative expectations / emotional state
☐ inability to experience positive emotions
☐ depression
☐ difficulties with attention / concentration
☐ regression (behavior, skills)
☐ traumatic grief

Developmental Issues:

☐ Developmental delay / Intellectual disability
☐ Poor school performance
☐ Symptoms of prenatal alcohol exposure
☐ Other

Medical Issues:

Recommendations:

☐ Parenting strategies for home: Handouts provided
☐ Trauma-informed mental health evaluation / treatment
☐ Psychiatric evaluation:
☐ School evaluation: Letter of request for evaluation by special education department

Additional recommendations / medical evaluations:

☐ Vision:
☐ Specialist referral:
☐ Hearing:
☐ Other:
☐ Bloodwork / laboratory studies:

Resources:

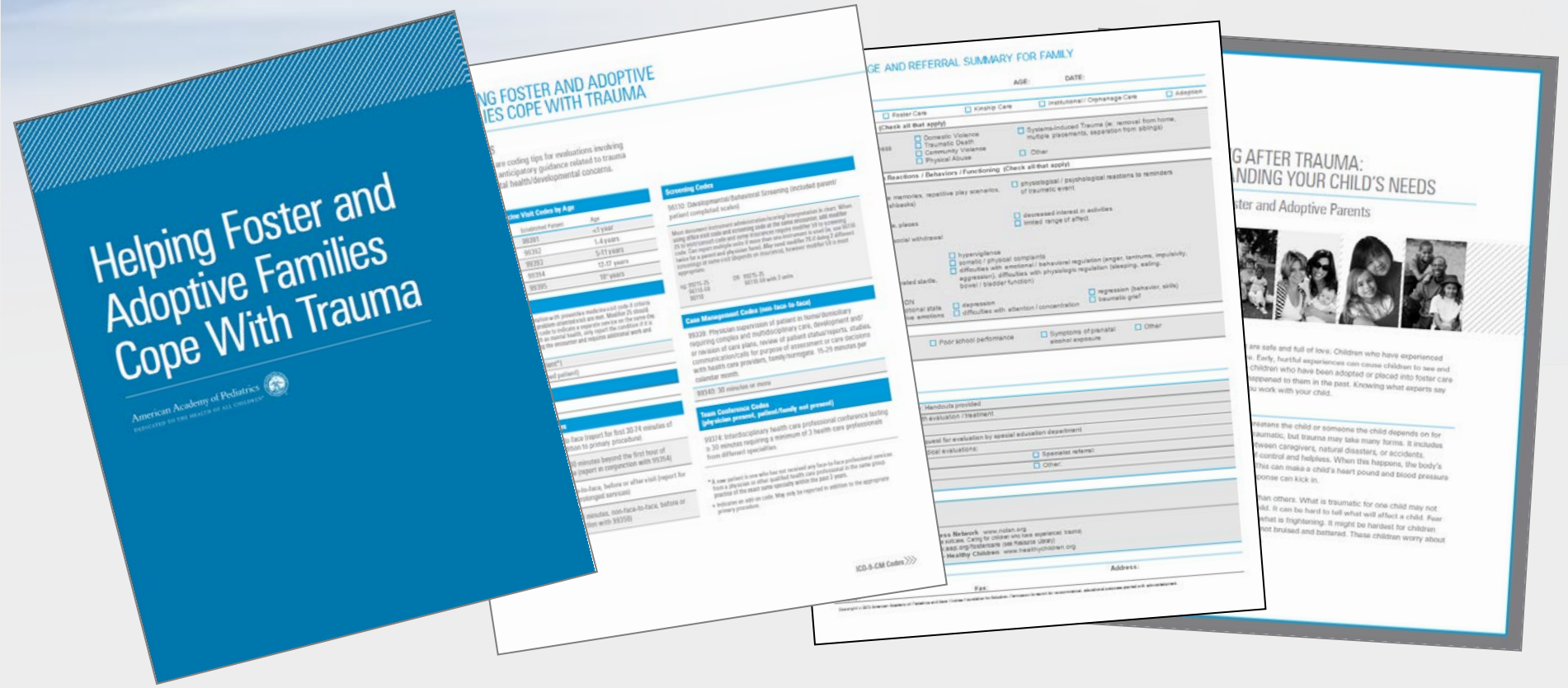
Local:

National Childhood Traumatic Stress Network www.nctsn.org
(search: What is child traumatic stress, Invisible suitcase, Caring for children who have experienced trauma)
Healthy Foster Care America www.aap.org/fostercare (see Resource Library)
American Academy of Pediatrics – Healthy Children www.healthychildren.org

Follow-up

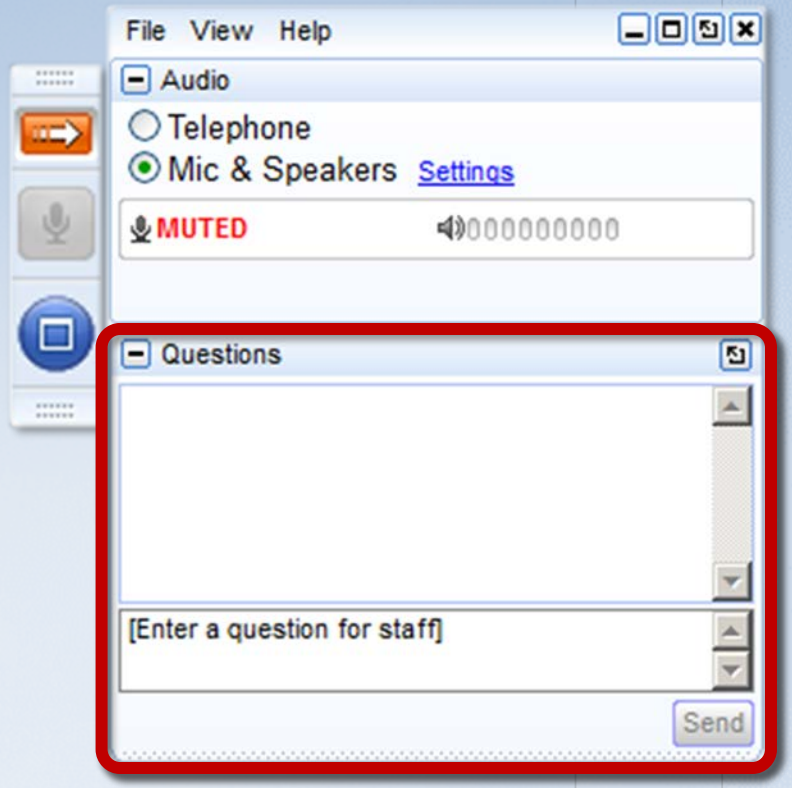
Doctor Name: Address:
Phone: Fax:

www.aap.org/traumaguide



PEDIATRICS 65

Pediatrics subscribers will receive a complimentary hard copy of the trauma materials in the November issue!



Questions?

To ask a question, please type your question in the box on the right