Trauma In Early Childhood: The Long-Term Dangers Of "Don't Ask, Don't Tell"

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An Ecological-Transactional Model of Development

"Development Lasts A Lifetime"

Protective & Risk Factors

"Allostatic load"

Macrosystem: Cultural practices

Exosystem: Neighborhood & community

Microsystem: Family inter-relationships

Ontogenetic development: The Individual

(Bronfenbrenner, 1979; Cicchetti & Lynch,1993; Sameroff, 1993; Rutter,2000)

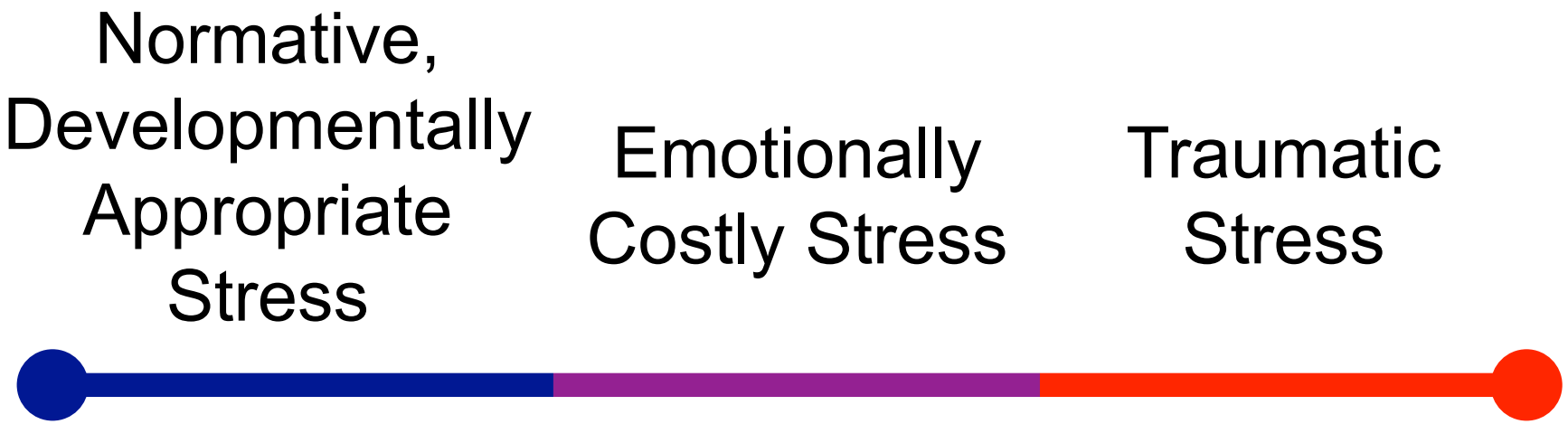
How The Brain Develops

- Brain is “experience-dependent”, operating on “use it or lose it” principle
- Areas of the brain that process pain, danger, and pleasure are nearly mature at birth
- Interpersonal experiences mediate early learning and the “on”-”off” function of genes

Amygdala:
Processing Of Fear, Anger, Pleasure

- Located in limbic brain
- Nearly mature at birth, fully mature at 12 m
- Center for giving meaning to stimuli
- Hyperstimulation lowers threshold for fear response – circuits “on”
- Involved in storage of memories

A Continuum
From Stress To Trauma



Defining Trauma

- A traumatic event overwhelms the capacity to cope
- Threatens physical or psychological integrity
- Key features of trauma:
  - Unpredictability
  - Horror
  - Helplessness

(DC:0-3R, 2004; Freud, 1926; Pynoos et al., 1999)

Frequent Traumatic Stressors In Childhood

- Exposure to violence
  - Child Abuse
  - Domestic Violence
  - Community Violence
- Accidents
  - Car crashes
  - Near drownings
  - Dog bites
  - Burns

Violence As Paradigm of Childhood Trauma

- More children die from abuse in their first year of life than at any other time
- Half of child abuse victims are under age 7
- 85% of abuse fatalities are under age 6
- U. S. ranks THIRD among 27 industrialized countries in child maltreatment deaths

(Gentry, 2004; UNICEF, 2003; Children's Bureau, 2003)

Children's Exposure to Violence

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Sources of Violence Overlap

- Children exposed to domestic violence
  - 15 times more likely to be abused than the national average
  - 30-70% overlap with child abuse
  - At serious risk of sexual abuse
- Battered women
  - Twice more likely to abuse their children than comparison groups

    (Osofsky, 2003; Edleson, 1999; Margolin & Gordis, 2000; McCloskey, 1995)

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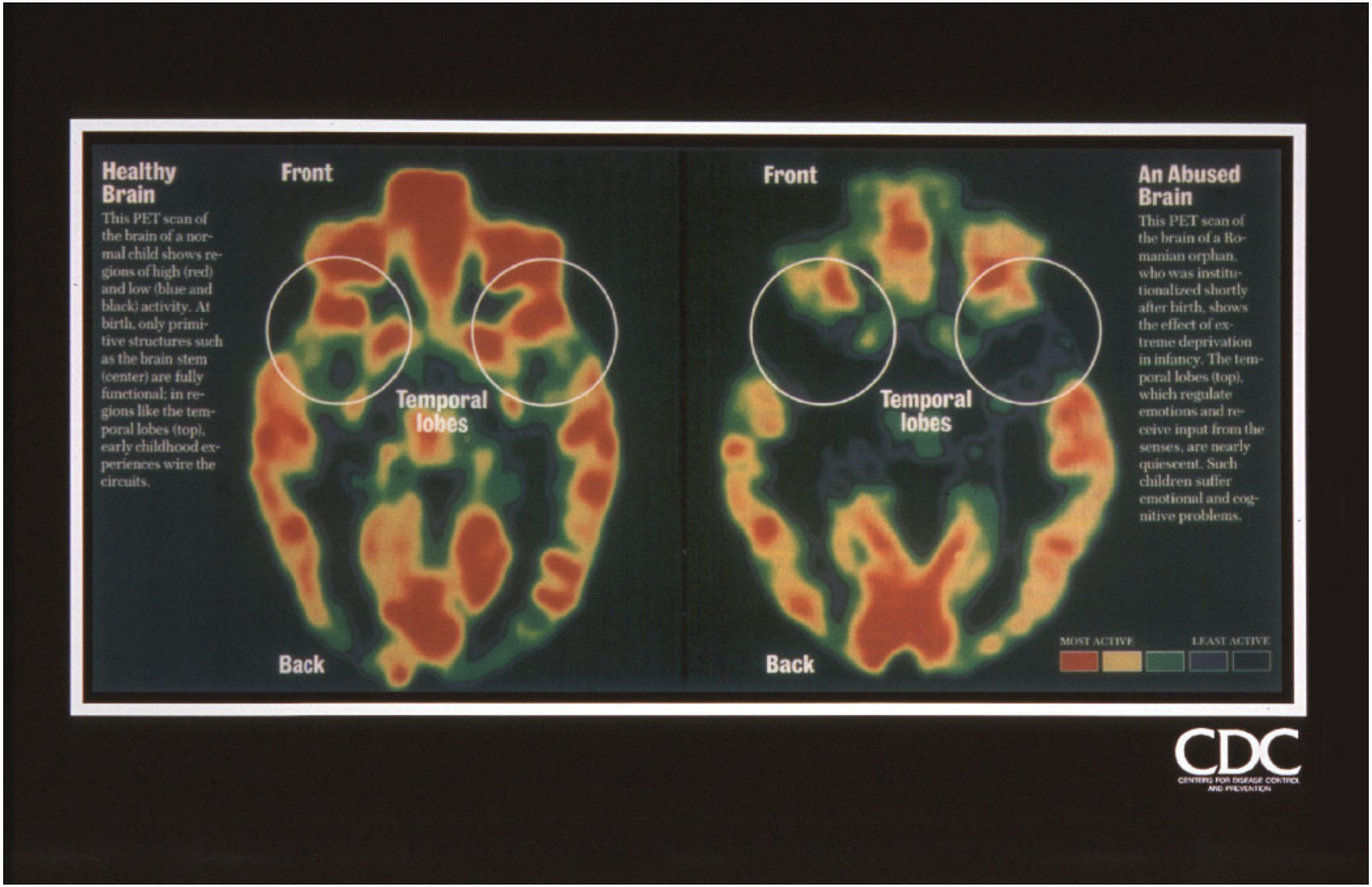
The Body Remembers



(As cited by Felitti & Anda, 2003; Source CDC)

Neurobiological Effects Of Early Childhood Trauma

- **Structural Effects**: Larger lateral ventricles; smaller intracranial volume (De Bellis, Keshavan, et al., 1999)

- **Chemical effects**: Dysregulation of stress hormones (De Bellis, Chrousos, et al., 1994; Hart, Gunnar, & Cicchetti, 1996; Kroupina et al., 1997; Tarullo & Gunnar, 2006)

- **Neuropsychological effects**: Higher neurological sensitivity to angry visual and auditory stimuli (Pollak, Cicchetti, Klorman, & Brumaghim, 1997; Shackman, Shackman, & Pollak, 2007)

- **Chromosomal Effects:** Telomere erosion; shorter telomere length (O'Donovan et al., 2011; Shalev et al., 2012)

Cognitive Effects Of Early Childhood Trauma

- Controlling for genetic factors, 5 year old twins exposed to domestic violence (DV) showed an 8-point loss in IQ
- DV-exposed preschoolers scored significantly lower than non-exposed peers matched on a range of variables
- DV-exposed preschoolers show decreased performance on memory tasks

(Koenen et al., 2003; Ybarra et al., 2007; Jouriles et al., 2008)

Socioemotional/Behavioral Effects Of Early Childhood Trauma

- Preschoolers exposed to violence have more relationship problems with peers and teachers: negative affect, aggression, inappropriate situational responses
- Preschoolers with trauma history had more oppositional behavior and separation anxiety, internalizing and externalizing problems
- Early physical abuse is more predictive of behavior problems 9 years later than physical abuse after age 5

(Litrownik et al., 2003; Scheeringa et al., 2003; Graham-Berman & Levendosky, 1998; Yates et al, 2003; Appleyard et al., 2005)

Do Young Children Remember?

- Implicit versus verbal memory
- After acquiring language, children describe pre-verbal experiences
- Children may misunderstand events that they remember
- Memory is not static

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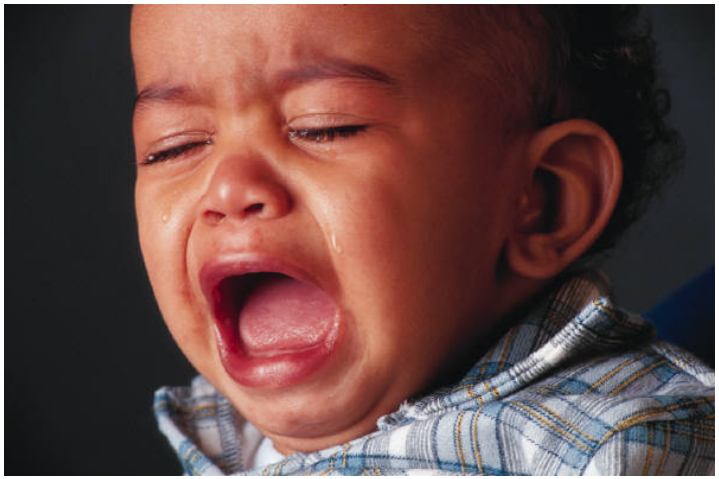
Traumatic Stress In Infants And Young Children

- Re-experiencing trauma (flashbacks, nightmares)
- Numbing (social withdrawal, play constriction)
- Increased arousal (attention problems, hypervigilance)
- **New Symptoms**
  - **Aggression**
  - **Sexualized behavior**
  - **New fears**
  - **Loss of developmental milestones (Regression)**



Prevalence of Trauma Exposure: Help Seeking Sample (Participants)

- Children aged 3-6
- Predominantly ethnic minority (31.8% Black, 43.5% Hispanic/Latino), low income, urban
- Families seeking mental health, developmental screening services
  - Social, emotional, and behavioral problems (42.9%)
  - Parent support and education (23.4%)
  - Developmental issues and concerns (14.3%)
  - Exposure to violence and abuse (13%)

(Crusto et al., 2010)

Prevalence of Trauma Exposure: Help Seeking Sample (Findings: Trauma Exposure)

- **On average, children experienced 4.9 traumatic and stressful life events**
- **Over 48% experienced 5+ traumatic and stressful life events**
- **39% had symptoms of Posttraumatic Stress Disorder**

Witnessing violence

- Domestic violence - heard or seen family assaulting each other: 42%
- Community violence – physical assault between nonfamily members: 27%

Separation from important people

- Been separated from a caregiver: 41%
- Death of someone close: 15%
- Severe injury or illness of someone close 15%
- Someone close to child attempted suicide: 6%

Direct abuse and/or neglect

- Physical aggression - been physically assaulted or beaten: 18%
- Been without food, water, shelter: 11%
- Forced to see or do something sexual: 6%

Crusto et al., 2010

Adverse Childhood Experiences Can Last A Lifetime

- Emotional, physical or sexual abuse
- Domestic violence against the mother
- Household member with mental illness
- Household member with substance abuse
- Household member ever imprisoned
- Absence of one or both parents
- Physical or emotional neglect

Predict the 10 leading causes of adult death/disability

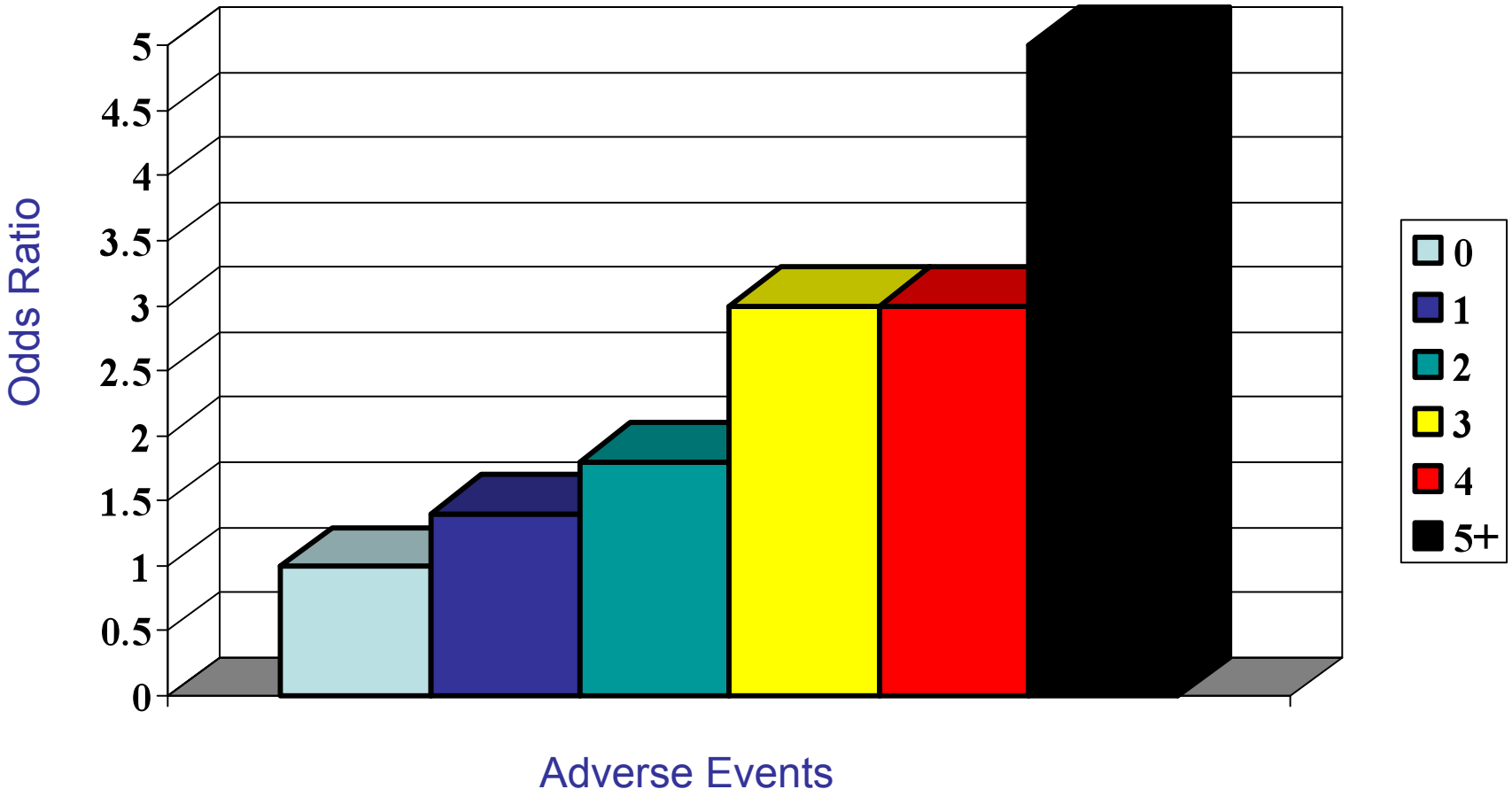
(ACE Study, Felitti et al. 1998)

Childhood Adversity Predicts Future Dysfunction

- Physical Illness
- Mental Illness
- School Failure
- Aggression
- Substance Abuse
- Criminal Behavior

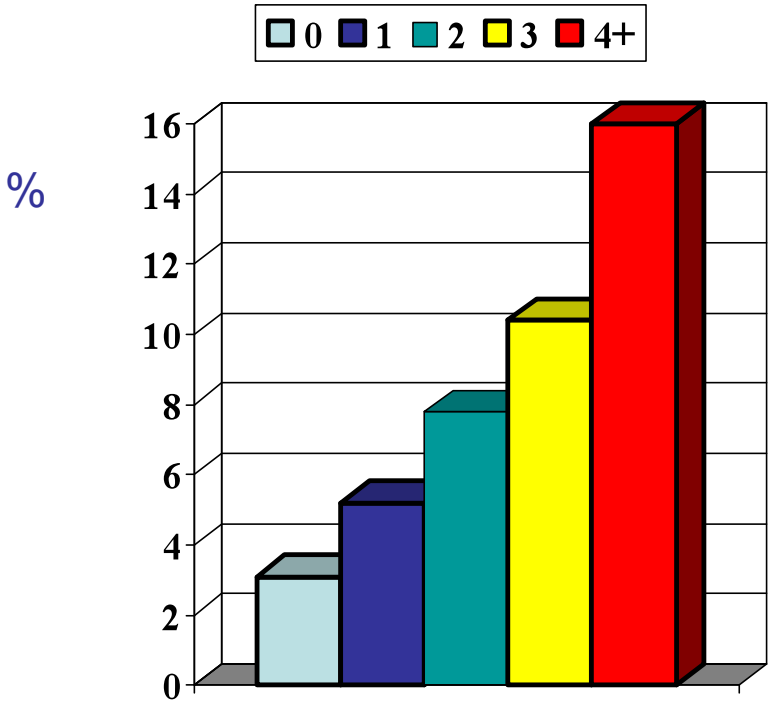
(Cook et al., 2003; Felitti et al., 1998; Pynoos et al., 1999)

Adverse Childhood Events And Adult Depression

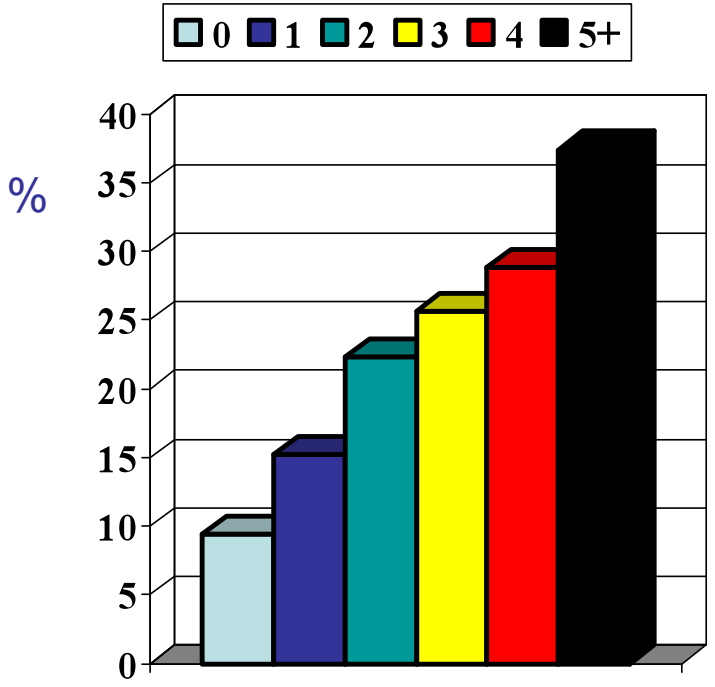


Chapman et al, 2004

Adverse Childhood Events And Adult Substance Abuse

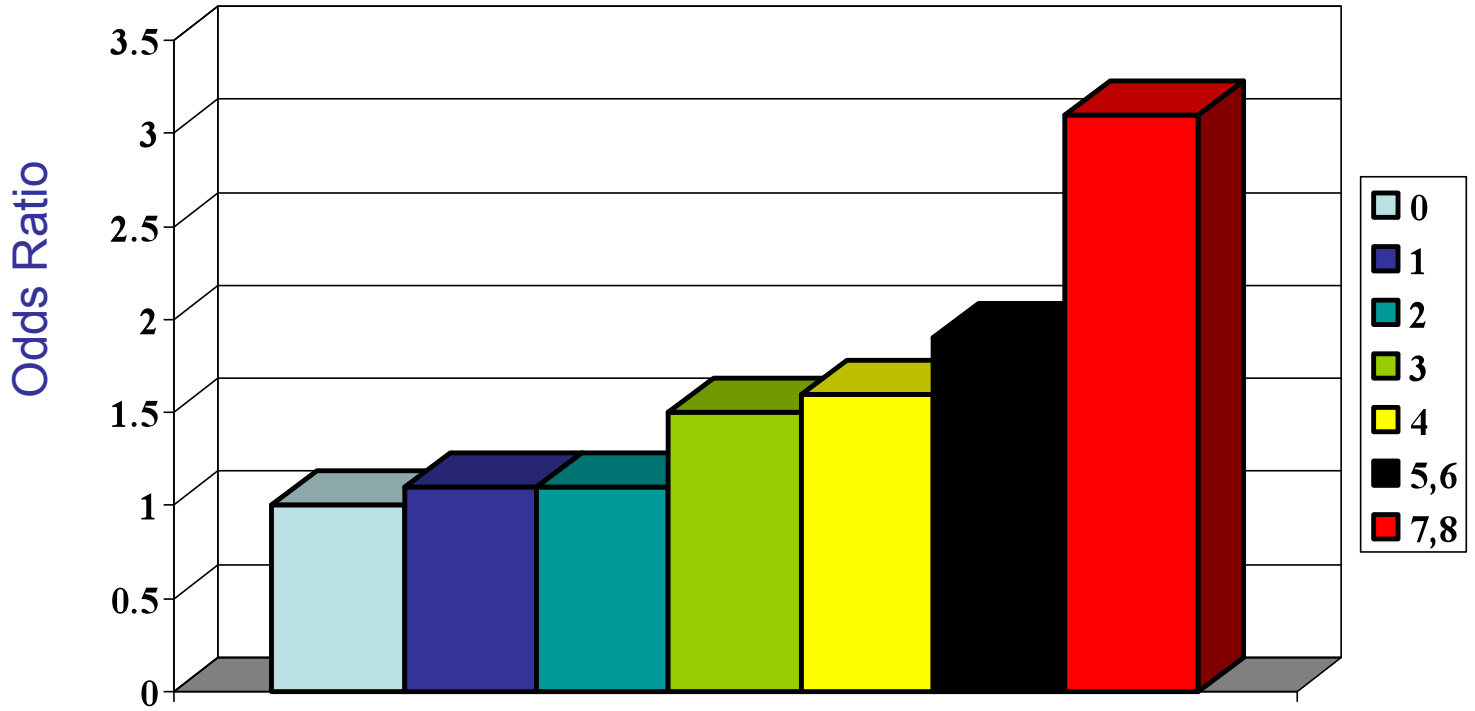


Self-Report: Alcoholism
Dube et al, 2002



Self-Report: Illicit Drug Use
Dube et al, 2005

Adverse Childhood Events And Adult Ischemic Heart Disease



Dong et al, 2004

National Comorbidity Survey Replication

- The National Comorbidity Survey Replication (NCS-R) sample was collected in 2001-2003 (N= 5692, response rate = 70.9%)
- Face-to-face structured diagnostic interview for 26 DSM Axis I disorders
- The weighted sample is representative of U.S. population on census indicators (age, gender, race, education, marital status, region)

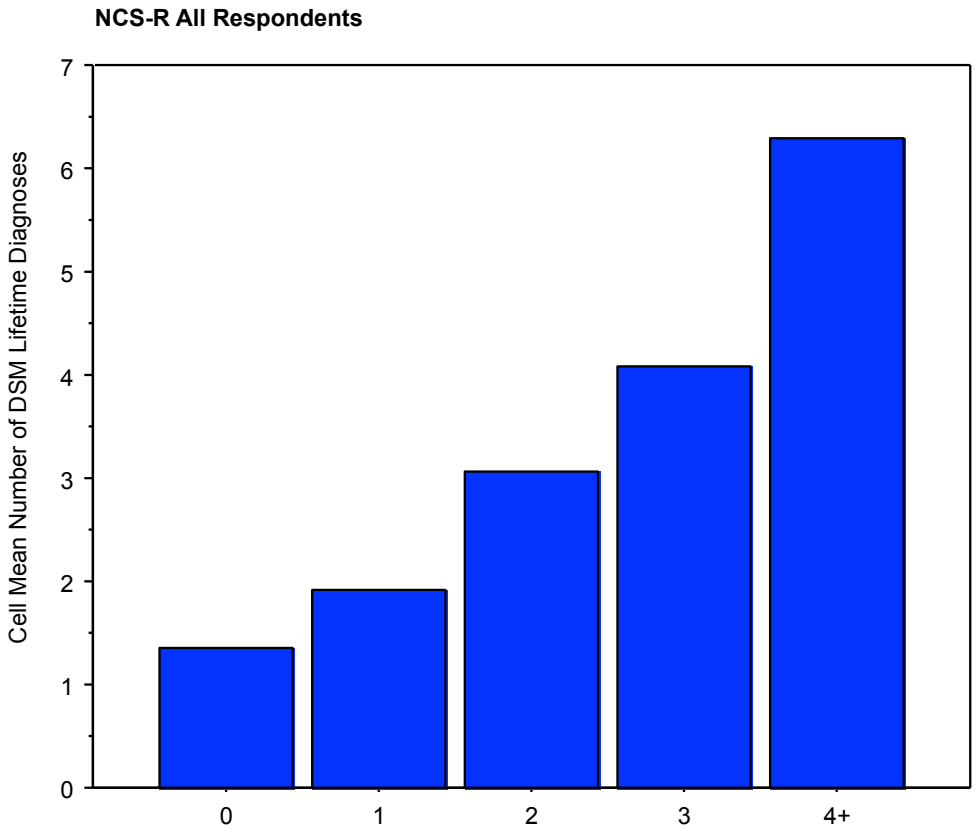
Cumulative Risk Scores

- The NCS-R inquired about adverse childhood antecedents occurring ≤18 years including: 1) sexual abuse, 2) physical abuse, 3) parental depression, 4) parental substance abuse, 5) being a crime victim, 6) loss of a parent and 7) exposure to domestic violence
- For each subject, a Cumulative Risk Score (CRS) was calculated by adding the number of positive childhood antecedents that happened '***most***' or '***all***' of the time.
- An "ACE-type" analysis was performed comparing the number of lifetime DSM diagnoses for CRS = 0, 1, 2, 3, and ≥ 4 or more childhood antecedents

Childhood Adversity is Cumulative

Individuals with CRS ≥ 4 average 6.29 (± 0.3) DSM Axis I Diagnoses

Mean Number of DSM diagnoses by Cumulative Risk Score

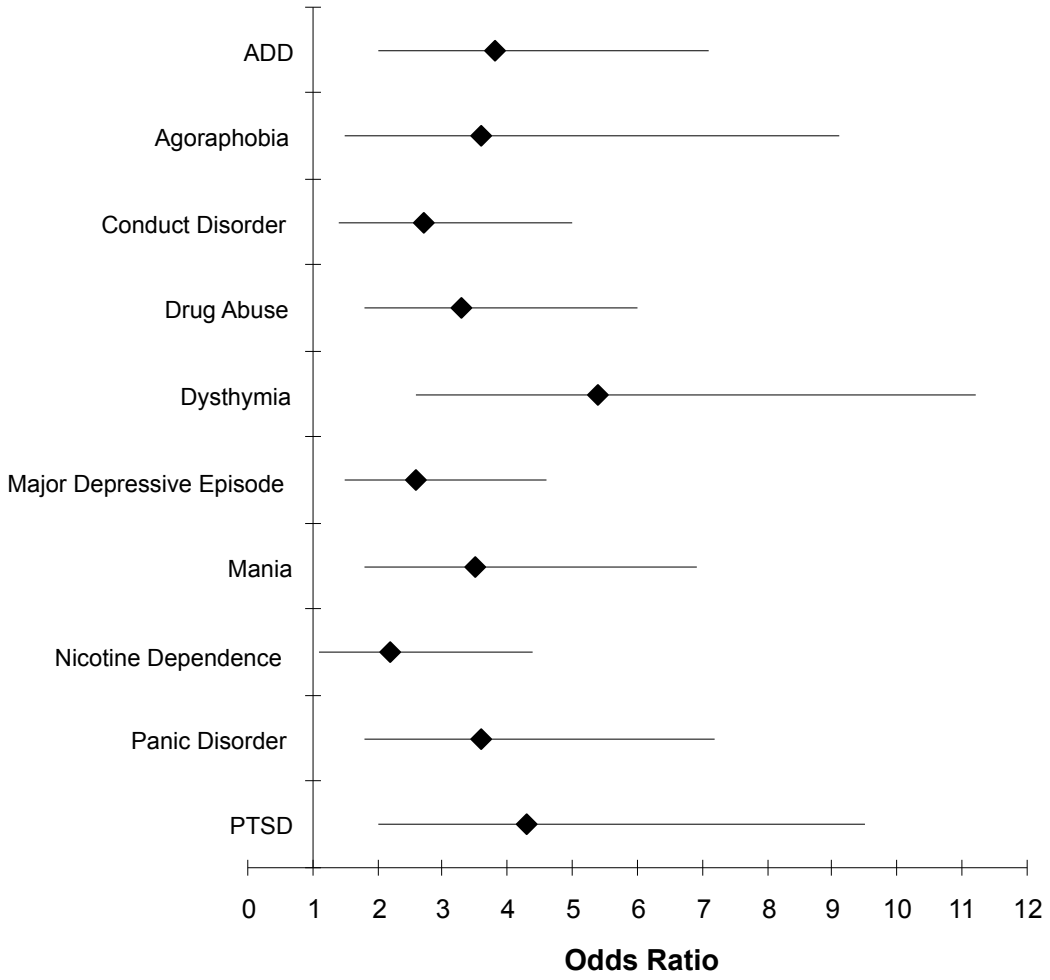


Overall Sample

CR score	mean	se	n
0	1.35	0.057	2806
1	1.92	0.09	1598
2	3.07	0.18	669
3	4.09	0.236	365
4+	6.29	0.3	252

OhioCanDo4Kids.Org

Childhood Sexual Abuse Alone Significantly Increases Risk for a Range of Psychiatric Disorders in Males



DSM Lifetime Diagnoses	OR	95% CI
ADD	3.8	2.0-7.1
Agoraphobia	3.6	1.5-9.1
Conduct Disorder	2.7	1.4-5.0
Drug Abuse	3.3	1.8-6.0
Dysthymia	5.4	2.6-11.2
Major Depressive Episode	2.6	1.5-4.6
Mania	3.5	1.8-6.9
Nicotine Dependence	2.2	1.1-4.4
Panic Disorder	3.6	1.8-7.2
PTSD	4.3	2.0-9.5

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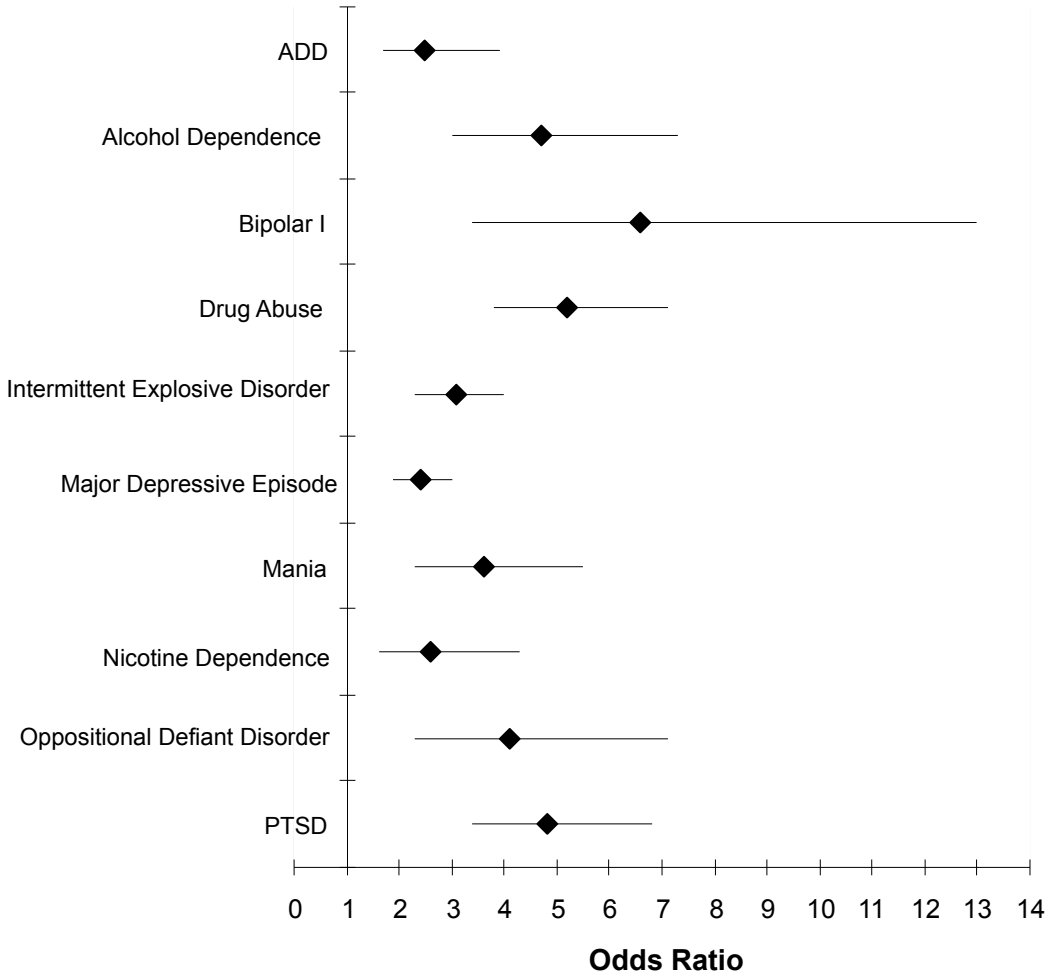
Childhood Sexual Abuse Alone Significantly Increases Risk for a Range of Psychiatric Disorders in Females



DSM Lifetime Diagnoses	OR	95% CI
ADD	2.5	1.7-3.9
Alcohol Dependence	4.7	3-7.3
Bipolar I	6.6	3.4-13
Drug Abuse	5.2	3.8-7.1
Intermittent Explosive Disorder	3.1	2.3-4
Major Depressive Episode	2.4	1.9-3
Mania	3.6	2.3-5.5
Nicotine Dependence	2.6	1.6-4.3
Oppositional Defiant Disorder	4.1	2.3-7.1
PTSD	4.8	3.4-6.8

OhioCanDo4Kids.Org

Conclusions From NCSR Data

- Increasing Childhood Risk Scores (CRS) are associated with an increased number of DSM diagnoses on structured interview in a nationally representative sample
- Individuals with CRS ≥ 4 average more than 6 DSM diagnoses
- Diagnoses in individuals with a high CRS cross multiple DSM diagnostic categories

AACAP Practice Parameters For Assessment/Treatment Of PTSD

- 1. Assessments should routinely include questions about traumatic experiences and PTSD symptoms
- 2. Parents and caregivers should be included whenever possible
- 3. Consider differential diagnoses
- 4. Comprehensive treatment approach
- 5. Include intervention for co-morbid disorders
- 6. Trauma-focused psychotherapies should be first line of treatment

Setting the Stage
Safety in the Environment

- Engage child and caregiver in
  --Safety planning
  --Meeting concrete needs
  --Protecting child from exposure to violence

- Maintain safety and consistency in the therapeutic relationship

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Therapeutic Objective: *Affect Regulation*

- Listening and observing: tracking emotions in the moment
- Giving words to the unspeakable
- Modeling soothing, calming interactions
- Helping the parent respond to the child
- Helping the child rely on the paren

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Therapeutic Objective: *Normalizing Traumatic Responses*

- "If you don't ask, they won't tell"
- Validate traumatic response as universal and legitimate
- Identify traumatic triggers
- Co-creation of trauma narrative
- Placing trauma in perspective with life goals

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Therapeutic Objective: *Trust in Bodily Sensations*

- **"Listening to the body"**
  Sensory numbness versus hyper-awareness

- **Appropriate physical affection**
  Proximity and closeness, holding, hugs

- **Care of the body, care of the soul**
  Hygiene, food, movement, rest

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Therapeutic Objective: *Reciprocity in Relationships*

- Legitimize client's perspective
- Articulate the other's perspective
- Highlight the positive
- Target maladaptive interactions
- Guide non-destructive expression of negative feelings

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Therapeutic Objective: *Differentiate Between Reliving and Remembering*

- Link current thoughts, feelings and behaviors with past experiences

- Focus on safety: Highlight differences between past and present circumstances

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Therapeutic Objective: *Engagement in learning*

Promote mastery and hope through

- Prosocial behavior
- Predictable routines
- Joint pleasurable activities
- Age-appropriate goals
- Memories of loving moments

  ("Angels in the nursery")

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Clinical Approaches To Trauma Narrative

- Planned, didactic, structured, verbal
- Spontaneous, unplanned, behavioral
- Optimal mixture:
  - -- “Progress favors the prepared clinician”
  - -- Preparing the ground
  - -- Extending/deepening narrative stems

Treatment Is Not Enough: Ecology Matters

Protective & Risk Factors

"Allostatic load"

Macrosystem: cultural practices

Exosystem:neighborhood & community

Microsystem: family inter-relationships

Ontogenetic development: individual adaptation

(Bronfenbrenner, 1979; Cicchetti & Lynch,1993; Sameroff, 1993; Rutter,2000)

Trauma As A Supra-Clinical Phenomenon

"This ecological-transactional approach, although long recommended, is seldom implemented. The psychiatric and behavioral manifestations of traumatic stress are so compelling that …child trauma is seen only as a clinical phenomenon… This narrow focus must be super-ceded by the ubiquity of trauma as the frequent cause of physical and mental illness, school underachievement and failure, substance abuse, maltreatment, and criminal behavior… we are dealing with a supra-clinical problem that can only be resolved by going beyond the child's individual clinical needs to enlist a range of coordinated services for the child and the family."

(Harris, Lieberman & Marans, 2007)

A Continuum of Services

TAKE HEART!

- Small changes matter
- Mistakes can be repaired
- You don’t need to be a therapist to be therapeutic
- Define yourself as part of a therapeutic community