PTSD, ACES and Resilience

Eve Spratt, MD, MSCR

The Four R's of Trauma Informed Care
BUILD RESILENCE TO CHILDHOOD TRAUMA

Realize – widespread impact of trauma and potential paths to recovery

Recognize signs and symptoms in clients, families, staff

Respond by fully integrating knowledge into policies, procedures and practices

Resist Retraumatization of children as well as the adults who care for them.

STRENGTHS BASED PERSPECTIVE – Encourage healthy habits, good sleep hygiene, exercise, mindfulness, belly breathing, positive self talk

Why focus on pediatric traumaticstress?

High prevalence

Poor Mental Health Outcomes

Poor health outcomes and lower life expectancy

High cost

Often under diagnosed and mis diagnosed

Early identification and integrated care using evidence based treatments can increase positive outcomes

Goals are to incorporate discussions into health care, increase screening, referrals and evidence based therapy. Ultimately to speed recovery and decrease risks for maltreatment.

Intermountain Healthcare

PTSD Starts with exposure to Potentially Traumatic Event

An incident, event, situation that includes

Significant fear activation

-Perceived threat of serious physical injury

-Actual physical injury

-Perceived threat of death

-Actual death

-Sexual violence

Direct experience

Witnessing in person an event that occurs to others

Learning of event

Experiencing repeated or extreme exposure to aversive details of traumatic events

LANGUAGE can help to decrease stigma – aggressor and caregiver

National Survey of Children's Exposure to Violence (N=4503)

58% of American youth had experienced or witnessed at least one victimization in the past year

41% were physically assaulted in the past year.

10% were physically injured by violence in the past year.

15.1% experienced 6 or more victimizations in the past year

POLYVICTIMIZATION IS COMMON

National comorbidity study – 60% of adversity exposed adolescents reported multiple adversities

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Posttraumatic Stress Disorder -PTSD (DSM-5)

A. Exposure to a potentially traumatic event
B. Intrusion symptoms
C. Avoidance symptoms
D. Cognitive and Mood symptoms
E. Arousal and Reactivity symptoms
F. Symptoms persistent for at least 1 month
G. Symptoms cause significant impairment in social, occupational, school, or other important areas of functioning.
H. Not attributable to effects of substances or another medical condition.

Acute Stress Disorder – last 3 days to 1 month following exposure

Substantial progress made in understanding -the developmentatl manifestations of PTSD, -the complexities of evaluating and how to effectively treat

PTSD is one of most challenging disorders to accurately diagnose in C and A care.

Paradox – Child needing to describe experiences that they want to avoid thinking and talking about.

Comorbidity is common

- May be up to 60% with depressive disorders.
- Persistent complex bereavement can occur at any age and can be a delay before symptoms.
- May appear to have ADHD – fidgety, difficulty concentrating
- May mimic ODD – arousal symptoms present as angry outbursts or irritability.
- May present as panic or social anxiety due to distress on exposure.
- May be misdiagnosed as bipolar
- Has to be distinguished from psychotic disorders.
- In DSM-5 no longer classified with anxiety disorders–
  - new category Trauma and Stress Related disorders.

700,000 children substantiated victims of maltreatment in US each year.

Primary care providers often first line for trauma informed assessments, referrals and determining role of pharmacotherapy.
What is next? Mandated reporting, forensic evaluation, treatment with evidence based trauma informed evaluation, medical and mental health treatment

ABC- airway, breathing, circulation
DEF -reduce distress, emotional support, remember the family.

COLDER- Characteristics, onset, location, duration, exacerbation, relief

For items endorsed- how often and how severe? How disruptive to functioning?

SAFETY –home/ where is perpetrator?

Traumatic Factors predict PTSD onset, severity and persistence

Kidnapping and hostage situations

Physical abuse by caretaker

Physical assault by romantic partner

Sexual abuse and rape

Exposure to violence: domestic, terrorism, gang conflict, sniper attacks, warfare and war atrocities

Unexpected traumatic events

Witness to murder, rape, and suicide behavior

Severe accidental injury including burns, hit-and-run accidents, animal bites, toxic exposures

Life-threatening illness or life-endangering medical procedures – 20% youth with h/o CA tx. One study found nearly 20% of families with teenage survivors of childhood cancer had a parent who was experiencing PTSD.

Severe automobile, train, airplane, ship, boating accidents

Natural or human disasters

Chronic or poly victimizations

AFTERWARDS- Low parental support and hostile or coercive parenting style.

Trauma Severity and Risk Factors

Duration, Intensity, Sudden, Personal impact, Degree to which it is universally distressing. The greater the severity and chronicity, the more severe and durable are symptoms

Type I traumas (sudden, unpredictable, single-incident although may be multiply repeated) Crossover conditions from Type I to Type II are common

Type II traumas (chronic, expected, repeated, usually physical/sexual abuse) Toxic stress. Type II trauma is more likely to include denial, numbing, self-hypnosis, dissociation, and rage.

Behavioral Difficulties(e.g., impulsivity, aggression, sexual acting out, eating disorders, alcohol/drug abuse; other self-destructive actions such as SIB)

Emotional difficulties (e.g., affective lability, rage, depression, panic)

Cognitive difficulties (e.g., fragmented thoughts, dissociation, amnesia)

Psychotic symptoms Can occur with severe trauma with chronic symptoms. Proximity and severity of trauma

Only a minority of children develop PTSD following exposure to an acute overwhelming stressor

Chronicity of trauma , Age (worse younger), Previous psychopathology, Family history of anxiety or mood disorder, Lack of supports and Lack of validation

ADVERSE CHILDHOOD EXPERIENCES INCLUDE:

ADVERSE CHILDHOOD EXPERIENCES HAVE BEEN LINKED TO:

Risky Health Behaviors

Chronic Health Conditions

Low Life Potential

Early Death

Adverse Childhood Experiences

ACEs operational definition of Trauma

- Recurrent and severe physical abuse
- Recurrent and severe emotional abuse
- Sexual abuse

Growing up in household with:

- Alcohol or drug user;
- Member being imprisoned;
- Mentally ill, chronically depressed, or institutionalized member;
- Mother being treated violently;
- Both biological parents absent; and
- Emotional or physical abuse

(Fellitti et al, 1998)

ABUSE

Physical

Emotional

Sexual

NEGLECT

Physical

Emotional

HOUSEHOLD DYSFUNCTION

Mental Illness

Incarcerated Relative

Mother treated violently

Substance Abuse

Divorce

The ACE (Adverse Childhood Experience) Study

Conducted by the US Center for Disease Control & Kaiser Permanente

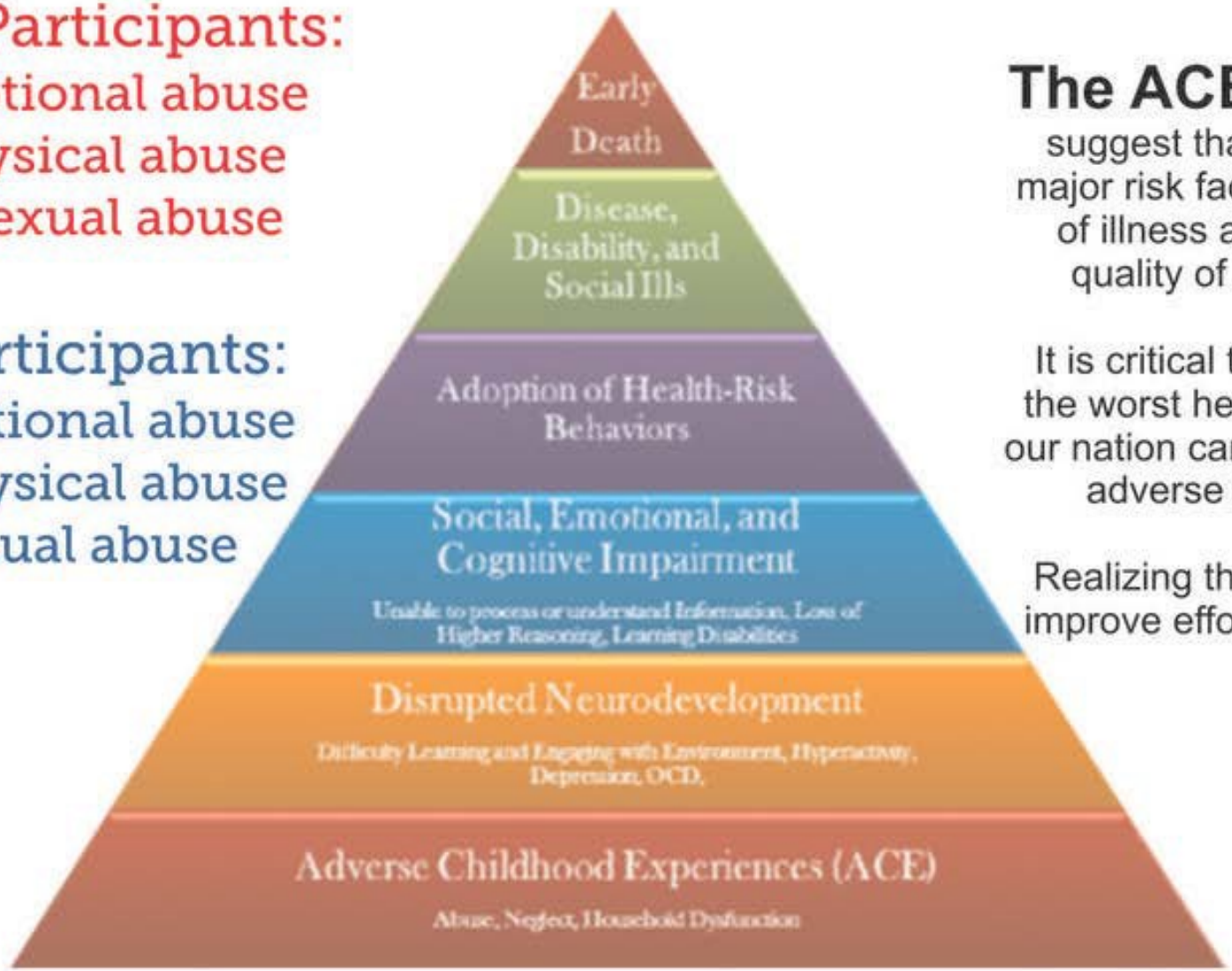
17,000 PARTICIPANTS SURVEYED

Female Participants:

13% emotional abuse
27% physical abuse
24.7% sexual abuse

Male Participants:

7.6% emotional abuse
29.9% physical abuse
16% sexual abuse



The ACE Study Findings

suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States.

It is critical to understand how some of the worst health and social problems in our nation can arise as a consequence of adverse childhood experiences.

Realizing these connections is likely to improve efforts towards prevention and recovery.

ACEs impact a child's development, their relationships with others, and increase the risk of engaging in health-harming behaviours, and experiencing poorer mental and physical health outcomes in adulthood. Compared with people with no ACEs, those with 4+ ACEs are:

2x more likely to binge drink and have a poor diet

3x more likely to be a current smoker

4x more likely to have low levels of mental wellbeing & life satisfaction

5x more likely to have had underage sex

6x more likely to have an unplanned teenage pregnancy

7x more likely to have been involved in violence

11x more likely to have used illicit drugs

11x more likely to have been incarcerated

Trauma is common, impairing and frequently missed

» Trauma/toxic stress impact health outcomes in *EVERY* organ system

. Depression, Psychiatric Illness
. Cardiovascular Disease, Stroke
. Asthma, COPD
. Liver Disease, Alcoholism
. Immune System Dysfunction
. Auto-immune disease
. Obesity
. Cancers
. ETC

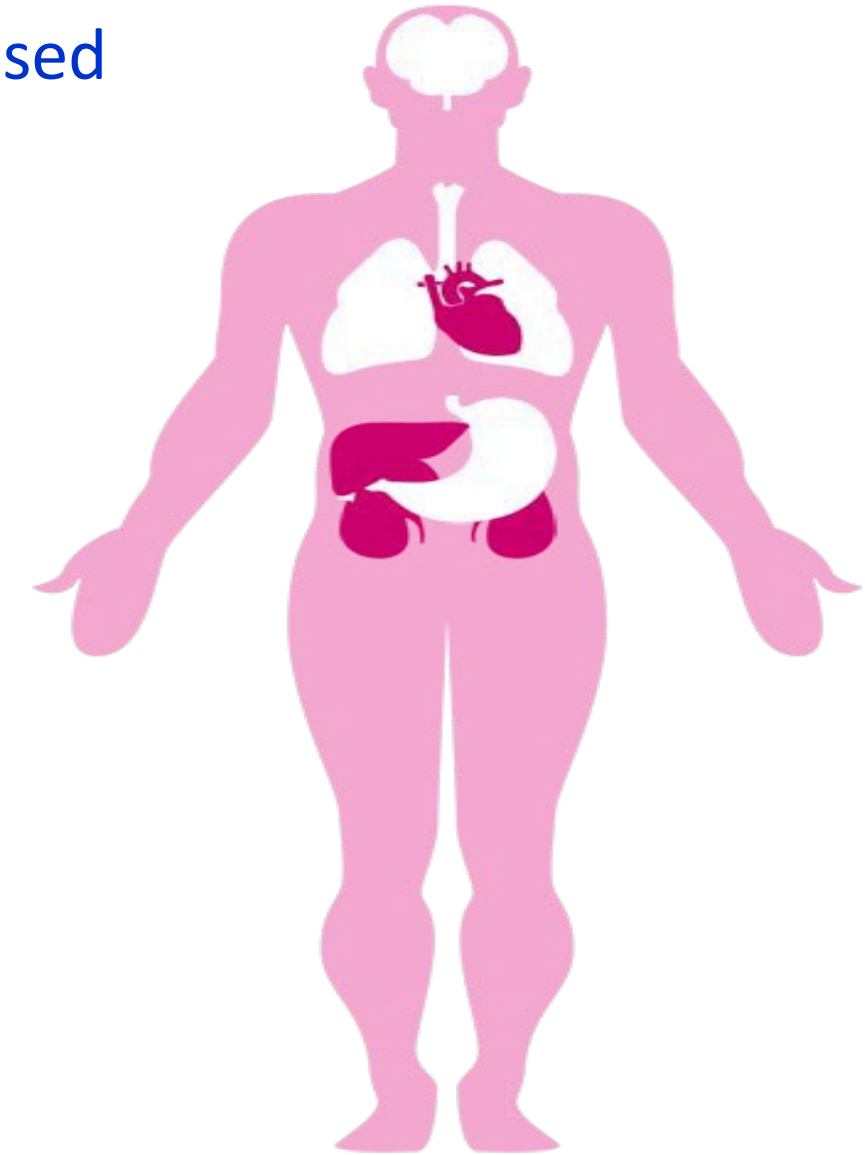


Table 1. ACE-Related Odds of Having a Physical Health Condition[1]

Health Condition	0 ACEs	1 ACEs	2 ACEs	3 ACEs	4+ ACEs
Arthritis	100%	130%	145%	155%	236%
Asthma	100%	115%	118%	160%	231%
Cancer	100%	112%	101%	111%	157%
COPD	100%	120%	161%	220%	399%
Diabetes	100%	128%	132%	115%	201%
Heart Attack	100%	148%	144%	287%	232%
Heart Disease	100%	123%	149%	250%	285%
Kidney Disease	100%	83%	164%	179%	263%
Stroke	100%	114%	117%	180%	281%
Vision	100%	167%	181%	199%	354%

A PERSON WITH 4 OR MORE ADVERSE CHILDHOOD EXPERIENCES IS*

2.2 TIMES AS LIKELY TO HAVE ISCHEMIC HEART DISEASE

2.4 TIMES AS LIKELY TO HAVE A STROKE

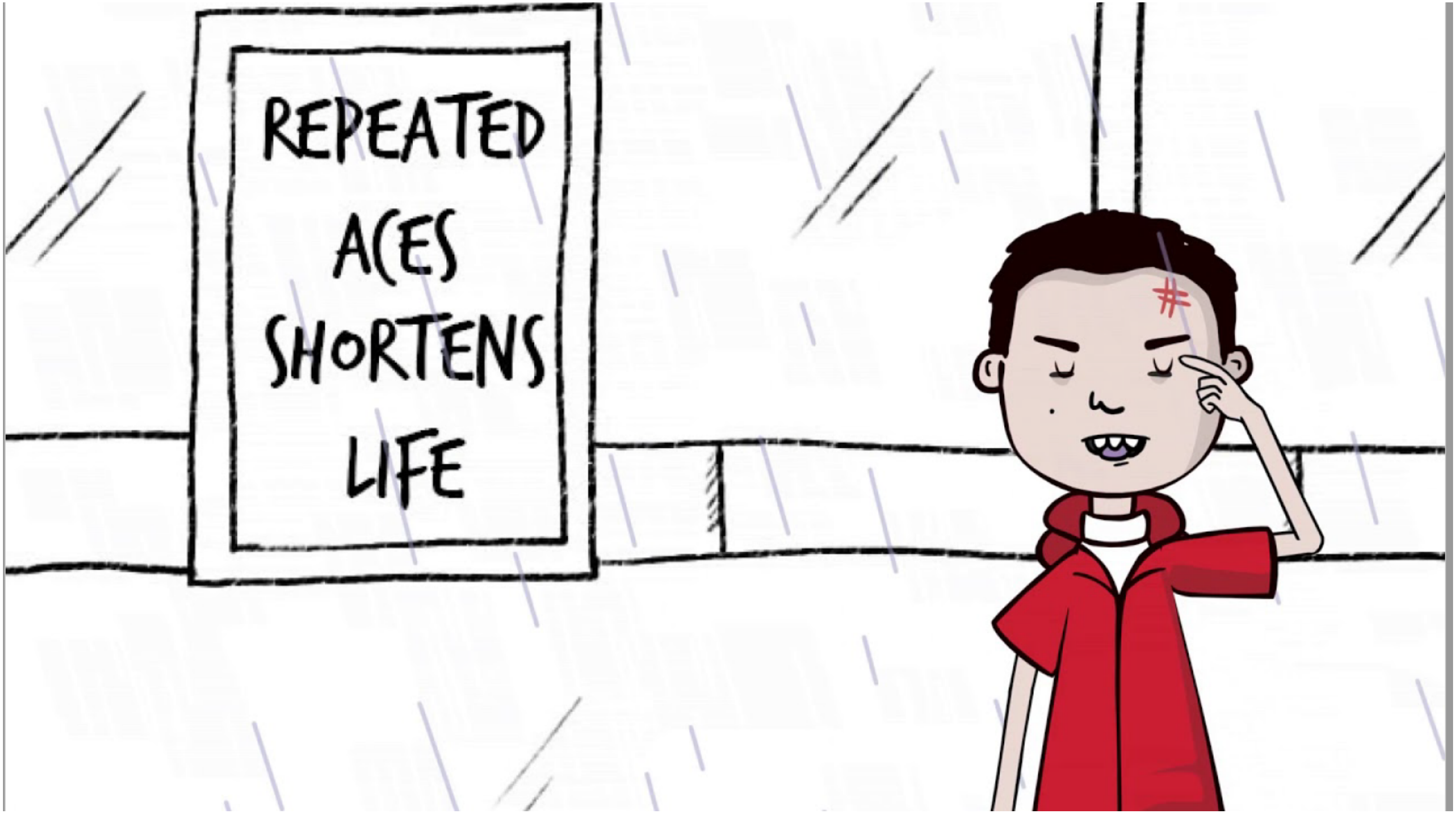
1.9 TIMES AS LIKELY TO HAVE CANCER

1.6 TIMES AS LIKELY TO HAVE DIABETES

*Vincent J. Felitti, et al., The Adverse Childhood Experiences (ACE) study, 14 AMERICAN J. OF PREVENTATIVE MEDICINE 245 (1998).

CENTER FOR YOUTH WELLNESS

health begins with hope


REPEATED
ACES
SHORTENS
LIFE

INTIMATE PARTNER VIOLENCE

Scope of the Impact

- Considered an international epidemic
- The leading cause of injury to women in the U.S.
- One in four women and one in six men experienced contact sexual violence, physical violence, and stalking in their lifetime
- Claims a life in the United States every six hours
- 40 million adult Americans grew up living with IPV (328,239,523 – current population; 199 million adults ages 18 to 64)
- More prevalent among married or cohabitating couples with children
- 275 million children in the world and more than 10 million children in the U.S. witness IPV annually (73.6 million children in the U.S.)

INTIMATE PARTNER VIOLENCE PLUS PHYSICAL ABUSE

The Double Whammy Phenomenon

- IPV co-occurs with physical abuse in 30% to 60% of cases
- Children who experience the "double whammy phenomenon" fare worse.
  - odds of committing felony assault are 2.19 times higher
  - odds of committing minor assault are 2.67 times higher
  - odds of delinquency are 2.47 times higher
  - odds of status offenses are 4.57 times higher
  - children are less attached to their caregivers in the years following exposure
- The presence of multiple stressors including abuse, housing problems, mental health difficulties, substance abuse has been termed the "adversity package" and this elevates risk for negative outcomes for the child

Intimate Partner Violence (CDC's IPV Survey)

WOMEN

20.5% were concerned for their safety

17.6% reported being fearful

14.9% experienced PTSD symptoms

12.4% were injured

11.5% needed help from law enforcement

MEN

5.3% were concerned for their safety

4.4% reported being fearful

4.% experienced PTSD symptoms

4.0% were injured

5.% needed help from law enforcement

INTIMATE PARTNER VIOLENCE

Children's Experience

- Parents may think children are not impacted because they keep them out of violent episodes
- Witnessing violence does not mean the child is in the visible range of the violence
- Children describe traumatic events they have heard but not seen
- Children describe traumatic events they have heard about or see the aftermath

OTHER STRESSORS

- ***Repeated separations***
- ***Ongoing violence during visitation***
- ***Prolonged child custody battles in court***
- ***Currently – COVID-related, staying home, financial worries***

ADULTS

- Thinking back on their childhood experiences and normalizing their own feelings if they were a child of IPV
- Prevention – Understanding the impact of IPV on their children may be a factor in caregiver motivation to change
  - *Most IPV aggressors are interested in treatment that includes their partner & family*
  - *Almost half report that their conflict occurred in front of children or grandchildren*
  - *Children who grow up in homes with IPV are 3 times more likely to repeat the cycle in adulthood- gives caregivers a chance to think of the future they want for their children, to consider what dreams they have for their children, what they want for their child in adulthood*

THE IMPORTANCE OF UNDERSTANDING THERE IS IMPACT FROM INTIMATE PARTNER VIOLENCE

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very 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?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very 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?
   Yes No If yes enter 1 _____

5. Did you **often or very 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?
   Yes No If yes enter 1 _____

6. Were your parents ever separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

092406RA4CR

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes No If yes enter 1 _____

10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

092406RA4CR

Consider adding
Racism
Bullying
Ostracism
Medical illness

Synergistic adversities-Putnam, Jackson, Putnam, Briggs, 2020

Higher ACES denoting elevated risk.

However 4 or more All ACES are not equal.

10,355 clinic referred youth ages 1.5 to 18 from NCTSN.

Only 4 pairings of adversity were synergistic on the CBCL for behavior problems–

3 involved sexual abuse with physical abuse, parental loss and domestic violence.

Sexual abuse most malignantly synergistic, pairing most frequently by physical abuse or neglect.

What Can We Do? STAR

- **S**creen –
- **T**ally – What do screens tell you?
- **A**sk - HOW to ask?
- **R**efer –
  - Forensic evaluation
  - Clinical evaluation
  - Mental health treatment
- Evidence-based, trauma-informed services
  - Trauma treatments (e.g., TF-CBT, CPT, PE)
  - Combination treatments (e.g., RRFT, FFT, MST, CBT, PCIT,
  - Other

- SYMPTOMS VARY BY AGE
- EBT always preferred tx
- Bridge the Interventions until EBT

Child ID: _____ Child Age: _____
Caregiver Relationship to Child: _____ Date: _____

Pediatric Symptom Checklist-17 (PSC-17)

INSTRUCTIONS: Emotional and physical health go together in children. Because caregivers are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child. We want to know how your child is doing at the present time or within the past 2-4 weeks, and not about problems from long ago.

	Please mark under the heading that best fits your child			For Office Use		
Does your child:	**Never**	**Sometimes**	**Often**	**I**	**A**	**E**
1. Feel sad, unhappy.						
2. Feel hopeless						
3. Feel down on him/herself.						
4. Worry a lot.						
5. Seem to be having less fun						
6. Fidget, is unable to sit still.						
7. Daydream too much						
8. Distract easily.						
9. Have trouble concentrating/paying attention						
10. Act as if driven by a motor						
11. Fight with other children.						
12. Not listen to rules.						
13. Not understand other people's feelings						
14. Tease others.						
15. Blame others for his/her troubles.						
16. Refuse to share.						
17. Take things that do not belong to him/her						
These next three questions are about violent, traumatic or upsetting events that may have happened to your child or that your child witnessed at any time in the past. Please answer if these behaviors have occurred (not the event) within the past 2-4 weeks.						
Does your child:	**Never**	**Sometimes**	**Often**			
Gets very upset if reminded of the events						
More physical complaints when reminded of the events, such as headaches or stomach aches						
Can't stop thinking about the events, even when she or he tries not to						

These next three questions are about violent, traumatic or upsetting events that may have happened to your child or that your child witnessed at any time in the past. Please answer if these behaviors have occurred (not the event) within the past 2-4 weeks.

Does your child:	Never	Sometimes	Often			
18. Gets very upset if reminded of the events						
19. More physical complaints when reminded of the events, such as headaches or stomach aches						
20. Can't stop thinking about the events, even when she or he tries not to						

INTIMATE PARTNER VIOLENCE

Effect on the Parent-Child Relationship

- Children look to caregivers for safety and modeling self-regulation, risk in one affects the other and interrupts the bond and damages the relationship
- Chronic unavailability of a parent for young children increases the risk of stressful experiences and difficulty in attachment and being able to self soothe in difficult times
- Children who experience abusive or unattached caregiving are likely to develop negative reactions to their caregiver
- Will the parent accept responsibility?

Re-Experiencing of Trauma may differ by age

Thoughts often focus on moments of extreme horror or hopelessness during the event

Memories (visual, auditory, somatic)

Recurrent distressing dreams of the event or frightening dreams without recognizable content

Flashbacks with arousal and emotions

Spontaneously or in response to traumatic reminders

Trauma -specific re-enactment

Repetitive traumatic play in children (e.g. sexual or aggressive play)

Mental re-visitation


BEHAVIOR
TRAUMA
(ACES)

Co-Morbidities and Differential Diagnosis

Co-Morbidities

- Depression
- ADHD and Bipolar disorder (which can be risk factors)
- Psychosis (seen with severe PTSD)
- Other anxiety disorders (especially panic disorder with agorophobia and separation anxiety disorder)
- Borderline personality disorder (with PTSD Type II)
- Eating disorders (with PTSD Type II)

Differential Diagnosis

- ADHD
- Bipolar disorder

The Effects of Early Neglect on Cognitive, Language, and Behavioral Functioning in Childhood

Eve G. Spratt1,2*, Samantha Friedenberg2, Angela LaRosa1, Michael D. De Bellis3, Michelle M. Macias1, Andrea P. Summer1, Thomas C. Hulsey1, Des K. Runyan4, Kathleen T. Brady2

Children, ages 3 to 10 years with a history of familial neglect (USN), were compared to children with a history of institutional rearing (IA) and children without a history of neglect

-Children with a history of neglect demonstrated lower cognitive and language scores and more behavioral problems.

-Externalizing behavior problems predicted parenting stress.

-Comparing the two neglect groups, shorter time spent in a stable environment, lower scores on language skills, and the presence of externalizing behavior predicted lower IQ.

Chronic and acute illness can be associated with PTSD

One study - Bullying and Ostracism associated with depression more than illness

Adjustment challenges- in general twice the risk of those without chronic illness.

From acute to chronic – the responsibility to manage illness is transferred from physician to patient/ family.

Complex treatment - Often daily adjustments

Pain as part of illness, pain as part of intervention. Severity. High risk periods

Family factors – only as happy as saddest child. Social support

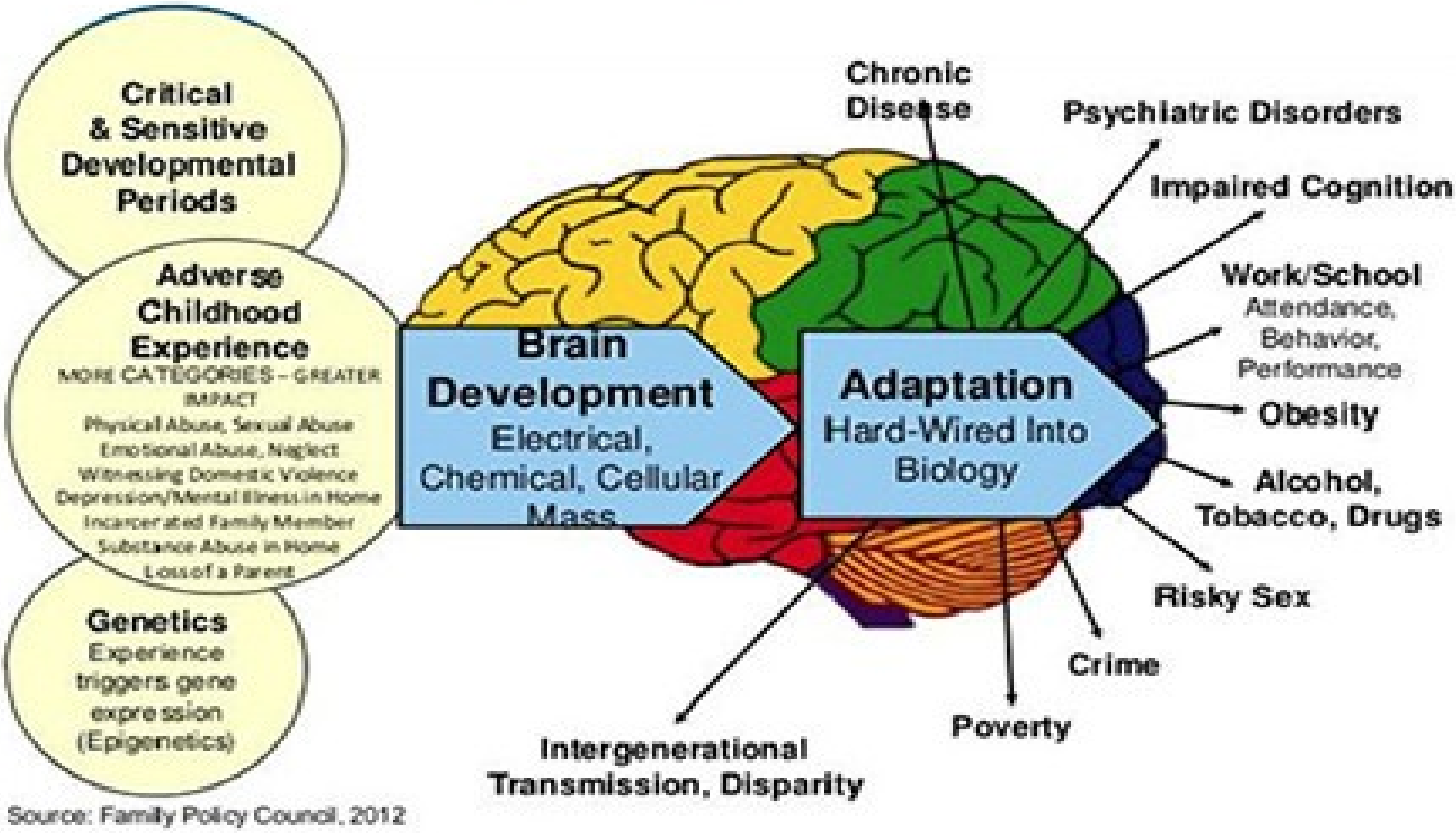
Developmental age - can have delayed onset - Piaget formal ope
independence compared to age expectations. Problem solving a

Parenting stress – Mothers with PTSD 20% with childhood CA

20% youth may have PTSD

INTERVENTION WILL TYPICALLY INVOLVE THE FAMILY

Lifespan Impacts of ACEs



Source: Family Policy Council, 2012

Neurodevelopmental Traumatology

Trauma leads to:

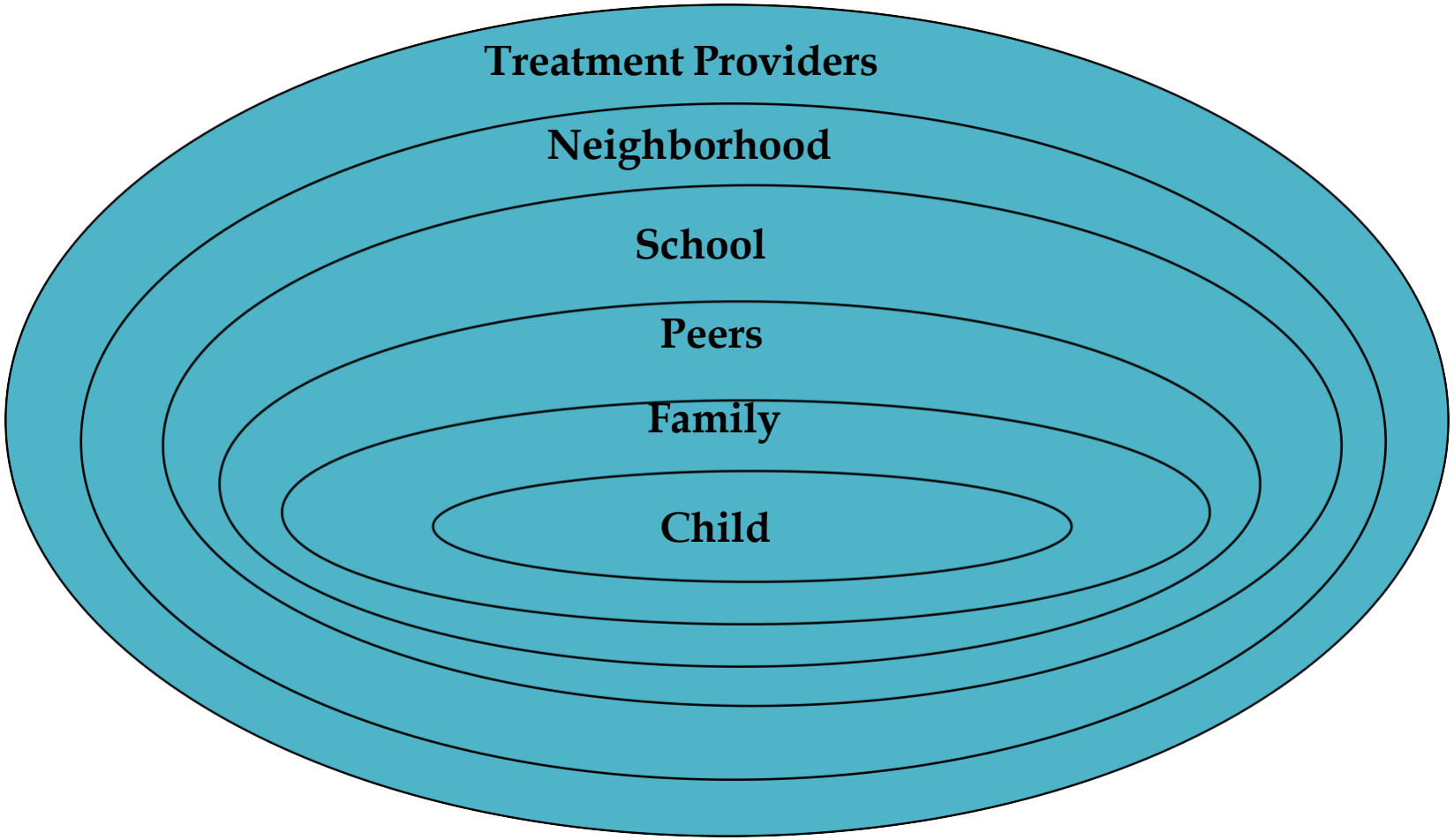
- Excess cortisol under stress, which damages:
  - *Hippocampus (memory; ability to distinguish part from present context)*
  - *Pre-frontal cortex (emotional regulation)*
  - *Amygdala (process emotions; fear responses)*
- Deficits in attention and frontal lobe function (hyperarousal –looks like ADHD)
- Dysregulation of noradrenergic and endogenous opioid systems -effect on drug cravings (mesolimbic system affected)

Neurobiological Impact of Trauma

- brain sequelae of psychological trauma
  - *Smaller hippocampal volume and less activity*
  - *Smaller amygdalar volume but more activity*
  - *Smaller pre-frontal cortex volume and lower activity*

Changes are partially reversible with psychological therapies, may need to consider pharmacotherapy as it potentially augments this effect

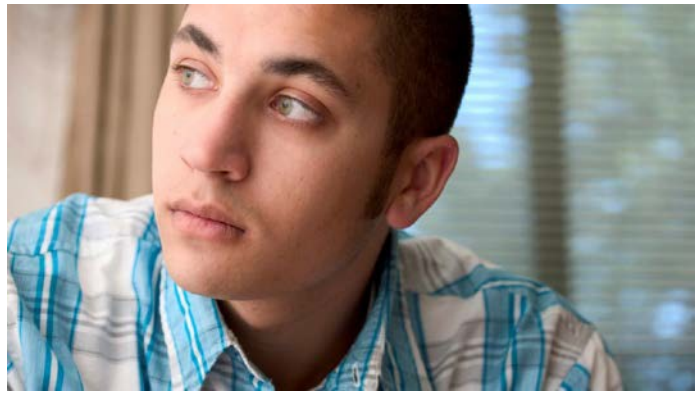
Ecological Models



Determinants of Clinical Course

Clinical course after exposure is highly variable and dependent on many other factors:

- Societal Conditions
- Secondary adversities
- Age
- Life circumstances
- Resiliency of the individual
- Response of significant others
- Genetics
- Multigenerational trauma history
- Effective treatment – always aim for Evidence based treatment

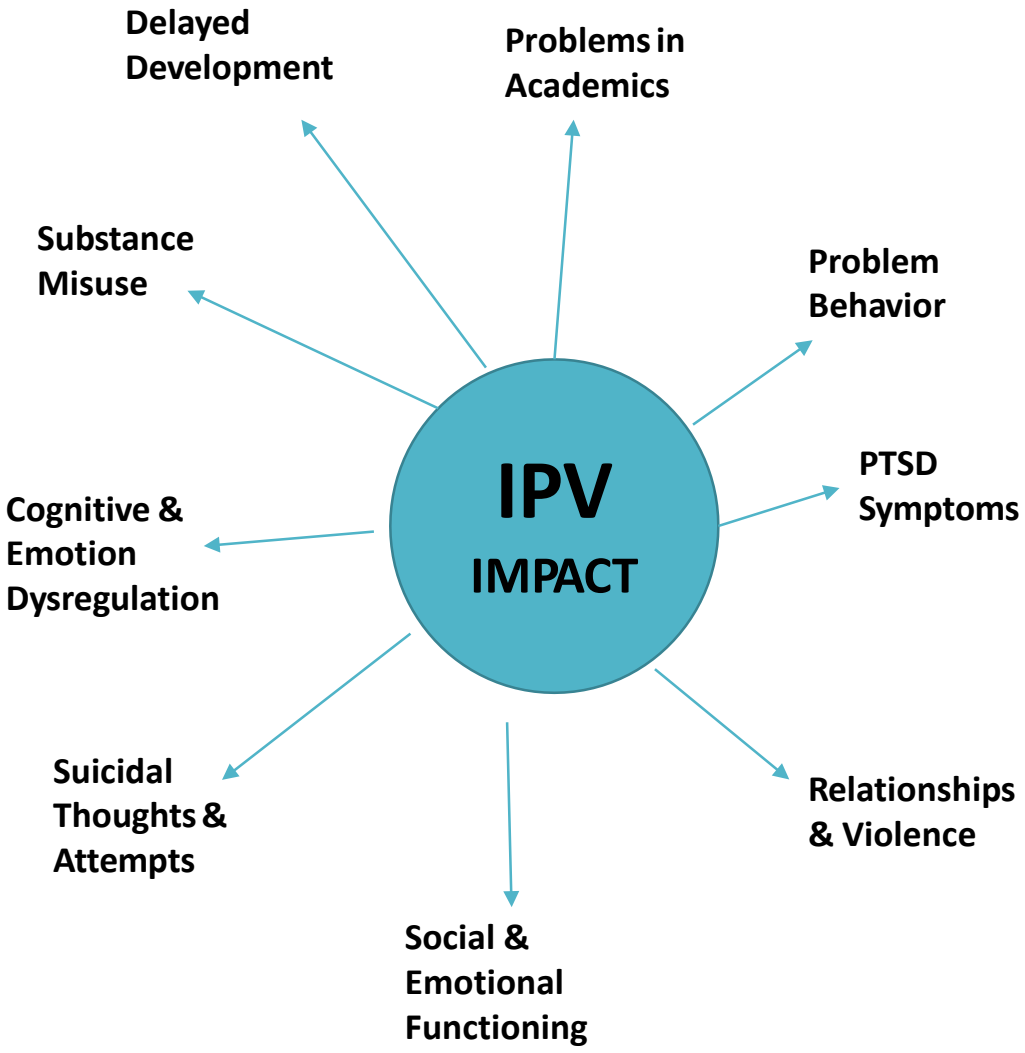


CHILDREN AND TEENS

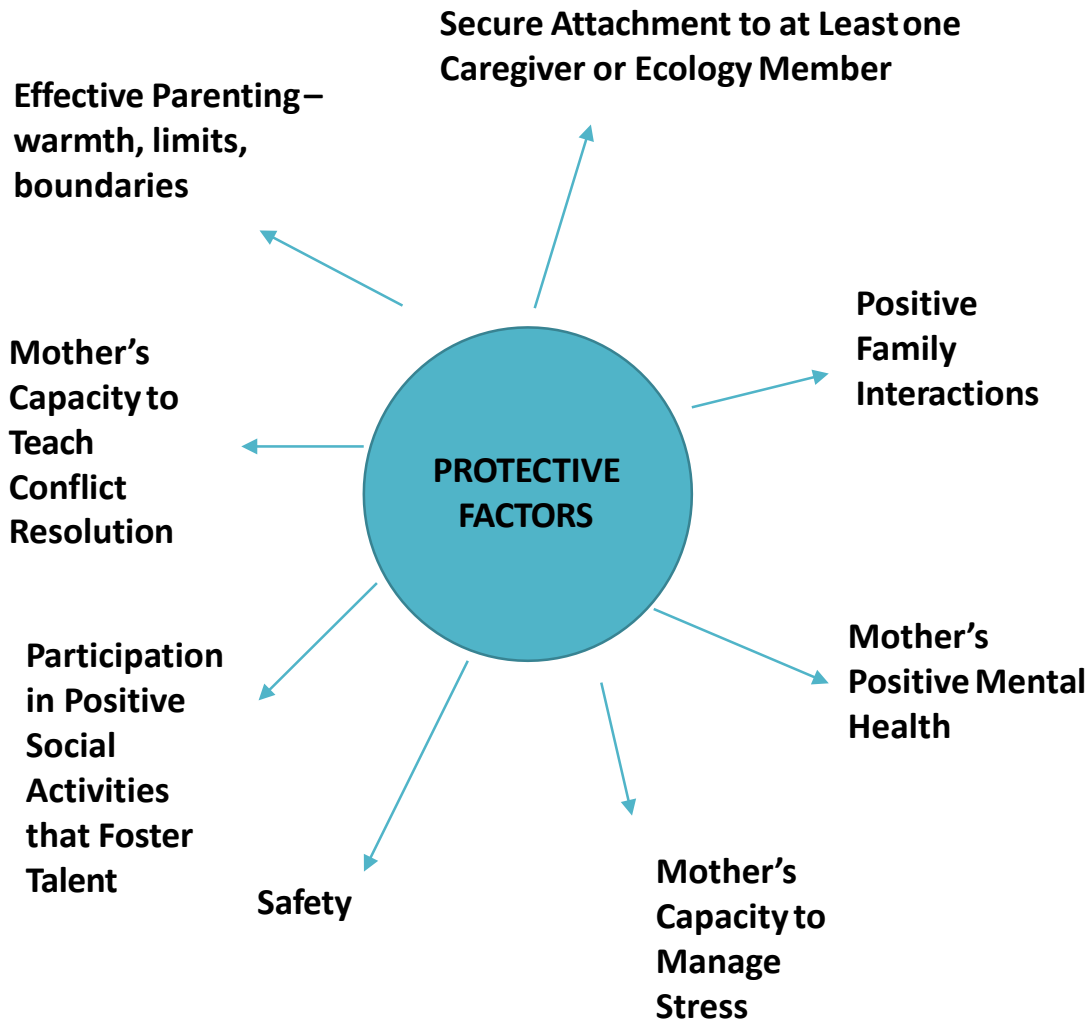
- Normalize feelings of children and teens
- Understand that IPV happens to many children but is not what happens in most families
- Help children and teens feel they are not alone
- Feeling of hope – many go through this and come out ok

THE IMPORTANCE OF UNDERSTANDING THERE IS IMPACT FROM INTIMATE PARTNER VIOLENCE

CONSIDERING INTERVENTIONS



IPV IMPACT ON CHILDREN AND TEENS



FACTORS THAT MAY REDUCE THE IMPACT OF IPV

30 years of research and development of EBT but few children receive evidence supported interventions- <20% ever saw a counselor.
Lack of service capacity
Not referred to trained therapists
Lack of collaboration between service providers
Lack of focus on treatment outcomes

Stable home environment with responsive and nurturing caregiving is most important. TX EBT demonstrated to be effective

1) Trauma informed approaches
2) Child protective services interactions can be complex with barriers and challenging issues.
3) During assessment families need to be supported
4) Treatment focused on psychosocial interventions and tailored to unique needs rather than medications is of greatest value.

Resiliency Tips - American Psychological Association

10 tips for building resilience in children and teens

Make connections
Teach your child the importance of engaging and connecting with their peers, including the skill of empathy and listening to others. Find ways to help children foster connectivity by suggesting they connect to peers in-person or through phone, video chats, and texts. It's also important to build a strong family network. Connecting with others provides social support and strengthens resilience.

Help your child by having them help others
Children who may feel helpless can feel empowered by helping others. Engage your child in age-appropriate volunteer work or ask for assistance yourself with tasks that they can master. At school, brainstorm with children about ways they can help others in their class or in grades below.

Maintain a daily routine
Sticking to a routine can be comforting to children, especially younger children who crave structure in their lives. Work with your child to develop a routine, and highlight times that are for school work and play. Particularly during times of distress or transition, you might need to be flexible with some routines. At the same time, schedules and consistency are important to maintain.

Take a break
While some anxiety can motivate us to take positive action, we also need to validate all feelings. Teach your child how to focus on something that they can control or can act on. Help by challenging unrealistic thinking by asking them to examine the chances of the worst case scenario and what they might tell a friend who has those worries. Be aware of what your child is exposed to that can be troubling, whether it's through the news, online, or overheard conversations. Although schools are being held accountable for performance or required to provide certain instruction, build in unstructured time during the school day to allow children to be creative.

Teach your child self-care
Teach your child the importance of basic self-care. This may be making more time to eat properly, exercise, and get sufficient sleep. Make sure your child has time to have fun, and participate in activities they enjoy. Caring for oneself and even having fun will help children stay balanced and better deal with stressful times.

Resiliency Tips - American Psychological Association

Move toward your goals
Teach your child to set reasonable goals and help them to move toward them one step at a time. Establishing goals will help children focus on a specific task and can help build the resilience to move forward in the face of challenges. At school, break down large assignments into small, achievable goals for younger children, and for older children, acknowledge accomplishments on the way to larger goals.

Nurture a positive self-view
Help your child remember ways they have successfully handled hardships in the past and help them understand that these past challenges help build the strength to handle future challenges. Help your child learn to trust themselves to solve problems and make appropriate decisions. At school, help children see how their individual accomplishments contribute to the wellbeing of the class as a whole.

Keep things in perspective and maintain a hopeful outlook
Even when your child is facing very painful events, help them look at the situation in a broader context and keep a long-term perspective. Although your child may be too young to consider a long-term look on their own, help them see that there is a future beyond the current situation and that the future can be good. An optimistic and positive outlook can enable children to see the good things in life and keep going even in the hardest times. In school, use history to show that life moves forward after bad events, and the worst things are specific and temporary.

Look for opportunities for self-discovery
Tough times are often when children learn the most about themselves. Help your child take a look at how whatever they're facing can teach them "what am I made of." At school, consider leading discussions of what each student has learned after facing a tough situation.

Accept change
Change often can be scary for children and teens. Help your child see that change is part of life and new goals can replace goals that have become unattainable. It is important to examine what is going well, and to have a plan of action for what is not going well. In school, point out how students have changed as they moved up in grade levels and discuss how that change has had an impact on the students.

?Rationale for Pharmacological Treatment

Psychotherapy ultimately best for recovery and relapse prevention, but not good at rapid symptom relief. Psychotherapy can trigger more distressing symptoms in the short run as the child/ youth re-lives trauma and associated emotions Eg.: nightmares, flashbacks, mood instability, aggression and rage, SIB, etc.

Pharmacotherapy offers more rapid symptom relief; also facilitates progress in therapy by ameliorating intervening distress

Rapid symptom relief ESENTIAL to maintaining safety (suicide, SIB, runaway, other impulsive behavior).

BEWARE - Medicaid eligible foster children are 4 x more likely to be prescribed a second generation antipsychotic than children not in foster care. (10% 3 or more psych meds). Suggests over treatment.

Half or children in foster care are moved to other homes or more restrictive settings while in foster care due to behavioral concerns.

Targets of Pharmacological Intervention

PTSD and its symptoms

- Nightmares, flashbacks, exaggerated startle, associated general anxiety symptoms
- SSRI's research evidence (ONLY with adults) PTSD; sertraline (Zoloft) 2 negative studies
- Added benefits: safe (low OD potential; SE's: GI, GU, headaches, transient agitation; concurrent treatment of co-morbid depressive and other anxiety disorders).

Main caution: Activation of mania in underlying Bipolar Disorder (at times difficult DDx with complex PTSD in youth).Start low doses to minimize SE's, but ultimately require high doses (150 mg. sertraline and above).

PTSD and its symptoms: Adjunctive agents

- Clonidine (Catapres) or Prazosin (Minipress)
  - *Has literature supporting reduction of hyper-arousal and impulsivity*
  - *Has literature of benefit with PTSD*
- Adjuctive agents for anxiety reduction
  - *Buspirone (BuSpar): Augment SRI and PRN use*
  - *Propanalol (caution with BP and pulse)*
  - *Diphenydramine (Benadryl) and hydroxyzine Vistaril): Can be used PRN at higher doses*

Hyper-Arousal

Sleep disturbance
Irritability
Concentration difficulties
Hyper-vigilance
Exaggerated startle response
Outbursts of aggression
Social withdrawal
Somatic signs
Incident-specific fears

Avoidance or Numbing

Cognitive and emotional suppression
Distraction
Behavioral avoidance
Memory disturbances

Targets of Pharmacological Intervention

- Sleep agents
  - Melatonin
    - Reduction of nightmares, reducing anxiety at sleep induction (fears of sleep)
    - Antihistamines (Benadryl, Vistaril)
    - Trazodone (can induce nightmares!)
    - Clonidine or prazosin
    - Dosing shorter-acting anticonvulsants at HS
- Symptoms of Complex PTSD (PTSD II)
  - Rage outbursts, mood lability, impulsivity, SIB, dissociate symptoms
  - Anticonvulsants: Mood stability, reduction of aggression, rage, impulsivity
  - Atypical antipsychotics (risperidal, olanzepoine- more serotonergic): Aggression, mood stability, reduction of dissociation and brief psychotic symptoms, SIB, even some anxiety reduction.
  - Naltrexone: Reduction of SIB (natural opioid blockade)

Psychoeducation

Educate to avoid misperceptions and misinformation (e.g., counter magical thinking)

Normalize trauma symptoms (efforts at coping) and educate on the course of PTSD symptoms– give hope

Educate on issues such as:

- abuse dynamics (normalize for parents and kids)
- death and dying
- Sexuality (e.g., fears of AIDS; homosexuality)
- divorce
- domestic violence
- alcoholism
- Legal process/ court preparation

Tasks of Trauma-Focused Therapy

Psychoeducation

Grounding/Safety

- Behavioral management
- Stress management
- Cognitive coping

Documenting the Trauma/Sorting Out

- Developing a “trauma narrative”
- Identifying triggers
- Clarification letter

Cognitive Processing/Perspective

The SEEK (SAFETY FOR EVERY KID) Algorithms help address targeted problems efficiently by prioritizing the most important aspects of the problem.

- The Algorithms incorporate principles of motivational interviewing to facilitate working with a parent and in developing the plan.
- There are also suggested responses to possible barriers, such as a parent who is resistant to help for substance use.
- It is recommended to use the Algorithms especially when first implementing SEEK.

Strength Based Model with FREE on line videos

- **Stress/Depression**
- **Substance Use**
- **Harsh Punishment**
- **IPV**
- **Food Insecurity**

Key action statements AAP

1) Openness to hearing about past and present

2) Comprehensive social hx for current and future planning

3)Be alert to SAFETY including intimate partner violence, parental mental health and substance use

4) Safety concerns and CPS emergent report will be made. Never assure confidentiality

5) Need focused assessment before psychosocial or medication treatment-EBT

6) Refer but provide resources to bridge until EBT, education, relaxation, parenting supports

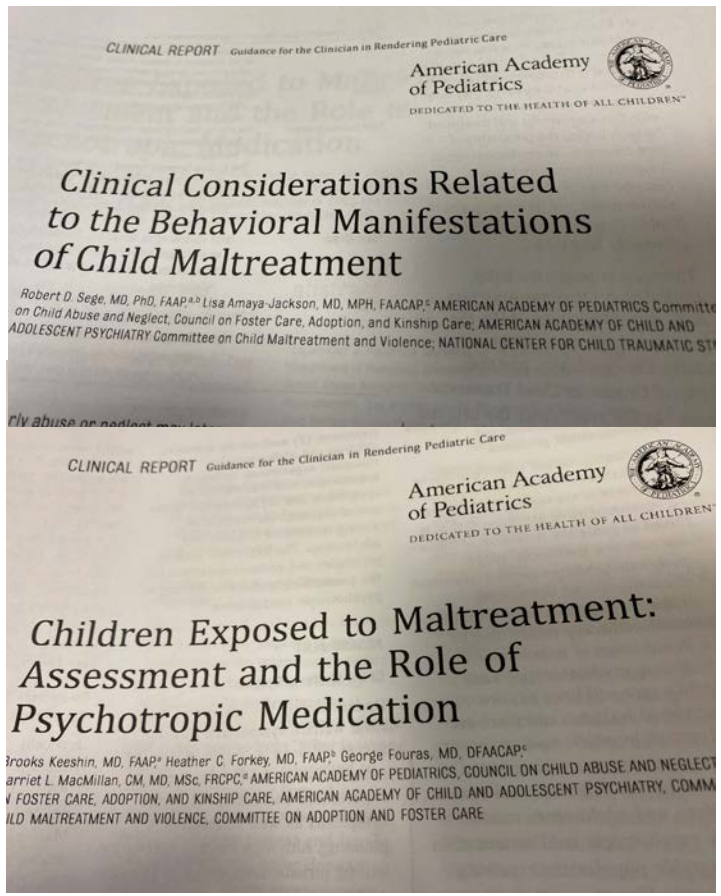
7) antipsychotic and benzodiazepines should not be used for sleep.

8) Always screen for comorbidity and suicide (Columbia suicide scale)

9) Consider med consultation before start or stop.

10) PTSD does not go away by itself.

NCTSN The National Child Traumatic Stress Network



CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Clinical Considerations Related to the Behavioral Manifestations of Child Maltreatment

Robert D. Sege, MD, PhD, FAAP,[a,b] Lisa Amaya-Jackson, MD, MPH, FAACAP,[c] AMERICAN ACADEMY OF PEDIATRICS Committee on Child Abuse and Neglect, Council on Foster Care, Adoption, and Kinship Care; AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY Committee on Child Maltreatment and Violence; NATIONAL CENTER FOR CHILD TRAUMATIC ST

CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

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Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication

Brooks Keeshin, MD, FAAP,[a] Heather C. Forkey, MD, FAAP,[b] George Fouras, MD, DFAACAP,[c] Harriet L. MacMillan, CM, MD, MSc, FRCPC,[d] AMERICAN ACADEMY OF PEDIATRICS, COUNCIL ON CHILD ABUSE AND NEGLECT, COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, COMMITTEE ON CHILD MALTREATMENT AND VIOLENCE, COMMITTEE ON ADOPTION AND FOSTER CARE

On Heroes Without Capes

"When I was very young, most of my childhood heroes wore capes, flew through the air, or picked up buildings with one arm. They were spectacular and got a lot of attention. But as I grew, my heroes changed, so that now I can honestly say that anyone who does anything to help a child is a hero to me."

From *The World According to Mister Rogers*

Helpful resources

Johnson, S. B., Riley, A. W., Granger, D. A., & Riis, J. (2013). The science of early life toxic stress for pediatric practice and advocacy. Pediatrics, 131(2), 319–327. https://urldefense.com/v3/ http://doi.org/10.1542/peds.2012-0469 ;!!Ab1_Rw!X6RK65gjkwJ9xvTp XDNByqHJ6PakMPYA6tRu-xIN0E6iUrneDil9iJCYxlkwM$

Sege, R. D., Amaya-Jackson, L., AMERICAN ACADEMY OF PEDIATRICS Committee on Child Abuse and Neglect, Council on Foster Care, Adoption, and Kinship Care; AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY Committee on Child Maltreatment and Violence; NATIONAL CENTER FOR CHILD TRAUMATIC STRESS. (2017). Clinical Considerations Related to the Behavioral Manifestations of Child Maltreatment. Pediatrics, 139(4), e20170100. https://urldefense.com/v3/ http://doi.org/10.1542/peds.2017-0100 ;!!Ab1_Rw!X6RK65gjkwJ9xvTp_XDNByqHJ6PakMPYA6tRu-xIN0E6iUrneDil9iJOw3uTR4$

Keeshin, B., Forkey, H. C., Fouras, G., Macmillan, H. L., AMERICAN ACADEMY OF PEDIATRICS,COMMITTEE ON CHILD ABUSE AND NEGLECT,COUNCIL ON FOSTER CARE,ADOPTION, AND KINSHIP CARE, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, COMMITTEE ON CHILD MALTREATMENT AND VIOLENCE, COMMITTEE ON ADOPTION AND FOSTER CARE. (2020). Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication. Pediatrics, 145(2), e20193751. https://urldefense.com/v3/ http://doi.org/10.1542/peds.2019-3751 ;!!Ab1_Rw!X6RK65gjkwJ9xvTp_XDNByqHJ6PakMPYA6tRu-xIN0E6iUrneDil9iJ7DX1Psg$

https://urldefense.com/v3/ https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796906 ;!!Ab1_Rw!X6RK65gjkwJ9xvTp_XDNByqHJ6PakMPYA6tRu-xIN0E6iUrneDil9iJN4JaOg4$

https://www.nctsn.org/resources/12-core-concepts-concepts-understanding-traumatic-stress-responses-children-and-families ;!!Ab1_Rw!X6RK65gjkwJ9xvTp XDNByqHJ6PakMPYA6tRu-xIN0E6iUrneDil9iJ3Cg8Qag$

AAP Article: Children Exposed to Maltreatment: Assessment and the Role of Psychotropic Medication

AAP Article: Clinical Considerations Related to the Behavioral Manifestations of Child Maltreatment

Child Mind

CDC

Trends

Healthcare tool box

12 Core Concepts for Understanding Traumatic Stress Responses in Childhood

1.Traumatic experiences are inherently complex. Every traumatic event—different traumatic moments. Varying degrees of objective life threat, physical violation, and witnessing of injury or death. Trauma-exposed children experience subjective reactions -changes in feelings, thoughts, and physiological responses; and concerns for the safety of others. Children's thoughts and actions (or inaction) during various moments may lead to feelings of confict at the time, and to feelings of confusion, guilt, regret, and/or anger afterward. Reactions strongly infuenced by prior experiences and developmental level. Events (both beneficial and adverse) that occur in the aftermath of the traumatic event introduce additional layers of complexity. The degree of complexity often increases in cases of multiple or recurrent trauma exposure, and in situations where a primary caregiver is a perpetrator of the trauma.

2.Childhood trauma occurs within a broad ecology of a child's life that is composed of both child-intrinsic factors i.e.genetic factors, temperament, prior exposure to trauma, and prior history of psychopathology. Child-extrinsic factors include the surrounding physical, familial, community, and cultural environments. Both influence children's experience and appraisal of traumatic events; expectations regarding danger, protection, and safety; and the course of posttrauma adjustment.

3.Traumatic events often generate secondary adversities, life changes, and distressing reminders in children's daily lives i.e. family separations, financial hardship, relocations to a new residence and school, social stigma, ongoing treatment for injuries and/or physical rehabilitation, and legal proceedings. Cascade of changes - Secondary adversities, trauma reminders –impact survivors' posttrauma emotional and behavioral functioning.

12 Core Concepts for Understanding Traumatic Stress Responses in Childhood

4.Children can exhibit a wide range of reactions to trauma and loss that vary in their nature, onset, intensity, frequency, and duration.Posttraumatic stress and grief reactions can develop over time into psychiatric disorders, including posttraumatic stress disorder (PTSD), bereavement-related or adjustment disorder, separation anxiety, and depression. Can disrupt major domains of child development, including attachment relationships, peer relationships, and emotional regulation; and can reduce children's level of functioning at home, at school, and in the community and can exacerbate preexisting mental health problems. Awareness of the broad range of children's potential reactions to trauma and loss is essential to competent assessment, accurate diagnosis, and effective intervention.

5.Danger and safety are core concerns. Traumatic experiences can undermine children's sense of protection and safety, and can magnify their concerns about dangers to themselves and others. Ensuring children's physical safety is critically important to restoring the sense of a protective shield. Trauma exposure can make it more difficult for children to distinguish between safe and unsafe situations, and may lead to changes in their own protective and risk-taking behavior. Those in a dangerous family and/or community circumstances may have greater difficulty recovering.

6.Traumatic experiences affect the family and broader caregiving systems- families, schools, and communities. This can lead to serious disruptions in caregiver-child interactions and attachment relationships. Caregivers' own distress and concerns may impair their ability to support traumatized children. In turn, children's reduced sense of protection and security may interfere with their ability to respond positively to their parents' and other caregivers' efforts to provide support. Assessing and enhancing the level of functioning of caregivers and caregiving systems are essential to effective intervention with traumatized youths, families, and communities.

12 Core Concepts for Understanding Traumatic Stress Responses in Childhood

7.Protective factors buffer the adverse effects of trauma and its stressful aftermath, whereas promotive factors generally enhance children's positive adjustment and well-being regardless of whether risk factors are present or absent. Promotive and protective factors may include child-intrinsic factors such as high self-esteem, self-efficacy,and possessing a repertoire of adaptive coping skills. Protective child-extrinsic factors such as positive attachment with a primary caregiver, possessing a strong social support network, the presence of reliable adult mentors, and supportive school and community environment. The presence and strength of promotive and protective factors—both before and after traumatic events—can enhance ability to resist, or quickly recover from (resiliently "bouncing back"), harmful effects of trauma, loss, and other adversities.

8.Trauma and posttrauma adversities can profoundly influence children's acquisition of developmental competencies and their capacity to reach important developmental milestones in such domains as cognitive functioning, emotional regulation, and interpersonal relationships. Trauma exposure and its aftermath can lead to regressive behavior, reluctance or inability to participate in developmentally appropriate activities, and developmental accelerations such as leaving home at an early age and engagement in precocious sexual behavior. In turn, age, gender, and developmental period are linked to risk for exposure to specific types of trauma (e.g., sexual abuse, motor vehicle accidents, suicide or homicide of a peer).

9.Developmental neurobiology underlies children's reactions to traumatic experiences. Linked to an evolving neurobiology that consists of brain structures, neurophysiological pathways, and neuroendocrine systems. Traumatic experiences evoke strong biological responses that can persist and alter the normal course of neurobiological maturation and depend in part on the developmental stage in which they occur. Exposure to multiple traumatic experiences carries a greater risk for significant neurobiological disturbances including impairments in memory, emotional regulation, and behavioral regulation. Conversely, ongoing neurobiological maturation and neural plasticity also create continuing opportunities for recovery and for adaptive developmental progression.

12 Core Concepts for Understanding Traumatic Stress Responses in Childhood

10.Culture is closely interwoven with traumatic experiences, response, and recovery. Culture can profoundly affect the meaning that a child or family attributes to events such as sexual abuse, physical abuse, and suicide. Culture can influence the ways in which children and their families respond to traumatic events -the ways in which they experience and express distress, disclose personal information, exchange support, and seek help. A cultural group's experiences with historical or multigenerational trauma can affect responses to trauma and loss, their world view, and their expectations i.e.self, others, and social institutions. Culture influences rituals and ways children and families grieve over and mourn their losses.

11.Challenges to the social contract, including legal and ethical issues, affect trauma response and recovery. Traumatic experiences often constitute a major violation of the expectations of the child, family, community, and society. This includes family members, teachers, peers, adult mentors, and agents of social institutions such as judges, police of"cers, and child welfare workers. Children and their caregivers frequently contend with issues involving justice, obtaining legal redress, and seeking protection against further harm. They are often acutely aware of whether justice is properly served and the social con¬tract is upheld. The ways in which social institutions respond to breaches of the social contract may vary widely and often take months or years to carry out. The perceived success or failure of institutional responses may exert a profound influence on the child's posttrauma adjustment and their evolving beliefs, attitudes, and values -family, work, and civic life.

12.Working with trauma-exposed children can evoke distress in providers that makes it more difficult for them to provide good care. Mental healthcare providers must deal with many personal and professional challenges as they confront details of children's traumatic experiences and life adversities, witness children's and caregivers' distress, and attempt to strengthen children's and families' belief in the social contract. Engaging in clinical work may also evoke strong memories of personal trauma- and loss-related experiences. Proper self-care is an important part of providing quality care and of sustaining personal and professional resources and capacities over time.

Layne, C. M., Strand, V., & the NCTSN Core Curriculum on Childhood Trauma Task Force (2012). Traumatic Stress Responses in Children and Families. Core Curriculum on Childhood Trauma. Los Angeles, CA, and Durham, NC: UCLA-Duke