WORKING WITH CHILDREN WITH COMPLEX TRAUMA

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- A method for identifying the effects of trauma – the relational learning framework
- Therapeutic concepts and approaches for children with complex trauma

Maltreatment and mental health

- “Childhood maltreatment is the most important preventable cause of psychopathology accounting for about 45% of the population attributable risk for child onset psychiatric disorders”. (Teicher & Samson, 2016, p. 241).
- This means that *45%* of childhood psychiatric disorders would not exist if there was *no child maltreatment.*

Barriers to mental health services

- Children may not fit current diagnoses – complex trauma not in DSM 5
- Symptoms of PTSD and complex trauma may be unrecognised and can be labelled as “behavioural”.
- Catch 22 – children need to be in a stable, long term placement to access therapy but can’t achieve that without help.

Case example: 5 year old Max

- Neglected by his mother and regularly beaten by his step-father.
- In foster care, Max has little interest in toys but with other children he snatches their toys, swears at them and hits them. He cannot focus and drifts around a lot, annoying others.
- He loves being cuddled but will hiss and scream when asked to do ordinary things like have a bath or pick up his toys.
- How do we conceptualise Max's problems?

Diagnostic dilemmas

- Externalising behaviour problems are common in maltreated children, especially in foster care.
- Most common diagnoses are ADHD, ODD and conduct problems, particularly for boys.
- How do these diagnoses relate to trauma?
- Why is PTSD uncommon in maltreated children (10 -15%) but highly elevated in adults with a child welfare file (5 - 10 times the rate).
- Are symptoms not recognised? Delayed onset?

Trauma and ADHD

(www.NCTSN.org)

- Overlap between the symptoms of ADHD and the effects of trauma
- Trauma – increased agitation and edginess can look like hyperactivity; dissociation and avoidance can look like inattention.
- Is a link between trauma and ADHD but not clear.
- Risk of misdiagnosis high.

Conceptualising severe symptoms

(See Tarren-Sweeney, 2007)

Examples include:

- Self-injury e.g. hitting or biting self
- Sexualised behaviour
- Soiling and smearing
- Desperation for food, gorging
- Not showing pain
- Obvious lying
- Cruelty, including laughing at the pain of people or animals (lack of empathy or guilt).
- Not genuine – charming, changing for different people and situations.

What is complex trauma?

(Courtois, 2004)

- Repetitive, prolonged, or cumulative
- Most often interpersonal, involving direct harm, exploitation, and maltreatment including neglect and abandonment.
- Often occur at developmentally vulnerable times in the victim's life, especially in early childhood or adolescence, but can also occur later in life and in conditions of vulnerability.

Developmental Trauma Disorder

(van der Kolk, 2005)

- A. Multiple or chronic exposure to adverse interpersonal trauma and subjective experience of rage, betrayal, fear, defeat, shame.
- B. Triggered pattern of repeated dysregulation in response to trauma cues
  - Affective, somatic and behavioural dysregulation (rage, re-enactment, cutting).
  - Cognitive (thinking that it is happening again, confusion, dissociation, depersonalization).

- Relational (clinging, oppositional, distrustful, compliant).
- Self-attribution (self-hate and blame).

- C. Persistently altered attributions and expectancies:
  - distrust protective caretaker , loss of expectancy of protection by others
  - D. Functional Impairment: educational, familial, peer, legal, vocational.

How is that similar and different to PTSD?

Stress and fear

- Babies and young children can’t manage their own stress
- Parents acts as a buffer against high stress levels through physical contact and emotional communication.
- When trauma occurs within early parent child relationships – parent may arouse fear or be unresponsive to the infants fear – leaves child in a state of fear without a way of calming down.

- If there is too much stress or fear, the child's biological systems are flooded and become hard to regulate (control)
- Cortisol patterns are changed
- Fight or flight reactions and adrenaline and are triggered more easily
- The child may be in a state of fear and others wouldn't know
- Child may be fearful but can't seek comfort
- Child may dissociate or develop disorganised attachment.

Adoption and foster care

- Cortisol typically peaks early morning and lowest level about midnight
- Children in orphanages – absence of diurnal fluctuation and no early morning peak - HPA rebounds when adopted.
- –Children in foster care have either
  - blunted levels of cortisol - externalising problems
  - high cortisol – internalising problems (Laurent et al, 2014)
- Increasing carer sensitivity restores typical cortical rhythm, reduces basal cortisol and reduces behaviour problems (Dozier et al., 2006).

How do we recognise trauma behaviours?

- Dissociation
- Rage
- Recklessness, endangering self or others (now in DSM 5)
- Re-enacting trauma and trauma play
- Self-medicating
- Avoidance including losing control to avoid activities, scary people or in residential care – getting into secure.
- Shutting down.

Dissociation

- “Dissociation occurs when individuals unintentionally find themselves shutting down and disconnecting from experiences and from the world…” (Shemmings & Shemmings, 2011).
- Blank, trance-like state affecting consciousness and memory.
- Can occur in a hyper-aroused (rage) and hypo-aroused (shut down) state (Struik, 2014).

In practice

- Recognise dissociation and shutting down, especially under stress (may need careful observation) – child may “look alright”.
- Be willing to consider the child’s experience and history.
- If child has CYF involvement, access to file is important.
- Quality of behaviour or play – makes people uncomfortable, not easy to correct, repetitive quality, doesn’t get resolved.

Relational Learning Framework

(Kelly & Salmon, 2014; Kelly, 2015)

Child's history and culture	Problems and strengths	View of self	View of world	Treatment needs
Example: 7 year old girl raised by a drug addicted mother who was "out of it" most of the time. Sexually abused by a friend of her mother's. In foster care.	Problems Vomits when stressed. Stares vacantly. Scared of going to bed. Rocks backwards and forwards. Strengths Loves younger sister and grandmother.			

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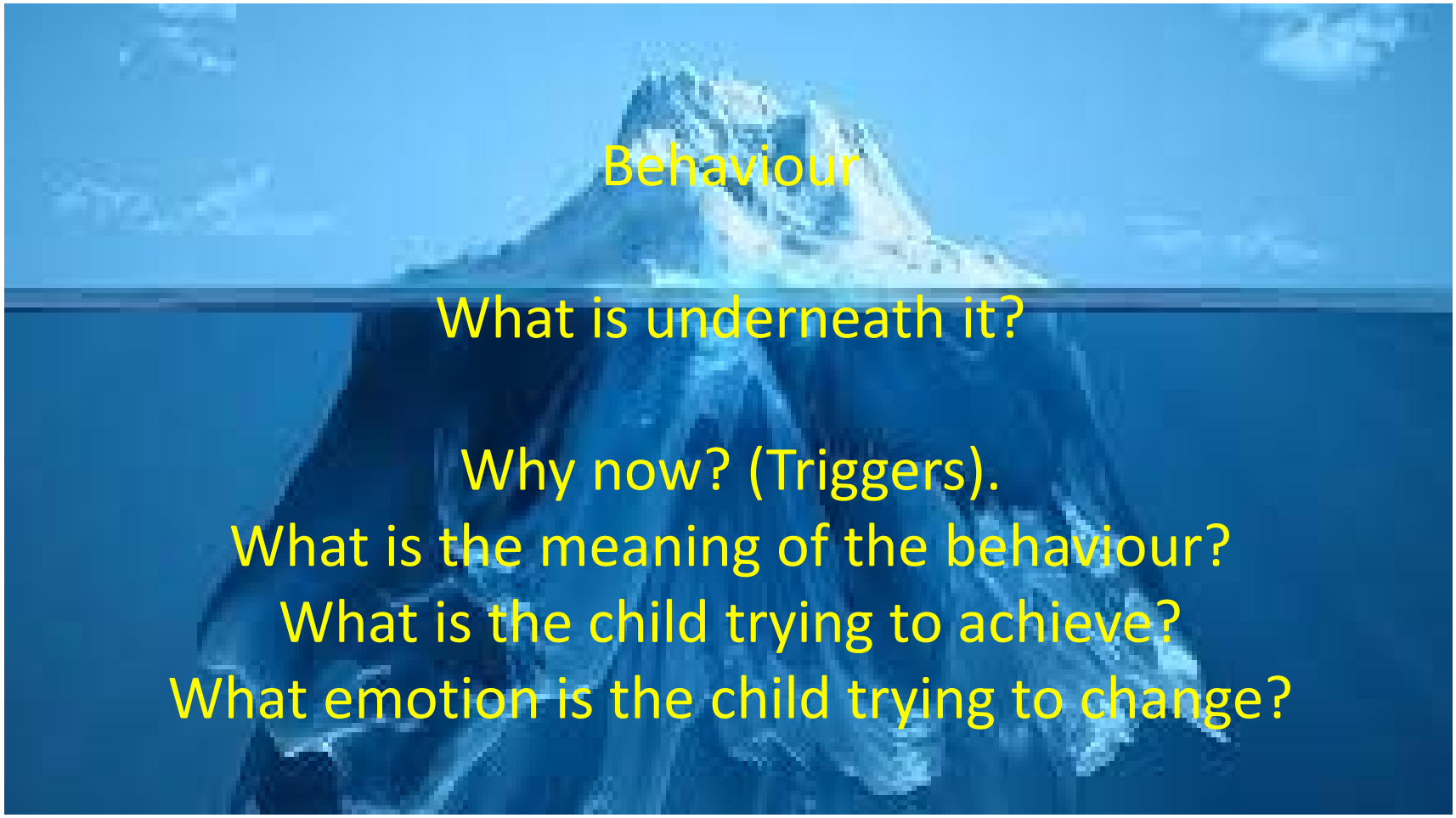
Iceberg exercise



Worked example

A 7 year old boy who has been in foster care for 18 months is very excited about his birthday party. He is having 3 friends over but just as they arrive he throws a tantrum about a toy he can't get to work. He screams and yells, pulls the table cloth off the table, with food attached, and smashes the toy. His foster parents are devastated, they were looking forward to giving him his first birthday party.

Behaviour: destruction of birthday party and present

- What is underneath?
- Why now?
- Meaning of the behaviour?
- What is child trying to achieve?
- What emotion is the child trying to change?

Approaches to therapy

Trauma and recovery (Herman, 1992)

- Phase 1: Safety and stability
- Phase 2: Remembering and mourning – putting words to what occurred, emotions, meaning.
- Phase 3: Reconnection and integration
- Common ideas: window of tolerance (Siegal), therapeutic window (Briere)
- Importance of exposure work.

Approaches for children

- Influenced by growing knowledge about the brain - examples
- Hand model of the brain (Dan Siegel)
- Neuro-sequential model (Bruce Perry)
- ARC Attachment, Self-regulation and Competency (Blaustein & Kinniburgh, 2010)
- Don’t let sleeping dogs lie! (Struik, 2014)

Don’t let sleeping dogs lie (Struik, 2014)

- Uses 6 tests in a stabilisation phase to ensure child is ready for trauma processing
- Safety
- Attachment
- Cognitive shift
- Explains traumatic reactions to child
- Trauma processing using EMDR.

Daily life

Emotion regulation

The nutshell

Modernisation of CYF Expert Panel: Final report

"Trauma theory suggests that many of the behavioural symptoms seen in vulnerable children, young people and their families and whānau are a direct result of attempts to cope with adverse, often overwhelming experiences" p.65.

Trauma-informed care

- CYF modernisation Expert Panel Final Report recommends Trauma- informed care for children involved with CYF
  - Requires recognition of trauma and it's impacts on children and adults including re-enactment.
  - Change system to limit re-traumatisation e.g. multiple placements, secure.
  - recognise staff trauma, possibility of re-traumatisation and making systems as good for staff as for clients

Common therapeutic tasks

- Establishing safety
- Psycho-education to decrease blame and judgement
- Provide empathy
- Increase emotion regulation
- Trauma processing to manage painful feelings
- Exploring meaning and negative appraisals such as I deserved it, I’m bad.

Trauma focussed CBT

(Cohen et al. 2006) www.musc.edu/tfcbt

- Structured and directive approach, developed for one off trauma but has been found to be successful with multiple traumas and has been used with children in care.
- Involves parallel work with child and parent

Components include:

- Psychoeducation and parenting skills
- Relaxation and mindfulness

- Emotion regulation such as naming feelings and helping parent to reflect child's feelings.
- Cognitive coping and examining of conclusions has child drawn from the event such as " my life is spoiled".
- Trauma narrative – child writes about the trauma in a book. For children in care, may need to be a life narrative. Include the worst aspects/memories.
- Needs to go at own pace, begin with reading stories and first chapter is about the child in general. Go slower if distressed and use skills learned.

- In vivo mastery of trauma reminders – help child stop avoiding specific trauma reminders
- Conjoint parent-child sessions
- Enhancing future safety and development.

EMDR therapy

(Adler-Tapia & Settle, 2017)

- 8 stages to EMDR therapy
- History taking, preparation, assessment, desensitisation, installation, body scan, closure and re-evaluation.
- Bi-lateral stimulation only one part of the therapy
- Comparatively non-verbal technique
- Can be adapted successfully for children
- Developing evidence base.

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