TRAUMA AND TOXIC STRESS IN YOUTH

Nayla M. Khoury MD, MPH November 2, 2020





DISCLOSURE STATEMENT.

 Neither I nor my spouse has a relevant financial relationship with a commercial interest to disclose.



LEARNING OBJECTIVES

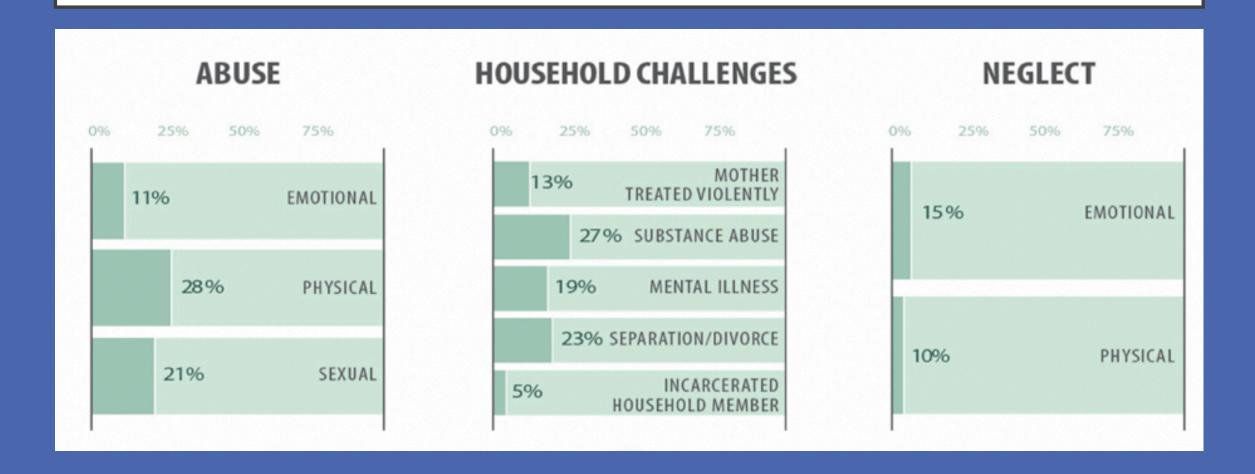
Recognize the importance of trauma and trauma sequelae in childhood mental illness.

Identify developmentally appropriate strategies for screening and inquiring about trauma and trauma-related disorders.

Review evidence based treatment principles for youth with trauma sequelae.

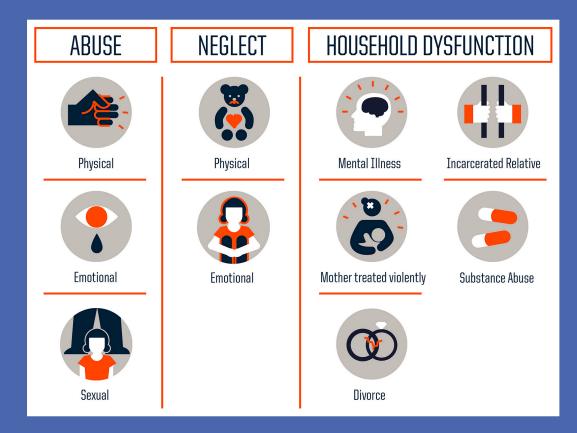
HOW PREVALENT IS TRAUMA?

~60% ADULTS REPORT AT LEAST I. 25% ADULTS REPORT 3 OR MORE ACES



From ACES study (90s, middle class, Kaiser)

TRAUMA TYPES: ACES AND MORE



- Bullying
- Community Violence
- Complex Trauma
- Disasters
- Medical trauma
- Refugee trauma
- Terrorism
- Traumatic Grief



RON, IOYR OLD BOY

- CC: Aggression at dad's house and refusing to go.
- Background: Split households with different rules, new baby in dad's household; h/o dad incarceration and alcohol use; historical traumas present and pattern of disrupted families, absent fathers.
- Ron presents as youth with social difficulty, inflexible play, negative outlook.
- At least 3 ACES and possibly more undisclosed trauma experienced.

WHEN IS STRESS "TOXIC"?

• Stress is a normal and necessary part of development. Becomes toxic when prolonged and in absence of protective relationships.

POSITIVE



A normal and essential part of healthy development

EXAMPLES getting a vaccine, first day of school

TOLERABLE



Response to a more severe stressor, limited in duration

EXAMPLES
loss of a loved one,
a broken bone

TOXIC



Experiencing strong, frequent, and/or prolonged adversity

EXAMPLES physical or emotional abuse, exposure to violence



Brief increases in heart rate, mild elevations in stress hormone levels.



Serious, temporary stress responses, buffered by supportive relationships.



Prolonged activation of stress response systems in the absence of protective relationships.

TRAUMATIC STRESS

- The physical and emotional responses to events that threaten the life or physical integrity of the child or of someone critically important to them.
- The physiologic arousal can lead to an initially adaptive response, but ultimately becomes maladaptive and destructive.
- Per the National Child Traumatic Stress Network

TRAUMA SPECTRUM: FUNCTIONAL SYMPTOMS, PTSD AND COMPLEX TRAUMA

A. Trauma mild or with support

Functional difficulties –
Sleep, tantrums, toileting, eating

B. Severe incident trauma with support

Functional difficulties AND

PTSD sx : Arousal, avoidance, re-experiencing, fear

C. Early interpersonal trauma, no support

Functional difficulties AND

PTSD sx: Arousal, avoidance, reexperiencing, fear AND

Affect dysregulation – violent reckless or self destructive, dissociation, attentional issues

Negative self-concept – persistent beliefs as diminished, defeated, worthless, shame, guilt

Interpersonal disturbances – difficulty with relationships

American Academy of Pediatrics

BIOLOGY OF TRAUMA

- Brain not structurally complete at birth.
- Myelination, synaptic connections, glial and circulatory development continue.
 - Depends on adequate nutrition and absence of toxins.
 - Guided by environmental cues (good enough environments).
 - Present, predictable, attentive enough primary caregivers.
- Critical periods of brain development are sensitive to traumatic insults.



CHALLENGES IN PRIMARY CARE

- Trauma may not be easily or willingly disclosed.
- Question of ongoing trauma.
- Overlapping sx: trauma ,
 ADHD, depression, & anxiety.
- Traumatic stress severity known to increase suicide risk.

TRAUMA PTSD

- Easily startled by noises or unexpected touch
- · Feeling of guilt, shame, anxiety
- · Irritability, quick to anger
- Tendency to isolate oneself or feelings of detachment (dissociation)
- Difficulty trusting and/or feelings of betraval
- Diminish interest in everyday activities
 - Acting helpless, hopeless or withdrawn
 - Unusually reckless, aggressive or self-destructive behaviors

OVERLAP

- Difficulties concentrating and learning in school
- Often doesn't seem to listen
- · Easily distracted
- · Hyperactive, restless
- Difficult sleeping
 - Disorganized

ATTENTION DEFICIT HYPERACTIVITY

- · Difficulties sustaining attention
- · Struggling to follow instructions
- · Fidgeting or squirming
- · Difficulty waiting of taking turns
- · Taking excessively
- Loses important items
- · Interrupts/intrude upon others

LEARNING OBJECTIVES

Recognize the importance of trauma and trauma sequelae in childhood mental illness, including historical and racial trauma.

Discuss developmentally appropriate strategies for screening and inquiring about trauma and trauma-related disorders.

Review evidence based treatment principles for youth with trauma and toxic stress.

ASKING DEVELOPMENTALLY

- Strategies for screening:
 - Promote safety.
 - ➤ Include choice.
 - ➤ If suspicious, ask separately.
 - > Listen. Listen. Listen.
 - Be clear about your role and reason for asking specific questions.
 - > Review confidentiality.

ASKING DEVELOPMENTALLY

- Strategies for screening:
 - Promote safety.
 - Include choice.
 - ➤ If suspicious, ask separately.
 - > Listen. Listen. Listen.
 - Be clear about your role and reason for asking specific questions.
 - > Review confidentiality.

"Has anything bad happened to you or your child since I last saw you?"

FRAYED: SIGNS OF TRAUMA



- Fits, frets, fear
- Restricted development
- Attachment difficulty
- Yelling and yawning
- Educational delays
- Defeated, dissociation

TRAUMA SX DEVELOPMENTALLY

Preschool:

Reduced play

School-age:

- New fears
- Regression

Adolescent:

- Reckless behavior
- Self-imposed restrictions

SCREENING FOR TRAUMA AND PTSD

- Child and Adolescent Trauma Screen
 - Self report, children 7-17
 - Caregiver report 3-17
 - Score > 12 suggests need to refer and possibly treat
- Child PTSD Symptom Scale
 - Self report, 8-18
 - Score > 15 suggests PTSD highly likely.
- UCLA Brief COVID-19 Screen for youth PTSD
 - Available in English and Spanish
 - Score >20 potential PTSD

Acknowledge

Validate

Follow up

Report if required

"I'm sorry that happened to you. That sounds like it might have been confusing and scary..."

Acknowledge

Validate

Follow up

Report if required

Acknowledge

Validate

Follow up

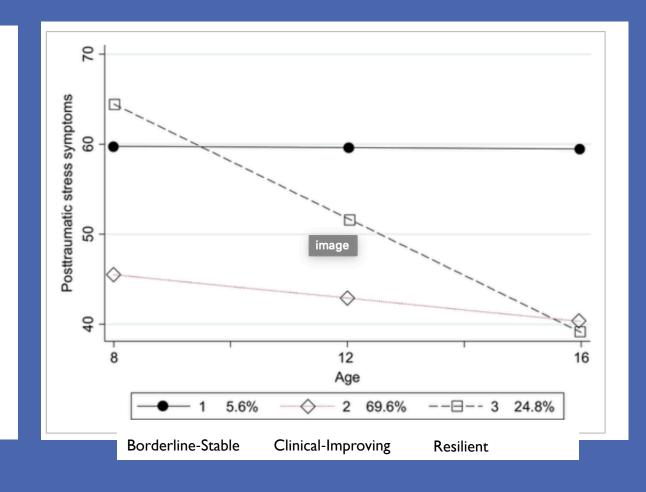
Report if required

"You are not alone, it is not your fault, and I will help."

PTSD PATTERNS OVER TIME: FORTUNATELY, MOST SX IMPROVE

3 patterns of symptoms:

- 70 % Resilient
- 25 % Clinical-Improving (evolve and improve over time)
- 5 % Borderline-Stable (chronic course with subclinical)
- From longitudinal Study of Child Abuse & Neglect
 - N = 1,178 at-risk children
 - Multiple evals between 4-18 years of age.
 (Miller-Graff & Howell, 2017).



MAJOR RISK FACTOR FOR PERSISTENT SYMPTOMS

Violence at Home (IPV) & Community is a common predictor for clinical and persistent symptoms

- Substantiated by many previous studies
- Some trauma screens do not include witnessing violence.
- Indirect exposure to trauma must be included in assessment

RESILIENCE: WHAT TIPS THE BALANCE?

Adverse Events



Benevolent Events

PROTECTIVE FACTORS

- Benevolent childhood experiences (BCE)
 - Did you have...a care giver with whom you felt safe?
 - At least one good friend?
 - Any beliefs that gave you comfort?
 - At least one teacher who cared about you?
 - Likes school?
 - Good neighbors?
 - An adult who could provide you with support or advice?
 - Opportunities to have a good time?
 - Did you like yourself or feel comfortable with yourself?
 - A predictable home routine?
 - Higher levels associated with less PTSD and stressful life events in pilot study with pregnant women (Narayan, Rivera, Bernstein, Harris, Lieberman; 2018)



PROTECTIVE FACTORS

Community:

- School engagement.
- Family & neighborhood.
- Participation in after school activities.

Relationships:

- Relationships with one supportive adult
- Friends

Individual:

- Positive thoughts of self
- Self-regulation
- Social competence
- Flexible thinking

SCREENING CAREGIVERS

- Given that a stable, consistent and healthy caregiver can be a buffer, can we screen and support primary caregiver?
 - Modifiable ACE: perinatal depression
 - Edinbburgh postnatal depression.
 - Partnering with parent
 - Meeting with parents alone when possible.
 - Referrals in place for more support for parents.

LEARNING OBJECTIVES

Recognize the importance of trauma and trauma sequelae in childhood mental illness, including historical and racial trauma.

Discuss developmentally appropriate strategies for screening and inquiring about trauma and trauma-related disorders.

Review evidence based treatment principles for youth with trauma and toxic stress.

EVIDENCE-BASED TX

- Multiple ACES/At-risk youth
 - Parent-child interactive therapy
 - Child parent psychotherapy to help child & parent attune
- PTSD
 - Trauma focused CBT (ages 3+)
 - Child and family traumatic stress intervention

- Complex trauma
 - ARC:Attachment, regulation, competency
 - ITCT: Integrative treatment of complex trauma

PTSD ESSENTIAL TX COMPONENTS

Direct exploration of trauma – building narrative, exposure

Stress management techniques

Exploration and correction of inaccurate attributions regarding trauma (cognitive reprocessing)

Parental inclusion if possible, to help understand and validate trauma narrative

The 5-4-3-2-1 Coping Technique

Ease your state of mind in stressful moments.

Acknowledge **5** things that you can see around you.





Acknowledge 4 things that you can touch around you.



Acknowledge **3** things that you can hear around you.

Acknowledge 1 thing that you can taste around you.



Acknowledge 2 things that you can smell around you.



WORKING WITH KIDS AND CAREGIVERS

- Psychoeducation to parents.
- Moving from understandable thoughts "It was my fault" or "Nothing is safe anymore" to validation/safety.
- Attributional distortions explored and challenged in a manner going beyond mere reassurances.
- Accomplished by step-by-step logical analysis during therapy.

Example:

Ron was able to say with father present that he believed it was his fault that father went to jail. Dad able to correct this distortion in session. And Ron may need help recognizing and correcting attributional distortions in Ron's story of his past.

PSYCHOPHARMACOLOGY

- Adjunctive NOT one of the established elements of treatment
- Theories; some reports of med efficacy; no randomized trials.
- Medications used to treat prominent symptoms or co-morbid psychiatric conditions.
- Examples:

Core PTSD sx

Hyperarousal - alpha agonists

Complex PTSD

 Emotion regulation -SSRIs

DEVELOPING A TRAUMA-INFORMED COMMUNITY

- Notice your own response to patient experiences & that of your colleagues.
- *Find care practices that work for you and are sustainable.
- Know you are not alone in this work.
- ❖Get to know your resources (internal and local).
- **❖**VOTE!

TAKE AWAYS

Trauma is ubiquitous.

Most youth are resilient.

Most severe trauma sequalae occurs in context of absent protective relationships.

Promote safety. Screen frequently. Validate.

CBT WITH CHILDREN, ADOLESCENTS AND FAMILIES

Post Traumatic Stress Disorder

Cognitive Therapy with Children and Young People

Patrick Smith, Sean Perrin, William Yule and David M. Clark

interest to all pro child and adole

✓ Programs That Work[™]

Prolonged Exposure Therapy for Adolescents With PTSD

Emotional Processing of Traumatic Experiences

Therapist Guide

Edna B. Foa Kelly R. Chrestman Eva Gilboa-Schechtman Treating
Trauma and
Traumatic Grief
in Children and
Adolescents

JUDITH A. COHEN

ANTHONY P. MANNARINO

ESTHER DEBLINGER

A NEW YORK TIMES BESTSELLER

THE BODY KEEPS THE SCORE

BRAIN, MIND, AND BODY
IN THE HEALING OF TRAUMA



BESSEL VAN DER KOLK, M.D.

"A MASTERFIECE THAT COMBINES THE BOUNDLESS CURIOSITY OF THE SCIENTIST, THE EAUDITION OF THE SCHOLAR, AND THE PASSION OF THE TRUTH TELLER," — JUDITH HERMAN, M.B.

REFERENCES & RESOURCES

- ACES: https://vetoviolence.cdc.gov/apps/phl/resource-center-infographic.html
- Berlinner, L et al. (2016). Trauma Informed Care: A Commentary and Critique. Child Maltreatment. Vol. 21 (2) 168-172.
- Care Process Model. (2020). https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796906
- Finkelhor, D. (2015). JAMA Pediatr. 2015; 169(8): 746-75.
- Lane, S. et al. (2017). Neighborhood Trauma Due to Violence: A Multilevel Analysis. Journal of Health Care for the Poor and Underserved. 28: 416-462.
- McLaughlin et al. Childhood Adversities and First Onset of Psychiatric Disorders in a National Sample of US Adolescents. Arch Gen Psychiatry. 2012; 69 (11): 1151-1160
- Van der kolk, B. (2003). The neurobiology of childhood trauma and abuse. Child Adolesc Psychiatric Clin N. Am. 12:293-317.
- Miller-Graff & Howell (2015). Posttraumatic Stress Symptom Trajectories Among Children Exposed to Violence. Journal of traumatic stress.