Mitigating the Impact of Toxic Stress and Trauma Through Healthy Social Emotional Development

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What is Toxic Stress?

• Strong, frequent, or prolonged activation of the physiological stress response systems without the buffering protection provided by responsive, supportive relationships

• (Shonkoff, Garner, et al., 2012)
What is Trauma?

• An exceptional experience that overwhelms the capacity to cope effectively with the threat and/or danger

• Regulatory processes are insufficient to manage the trauma emotionally and behaviorally

• (Marans & Adelman, 1997)
Toxic Stress and Trauma

• Possible causes
  – Physical, emotional, or sexual abuse
  – Chronic neglect
  – Substance abuse
  – Family and community violence
  – Parental mental illness, including severe depression
  – Loss of a parent
  – Extreme poverty
Prevalence of Exposure to Trauma in Young Children

• Young children are exposed to traumatic stressors at rates similar to those of older children

• In one study of children aged 2-5 years, 52.5% had experienced a severe stressor in their lifetime

• Many of these children had experienced multiple stressors
  • (Egger & Angold, 2004)
Prevalence of Accidents, Injuries, Community Violence

• Children aged 0–5 years are hospitalized or die from drowning, burns, falls, choking, and poisoning more frequently than do children in any other age group

• Nearly two-thirds of young children attending a Head Start program had either witnessed or been victimized by community violence, according to parent reports

• (Grossman, 2000; Shahinfar, Fox, & Leavitt, 2000)
Prevalence of Maltreatment, Partner Violence

• Children aged 0-3 years constituted 32.6% of all maltreatment victims reported in 2007
• Approximately 15.5 million children are estimated to live in families in which partner violence occurs
• 7 million estimated to live in families in which severe partner violence occurs

• (McDonald et al., 2006; U.S. Department of Health & Human Services, 2010)
Physiological Responses to Trauma

• Increased cortisol levels, if persistent, can disrupt developing brain architecture by impairing cell growth and interfering with the formation of healthy neural circuits
• May affect the growth and pruning of neural connections
• May contribute to problems with memory, cognitive abilities, learning, & dissociative states

• (McEwen, 2007)
Toxic Stress and Physical Health

• Toxic stress in early childhood may cause physiologic disruptions that persist into adulthood and lead to disease in the absence of later unhealthy behaviors
  – Alterations in immune functioning
  – Measurable increases in inflammatory markers
  – Can precipitate physiological processes that confer lifelong risk
• (McEwen, 2007)
Long-Term Effects of Childhood Trauma

• There are direct and indirect impacts of early toxic stress on physiological functioning and physical health:

• Heart disease, cancer, chronic lung disease, skeletal fractures, liver disease, autoimmune diseases, poor dental health and obesity

• (Felitti et al., 1998; Korte et al., 2005)
Long-Term Effects of Childhood Trauma

• In the absence of more positive coping strategies, children who have experienced trauma may engage in high-risk or destructive coping behaviors.

• These behaviors place them at risk for serious mental and physical health problems, including:
  – Alcohol and/or drug abuse
  – Depression
  – Suicide attempts
  – Mental illness
  – Sexually transmitted diseases (due to high risk activity with multiple partners)
  – A range of physical health problems and diseases

• (Felitti et al., 1998)
The Influence of Developmental Stage

- Children who have been exposed to trauma use a great deal of energy responding to, coping with, and resolving trauma.
- This may reduce their capacity to explore the environment and to master age-appropriate developmental tasks.
- The longer traumatic stress goes untreated, the farther children tend to stray from appropriate developmental pathways.

(Ko, Groves, & Wilson, 2009)
Links between Early Adversity and Later Impairments

• Individuals who engage in higher rates of risk-taking and destructive coping are more likely to:
  – Have trouble maintaining supportive social networks
  – Have school failure, unemployment, poverty, homelessness, violent crime, & incarceration
  – As parents, are less likely to provide supportive relationships that protect their children from toxic stress, so the intergenerational cycle continues

• (Kahn et al., 2004; Wickrama et al., 2008)
What Can We Do?

• Prevention is essential
• Strengthen foundations in prenatal and early childhood periods across all systems that serve children and families
• Collaborations that provide trauma-informed continuum of care
• Strengthen relationships that buffer children
Infant and Early Childhood Mental Health Defined

• Young child’s capacity to experience, regulate, and express emotions
• Form close and secure relationships
• Explore environment and learn
• Best accomplished within the caregiving environment that includes family, community, and cultural expectations
• Synonymous with healthy social and emotional development
  • (Zero to Three, 2001)
Relationships are the “Active Ingredients" of Early Experience

• Essential aspect of infant experience is in the nature of caregiving relationships
• Nurturing, responsive relationships build healthy brain architecture that provides a strong foundation for learning, behavior, and health
• Increasing security in attachment relationships is a robust protective factor for all aspects of development

• (Knudsen, Heckman, Cameron, & Shonkoff, 2006)
Traumatic Experiences in the Early Years

• Young children are most vulnerable to the physical and psychological effects of trauma
  – Trauma disrupts all aspects of normal development including:
    • Cognitive growth and learning
    • Emotional self-regulation
    • Attachment to caregivers and social-emotional development

• Often disrupts the caregiver-child relationship
  • (Groves, 2002; Osofsky, 1997)
Traumatic Experiences in the Early Years

• Trauma often disrupts the child’s ability to use relationships with caregivers to:
  – Regulate physiological responses
  – Provide a secure base for exploration and learning
  – Model acceptable and protective behavior

• (Groves, 2002; Lieberman & Van Horn, 2005)
Impact of Trauma on Caregiver-Child Relationship

- When caregivers have also experienced interpersonal trauma:
  - Their ability to establish and maintain an empathic relationship with the child may be impaired
  - They may have a decreased capacity to recognize danger or stress
  - The child may take the role of caregiver

  (Groves, 2002; Osofsky, 1997)
Effects of Trauma on Caregivers

• Caregiver’s ability to listen to child’s distress may be limited
• Caregiver may need to protect him/herself from feelings of vulnerability and trauma
• Caregiver may have trouble tolerating child’s sadness, anxiety, and aggression
• Caregiver may be source of trauma for child

• (Groves, 2002; Lieberman & Van Horn, 2005)
What Can We Do?

• Reduce adversities
• Early intervention is effective
• Evidence–based interventions exist, even for very young children
• They are relationship-based
• Learn to recognize possible signs of trauma
• Comprehensive assessment is important
Behavioral Manifestations of Early Trauma

- Sleep difficulties
- Somatic symptoms
- Increased anxiety
- Increased aggression
- Increased distractibility and activity level
- Increased withdrawal/apathy
- Developmental regression
- Repetitive talk or play about the event
- Intrusive thoughts, memories, worries
- Posttraumatic Stress Disorder
How Do We Know if a Child has Experienced Trauma?

• Posttraumatic Stress Disorder is not always obvious
• I cannot look at a person and tell that he or she has PTSD
• Symptoms of trauma in children may be interpreted as other problems (ADHD, Oppositional Behavior, Developmental Delay)
• Universal standardized screening is recommended
  • (Scheeringa, 2014)
Why Screening for Trauma is Important

- Two mental health agencies thought to be sensitive to trauma were studied
- Their usual practice did not include a standardized measure for PTSD:
  - PTSD diagnoses were 2% and 5% at the agencies
- Re-evaluated all patients with a standardized measure for PTSD
  - Diagnoses of PTSD were 48% and 45%
- Trained and licensed clinicians were missing the diagnosis of PTSD about 90% of the time

(Miele & O’Brien, 2010)
Why Screening for Trauma is Important

• Investigators re-visited one of the agencies 10 years later

• Despite increasing awareness of trauma and PTSD over those 10 years, the agency was not using a standardized measure and the rate of identification of PTSD was back down to 11%

• Screening needs to be embedded, universal, and sustainable

• (Miele & O’Brien, 2010)
Intervention

• To change young children’s developmental trajectories, we must change the quality of their relationships

• Treatment always includes prevention:
  – Every intervention is designed to relieve suffering in the here and now AND to prevent maladaptation in the future
Examples of Evidence-Based Treatments for Young Children

• Child-Parent Psychotherapy (CPP) – Birth to 6 years (Lieberman & Van Horn, 2005)
• Attachment and Biobehavioral Catch-up (ABC) – Birth to 2 years (Dozier et al., 2013)
• Preschool PTSD Treatment (PPT) – 3 years to 6 years (Scheeringa, Amaya-Jackson, & Cohen, 2002)
• Parent-Child Interaction Therapy (PCIT) – 3 years to 6 years (Eyberg et al., 2001)
  – There is a special adaptation for parents who have physically abused their children, ages 4 - 10 years (Chaffin et al., 2004)
Examples of Evidence-Based Treatments for Young Children

• *All of these treatments include the parent in the intervention; it is dyadic work
  o Additional collateral sessions often vital when working with trauma of child and parent; provides time with caregiver alone to process trauma that is not appropriate to discuss in front of child
  o These treatments provide depth; length of time for treatment depends upon nature of trauma and symptom presentation
• A trauma-informed mental health professional can recommend which treatment is most appropriate for a given child and parent
Questions to Ask Therapists/Agencies That Provide Services

• Do you provide trauma-specific or trauma-informed therapy?
• How do you involve parents or caregivers?
• How do you work with collaterals?
• How would you determine that the therapy has been effective?
• What is the ethnic/racial composition of your service population?
• What age group(s) do you work with?
• How do you work collaboratively with other systems?
• (Ko, Groves, & Wilson, 2009)
Traumatic Stress and Use of Services

• Education, child care, and primary health care settings are prime portals of entry into services
• Traumatic stress increases use of health and mental health services
• Increases involvement with other child-serving systems
  – Child welfare
  – Juvenile justice systems
• (Ko et al., 2008)
All Child-Serving Systems

• See children who have experienced trauma
• Share the goal to improve outcomes for children
• Must have as a priority addressing the impact of trauma on children and families
• Need a workforce knowledgeable about trauma and the impact of traumatic stress to achieve outcomes important to the system
  • (Ko et al., 2008)
Policies to Benefit Infants, Toddlers, and Families

• Include infant-toddler focus in priorities of collaborative planning and governance
• Coordinate across services that support expectant parents, infants and toddlers
• Implement cross-sector professional development to support infant-toddler workforce
• Focus on infants and toddlers in Quality Rating and Improvement

  (Zero to Three, 2015)
Policies to Benefit Infants, Toddlers, and Families

• Articulate an intentional strategy for maternal, infant, and early childhood mental health embedded into services
• Embed a developmental approach into child welfare
• Maximize funding to sustain and expand services for infants, toddlers, and families
• Include measures of infant-toddler health in state’s desired outcomes and monitor indicators
  • (Zero to Three, 2015)
Systems Working Together

• Designed for collaborative work in rural and tribal jurisdictions in MN on the interrelated issues of domestic violence and child maltreatment

• *Collaborating for Woman and Child Safety: A Training Curriculum for Multidisciplinary Teams to Enhance Practice and Policy When Domestic Violence and Child Maltreatment Co-occur*

• Interdisciplinary collaboration reduces risk children will be re-exposed to traumatic material by being asked to repeat their story as they enter each new system

• (Hagemeister et al., 2003; Ko et al., 2008)
Cross-Systems Collaboration

- Professionals working within Child Protective Services and Domestic Violence organizations determined similarities and differences in practices.

- **Some barriers to collaborative practice**
- Tension between the two philosophies
- Belief that CPS was holding mothers accountable for things they shouldn’t
- Belief that male perpetrators were not held responsible
- Lack of communication and formalized collaboration within and across systems
- Lack of culturally appropriate services
- Multi-issue families (e.g. chemical dependency, poverty, housing)
- (Beeman, Hagemeister, & Edleson, 1999; Hagemeister et al., 2003)
Principles of Successful Collaboration in Overlapping Cases

• Improve collaborative community response to children exposed to domestic violence
• Understand the workings and limitations of the other systems
• Develop liaisons who can act as unbiased mediators between systems
• Start small and build support one step at a time
  • (Hagemeister et al., 2003)
Principles of Successful Collaboration in Overlapping Cases

• Support your work with data (be proactive; collect it from the start)
• Involve key stakeholders from the beginning; they will support the things they help to create
• Build an atmosphere of personal and professional safety so that you can talk honestly about differences and issues
• Get beyond turf battles to the real purpose at hand: the safety and well-being of children and families
  • (Hagemeister et al., 2003)
WORKING WITH FAMILIES AND TRAUMA
Vulnerabilities and Resilience
Personal Reactions and Self-Care

- Emotionally challenging to work with, and on behalf of, young children and parents, especially when trauma is involved
  - many difficulties
  - urgent needs
  - substantial challenges to meeting those needs
  - Consider impact of historical and intergenerational trauma as well
Personal Reactions and Self-Care

• Very common for this difficult work to cause strong feelings and reactions
• Experiencing strong emotions in our work can be helpful – it can inform and motivate us
• Working with children, especially very young, traumatized children can result in
  – Reactions that can become negative, overwhelming, and harmful
Secondary Traumatic Stress

• STS is a set of observable reactions to working with the traumatized
• Mirrors the symptoms of post-traumatic stress disorder (PTSD)
• Indirect source through helping others who have experienced trauma
• Empathic engagement with survivors’ trauma
  • (Bride, 2004; Saakvitne, Gamble, Pearlman, & Lev, 2000)
Secondary Traumatic Stress

• Experiencing traumatic symptoms similar to those of clients
  – Seeing flashes of traumatic images
  – Recollections, nightmares
  – Avoidance of thoughts, feelings
  – Emotional numbing or flooding of strong emotions
  – Loss of interest in normal daily pleasures
  – Sleep problems, persistent arousal
Secondary Traumatic Stress

- Changes in one’s sense of identity, worldview, beliefs
- Increased feelings of personal vulnerability
- Difficulty trusting others
- Pulling away from family and friends who could be sources of support
- Has been related to job dissatisfaction, turnover, and illness
  
  • (Shackelford, 2012)
Agency Questions and Solutions

• How would you describe the organizational culture and climate in your agency? How does this climate impact risk of developing STS?

• Consider how STS may be experienced differently among professionals in your agency, based upon the diverse backgrounds represented by your personnel

• (CW360 Editors, 2012)
Agency Questions and Solutions

• Consider impact on supervisors as well as their supervisees/frontline staff/clinicians
• Anyone who makes decisions around traumatized families is at risk
• Raise awareness throughout all levels of personnel:
  – What may be trauma triggers for each person?
  – What are realistic work goals for each person?
• (CW360 Editors, 2012)
Agency Questions and Solutions

• Managing professional and personal stress is a necessity and a responsibility of ethical practice

• How does your organization support the management of stress in your workforce?
Agency Questions and Solutions

• Screen for Secondary Traumatic Stress
• Ongoing monitoring is recommended, can be done by individuals and discussed with supervisors
• Limit cases of trauma, as possible
• Provide ongoing training
• Provide retreats and respite
• Provide therapy/Employee Assistance Program
• Reflective supervision/consultation is essential
• (CW360 Editors, 2012)
Agency Questions and Solutions

- Prevention is key in organizations as well as with families
- Support a culture of connection
- Relationships are built over time; they can provide foundation and support when crises occur
Agency Questions and Solutions

• Adopt evidence-based practices; they demonstrate it is possible to make a difference for traumatized families

• Evidence-based practices enhance services for traumatized child and families:
  – Improve outcomes
  – Reduce recidivism
  – Can lead to sustained adoption of trauma-informed practices

• Include trauma training for new practitioners in every child-serving system
Resources on Child Trauma

- National Child Traumatic Stress Network
- 79 centers across the U.S.
- Affiliates in Wisconsin
- Information about NCTSN and policy
- [http://www.nctsn.org/sites/default/files/assets/pdfs/policy_and_the_nctsn_final.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/policy_and_the_nctsn_final.pdf)
Resources on Child Trauma

• National Child Traumatic Stress Network
• Child Trauma Toolkit for Educators:
• Child Welfare Trauma Training Toolkit:
Resources on Child Trauma

• National Child Traumatic Stress Network

• Pediatric Medical Traumatic Stress Toolkit for Healthcare Providers:

• Domestic Violence:
  • *Cops, Kids, and Domestic Violence: Protecting our Future* – video and instructional information
Resources on Child Trauma

• National Child Traumatic Stress Network
• Children and domestic violence fact sheet series, accessible at:
  • http://www.nctsn.org/sites/default/files/assets/pdfs/childrenanddv_factsheetseries_complete.pdf
Resources for Collaborative Efforts

• Child Welfare and Domestic Violence
  – http://www.mincava.umn.edu/link/documents/fvpf1/fvpf1.shtml
Resources for Dealing with Stress and Trauma in our Work

• Special publication on secondary trauma and the child welfare workforce

  www.nctsn.org
Policy Initiatives: Infants, Toddlers, and Families

- Zero to Three National Center for Infants, Toddlers, and Families
- *Early Experiences Matter Policy Guide*

See *A Self-Assessment Checklist for States*, pp. 113-124
Resource for States’ Policies Impacting Infants, Toddlers and Families

• *Baby Matters: A Gateway to State Policies and Initiatives!*

• A searchable database on state policies and initiatives that impact infants, toddlers and their families

• Systems issues are addressed, including
  – Governance/Leadership
  – Quality Improvement
  – Accountability and Evaluation
  – Financing
  – Public Engagement and Political Will Building
  – Regulations and Standards
  – Professional Development

• [http://policy.db.zerotothree.org/policyp/home.aspx](http://policy.db.zerotothree.org/policyp/home.aspx)
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