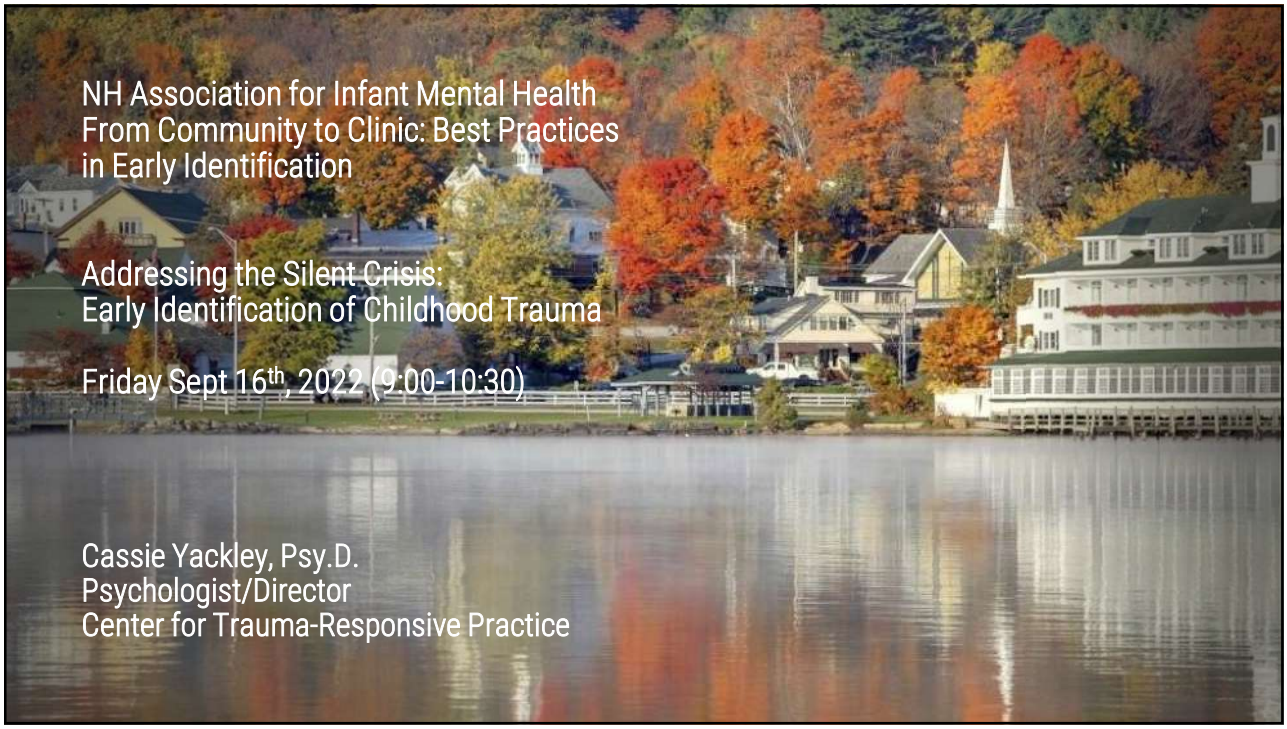
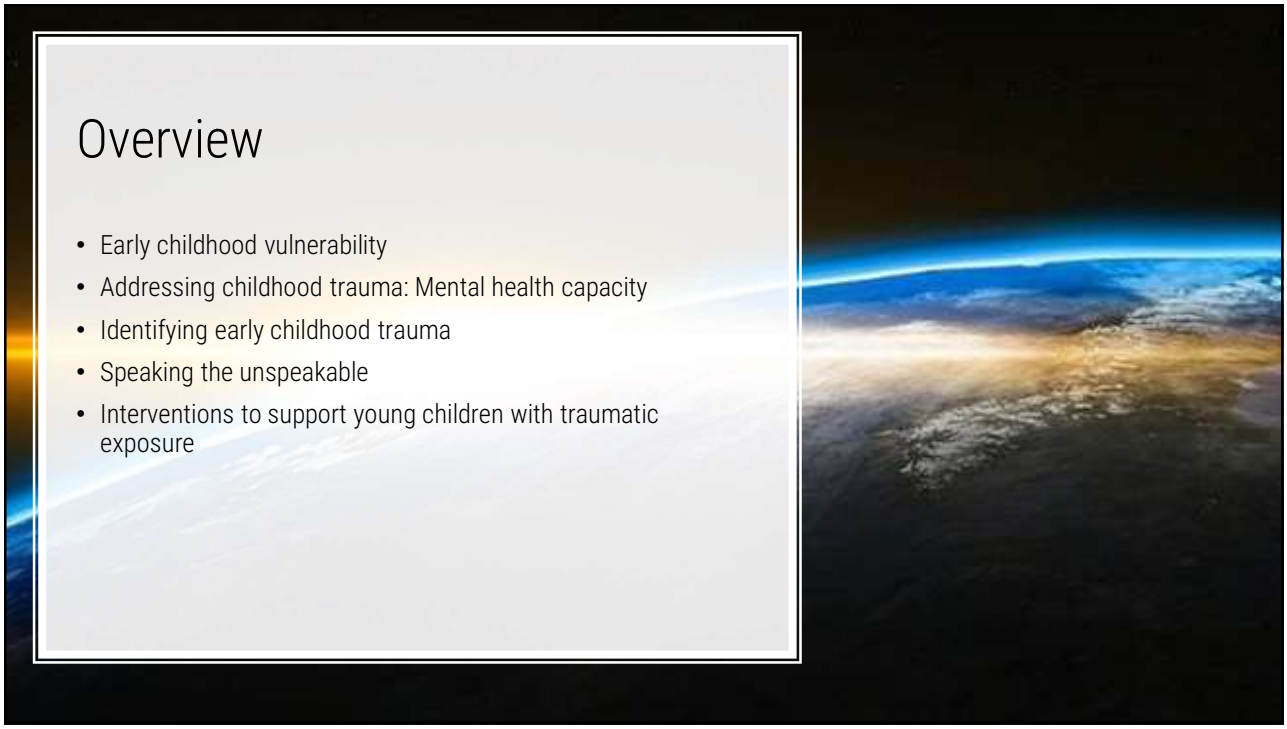

NH Association for Infant Mental Health
From Community to Clinic: Best Practices
in Early Identification
Addressing the Silent Crisis:
Early Identification of Childhood Trauma
Friday Sept 16th, 2022 (9:00-10:30)
Cassie Yackley, Psy.D.
Psychologist/Director
Center for Trauma-Responsive Practice

1


Overview
• Early childhood vulnerability
• Addressing childhood trauma: Mental health capacity
• Identifying early childhood trauma
• Speaking the unspeakable
• Interventions to support young children with traumatic exposure

2

Vulnerability of Young Children

3

Prevalence of IPV

(Postmus & DiBella, 2016)

- Annually in the U.S. IPV impacts 4 to 6 million people
  - This is true regardless of SES, ethnicity, gender, sexuality, or religion
- Between 3.3 million and 10 million children in the United States are exposed to Domestic/Intimate Partner Violence each year (Domestic Violence and Children: Analysis and Recommendations Study)
  - That IPV is ongoing, severe, physical violence for about 7 million children
- Children can provide detailed accounts of the violence in 80-90% of the cases

4

Infant Exposure to IPV

- In cross-sectional research (national telephone survey) that included 503 children under the age of 2 years
- Nearly 10% of infants had witnessed family violence
- **And witnessing family violence and one other factor (sibling assault) had the highest correlations with infant emotional and behavioral symptoms**

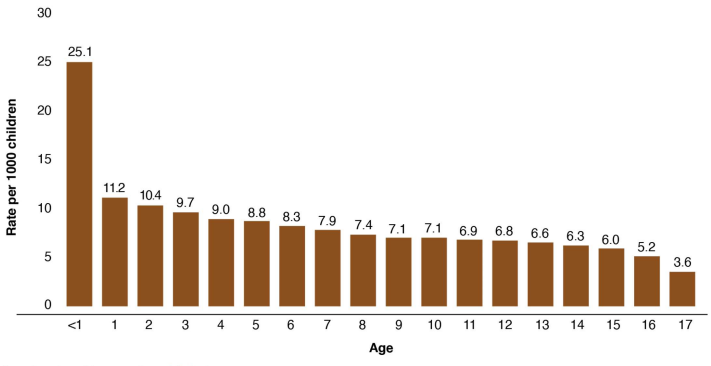
(Turner, H., Finkelhor, D., & Ormrod, R., & Hamby, S., 2010)

5

Young Children: Disproportionate Impacts of Child Maltreatment
(NCANDS, 2020)

Exhibit 3–D Victims by Age, 2020

The youngest children are the most vulnerable to maltreatment



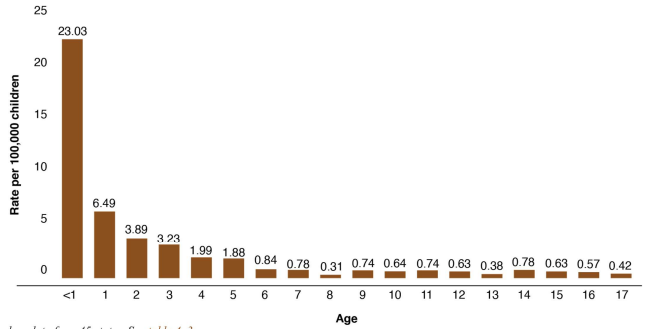
Based on data from 52 states. See table 3–6.

6

Young Child Fatalities
(NCANDS, 2020)

Exhibit 4–B Child Fatalities by Age, 2020

Children <1 year old died from abuse and neglect at more than three times the rate of children who were 1 year old.

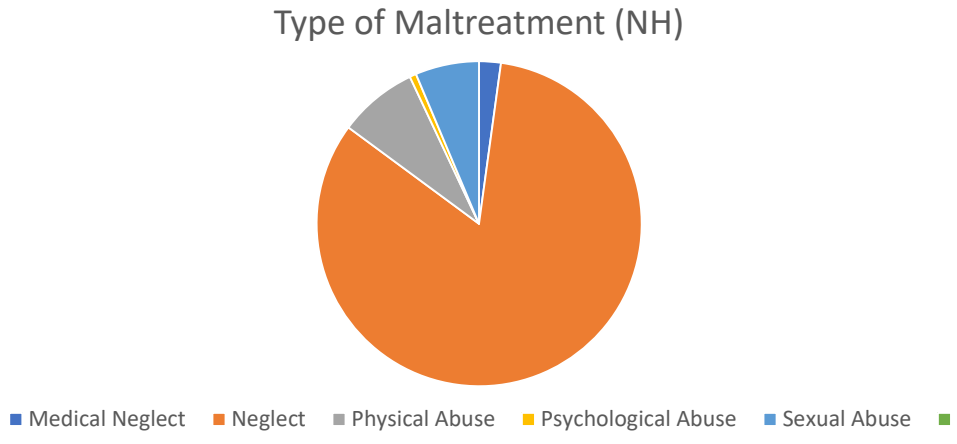


Based on data from 45 states. See table 4–3.

7

Child Maltreatment in New Hampshire in 2017

National Child Abuse and Neglect Data System (NCANDS) – 2017 Child Maltreatment Report



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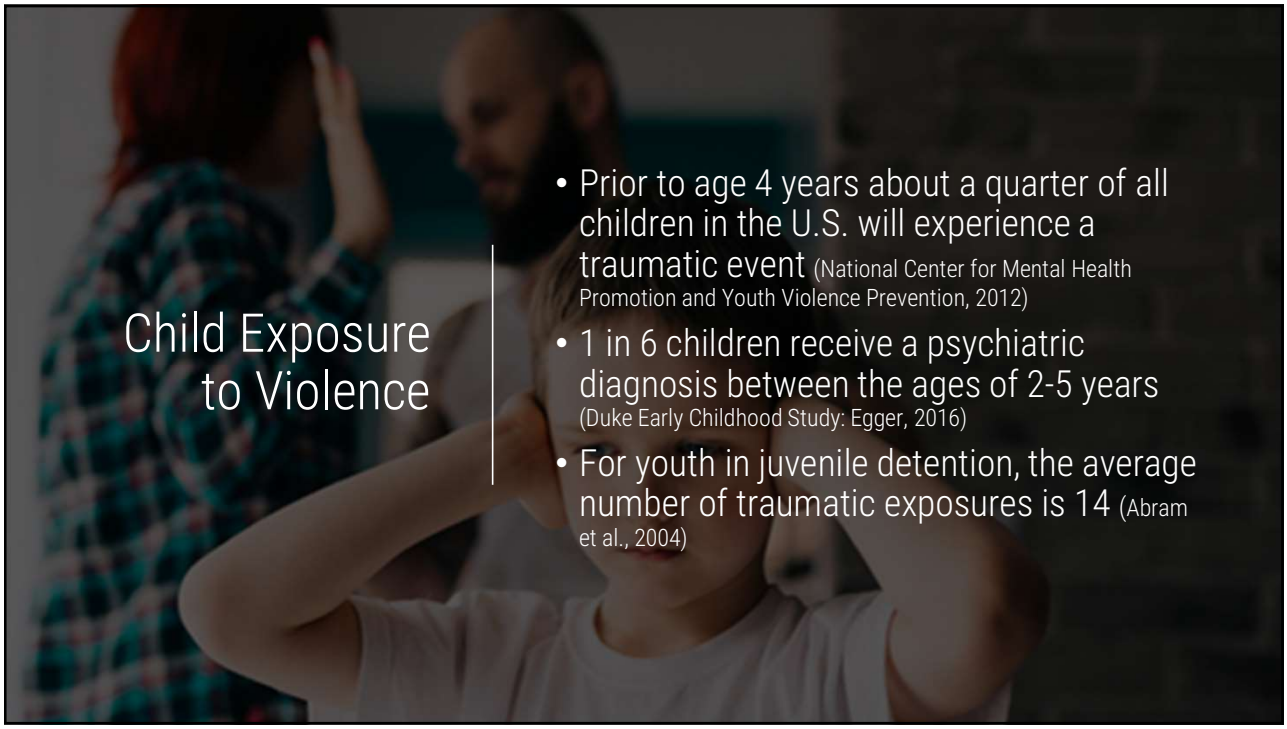
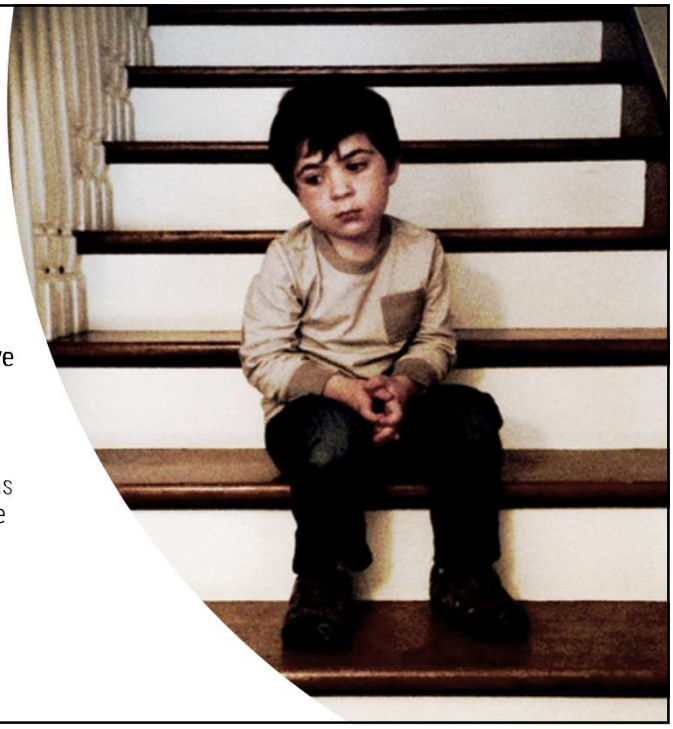


9

Young Children and Mental Illness

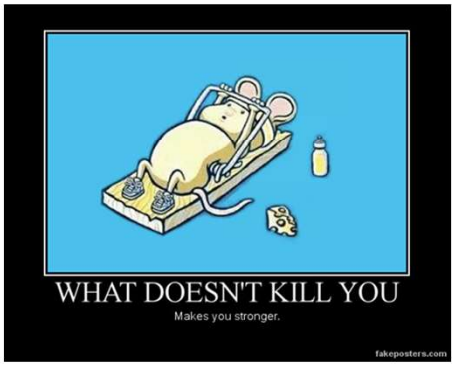
- Contrary to typical views, young children CAN suffer from mental health problems
  - 1 out of 7 U.S. children aged 2 to 8 years have a diagnosed mental, behavioral, or developmental disorder (National Survey of Children's Health, 2012)
- Addressing mental health problems early is key, as they will disrupt brain development and hinder the capacity to learn and grow



10

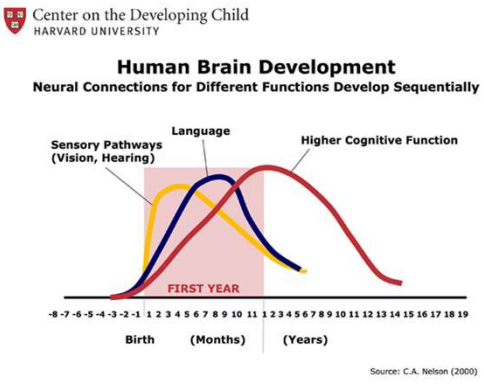
What We Believed About Young Children

- He/she won't remember what happened
- Young children are resilient
- Adversity makes you stronger
- It might be distressing or re-traumatizing to bring it up



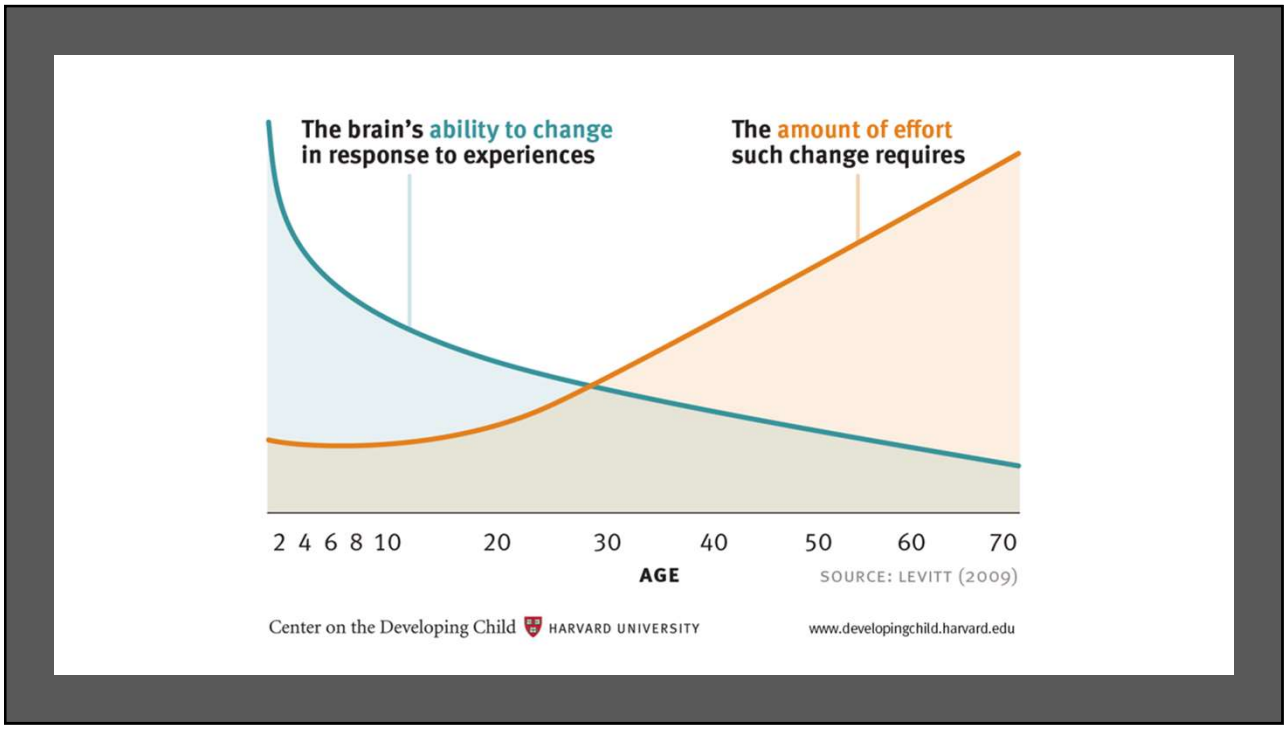
11

What We KNOW About Early Childhood



- Every second more than a million new neural connections are created during the first few years of life
- Both genes and the baby's experiences form these connections
- Built through serve and return interactions
- These connections form the "brain architecture – the foundation upon which all later learning, behavior, and health depend."

12


The brain's ability to change in response to experiences
The amount of effort such change requires
2 4 6 8 10 20 30 40 50 60 70
AGE
SOURCE: LEVITT (2009)
Center on the Developing Child HARVARD UNIVERSITY
www.developingchild.harvard.edu

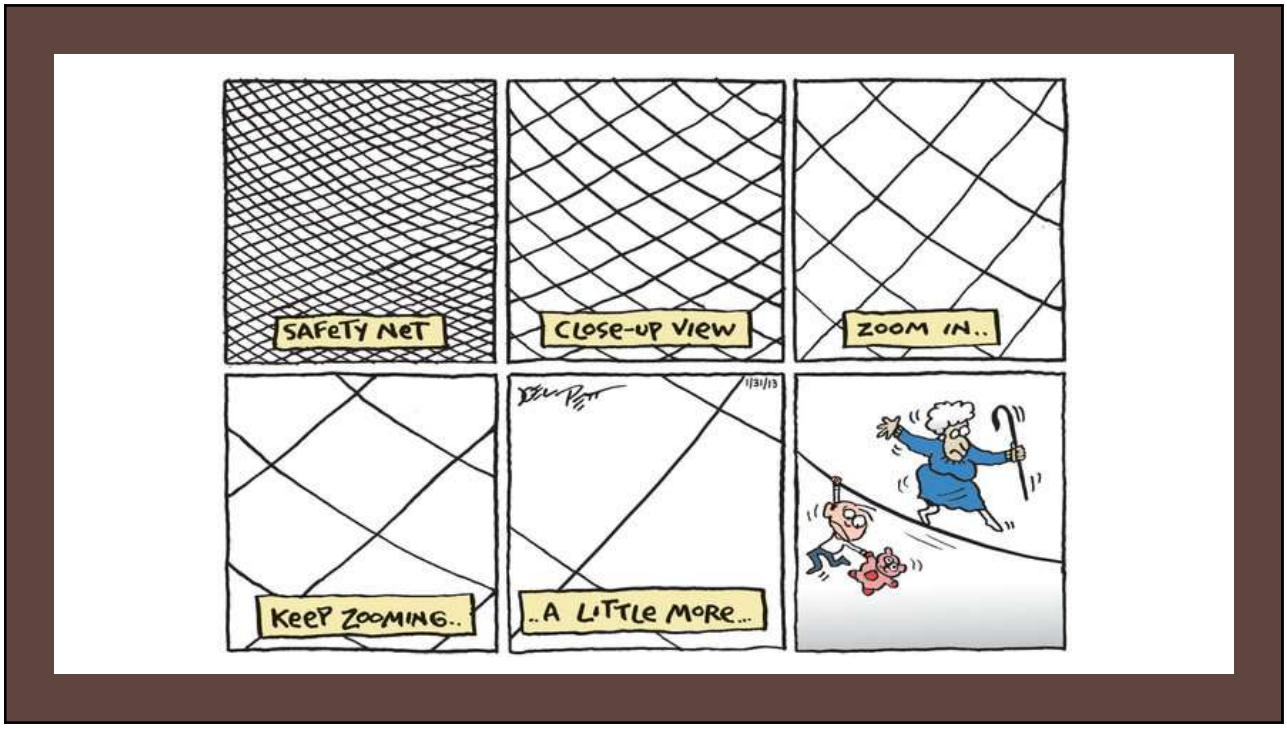
13


Adversity/Trauma
Relationships
Adversity & Relationships

14

Addressing childhood trauma: Mental health capacity

15



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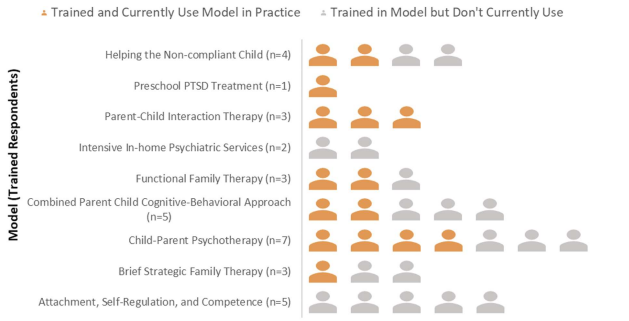
EC Mental Health Field Capacity (EFH)



DATA SOURCE: New Hampshire Early Childhood and Family Mental Health Workforce Assessment Survey, 2019

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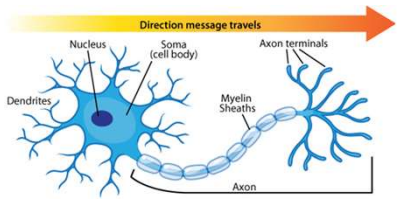
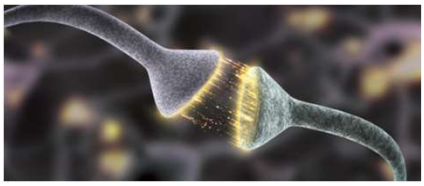




It involves the creation of a complex web of neural networks or associations - "Neurons that fire together, wire together"

A Deeper Look at Brain Development

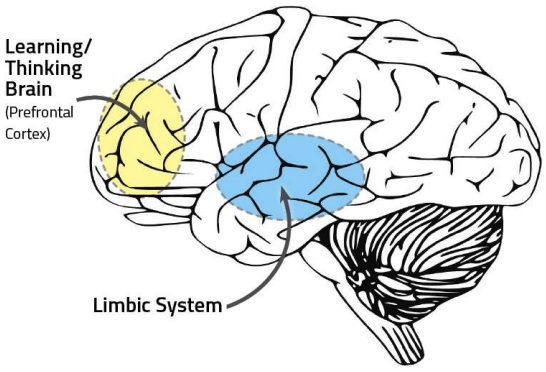
19

Development of the Prefrontal Cortex:

"Use It or Lose It"

Survival Mode: Flight/Fight/Freeze

Frontal lobe (Prefrontal cortex) goes offline
Limbic system / mind and lower brain functions take over



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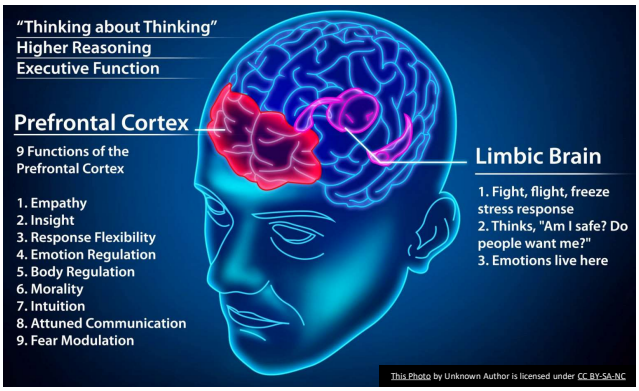
Prefrontal Cortex

- Executive functioning
- Learn from consequences
- Plan for the future
- Think about one's behavior
- Have empathy for others
- Start and stop behavior



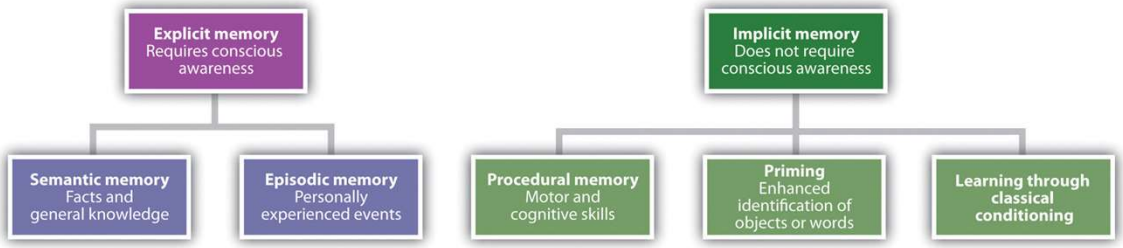
21

Memory and Stress

- Short-term stress
  - Increased implicit memory encoding
  - Explicit memory hindered
- Long-term stress
  - Damage to hippocampus

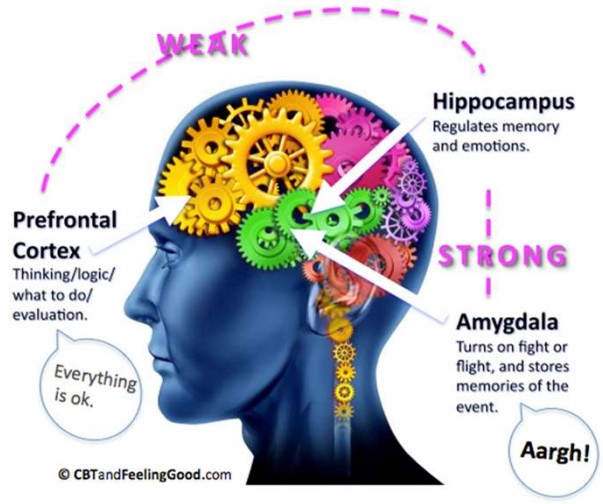
22

Forms of Memory



23

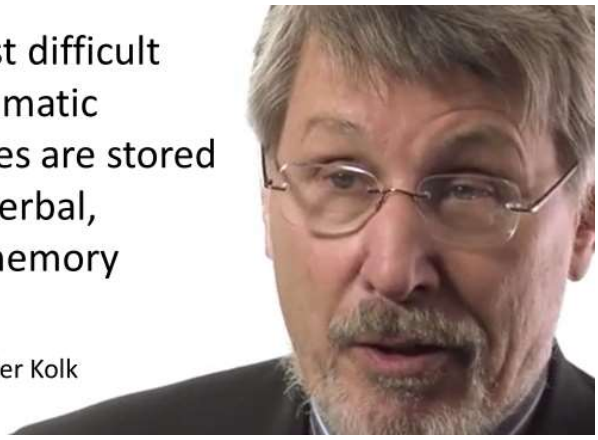
What Really Drives Our Behavior?



24

Implicit Memories

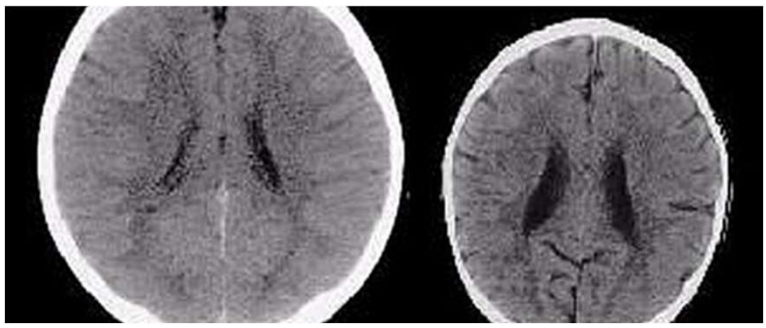
The most difficult and traumatic memories are stored in non-verbal, bodily memory



Bessel Van der Kolk

- Memories for external AND internal events
- Physiological reactions
- Emotions/feelings ("emotional tagging")
- Automatic

25



Neglectful Experiences & Lack of Brain Integration

26

The Fear Response: The Path Most Taken

27

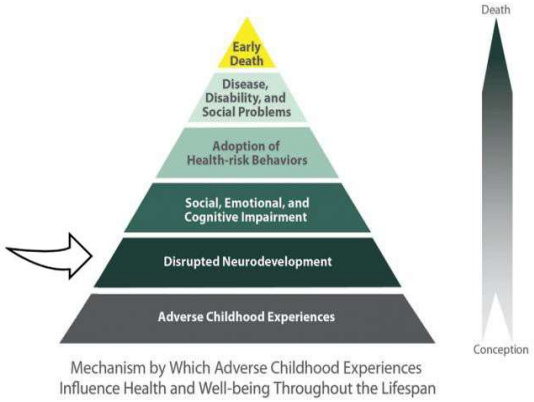
"How States Becomes Traits" (Bruce Perry, MD, PhD)

- Persistent states of arousal become neutrally-based habits of responding
  - "Neurons that fire together, wire together"
- Sensitization of the fear response – (a.k.a., the "kindling effect")

28

ACEs and Neurodevelopment: Overview

- Overdeveloped fear response system
- Inability to use relationships for safety & regulation
- Lack of development of the prefrontal cortex



Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

29

Early Experiences

30

Understanding Brain Development

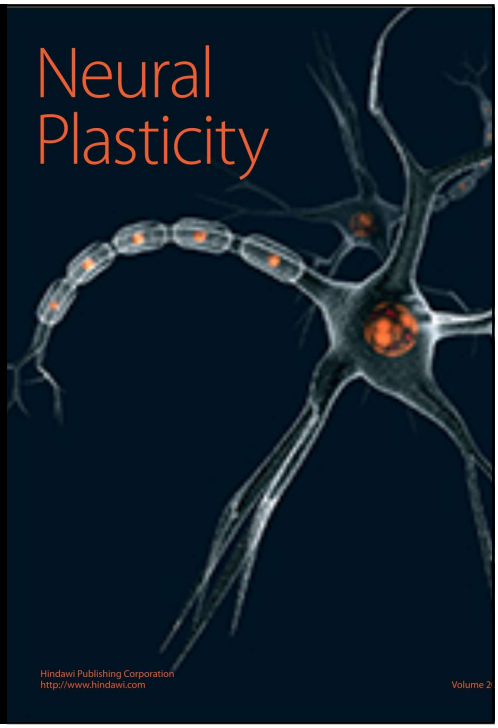
- Brain development is…
  - Sequential & hierarchical (bottom up and inside out)
  - Use dependent development
  - Shaped by experiences

31

Disrupted Neurodevelopment

Earlier to Develop – Decreased Plasticity

- Brain Stem
  - ANS functions
- Cerebellum and Diencephalon
  - Motor control
  - Arousal level
- Limbic System
  - Emotions
  - Relationships
- Prefrontal Cortex
  - Executive functions



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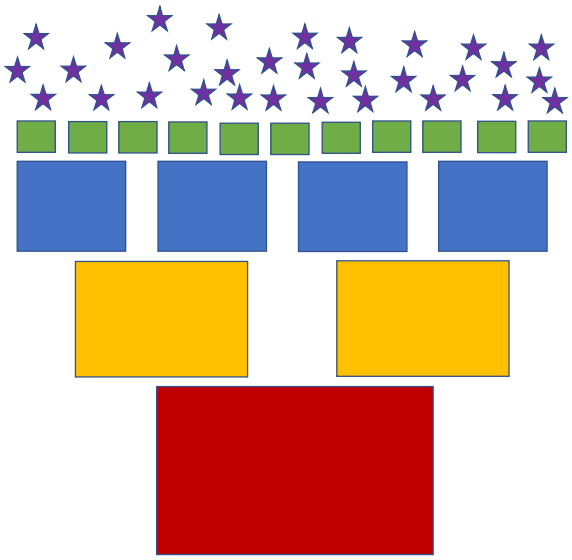
Early Childhood Experiences: The Building Blocks of Healthy Development



33

Intellectual & Developmental Disabilities (IDD)

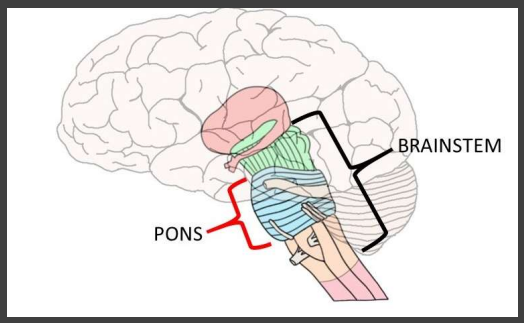
Home > Intellectual and Developmental Disabilities

Research indicates that youth living with intellectual and developmental disability (IDD) experience exposure to trauma at a higher rate than their non-disabled peers. Children with IDD appear to be at an increased risk for physical abuse, physical restraint and seclusion, sexual abuse, and emotional neglect. In addition, psychological distress secondary to medical procedures is more common among children living with IDD than their typically developing peers, as they also may have chronic medical problems that necessitate surgeries and other invasive procedures. When trauma occurs with children and families with IDD, it is challenging to effectively address the psychological impact of the event.

34

Birth to Nine Months of Age: Brainstem Development – "Bottom Up"

- Critical functions being organized:
  - Regulation of arousal, sleep, & fear states
- Primary developmental goal:
  - State regulation
  - Primary attachment
  - Flexible stress response
  - Resilience
- I need…
  - Rhythm & touch



35

Disrupted Neurodevelopment: Brain Stem Functioning (AAP)

Response to Trauma: Bodily Functions

FUNCTION	CENTRAL CAUSE	SYMPTOM(S)
Sleep	Stimulation of reticular activating system	1. Difficulty falling asleep 2. Difficulty staying asleep 3. Nightmares
Eating	Inhibition of satiety center, anxiety	1. Rapid eating 2. Lack of satiety 3. Food hoarding 4. Loss of appetite
Toileting	Increased sympathetic tone, increased catecholamines	1. Constipation 2. Encopresis 3. Enuresis 4. Regression of toileting skills

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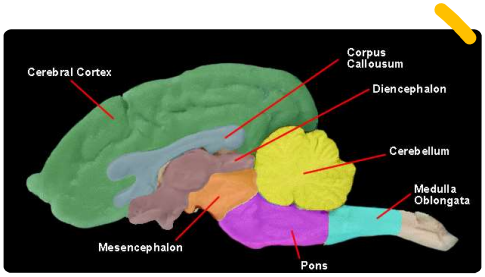


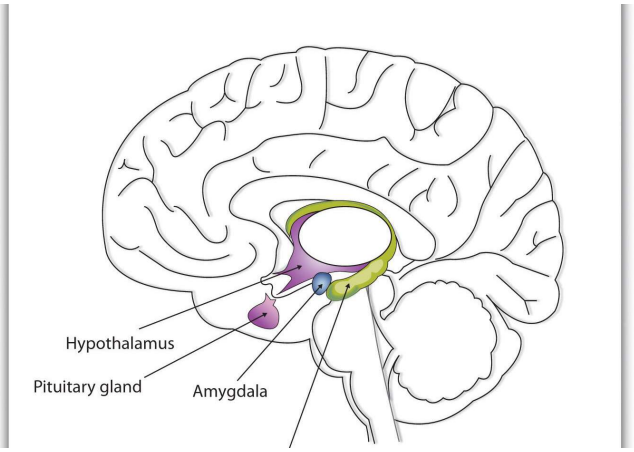
My Body in Space (6 months to 2 years): Diencephalon & Cerebellum Development

- Critical functions under construction:
  - Sensory input integration
  - Control of fine motor functions
- "I'm learning to…"
  - Move my body in complex rhythmic movements
  - Experience emotional and physical warmth, nurturing, and closeness
  - Develop a simplistic narrative or story about experiences/self
- I need music and movement

37

Limbic System Development (1-4 years): The Foundation of Social & Emotional Functioning

- Critical functions under construction:
  - Understanding and managing emotions
  - Connecting with others – interpreting nonverbal communication
    - Developing "social language"
- Developmental goals:
  - Emotion regulation
  - Empathy
  - Affiliation
  - Tolerance



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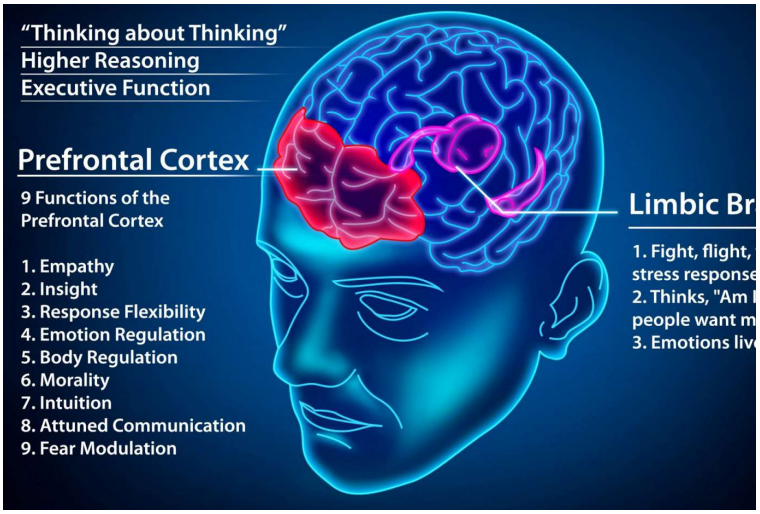
Limbic System Development (1-4 years): The Foundation of Social & Emotional Functioning

- I'm learning to…
  - Move my body in complex ways
  - Create a story about my life
  - Engage in social experiences
- Help me to use play and creative expression to understand myself

39



Early Childhood (3-6 years): Cortex Development

40

Self-Control & Executive Functioning

Critical functions:

Connecting emotional and social experiences meaningfully

Abstract thinking (not about concrete objects)

Developmental goals:

Reasoning in an abstract way

Being creative

Understanding respect

Starting to think about moral (values) and spiritual (meaning-making) issues

41

Developing the Cortex: "Everybody Has A Story"

I'm learning to…

- Be okay alone (solitude), feel satisfied in terms of needs (satiety), and feel safe and secure in the world
- Participate in social interactions
- Engage in complex conversations

Help me to…

- Use story to make sense of my world
  - Drama
  - Performing arts
  - Educational experiences
  - Thought-based (cognitive-behavioral) approaches

42

Speaking the Unspeakable

43

"The Gold is in the Shadows" (Siegel)

44

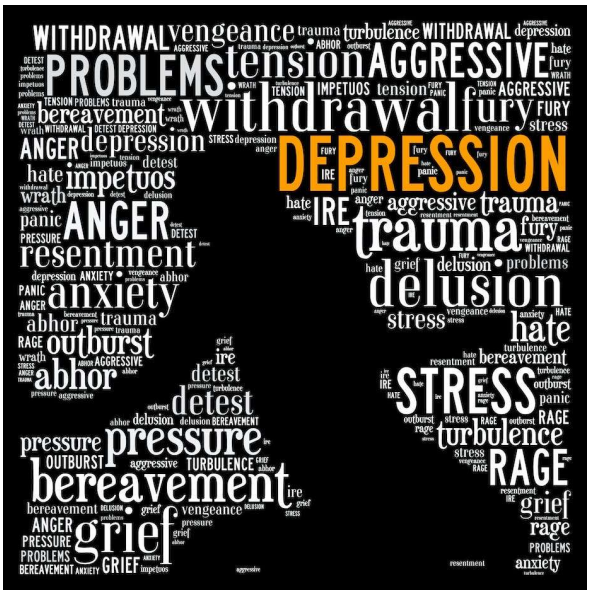
Knowing What You're Not Supposed to Know

- "Children not infrequently observe scenes that parents would prefer they did not observe; they form impressions that parents would prefer they did not form; and they have experiences that parents would like to believe they have not had. Evidence shows that many of these children, aware of how their parents feel, proceed then to conform to their parents' wishes by excluding from further processing such information as they already have, and that, having done so, they cease consciously to be aware that they have ever observed such scenes, formed such impressions, or had such experiences. Here, I believe, is a source of cognitive disturbance as common as it is neglected." (John Bowbly)

45

Distress NOT Disorder

- "…providing context to a person's behaviors and emotions not only allows individuals to make meaning of their experience and understand how they make sense given their circumstances, it also locates the problem outside of the person and within relationships" (Hunter, 2018, p. 6).



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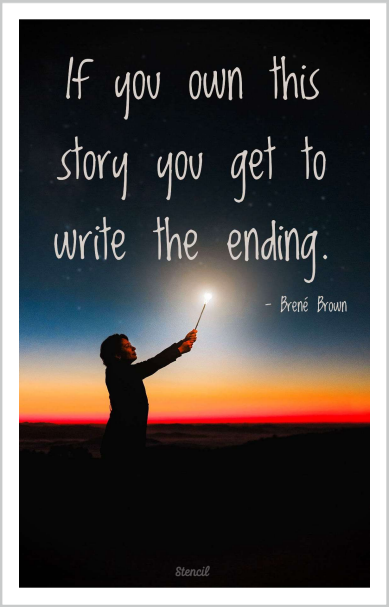

Does it hurt to ask?

Meta-Analytic Study Results
Jaffe, E, A., DiLillo A., Hoffman L., Haikalis M., & Dykstra, E. R. (2015)

- Is It Distressing?
- "…although trauma-related research can lead to some immediate psychological distress, this distress is not extreme."
- Trauma history and PTSD do increase distress, particularly with interviews
- Endorsing sexual trauma does not produce more distress than other forms of trauma

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Why Talk About It?

- "Anything that's human is mentionable, and anything that is mentionable can be more manageable. When we can talk about our feelings, they become less overwhelming, less upsetting, and less scary. The people we trust with that important talk can help us know that we are not alone."

— Fred Rogers

48

Share-ability Theory

(Goldsmith, Barlow, & Freyd, 2004)

- "Share-ability theory proposes that the process of sharing information makes information more discrete, stable, and communicable" (p. 455)
- Factors that facilitate memory:
  - Rehearsal
  - Corroboration by others
  - Verbal skills

49

Empowering and Equipping the Field

"Good Afternoon Ladies,

I am so excited that I just have to share this story…This is a TRUE STORY, that just happened.

I just left a visit with a family. Mom and dad both work full-time, and I was visiting during the brief 2 hours they have together during their shifts'. Dad walks in the door shortly after I got there visibly exhausted from a long day at work. There are twin one y/o's eating lunch in their highchairs, a 5 y/o and an 8 y/o all fighting for a brief second of attention from anybody. Mom's trying to get ready to go to work, I'm there on my first visit trying to explain our home visiting program and get out of their hair so they can go about their routine. It was a little chaotic. Dad was barking orders at his wife while also yelling at the kids to stay in the room and stop bothering "Home Visitor so she can get this done". He clearly is not in the mood to work on any goals and wants me gone as soon as possible.

Then mom looks at me and starts' telling me how they never listen and their behavior is just awful. BEHAVIOR!! IT'S THE WORD!

The 8 year old boy has been talking about dogs since I had arrived. Then he looks at me and says his grandma and grandpa's dog bit him on the head and then they had to burn his bones. Dad immediately scolds him saying, "you know we do NOT talk about that day". Mom covers it up to me saying he is lying and that is not what happened. The child lowers his head in shame. (Cassie by now my heart is pounding as I'm reciting in my head how I am going to say what I'm about to say that I just learnt from you yesterday. This is the perfect scenario so far, almost word for word what you trained us. BUT I COULDN'T MESS IT UP)

I said, "that must have been really scary. How did it make you feel?"

He raised his little eyes and glanced at dad, stood up and as he walked past me to go back into his room he said, "it made me feel so sad my eyes did this thing where water came from them". He was off in his room.

It was such an uncomfortable awkward silence I just sat there waiting for them to ask me to leave and knew he was in big trouble….except that is not at all what happened. Dad called him back into the room. The boys eyes were red and bloodshot. He took the little boy on his knee and told him that it made him sad too, but his job was to protect him first. They hugged and I felt like I was in the middle of a Hallmark movie.

He went on to admit to me (really himself) that he has some issues with anger, he was abused as a child and has never been to counseling and he doesn't want that for his family. Our first goal in the IFSP was for him to call the list of numbers I left him to make an appointment.

I'm sure this was a rare coincidence and they do not always falls so perfectly in place like this, but affirmation felt so good I had to share."

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Trauma Screening Definition

Designed to be able to be administered to **every child** within a given system (such as child welfare) to determine whether he or she has experienced trauma or displays symptoms related to trauma exposure

Screening is *often followed by a referral* for a more comprehensive trauma-informed mental health assessment

Trauma screening should evaluate the presence of **two critical elements**:

- (1) Exposure to potentially traumatic events/experiences, including

traumatic loss

- (2) Traumatic stress symptoms/reactions

51

Is it within your role to:

- Screen for traumatic exposure and symptoms?
- Talk about trauma with young children?
- Have conversations with caregivers about adverse experiences?
- Provide trauma intervention individually?
- Conduct groups for traumatized children?
- Advocate for a trauma-informed lens in meetings?
- Provide training and consultation to teachers about trauma?

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Whose Role Is It To Ask About Trauma?

- "It's not my job"
- "I'm not qualified"
- "I'm not comfortable"
- "That's not my role"
- If you don't do it, who will? May be that child's only chance to be heard and get help
    - May never get to mental health
    - Sometimes mental health doesn't ask
- What message does it send if we don't ask?
- All of us!

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The Pathway to Trauma Healing

Adapted from the Child Welfare Trauma Referral Tool Kit by the NCTSN & Nebraska Babies.

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Screening Young Children

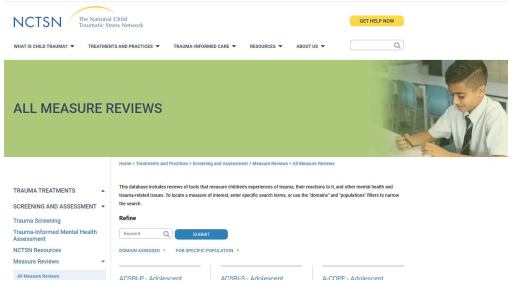
Difficult to screen specifically for "trauma symptoms"

May screen for exposure to traumatic events and social and emotional difficulties

- Attachment difficulties
- Mood dysregulation

55

Screening Measures



School Psychology Quarterly
2018, Vol. 33, No. 1, 30–43

1045-3830/18/$12.00 http://dx.doi.org/10.1037/spq0000244

A Systematic Review of Trauma Screening Measures for Children and Adolescents

Katie Eklund
University of Missouri

Eric Rossen
National Association of School Psychologists, Bethesda, Maryland

Taylor Koriakin, Sandra M. Chafouleas, and Cody Resnick
University of Connecticut

Traumatized youth are at an increased risk of a host of negative academic and psychoeducational outcomes. Screening and identification of students who experience potentially traumatic events may help schools provide support to at-risk students. In light of this, the current study examines the availability and use of trauma screening measures to detect early indicators of risk among youth in schools. A systematic review was conducted to identify measures available to screen children and youth for trauma exposure and/or symptoms, as well as the associated psychometric properties to support each instrument's applied use in schools. Eighteen measures met inclusion criteria, which consisted primarily of student self-report rating scales and clinical interviews. While many instruments measure the symptomology or exposure to trauma among children and youth, very little psychometric evidence was available to support the use of these measures in schools. Additional research is needed to endorse and expand the use of trauma screening measures in schools.

Impact and Implications
The current study examines the availability of trauma screening measures to detect early indicators of trauma exposure and/or symptoms among youth. This systematic review provides descriptive

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Selecting A Measure: Resources

- National Child Traumatic Stress Network
  - www.nctsn.org
- Birth to 5: Watch Me Thrive
  - www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive#compendium
- Buros Center for Testing
  - http://buros.org

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Screening Measures for Young Children

HOW YOUNG CHILDREN SHOW US THEY NEED HELP

When problems last more than one month, happen more often, or are stronger than would be expected given the child's age.

- ☐ **Continued Problems with Body Functions**
  - ☐ Sleeping
  - ☐ Feeding or eating
  - ☐ Potty training or going to the bathroom
- ☐ **Easily Upset by Noise, Touch, Smells, Tastes, Open or Busy Spaces**
- ☐ **Serious Developmental Delays**
  - ☐ Speech
  - ☐ Motor
  - ☐ Social skills
  - ☐ Exploration and play
- ☐ **Frequent Health Problems (e.g. illness, aches, asthma)**

Young children often show distress through their bodies, which can lead to health problems. See your doctor for all health concerns.

- ☐ **Emotional Difficulties**
  - ☐ Often angry, irritable
  - ☐ Tantrums (stronger and longer than others their age)
  - ☐ Sad, cries a lot, hard to comfort
  - ☐ Overly worried or scared
  - ☐ Serious problems separating, overly clingy
  - ☐ Overly quiet, shy, shut-down
- ☐ **Challenging Behaviors**
  - ☐ Aggressive, defiant
  - ☐ Overactive
  - ☐ Problems paying attention
  - ☐ Reckless, frequent accidents (gets hurt a lot)
- ☐ **Relationship Difficulties**
  - ☐ More distant or less connected to people than usual
  - ☐ Doesn't play with other children, wants to be alone
  - ☐ Overly friendly with strangers
- ☐ **Other Common Responses to a Scary or Painful Event**
  - ☐ Bad dreams
  - ☐ Easily scared
  - ☐ Talking or playing a lot about what happened
  - ☐ Avoiding talking about what happened or avoiding places, people, or things connected to the event
  - ☐ Sudden change in mood or behaviors when reminded of what happened
  - ☐ Spacing out frequently or when reminded of what happened
  - ☐ Worrying that bad things will happen again
  - ☐ Looking out for danger, jumpy
  - ☐ Engaging in sexual behaviors that are not age appropriate

ChildParent Psychotherapy

childparentpsychotherapy.com

CPP Symptom Screener

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Introducing the Questions

- State the purpose, which is a reflection of the latest science about children's learning
  - "We believe that all aspects of a child's well-being contribute to their success academically."
- Recognize the primary significance of their role
  - We know that a child's parents/caregiver are the ones who know them best and are responsible for their welfare.
- Invite a partnership
  - Therefore, we are asking for you to partner with us in fully understanding your child's history.

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Introducing the Questions

Introduce the premise of trauma theory: our experiences impact our behavior

Invite the caregiver to identify if there have been upsetting events rather than point them out yourself (at least initially)

- We ask about this so we can know if there are experiences that have been challenging or potentially upsetting for your child that you believe may contribute to how he/she is developing and/or behaving.

Encourage the caregiver to think about their child

Connect the questions to their child's success at school

- Please share your thoughts about your child so that we can better help him/her to learn here at school.

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Responding to Anger, Fear, or Defensiveness

- Check in with yourself – don't be defensive
- Use listening as a tool for change
- Validate
- Allow the caregiver to hold the concern
- Frame benign intentions
- Use reflective language/process
- Focus on safety

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Providing a Rationale for Talking About Trauma

It happens more frequently than we would like to believe it does

"Everybody has a story" – life can be hard

Meaning and words calm the amygdala

It can explain challenging behaviors and make them more bearable

It helps to build a connected (integrated) brain

It makes behavior more controllable

It builds insight

It prevents experiences and behaviors from becoming your child's identity

To shield against shame (and blame)

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Introducing a Referral for Further Assessment & Intervention

- [ ] Recognize that the caregiver has valid concerns about their child
- [ ] Encourage them to think about what might be most supportive for their child and their family is addressing these concerns
- [ ] Talk about the need for further exploration
- [ ] Discuss the difference between screening, assessment, and psychological evaluations (if needed)
- [ ] Acknowledge that it can be scary to seek an assessment for their child and fears they may have associated with reporting their experiences and concerns
- [ ] Talk about what the process may look like
- [ ] Encourage them to keep "trauma" the focus

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Trauma Screening Rationale: The Elevator Speech

- Why are we asking about traumatic experiences & impacts?
- What is the role of the caregiver?
- Statement of partnership
- Invitation to reflect on events and impacts
- How it is connected to your program

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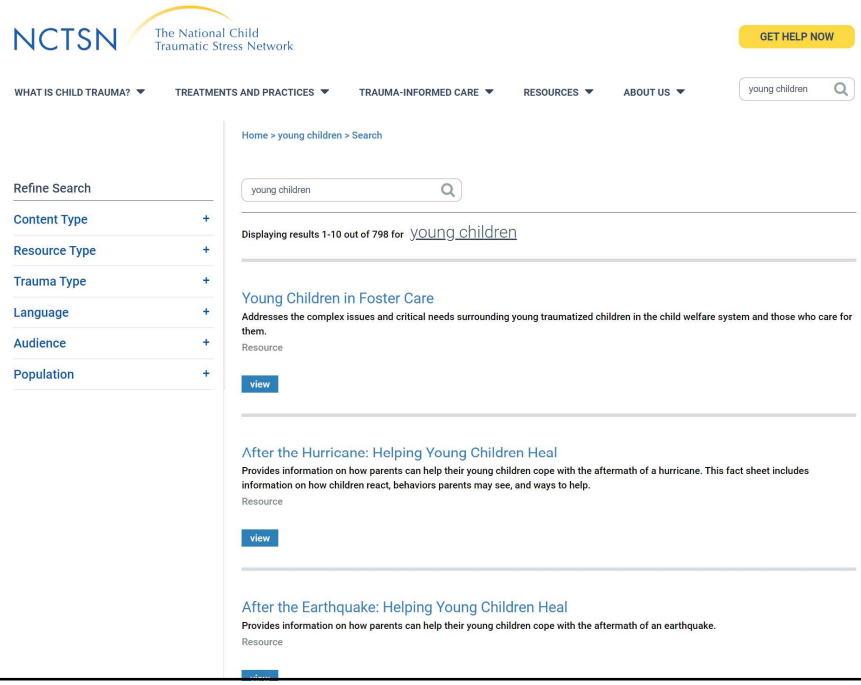
NCTSN



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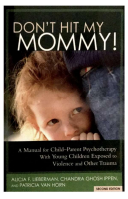
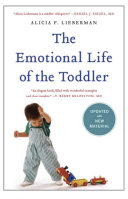


Don't Hit My Mommy (2nd Edition)

A manual for Child-Parent Psychotherapy with young children exposed to violence and other trauma



The Emotional Life of the Toddler (2nd Edition)

A detailed look into the varied and intense emotional life of children aged one to three

CPP Booklists

Recommended books by topic (e.g. emotion regulation, honoring differences, attachment, separation & connection)

Once I Was Very Very Scared

This book was written to help young children who have experienced stressful or traumatic events

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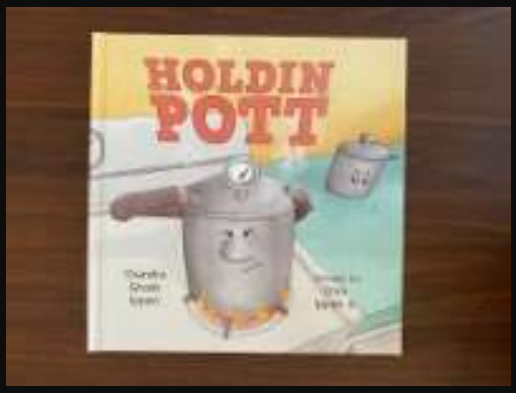
Handling Big Emotions



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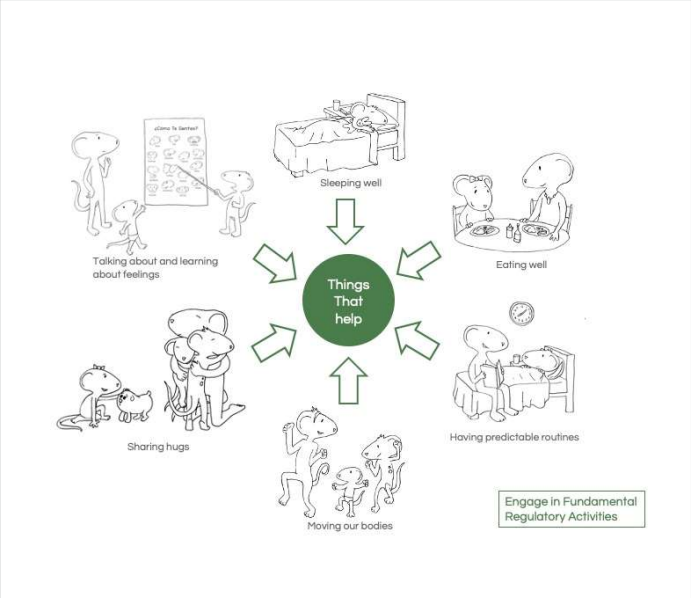
Engagement in Fundamental Regulatory Activities

- Predictable routines
- Body movement
- Sharing hugs
- Talking & learning about feelings
- Sleeping well
- Eating Well



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Helping Young Children Heal

- NCTSN & the ETTN
- Offers tips to parents on how to help young children, toddlers, and preschoolers heal after a traumatic event.
- S = safety first
- A = allow expression of feelings
- F = follow your child's lead
- E = enable your child to tell the story
- T = ties & reconnections
- Y = YOUR CHILD NEEDS YOU!

EARLY TRAUMA TREATMENT NETWORK
Child Trauma Research Program
University of California, San Francisco

A PARTNER IN NCTSN

AFTER A CRISIS: HOW YOUNG CHILDREN HEAL

Young children, toddlers, and preschoolers know when bad things happen, and they remember what they have been through. After a scary event, we often see changes in their behavior. They may cry more, become clingy, and not want us to leave, have temper tantrums, hit others, have problems sleeping, become afraid of things that didn't bother them before, and lose skills they previously mastered. Changes like these are a sign that they need help. Here are some ways you can help them.

S SAFETY FIRST—YOUR YOUNG CHILD FEELS SAFE WHEN YOU

- ☐ Hold your child or let them stay close to you.
- ☐ Tell your child you will take care of them when things are scary or difficult. With children who are learning to talk, use simple words, like saying "Daddy's here."
- ☐ Keep them away from frightening TV images and scary conversations.
- ☐ Do familiar things, like singing a song you both like or telling a story.
- ☐ Let them know what will happen next (to the degree that you know).
- ☐ Have a predictable routine, at least for bedtime: a story, a prayer, cuddle time.
- ☐ Leave them with familiar people when you have to be away.
- ☐ Tell them where you are going and when you will come back.

A ALLOW EXPRESSION OF FEELINGS

- ☐ Young children often "behave badly" when they are worried or scared. Children can "act out" as a way of asking for help. Remember! Difficult feelings=Difficult behavior.
- ☐ Help your child name how they feel: "scared," "happy," "angry," "sad." Tell them it's OK to feel that way.
- ☐ Show your child the right way to behave, like saying "It's OK to be angry but it's not OK to hit me."
- ☐ Help your child express anger in ways that won't hurt, using words, play, or drawings.
- ☐ Talk about the things that are going well to help you and your child feel good.

F FOLLOW YOUR CHILD'S LEAD

- ☐ Different children need different things. Some children need to run around, others need to be held.
- ☐ Listen to your child and watch their behavior to figure out what they need.

E ENABLE YOUR CHILD TO TELL THE STORY OF WHAT HAPPENED DURING & AFTER

- ☐ Having a story helps your child make sense of what happened and cope better with it.
- ☐ Children use play to tell their story. For example, they may make popping sounds to show what they experienced. They may hide in the closet to show what it was like to shelter-in-place.
- ☐ Join your child in showing and telling not only what happened, step by step, but also how you both felt.
- ☐ As you tell the story, follow your child's lead. When the story is difficult, your young child may need breaks: running around, being held, playing something else. This is OK. They will come back to the story when they are ready.
- ☐ It can be hard to watch your children's play or listen to their stories of what happened. Get support if it is too hard for you to listen without becoming upset.

T TIES—RECONNECT WITH SUPPORTIVE PEOPLE, COMMUNITY, CULTURE & RITUALS

- ☐ Simple things like a familiar bedtime story, a song, a prayer, or family traditions remind you and your child of your way of life and offer hope.
- ☐ If you belong to a group, like a church, try to find ways of reconnecting with them.
- ☐ You can help your child best when you take care of yourself. Get support from others when you need it.

Y YOUR CHILD NEEDS YOU

- ☐ Reassure your child that you will be together.
- ☐ It is common for children to be clingy and worried about being away from you.
- ☐ Just being with your child, even when you can't fix things, helps your child.
- ☐ If you need to leave your child, tell them how far how long, and when you are coming back. If possible, leave something that belongs to you, or a picture that your child can have.

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Acknowledging Grief (Megan Devine)

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Addressing the Problem: Examples & Exemplars

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Evidence-Based Intervention: Child-Parent Psychotherapy | CPP

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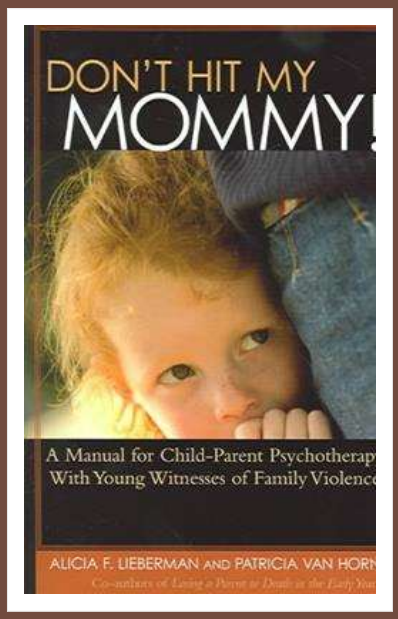
Child Parent Psychotherapy (CPP)

- CPP is a attachment-based treatment for young children exposed to interpersonal violence that focuses on the child-parent interaction and on each partner's perception of the other.
- "The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning" (NREPP)



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CPP: Basic Elements of the Model

- Session duration: 50 sessions
- Session length: 1 to 3 hours weekly
- Broad range of settings
- Includes ongoing consultation specific to the model
- Typically does NOT include child-only sessions, but often includes caregiver sessions (though it is not a substitution for individual therapy)

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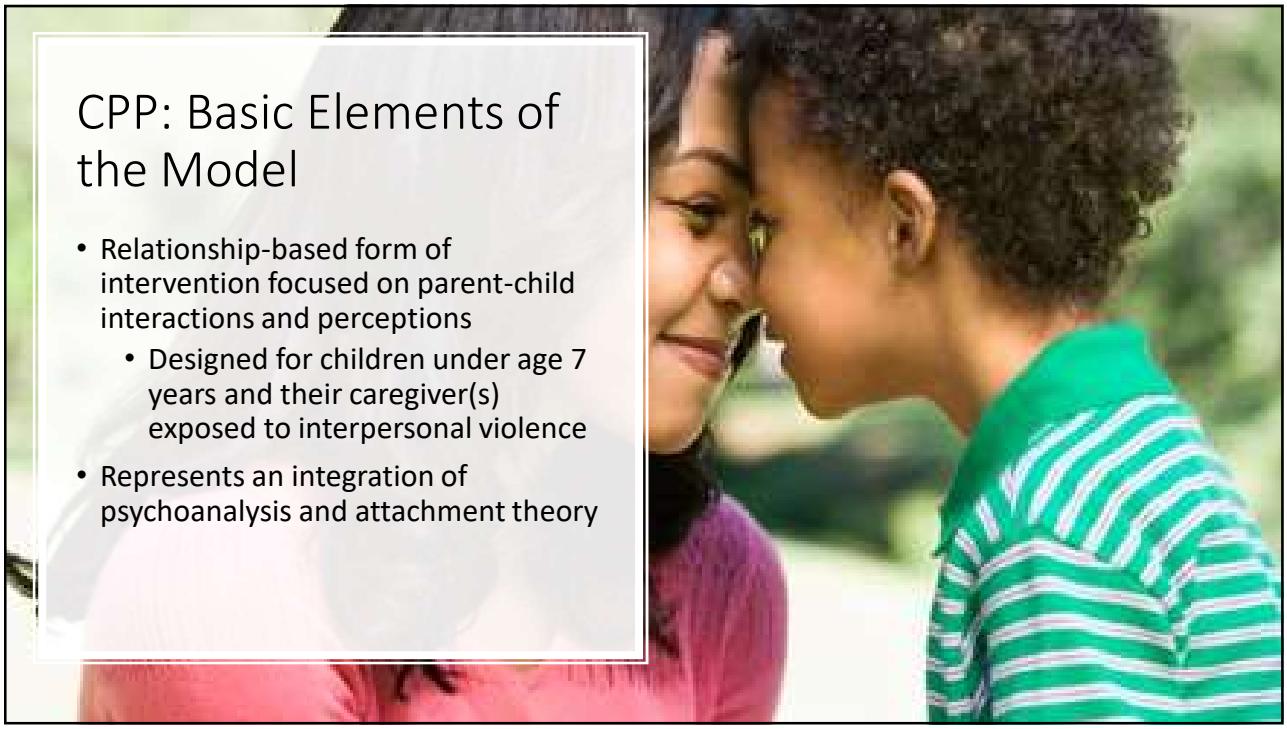
CPP: Basic Elements of the Model

- Relationship-based form of intervention focused on parent-child interactions and perceptions
  - Designed for children under age 7 years and their caregiver(s) exposed to interpersonal violence
- Represents an integration of psychoanalysis and attachment theory



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CPP: Basic Elements of the Model

- Techniques are derived from:
  - Developmental theory
  - Cognitive-behavior approaches
  - Social learning theory
- Employs play, verbal interpretation, and behavioral strategies as agents of therapeutic change
- Initial and ongoing assessment is integral to the approach

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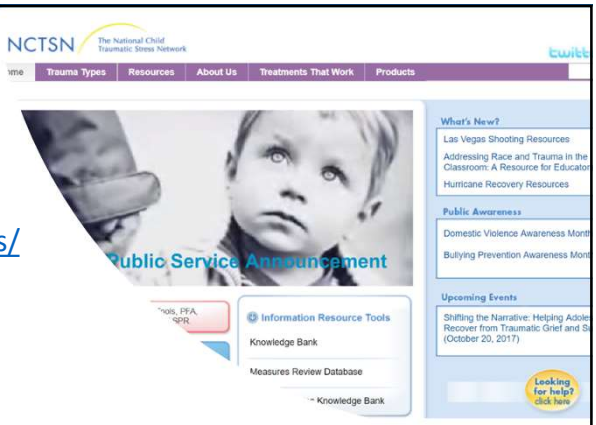
Support for the CPP Model

- Identified as an EBP by NCTSN and NREPP
  - National Child Traumatic Stress Network (NCTSN)
    - http://www.nctsnet.org/
      - http://www.nctsnet.org/resources/topics/treatments-that-work/promising-practices
  - National Registry of Evidence-Based Programs and Practices (NREPP)
    - http://nrepp.samhsa.gov/



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The "Ask Every Child" Initiative

(Post Traumatic Stress Center, Dr. D. R. Johnson)

- Post Traumatic Stress Center in New Haven, CT
- David Read Johnson, PhD
- Proposes a public health model for early detection and prevention
- Why?
  - Prevalence of child maltreatment
  - Demonstrated negative effects of maltreatment
  - Costs associated with addressing maltreatment
- Calls for an urgent need for action

"How may times do we have to hear the same sentence from so many victims, often years after their abuse: "If only someone had noticed…if only someone had asked!" (p. 4)

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The "Ask Every Child" Initiative

(Post Traumatic Stress Center, Dr. D. R. Johnson)

- Attempts to prevent the prepetition of abuse by asking children frequently and openly about their experiences
- Recognizes that children may not report on their own
- Often there aren't overt signs of abuse

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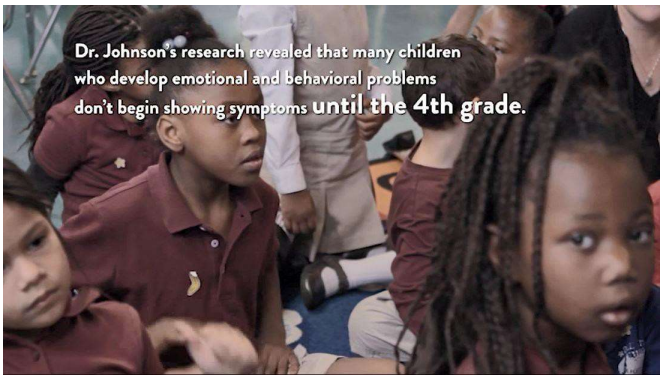
Elementary School Program

- Miss Kendra's List
- Red Bead Clubs – "Group events where students and parents share Miss Kendra activities, write letters to their families, and celebrate overcoming adversity."
- Stress Reduction Sessions
- After School Support



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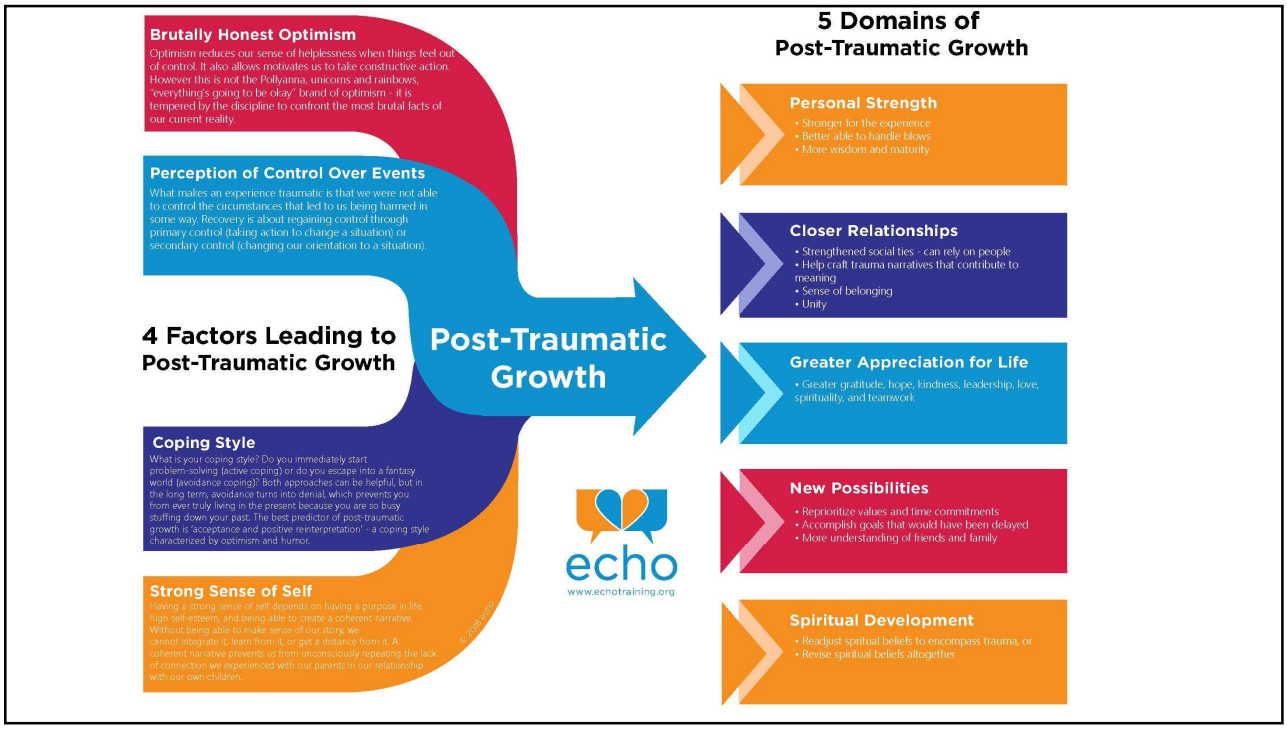

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Center for Trauma-Responsive Practice Change

OUR MISSION:
Promote a trauma-responsive system of care for children and families in New England through the provision of high-quality training and consultation services to communities.

Trauma-responsive systems enhance equity, wellness, and post-traumatic growth with people and systems impacted by violence, adversity, and systemic oppression

BE THE CHANGE

Partner with Our Team

Licensed Psychologists & Trauma Experts

Cassie Yackley, Psy.D., Director

www.centerforTRPchange.com
www.cassieyackleypsyd.com
cassie.yackley@centerfortrpchange.com

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Under Stress We Regress

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Window of Tolerance

Hyperarousal Zone

2. Sympathetic "Fight or Flight" Response
Increased sensations, flooded
Emotional reactivity, hypervigilant
Intrusive imagery, Flashbacks
Disorganised cognitive processing

Window of Tolerance
Optimal Arousal Zone

1. Ventral Vagal "Social Engagement" Response
State where emotions can be tolerated and information integrated

Hypoarousal Zone

3. Dorsal Vagal "Immobilisation" Response
Relative absence of sensation
Numbing of emotions
Disabled cognitive processing
Reduced physical movement

Adapted from Ogden, Minton, & Pain, 2006, p. 27, 32; Corrigan, Fisher, & Nutt, 2010, p. 2

The Stress Response System via Polyvagal Theory (Porges)

1. Ventral vagal parasympathic (safety)
   - The default mode of arousal
   - "Rest and digest"
   - Slows the fear response and allows for connection and co-regulation
2. Sympathetic (hyperarousal)
   - Danger or play and joy
   - Overrides the ventral vagal
   - Results in bodily changes (increased heart rate, mobilization, rage & panic)
3. Dorsal vagal parasympathetic (hypoarousal)
   - Life threat or deep rest and contemplation
   - Overrides sympathetic
   - Activated by helplessness and shame/humiliation

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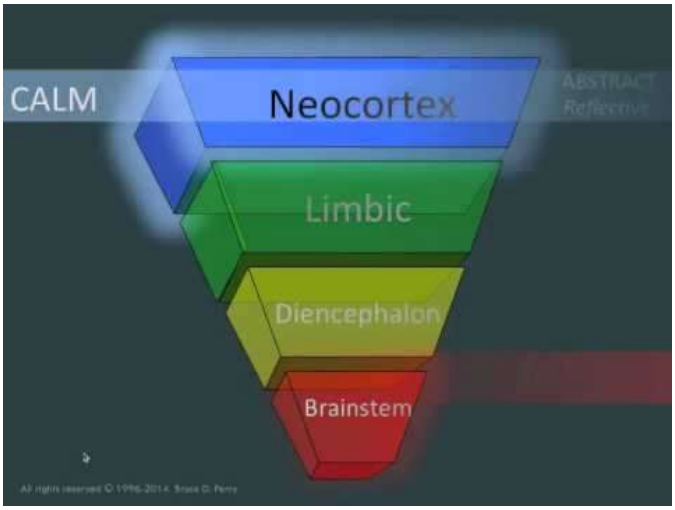

State Dependent Functioning

This is your brain on fear/stress…

Bruce Perry, MD, PhD

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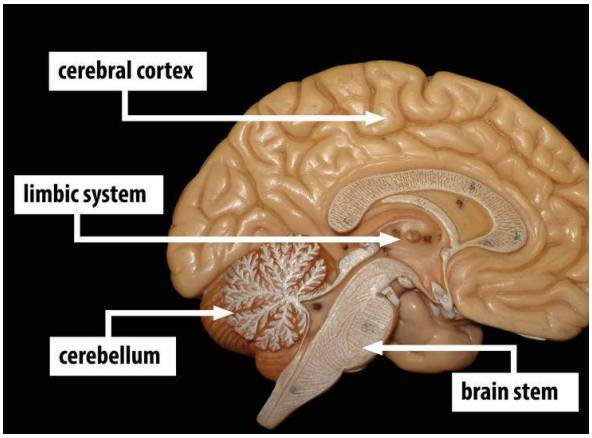
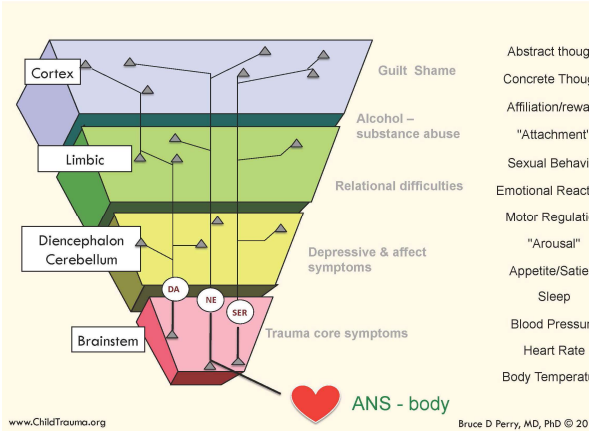
Hierarchy of Brain Function (Bruce Perry, MD, PhD, 2006)





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State Dependent Functioning (Bruce Perry, MD, PhD)

Internal State	CALM Reflect	ALERT Flock	ALARM Freeze	FEAR Flight	TERROR Fight
Brain Regulating Region	NEOCORTEX Subcortex	SUBCORTEX Limbic	LIMBIC Midbrain	MIDBRAIN Brainstem	BRAINSTEM Autonomic
Arousal Continuum	REST	VIGILANCE	RESISTANCE Crying	DEFIANCE Tantrums	AGGRESSION
Dissociative Continuum	REST	AVOIDANCE	COMPLIANCE Robotic	DISSOCIATION Fetal Rocking	FAINTING
Cognitive Style	Abstract	Concrete	Emotional	Reactive	Reflexive
Sense of time	Extended Future	Days Hours	Hours Minutes	Minutes Seconds	No Sense of Time
Brain Region Accessibility	Neocortex = 85% Limbic = 90% Lower Brain = 10%		Neocortex = 10% Limbic = 60% Lower Brain = 60%		Neocortex = 5% Limbic = 30% Lower Brain = 85%

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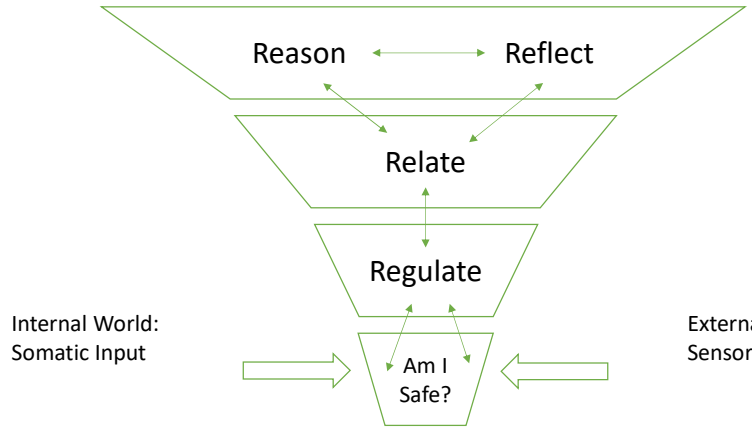
Sequence of Engagement (Bruce Perry, MD, PhD)



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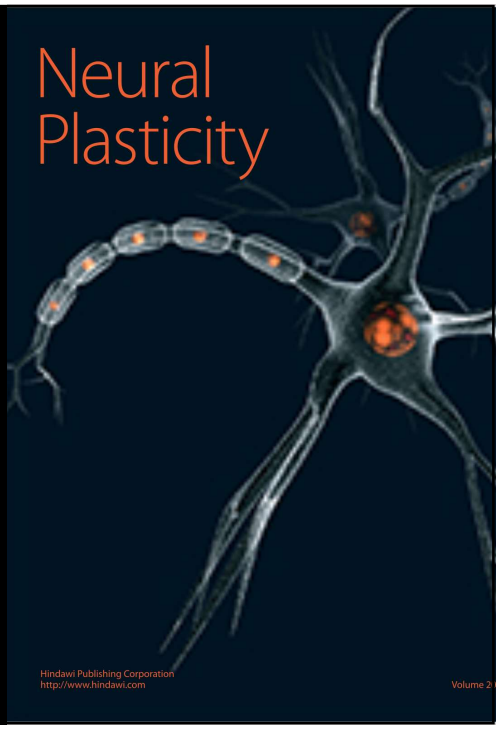
Disrupted Neurodevelopment

Earlier to Develop – Decreased Plasticity

- Brain Stem
  - ANS functions
- Cerebellum and Diencephalon
  - Motor control
  - Arousal level
- Limbic System
  - Emotions
  - Relationships
- Prefrontal Cortex
  - Executive functions



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Disrupted Neurodevelopment
(AAP)

Response to Trauma: Bodily Functions

FUNCTION	CENTRAL CAUSE	SYMPTOM(S)
Sleep	Stimulation of reticular activating system	1. Difficulty falling asleep 2. Difficulty staying asleep 3. Nightmares
Eating	Inhibition of satiety center, anxiety	1. Rapid eating 2. Lack of satiety 3. Food hoarding 4. Loss of appetite
Toileting	Increased sympathetic tone, increased catecholamines	1. Constipation 2. Encopresis 3. Enuresis 4. Regression of toileting skills

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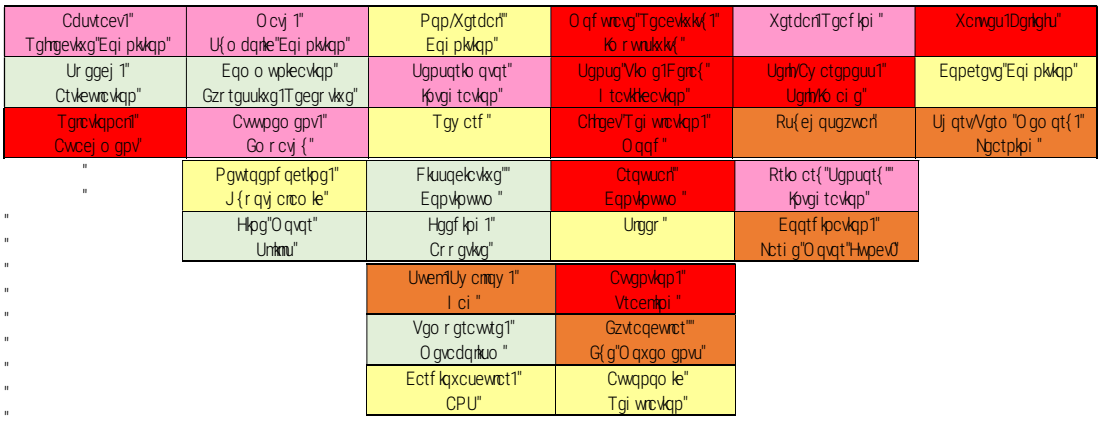
“Neuro-archeology”: History & “Use Dependence”



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“How States Becomes Traits” (Bruce Perry, MD, PhD)

- Persistent states of arousal become neutrally-based habits of responding
  - **“Neurons that fire together, wire together”**
- Sensitization of the fear response – (a.k.a., the “kindling effect”)

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Behavioral Manifestations of Trauma (AAP)

Response to Trauma: Behaviors[15,16]

CATEGORY	MORE COMMON WITH	RESPONSE	MISIDENTIFIED AS AND/OR COMORBID WITH
Dissociation (Dopaminergic)	• Females • Young children • Ongoing trauma/Pain • Inability to defend self	• Detachment • Numbing • Compliance • Fantasy	• Depression • ADHD Inattentive Type • Developmental delay
Arousal (Adrenergic)	• Males • Older children • Witness to violence • Inability to fight or flee	• Hypervigilance • Aggression • Anxiety • Exaggerated response	• ADHD • ODD • Conduct disorder • Bipolar disorder • Anger management difficulties

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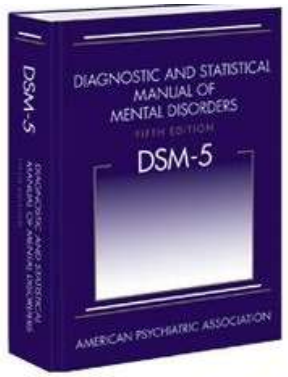
Post-Traumatic Stress Disorder

A. Exposure to death, violence, injury
B. Intrusion
   1. Distressing memories – recurrent, involuntary, intrusive
   2. Nightmares
   3. Dissociative reactions – flashbacks
   4. Intense distress at exposure to reminders
   5. Physiological reactions
C. Avoidance – memories, thoughts, feelings, external reminders
D. Negative alterations in cognitions and mood
E. Alterations in arousal – Irritability, recklessness, hyper-vigiliance



DSM-5
2013

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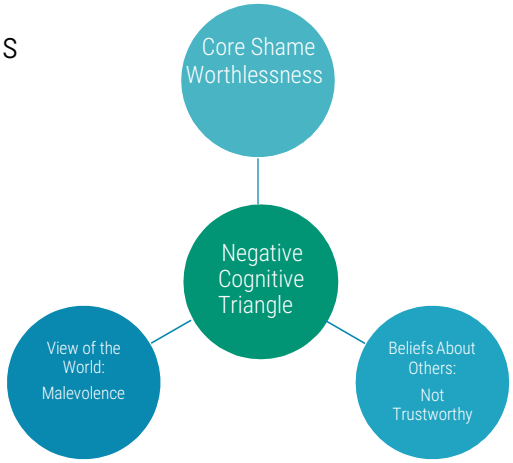
Negative Alterations in Cognitions and Mood

Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world



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