
# Trauma and Resilience

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HOSPITAL • RESEARCH • FOUNDATION

# Speaker Disclosure

- Financial: In addition to my work at SCH, I am a consultant to Optum and a pharmacy benefits management company.

- Unlabeled/unapproved uses: Off-label medication use is discussed in this presentation and will be highlighted when it occurs.

# What is trauma?

Federal Child Abuse Prevention and Treatment Act: act/failure to act which results in death, physical or emotional harm, sexual abuse or exploitation, or results in imminent risk of serious harm.

Sadly, there are many possible traumatic experiences for kids, such as abandonment by a parent, exposure to parental substance abuse, gang or community violence, bullying, medical trauma, vehicular accidents, refugee experience, death of a loved one, or any terrifying and unexpected experience.

# Not an uncommon human experience

- 1 in 4 people experience trauma, commonly accepted rate
- Up to 2/3, depends on environment
- 10% of all women and 4% of all men will develop PTSD at some point in their life.

# Humans have endured

- Many recover from trauma without difficulty by using inherent resiliency, learned coping mechanisms, and social supports.
- About half recover within 3 months.
- Many others experience slow decrease in symptoms over longer timeframe.
- Can have episodic increased difficulty with new stressors
- Can create uncertainties about future danger and loss

# Who is most at-risk of negative outcomes?

- One traumatic experience is better than multiple.
- Children or families with preexisting psychiatric difficulties
- Girls, unknown why
- If parent is having difficult time recovering from trauma him/herself
- Changes to caregiver situation, disrupted attachments, limited or loss of social, community, family, school supports

# Foster children can have all the risk factors

- 80% of children involved with child welfare have developmental, behavioral, emotional concerns requiring mental health treatment.

- ACE score–now what?
  Focus on building resilience.

# Impacts

Across lifespan, children with trauma reactions go on to have…

more functional impairment,
more psychiatric diagnoses other than PTSD,
increased healthcare utilization and costs, &
increased polypharmacy.

# A statewide pediatric psychiatry consultation to primary care program and the care of children with trauma-related concerns

**Barclay, Hilt, and Garrison; Journal of Behavioral Health Services & Research**

**ABSTRACT**

The Partnership Access Line is a Medicaid-sponsored child and adolescent psychiatry consultation service for primary care providers in Washington and Wyoming. Primary care providers and consultants seek data about the children cared for within this model, and the sub-group of patients with trauma-related difficulties is the focus of this study. Among 4381 sequential patients the PAL team consulted about, those with trauma-related concerns were more likely to have Medicaid insurance (72% vs. 51%, p<.001), have been in foster care (36% vs. 9%, p<.001), have lower functioning (59% vs. 45% with CGAS < 50, p<.001), be prescribed ≥2 concurrent psychotropics prior to consultation (29% vs. 21%, p<.001), and be using an antipsychotic (16% vs. 11%, p=.002). 1 in 8 children with past trauma had received child psychiatrist care. Within a primary care referred population, children with a trauma history are psychiatrically more ill, have more complicated medication regimens, and are more likely to have unmet care needs.

# Symptoms often non-specific and broad

- Clingy, fearful, easily frightened, difficult to console
- Irritable, aggressive, tantrums, impulsive, inattentive
- Sleep, appetite issues
- Sensory sensitivity
- Somatic complaints
- Flashbacks, avoidance, disengagement from people/activities/idea of a positive future
- World feels unsafe
- Regression, difficulty with skill acquisition and academic progress
- Sexualized behaviors

# Some age specific features

- Traumatic play in youngest children, who may be preoccupied by trauma in play or avoidant.

- School age children may self-blame, seek to understand why (was it because of him/herself?), or have irrational beliefs about the trauma.

- Teens may have revenge fantasies, mask responses to fit in, use substances, or be more oppositional than typical to regain control.

# Differential

Mood disorder

Anxiety disorder

ADHD, oppositional defiant disorder

Psychosis

Developmental delay

Attachment difficulties

Adjustment (related to separation from primary caregivers)

Grief

Reaction to inappropriate placement

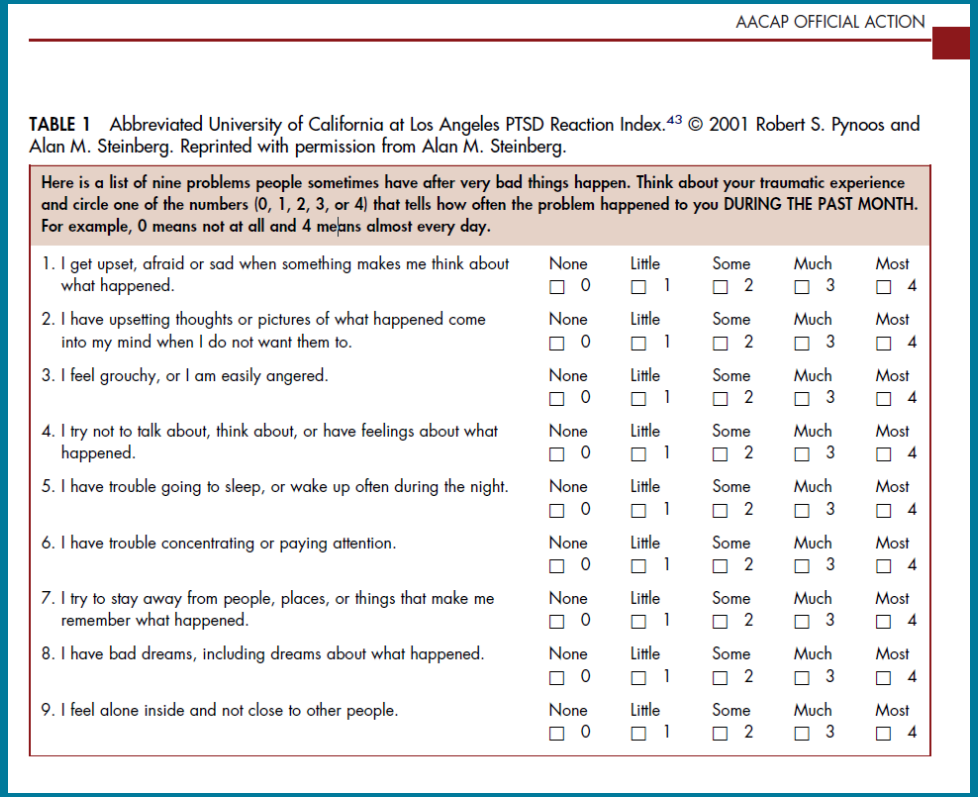
# Biology

- Trauma is a toxin with neuroanatomic, neuroendocrine, and gene transcription impacts.
- The more charged the trauma, the more the brain learns or accommodates.
- Adaptive changes become maladaptive.

# Biology (cont)

Cortisol—stress response, fear processing
T3:T4 ratio—anxiety
Dopamine—fear conditioning
Norepinephrine—arousal, startle, memory encoding, pulse, blood pressure, bowel/bladder function
Serotonin—amygdala and hippocampus dynamic impacts
GABA—anxiety
Glutamate—dissociation
CSF b-endorphin levels—numbing
Reticular activating system—sleep, nightmares

# UCLA PTSD Reaction Index



AACAP OFFICIAL ACTION

**TABLE 1** Abbreviated University of California at Los Angeles PTSD Reaction Index.[43] © 2001 Robert S. Pynoos and Alan M. Steinberg. Reprinted with permission from Alan M. Steinberg.

**Here is a list of nine problems people sometimes have after very bad things happen. Think about your traumatic experience and circle one of the numbers (0, 1, 2, 3, or 4) that tells how often the problem happened to you DURING THE PAST MONTH. For example, 0 means not at all and 4 means almost every day.**

| | | | | | |
|---|---|---|---|---|---|
| 1. I get upset, afraid or sad when something makes me think about what happened. | None ☐ 0 | Little ☐ 1 | Some ☐ 2 | Much ☐ 3 | Most ☐ 4 |
| 2. I have upsetting thoughts or pictures of what happened come into my mind when I do not want them to. | None ☐ 0 | Little ☐ 1 | Some ☐ 2 | Much ☐ 3 | Most ☐ 4 |
| 3. I feel grouchy, or I am easily angered. | None ☐ 0 | Little ☐ 1 | Some ☐ 2 | Much ☐ 3 | Most ☐ 4 |
| 4. I try not to talk about, think about, or have feelings about what happened. | None ☐ 0 | Little ☐ 1 | Some ☐ 2 | Much ☐ 3 | Most ☐ 4 |
| 5. I have trouble going to sleep, or wake up often during the night. | None ☐ 0 | Little ☐ 1 | Some ☐ 2 | Much ☐ 3 | Most ☐ 4 |
| 6. I have trouble concentrating or paying attention. | None ☐ 0 | Little ☐ 1 | Some ☐ 2 | Much ☐ 3 | Most ☐ 4 |
| 7. I try to stay away from people, places, or things that make me remember what happened. | None ☐ 0 | Little ☐ 1 | Some ☐ 2 | Much ☐ 3 | Most ☐ 4 |
| 8. I have bad dreams, including dreams about what happened. | None ☐ 0 | Little ☐ 1 | Some ☐ 2 | Much ☐ 3 | Most ☐ 4 |
| 9. I feel alone inside and not close to other people. | None ☐ 0 | Little ☐ 1 | Some ☐ 2 | Much ☐ 3 | Most ☐ 4 |

Score of 10 or higher suggests clinically significant PTSD symptoms.

AACAP. Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder. J. Am. Acad. Child Adolesc. Psychiatry 2010;49(4).

# SCARED PTSD

- I have scary dreams about a very bad thing that once happened to me.
- I try not to think about a very bad thing that once happened to me.
- I get scared when I think back on a very bad thing that once happened to me.
- I keep thinking about a very bad thing that once happened to me, even when I don't want to think about it.

PAL care guide describes scoring.

# Ask Routinely

- Acknowledge that it can be hard to talk about these topics.
  - Caution in the kid is okay, normal even.
  - Self-initiated disclosure is rare.
- Avoid asking for details (could ask caregiver instead).
- Meet with child and caregiver separately.

# Open ended questions

- “I’m going to ask you now a question I ask all children I meet with – do you feel safe at school and home and in your community?”

- “Has anything traumatic or really scary or upsetting ever happened to you?” Or… “since we last met?”

- “What differences have you noticed in your child since the event?”

# Elicit more

Consider language choice to plant idea that he/she is not alone in this experience and response, and that a child should not have had that experience.

“Sometimes kids who have been through scary or difficult things, things kids shouldn’t have to go through, can really be bothered or upset by it, even if the events were in the past.  Are you feeling bothered or upset by bad things you’ve had to go through?”

# If child denies a known event

- Be authentic—let them know you know.

- Reassure you don’t want a lot of details of the event, but just want to know if the child is having any problems as a result.

# Complexities of disclosure

- Kids under-report abuse.

- Multiple informants can be helpful.

# Assessment summary points

- Look for correlation in timing of new difficulties with the trauma experience (harder with complex or chronic trauma).

- Even if DSM criteria not met for PTSD, child can still be suffering the emotional, physical, and interpersonal effects of trauma.

# DSM 5

A. Exposure to actual or threatened death, serious injury, or sexual violence.

- Can be direct, witnessed, learning about an event occurring to close family or friend
  - Does not include exposure through electronic media, TV, movies.

B. Intrusive symptoms (1 or more)

- Recurrent, involuntary, intrusive memories *(or play in children—not necessarily obviously distressing*)
- Distressing dreams *(non-specific frightening dreams in children)*
- Dissociative reactions in which person feels trauma events recurring *(trauma-specific reenactment in play)*
- Psychological distress at trauma cues
- Physiologic reaction to trauma cues

# DSM 5

C. Avoidance (1 or more)

- Avoid distressing memories, thoughts, feelings of trauma
- Avoid trauma reminders
- For children <7 yo, *increased frequency of negative emotional states, diminished interest or participation in activities (including play constriction), social withdrawal, reduction in positive emotions.*

D. Negative alterations in cognitions and mood (2 or more)

- Inability to remember aspects of trauma
- Exaggerated beliefs about oneself or the world – “I am bad”
- Distorted cognitions about cause of events leading to incorrect blame
- Negative emotional state (fear, horror, guilt, shame)
- Diminished participation or interest in activities
- Detachment or estrangement
- Inability to experience positive emotions
- For children < 7 yo, *these features are grouped with C criteria (previous slide).*

# DSM 5

E. Alterations in arousal and reactivity (2 or more)

- Irritable, angry outbursts
- Reckless behavior
- Hypervigilance
- Exaggerated startle
- Concentration problems
- Sleep disturbance

Duration of symptoms—1 month or more.

- Prior to that, acute stress disorder.

With delayed expression (at least 6 months after event) also a diagnostic specifier.

# Talking Points

1) Empathy: “I’m sorry to hear that happened to you.”
2) Reassure that child is safe (if so).
3) Praise child if coping well.
4) Emphasize the trauma was not the child’s fault. Correct distortions.
5) Normalize, instill hope: “It can be really scary for kids at first, but most get back to feeling the way they did before.”
6) Convey idea of resilience and competence— “There are ways to make it easier to get yourself through this.”

# Helping to Heal

- First, ensure the child is safe (not only is the child safe, but the child feels as safe as possible).

- A child cannot heal from trauma if the trauma is on-going or child perceives it to be on-going or at imminent risk of recurring.

# Specific psychoeducation

Feelings are normal. Some regression and relationship strain are normal too.

- It's okay to talk about the event and feelings surrounding it and/or what could have been done to prevent the event. An older child might want to talk about what he/she feels like doing now (intro to discuss realistic consequences of revenge urges).

- Encourage additional constructive outlets for feelings (drawing, dancing, relaxation, mindfulness).

# Encourage scheduling activities of well-being

Routines, including consistent caretaking, foster sense of security.

Brainstorm how to build/strengthen protective factors such as,

- Maintain or build social connections (school, friends, church, clubs, sports)
- Self-care (exercise, sleeping, healthy eating, meditation, time in nature, appreciating art/music)
- Support engagement (opportunities to feel sense of accomplishment, hope for future, gratefulness)

# Resilience—thriving despite adversity

- Face fears, positively reframe stressful events, derive more benefit from supports, cope
- Shaped by genes and environmental interactions, as well as epigenetics
- Like a muscle, can be strengthened through habits, practice
- Family habits of resilience help children internalize these habits for themselves.

# Parental Support

- Acknowledge the challenges and stress for the whole family.
- Convey message that child is doing best they can (and parent too).
- Encourage parental modeling of self-care, that parent should not feel guilty for focusing on own self and healing, which is foundation for child's recovery.

# When to refer

Consider how long child has been struggling and the severity of symptoms.

# For PTSD, psychotherapy is first line

- Goal—child integrates trauma experience into a broad and hopeful narrative through directly addressing the trauma in the therapy.
- Tasks include learn effective coping strategies, master avoidance (typically through narration or exposure), and enhance relationships.
- Post traumatic growth—deeper relationships, sense of meaning/purpose, sense of personal strength.
- For younger children, parent-child joint therapy. For older children, individual therapy best.

# When referring, seek domain knowledge

Seek providers with experience working with children after trauma.

- Ask how provider plans to approach the child's issues.
- Treatment should focus on enhancing emotional regulation and anxiety management.
- Child needs an opportunity to talk or play about what happened. Non-specific supportive therapy may not necessarily do this.
- Therapy is one way of promoting resilience—enhances optimism, facilitates a more positive reappraisal of events, makes meaning, nurtures attachment and helps build sense of purpose.

# TF-CBT

- Incorporates tenets of treatment just discussed using CBT framework
- Manualized
- Typically 12-16 weeks
- Effective for wide range of traumas

# Psychopharmacology

There are no FDA approved medications for PTSD in children and adolescents.

# Psychopharmacology—when to consider

Consider medications only when acute symptom reduction in severe PTSD is needed, a comorbid disorder requires medication treatment, or there is an unsatisfactory response to psychotherapy.

If treating a comorbid condition, go slow and assess outcome of the intervention. Follow evidence based guidelines and assess outcome. If not helpful, stop the medication.

# Psychopharmacology cont.

When symptoms are prolonged and severe and therapy not adequately helpful, could consider medications. But little evidence for available options.

No evidence from randomized trials for benefit from SSRI treatment. May make matters worse in youth (not adults).

# Psychopharmacology cont.

Guanfacine extended release with some benefit in an open label study, possibly through reducing noradrenergic reactivity. Clonidine could also be considered. Both off label for this indication.

Sometimes starting with restful sleep can have a generative effect on overall recovery and functioning—melatonin or prazosin (case reports, off label).

# Foster children and medications

Care plan may be impacted by…

- insufficient history to guide targeted treatment,
- poor continuity,
- accessing care abruptly after not receiving care,
- or a desire by providers to do something/ anything to help.

# Caring for Ourselves

- It is hard to hold patients and families dealing with trauma.
- Practice the resilience promoting strategies you prescribe.
- Mindful—stay in the moment, how you can help
- Strengths based interview style
- Consult (PAL), build a team.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