Building Resilience in Traumatized Children

Neurobiological & Neurodevelopmental Impact of Traumatic Stress & Prenatal Alcohol Exposure in Children & Adolescents:

*Using a Brain-Based Model to Transform Child Welfare*

Frank Vandervort, JD
Mark A. Sloane, DO, FACOP, FAAP
Kalamazoo, MI / Ann Arbor, MI
26 June 2013
The relationship that matters most!

• In a 1997 study of system trauma (Henry, 1997) the majority of 90 children interviewed indicated that they “trusted” their attorney more than anyone, including the social worker.
Trauma-Informed Child Advocacy

• Why do it?

• How do we advocate for resiliency?

• What toll does it take?
Secondary Traumatic Stress (STS) / Compassion Fatigue

• “The natural and consequent behaviors and emotions resulting from knowing about a traumatized event from a significant other, the stress from helping or wanting to help a traumatized or stressed person.” (Figley, 1995)
Agency Symptoms of STS

86% reported signs of STS among their staff or colleagues

- Pessimism/Negativism about clients (63%)
- Pessimism/Negativism about coworkers (63%)
- Avoidance of certain clients/families (40%)
- Concentration/attention problems (39%)
- Decreased collaboration (38%)
- Excessive absenteeism (18%)
Secondary Traumatic Stress

• *In order to have a resilient work force...*

• *We MUST address this in:*
  – All agencies
  – All professionals (including lawyers / advocates!!!)
  – All caregivers
    • Biological
    • Kinship
    • Foster / adoptive
Child Well Being
A National Mandate

• *Shifting pathways:* The road to permanency is *through* well being

• Why should lawyers/advocates *care*?

• How are well being and advocacy *linked*?
Embracing a Paradigm Shift

“An entirely different way is being developed of viewing all kinds of individual and social misbehaviors and maladaptions, moving from viewing as “sick” or “bad” or (or both) to injured”.

Bloom (1997)
“Hurt People...Hurt People!”

Bloom (2000)
“We must move from viewing the individual as failing if s/he does not do well in a program... to viewing the program as not providing what the individual needs in order to succeed.”

Dubovsky, 2000
Cindy – 10 years old

• Neglect and inconsistent living conditions in mother’s care
• Left alone frequently (at age 4-5) with brother
  – Acted out sexually with each other
• Exposed to drugs in the home
• Exposed to domestic violence and many strange men in and out of home
Cindy – 10 years old

- Inpatient psychiatric hospital stay at age 5 yrs
- Witnessed her mother’s death at age 6 yrs during a fatal MVA
- Blamed herself for mother’s death because the fatal MVA happened en route to school due to Cindy missing her bus
- Placed with biological maternal aunt after mother’s death...then into current placement
- More psych hospitals & residential placements
Cindy’s Comprehensive Assessment

Intelligence screening (K-BIT 2):
Verbal: 100 (56\textsuperscript{th} percentile)
Nonverbal, 110 (75\textsuperscript{th} percentile)
Composite: 106 (66\textsuperscript{th} percentile)

In contrast, definite \textit{delays in all ND areas} including: neuromotor, language, memory, visual processing, & attention
Cindy is described to be happy/related/regulated much of the time. However, her anger/explosive episodes can be severe during which she hits, kicks, swears, and throws things. She has also threatened to kill herself and others and has attempted to cut herself with a kitchen knife. She tends to be triggered by being told “no” and not getting her way.
Cindy – 10 years old

- The police have been called on more than occasion to the home because of her extreme behaviors

- Cindy exhibits hypersexualized behaviors including stripping down naked and on at least one occasion stripping and then masturbating in front of her foster father. Cindy will also use other items to help her masturbate. After sexually acting out, she has displayed some shame and guilt.
Trauma Symptom Checklist for Young Children (completed by foster parents)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>77+</td>
<td>X</td>
</tr>
<tr>
<td>Depression</td>
<td>76</td>
<td>X</td>
</tr>
<tr>
<td>Anger</td>
<td>95</td>
<td>X</td>
</tr>
<tr>
<td>PTS Intrusion</td>
<td>107+</td>
<td>X</td>
</tr>
<tr>
<td>PTS Avoidance</td>
<td>110</td>
<td>X</td>
</tr>
<tr>
<td>PTS Arousal</td>
<td>85</td>
<td>X</td>
</tr>
<tr>
<td>PTS-Total</td>
<td>106+</td>
<td>X</td>
</tr>
<tr>
<td>Dissociation</td>
<td>71</td>
<td>X</td>
</tr>
<tr>
<td>Sexual Concerns</td>
<td>79</td>
<td>X</td>
</tr>
</tbody>
</table>
The foster parents with who she has lived with the past 2 years *want to adopt* her. They are 73 years old. The agency designated them as pre-adoptive home. They are now seeking to *move* the child based on licensing violations. The foster parents want to continue to care for her but are *overwhelmed* at times with her dysregulated behaviors.
Building a Brain-Based Resiliency-Focused Trauma-Informed FASD-informed Transformational System for Children
Why should lawyers/advocates care about this???

• **Brain-behavior-resiliency connection:**
  – Critical link to vertical and horizontal integration of all professionals / agencies
  – Common language to explain behavior
  – Fuels creative collaboration
  – Enables well being to become a reality
A Vision for Children Everywhere
Focus on Challenging Behavior & Resiliency
The Brain-Behavior connection:

3 intertwined components

- Genetics / Epigenetics
  - What you inherit from both parents

- Intrauterine environment
  - During pregnancy

- Extrauterine environment
  - After pregnancy
Resiliency Highlights:

Remember…it is not automatic in children
Resiliency contextualizes a child’s strengths and adverse experiences.
Resiliency in Children

Key Components

- Mastery / Efficacy
- Relatedness
- Complex Affect Regulation
Resiliency

- Intelligence
- Academics
- Sports
- Art/Music
- Dance/Theater

Mastery/Efficacy

STOP

Adverse Child Experience
Resiliency

- Attachment
- Social Communication

Relatedness

STOP

Adverse Child Experience
Resiliency

Complex Affect Regulation

- Ability to calm
- Ability to regulate
- Ability to contain affect

STOP

Adverse Child Experience
A Vision for Children Everywhere
Focus on the Brain

- BEHAVIOR
- BRAIN
- STS
- WELL BEING
- SOLUTIONS
- HARM
- FUTURE
Our Next Resiliency Challenge: 
The Brain-Behavior Connection
Brain knowledge helps us really understand our traumatized children and resiliency
Brain – Behavior Functional Model: Building resiliency one level at a time

Neurodevelopmental Core Base
(IQ, Language, Learning Style, Attachment Potential, etc)

Sensory Processing / MSI

Brakes vs Accelerator

Complex Affect Regulation

Social Communication

Behavioral Choice / Free Will
Neurobiology of Resilience

Southwick & Charney (2012)

- Roots begin after Viet Nam War
  - NIMH research on surviving / thriving POW’s
  - Study of Special Forces (before Iraq deployment)

- Can we predict who will be resilient?
  - Neuropeptide Y
  - DHEA
  - Vulnerability & protective resiliency genes

- Can we enhance protective factors in kids?
  - Can we train kids to be more resilient?
Resiliency and the Brain

- Impact on comprehensive assessment
- Impact on multi-modal treatment
- Impact on well-being
- Impact on long-term prognosis
Brain – Behavior Functional Model: Building integration one level at a time

**Neurodevelopmental Core Base**
(IQ, Language, Learning Style, Attachment Potential, etc)

**Sensory Processing / MSI**

**Brakes-Accelerator Balance**

**Complex Affect Regulation**

**Social Communication**

**Behavioral Choice / Free Will**
Inspecting the Foundation: Resiliency & Assessment: Mastery/Efficacy

("Hard wiring” of the Brain)

- Cognition / IQ
- Learning Preferences / Differences / Disability
- Language
- Memory
- Neuromotor processing / control
- Visual-Spatial Processing
- Tempero-sequential processing
- Temperament / Personality
- Attachment Potential
Brain – Behavior Functional Model: Building resiliency one level at a time

Neurodevelopmental Core Base

(IQ, Language, Learning Style, Attachment Potential, etc)

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Social Communication

Behavioral Choice / Free Will
The Human Brain

Brakes (Upstairs)

Accelerator (Downstairs)

Neocortex
Limbic
Diencephalon
Brainstem

B. Perry, MD
Remote Control of the Accelerator

The Confusing Picture of Anxiety

Fight-Flight-Freeze in the JJ / CMH / DHS system

• Anxiety / Panic as source for reactive anger ➞ aggression

• Anxiety – Attention – Language interplay in kids/teens w/ aggression

• False machismo in anxious teen boys
Anger / Explosiveness:
Critical Link to Reactive Aggression

• Anger as coping skill
• ("Just" anger as clinical progress!)
• Reactive / emotive aggression = Anger $\textbf{plus}$
  "bad" brakes ➔➔

Many faces of anger!
The Prefrontal Cortex: The home of Executive Function

Executive Function: The “brakes” of the brain

• Working memory / memory recall
• Focusing (locking, shifting & sustaining)
• Planning / organizing
• Self-monitoring of behavior/action
  – Impulse control
  – Key role in interoception
• Major role in Regulation →
Accelerator vs Brakes: Real World Impact

Way too wound-up / “wild” ("Tigger - on crack")

Too wound-up (Tigger)

Optimal "Goldilocks" Arousal

"Goldilocks" Comfort Zone
“Just Right” Energy Level

Bored / Low energy / Tired & sleepy (Ee-yore)

Total shut-down (via parasympathetics) “Ee-yore on Quaaludes”
Delicate Balance of Arousal / Behavioral Regulation: Control of brain energy / behavior

Top-Down "Brakes" (Prefrontal Cortex)

Bottom-Up "Accelerator" (Brainstem/Limbic System)
Brain – Behavior Functional Model: Building integration one level at a time

**Neurodevelopmental Core Base**
(IQ, Language, Learning Style, Attachment Potential, etc)

**Sensory Processing / MSI**

**Brakes-Accelerator Balance**

**Complex Affect Regulation**

**Social Communication**

**Behavioral Choice / Free Will**
The Case for Complex Affect Regulation
Fine Tuning Energy, Emotions, & Behavior

- Arousal Regulation
- Behavior Regulation
- Emotion Regulation
Complex Affect Regulation
Resiliency & Assessment/Treatment

• Initial treatment can immediately impact this

• Physiologic treatments
  – Brain-based medication
  – Sensory-focused occupational therapy
  – Expressive therapies (music, dance, art)
  – Physical exercise / yoga / tai chi

• Psychological treatments
  – Cognitive behavior therapy / sensory-based therapy
  – Parent-child / family therapies
Complex Affect Regulation: Clinical Realities

- Arousal Regulation can be critical 1\textsuperscript{st} step
- Arousal regulation translates to behavior regulation / clinical “traction”
- Emotion regulation can be the most difficult to achieve in traumatized kids / adults
- Complex affect regulation \rightarrow true brain integration \rightarrow ?neuroplasticity?
- Link to social communication
Brain – Behavior Functional Model: Building integration one level at a time

Neurodevelopmental Core Base (IQ, Language, Learning Style, Attachment Potential, etc)

- Brakes-Accelerator Balance
- Complex Affect Regulation
- Social Communication
- Behavioral Choice / Free Will

Neurodevelopmental Core Base
Hyter-Sloane Model (2013) of Social Communication

- Language/Pragmatic Language
- Working Memory
- Social Cognition
- Complex Affect Regulation
Hyter-Sloane Model (2013) of Social Communication

All components are impacted by prenatal alcohol exposure and traumatic stress.
Brain – Behavior Functional Model: Building integration one level at a time

Neurodevelopmental Core Base
(IQ, Language, Learning Style, Attachment Potential, etc)

Sensory Processing / MSI

Brakes-Acccelerator Balance

Complex Affect Regulation

Social Communication

Behavioral Choice / Free Will
Don’t Forget About the Steering

- Conscious control of behavior
- Importance of **tight structure** for optimal behavior management
- Willfulness misconceptions
  - It’s not *all* willful!
  - But some *is* willful!
  - And some *looks* willful!
  - Behavioral “curve balls” in homes, schools, detention...
Final Thoughts re Regulation: Power Steering vs Manual Steering

- **Regulated** steering = *power* steering!
  - Easier to make appropriate motor / behavioral decisions while regulated

- **Dysregulated** steering = *manual* steering
  - Tougher to keep the behavioral “car” on the road
Searching for Goldilocks
When regulation turns into integration

Optimal Complex Regulation =

Optimal Learning, Behavior, Attention, Memory
Let’s Get Practical
“Assessment forms the foundation for effective practice with children and families.”

Child Welfare Information Gateway
From the Child and Family Services Review

“Agency risk and safety assessments are often not sufficiently comprehensive to capture underlying family issues that may contribute to maltreatment.”
Assessments

- Early
- Comprehensive
- Multidisciplinary
- Trauma-informed
Assessments--Early

• An early assessment is essential
  – To address the iceberg below the water line
  – To establish a baseline of functioning
    • In order to measure progress or lack thereof
  – To identify both strengths and weaknesses
  – To ensure that children and families are receiving the proper services—those of the right frequency, intensity and duration
  – Helps to meet the “RE” requirement and ADA
  – To identify cases ripe for early permanency decisions
Comprehensive

- Must assess child and parent across different domains of functioning:
  - Mental functioning
  - History of child maltreatment
  - Exposure to violence in the home/community
  - Loss of significant relationships
  - Medical needs
  - Educational status and needs
  - Neurodevelopmental functioning

- Must be functional in nature—not just a paper and pencil test or an IQ test
  - In most cases, evaluators should see the child and parent interact (except when such contact would be traumatic for the child)
Multidisciplinary

• No single discipline “owns” the problem of child maltreatment
Multidisciplinary Teams—Federal Law

• Federal Law recognizes the value of multidisciplinary teams

• Sample State Laws
  – Pennsylvania—23 Pa. C.S. 6365(b) and 6375(f)
  – Delaware—16 Del. C. 906 (e)(17)
  – Michigan MCL 722.629
Multidisciplinary Teams

- Composition may vary:
  - Social worker
  - Psychologist
  - Psychiatrist
  - Behavioral pediatrician
  - Occupational therapist
  - Speech and language professional
  - Lawyers
Multidisciplinary Teams

- Balance bias
- Provide a healthy process of critique
- Can bring more creativity to problem solving

- Maintaining such teams can be challenging
  - Expensive—shift resource to the front end of the case
  - Difficult to keep teams together
  - Time—may be slow process if inadequate resources
  - Turf wars
Trauma Informed

- Research has (and is) developing more understanding about the impact of trauma on brain development, behavior, and affect regulation.
- Chemical alterations in the brain that take place when children experienced traumatic stress may change the architecture of the brain.
- Knowing whether the child has experienced this is critically important for treatment planning.
Trauma Informed

• When the child is experiencing the consequences of trauma, it is important to connect child with trauma-informed services
  – Trauma focused cognitive behavioral therapy (TF-CBT)
  – Parent-child interaction therapy (PCIT)
  – Child-parent psychotherapy (CPP)

• While traditional talk therapies and psychopharmacology may be helpful with the symptoms of trauma, the underlying trauma itself must be addressed
As advocates for children, we have an ethical responsibility to advocate for what our clients need

– See SAMHSA site: www.samhsa.gov/nctic/trauma.asp

Need a trauma-informed assessment of parents, too
Trauma and Children’s Parents

• Trauma has impacted the lives of most parents of the children who enter child welfare system

• Substance abuse in CW parents
  – Some studies suggest 30-80% have experienced trauma
  – Others, 100%
In short, a trauma-informed assessment is necessary to fully understand the family’s needs and to identify the appropriate services to meet those identified needs.

This is the origin of intergenerational transmission.
Resilience-Based Advocacy

• Focus on building resilience
• Three elements of increasing child’s resilience
  – 1) Relatedness
  – 2) Mastery
  – 3) Affect regulation
Relatedness

- Sometimes “relational permanence” or “relational security” (think attachment)
- The idea is to connect the child to one (and, if possible, more) concerned, supportive, nurturing adults
- Generally, maintain relationship with parent(s)
- Others
Mastery

- Sometimes referred to as **efficacy**
- Trauma is largely about having no control or ability to influence the environment
- Mastery grows from a sense of success at influencing and affecting the environment
- Developing a sense that “I am in control of my life”
- When kids have a sense of mastery—they
  - Take reasonable risks
  - Fail
  - Struggle
  - Develop a belief that they can overcome obstacles
What We Can Do

• What is the child good at?
  – Help clients find and be involved in activities that they can develop mastery

• What can help the child to build his/her self esteem?

• You don’t have to be a therapist to do this type of advocacy
Affect Regulation

• A risk factor rather than a protective factor (relatedness and mastery)
• Inability to regulate affect (i.e., emotions) is the most consistent impact of trauma
• The two sides of the brain cannot “talk” to one another
• Traumatized children are retriggered into “flight/fight/freeze” (reactive anger, explosiveness, aggression)
Affect Regulation

• Advocates need to press for trauma-informed, evidence-based psychotherapy
  – Not simply the traditional talk therapy

• Focus is on skill-building—developing the capacity to control emotions “in the moment”
Learn More

- Learn More about trauma:
  - www.NCTSN.org
  - Bruce Perry, *The Boy Who Was Raised as a Dog*

- Vandervort, Henry and Sloane, Building Resilience in Foster Children: The Role of the Child’s Advocate, 32 Children’s Legal Rights Journal 1 (Fall 2012).
