THE GEORGE HULL CENTRE
for Children and Families

Supporting Children and Youth with Developmental Trauma: An Approach to Assessment of Commonly Presenting Symptoms and Identifying Optimal Treatment Interventions

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Agenda

- Developmental trauma in children and youth
- Neurobiological effects of trauma
- Common presenting symptoms and overlap with common neurodevelopmental disorders, anxiety, and mood disorders
- Implementation of Dyadic Developmental Therapy (DDP) at George Hull
- Case illustrations

“the neural connections in brain and body are vitally important for understanding human suffering, but it is important not to ignore the foundations of our humanity: relationships and interactions that shape our minds and brains when we are young and that give substance and meaning to our entire lives.”

Bessel van del Kolk

George Hull Centre for Children and Families

The George Hull Centre for Children and Families offers a full spectrum of children's mental health services to children from birth to age 18 and their families.

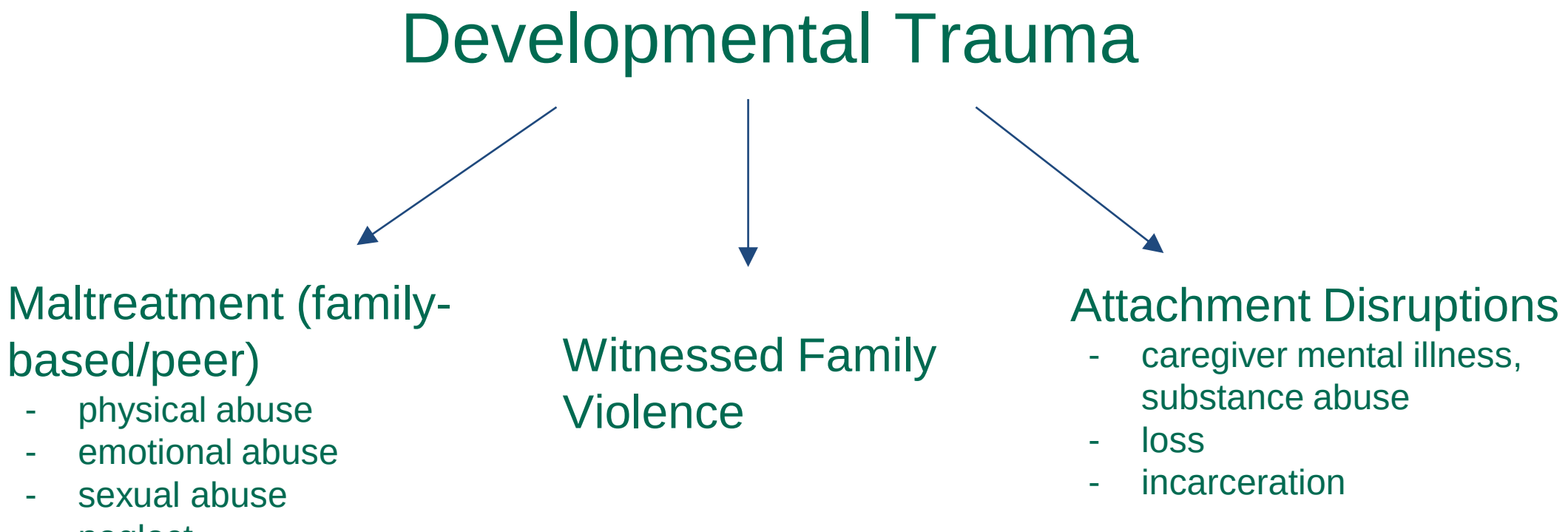
Community Clinic

- The Community Clinic offers clinical services to families with children and youth from birth through 18 who are experiencing significant emotional, behavioural, developmental and/or psychiatric difficulties.

- The Clinic Staff:
  - Psychiatry, Psychology, Social Work and Early Childhood Educators

- We offer:
  - Assessment, Individual, Family and Group therapy
  - Education and advocacy for the prevention of mental health problems
  - Educational workshops on topics relevant to today's family
  - Partnerships with other organizations serving children and their families

Words Matter: Developmental Trauma



Developmental Trauma: Clinical Features

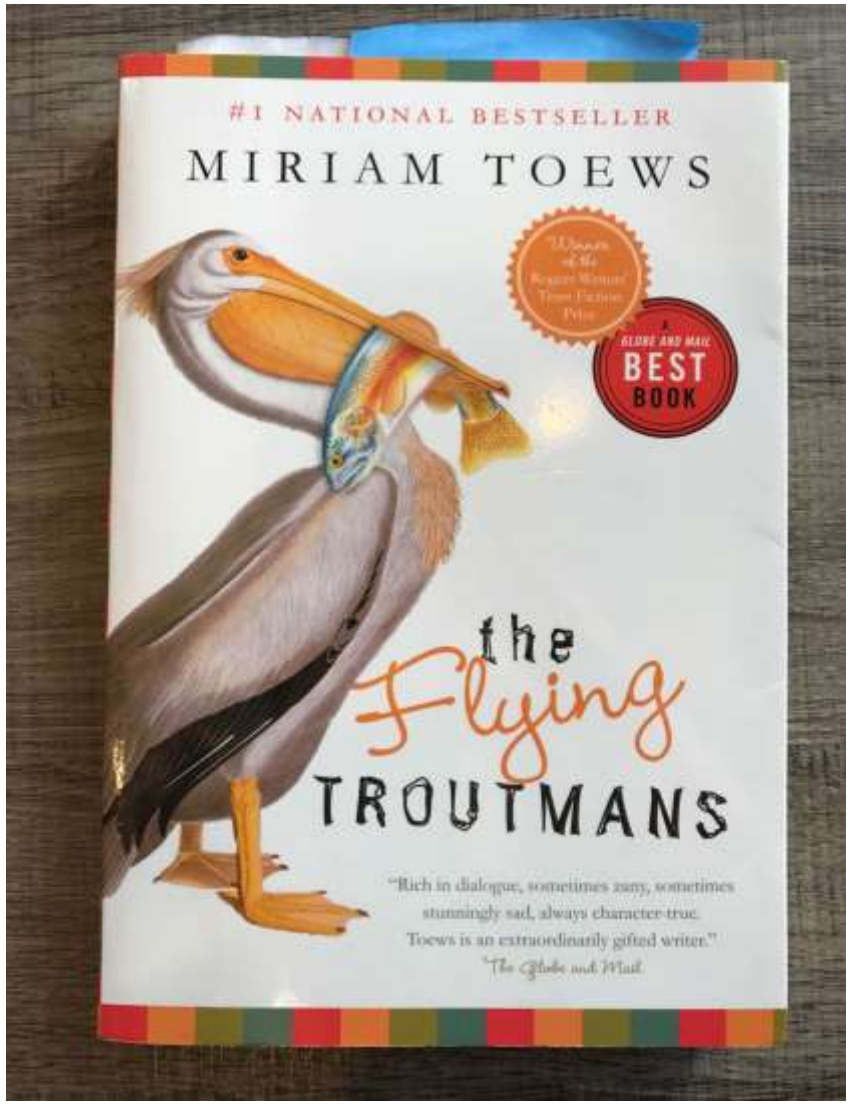
Who are the children we're talking about?

- DYSREGULATION:
  - Affect (intense affects such as rage, betrayal, fear, resignation, defeat and shame)
  - Physiology (sleep, eating, sensory, etc.)
  - Attention and executive functioning (including dissociation)
  - Behaviour (ie. maladaptive efforts to ward off the recurrence of those overwhelming emotions, such as impulsivity and risk taking; maladaptive self-soothing behaviours, such as self harm)
  - Self-identity (ie. poorly developed and predominantly negative sense of self)
  - Relationships (ie. distrusting; anxious; inappropriate; impaired capacity for empathy)

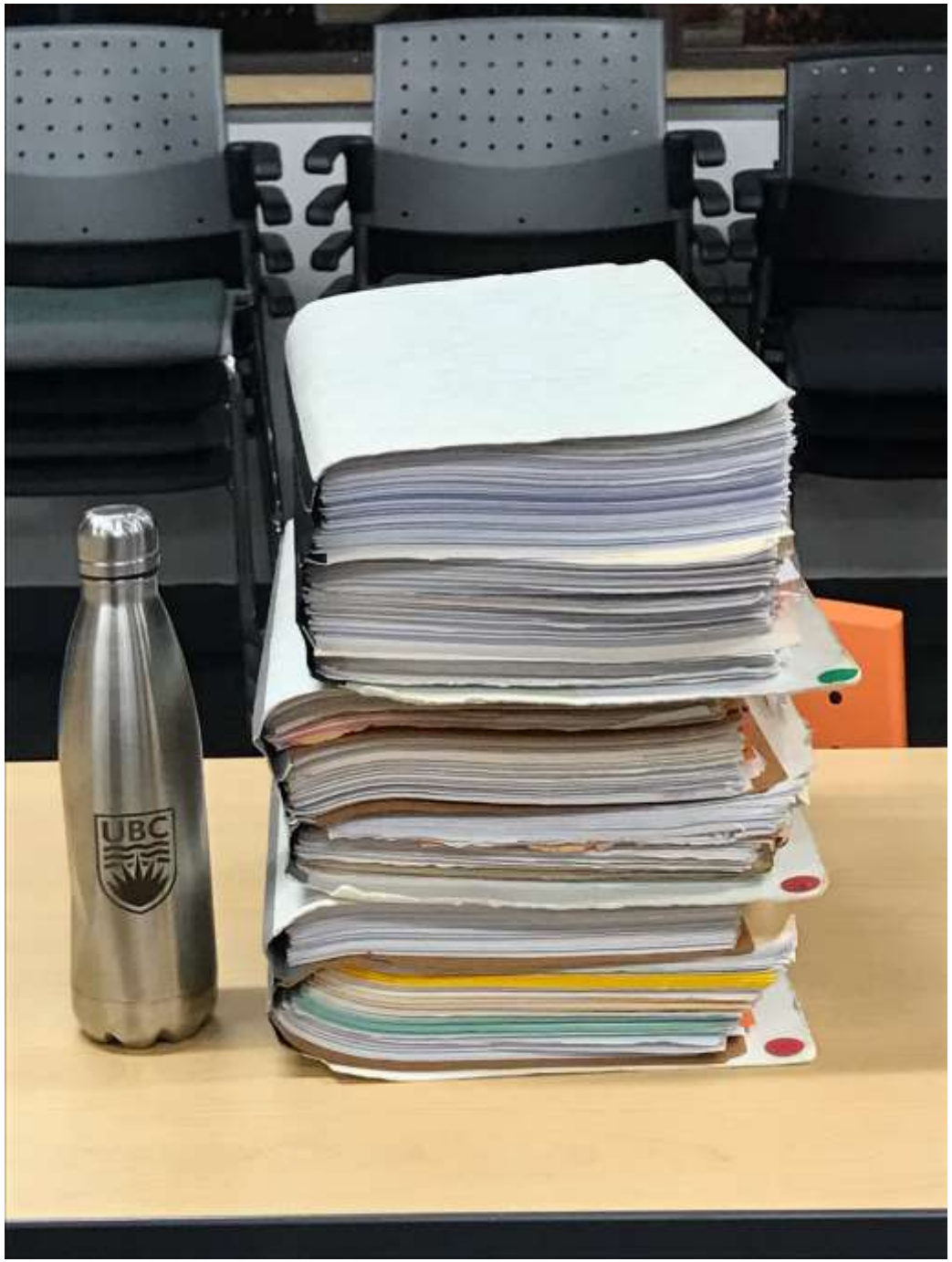
Developmental Trauma

Why the diagnosis of Post Traumatic Stress Disorder (PTSD) doesn't cut it in children with the experience of developmental trauma:

- established in 1980 in the DSM-III, largely in an effort to capture adults (including a significant number of war veterans) with the experience of acute trauma
- fewer than a quarter of children in treatment for trauma-related psychopathology (Child Traumatic Stress Network) meet criteria for PTSD


#1 NATIONAL BESTSELLER
MIRIAM TOEWS
GLOBE AND MAIL
BEST
BOOK
the
Flying
TROUTMANS
"Rich in dialogue, sometimes zany, sometimes
stunningly sad, always character-true.
Toews is an extraordinarily gifted writer."

I: The Challenge


UBC

Case Presentation: Suzy

- Middle of three children
- Physically, sexually, emotionally abused for several years until age 4
- Locked up for several days at a time without food
- Sustained severe burn by scalding in a bath
- Foster care for 2 years with her siblings and then all three adopted at ages 4, 5 and 7
- Extreme dysregulation, aggression (hitting, biting), running away, Pica (eating dirt), hoarding/stealing food, sibling rivalry
- Parents overwhelmed: resorting to ineffective and coercive discipline, depressed

Case Presentation: Noah

- 16 years old, middle of 5 children
- Parents struggled with substance abuse, domestic violence, neglect
- Noah and siblings apprehended (Noah was 4 years old)
- 10 -12 foster/kin/group home placements
- 11 school changes
- Eventually returned to mom as a crown ward at age 12
- Difficulties with emotional regulation, self harm, persistent suicidal ideation, serious suicide attempt, difficulties with peer relationships, gender dysphoria

Prevalence of Trauma in Children

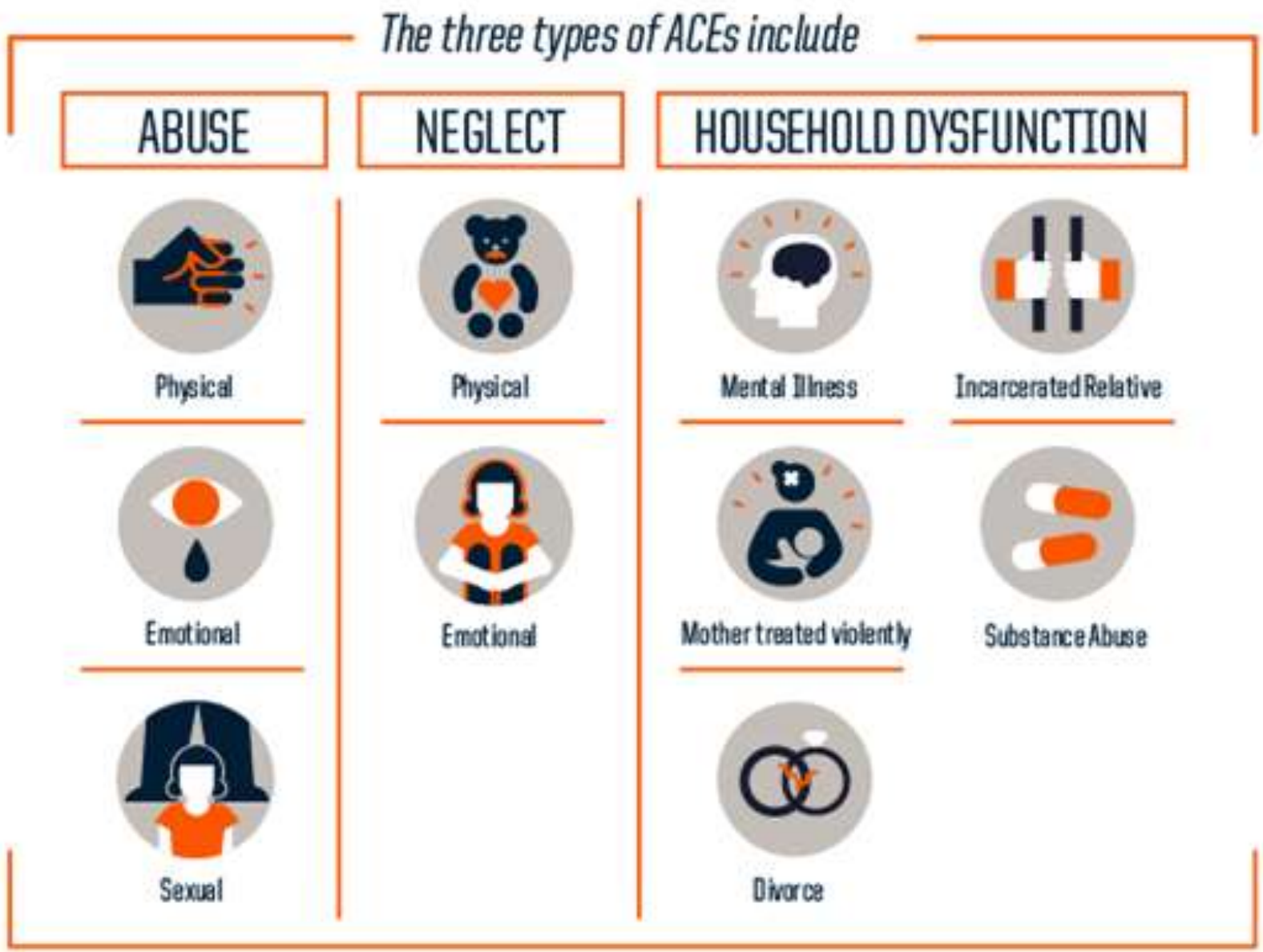
- Study using data from the 2012 Canadian Community Health Survey
  - 10 provinces (not included: territories, institutions and indigenous communities)
  - 18+ years of age
  - in person interviews
  - 23, 295 respondents
  - assessed: 1) history of physical abuse , sexual abuse, and intimate partner violence (IPV); 2) presence of various mental disorders

Prevalence of Trauma in Children

- Results from the 2012 Canadian Community Health Survey
  - 32% of survey respondents reported **ANY** form of child abuse (physical abuse was form most commonly reported: 26%)
  - 22% reported **ONE** form; 2% reported all **THREE**
  - Increase in odds of presence of many types of psychiatric disorders, as well as suicidal ideation and attempts
  - Dose-response relationship between the experiences of abuse/IPV and the odds of having a psychiatric diagnosis

The Prevalence of Developmental Trauma

- Adverse Childhood Experiences (ACE) Study
  - partnership between the Center of Disease Control (CDC) and Kaiser Permanente Department of Preventative Medicine (San Diego)
  - a series of questions targeting various forms of developmental trauma were developed and included in their Family Health Questionnaire, to go along with questions about health and wellness
  - 17, 337 respondents (54% women/46% men; age 18+)


The three types of ACEs include
ABUSE
NEGLECT
HOUSEHOLD DYSFUNCTION
Physical
Emotional
Sexual
Physical
Emotional
Mental Illness
Incarcerated Relative
Mother treated violently
Substance Abuse
Divorce

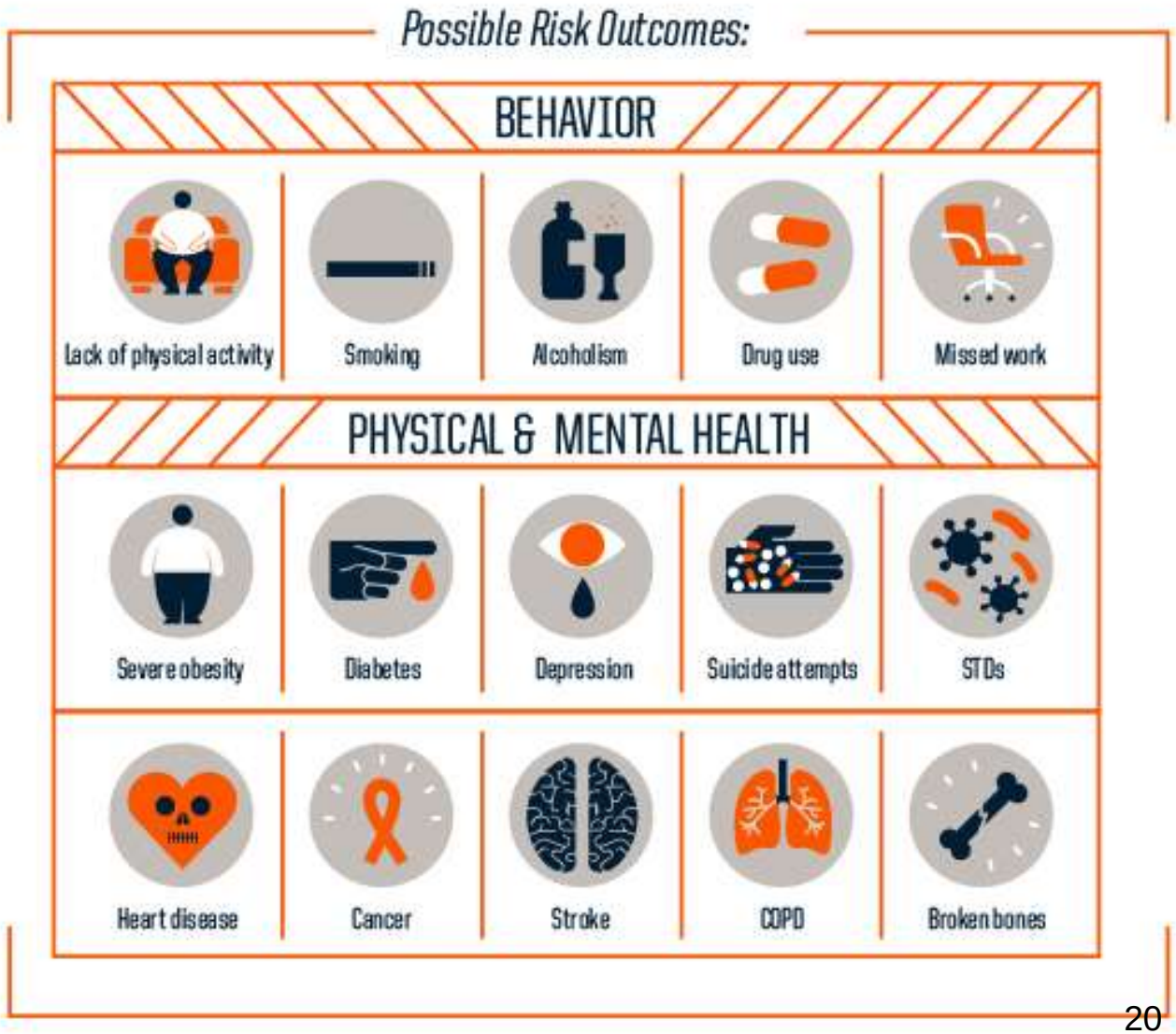
ACE Study: Results

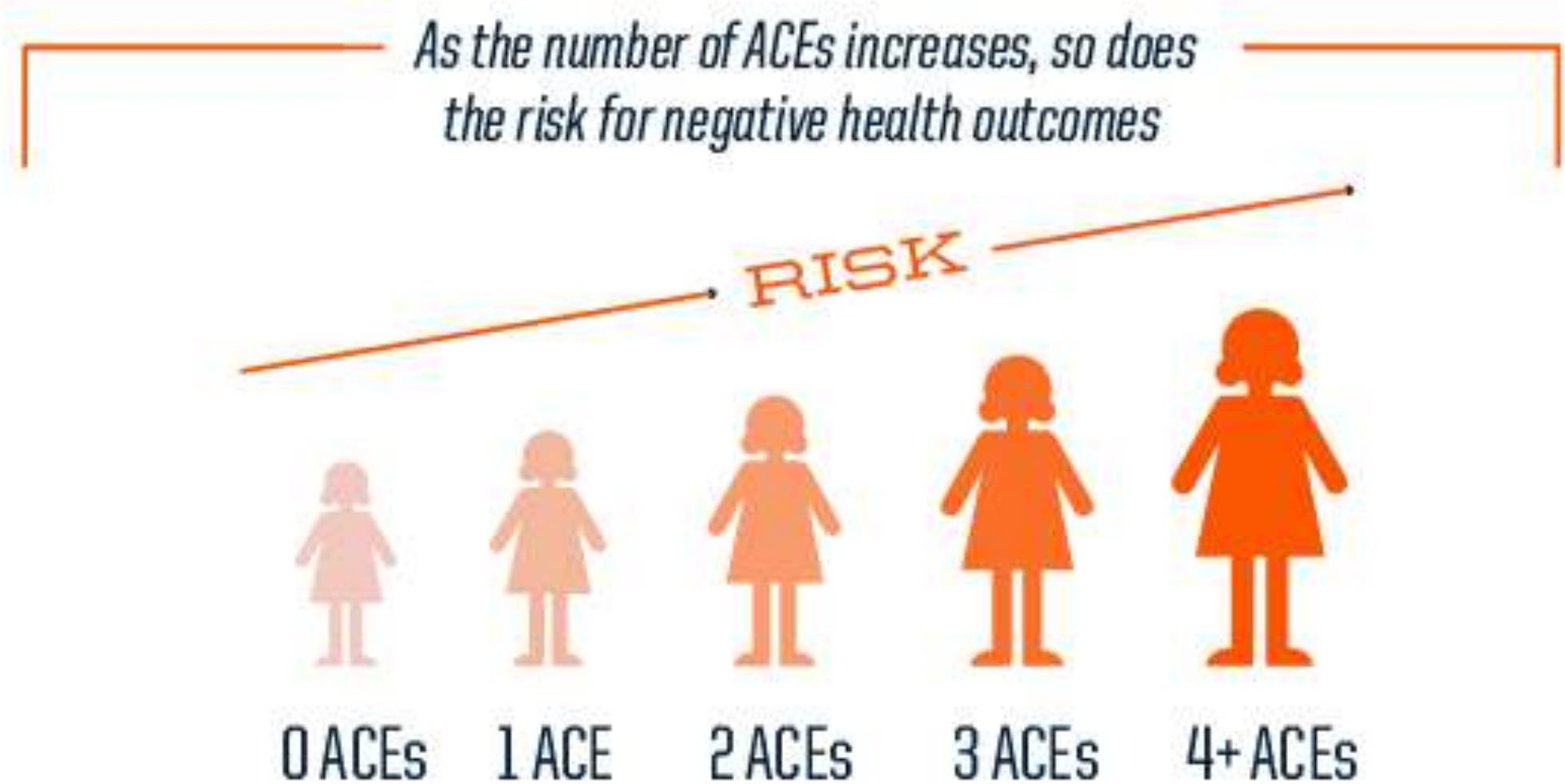
- **Lowlights:**
  - 64% of respondents had experienced 1 or more forms of ACE as children
  - One in four children had been beaten by a parent to the point of a mark being left
  - One in five were sexually molested as a child
  - One in eight children had grown up having witnessed their mother being hit or beaten

Developmental Trauma

- Linked to many negative and costly outcomes (major depression, poor school functioning, conduct disorders, relationship problems, suicide attempts, post-traumatic stress disorder and other anxiety disorders), many of which persist into adulthood (Giaconi 1995; Munson 1995; Caffo and Belaise 2003; Cook et al. 2005).
- When parents have unresolved trauma themselves, their capacity to support their child's treatment and recovery can be limited.

Developmental Trauma: The Costs




As the number of ACEs increases, so does the risk for negative health outcomes
RISK
0 ACEs
1 ACE
2 ACEs
3 ACEs
4+ ACEs

Neurobiological Impact

Questions

- How do we best help children with histories of developmental trauma?
- How do we help these children when caregivers are significantly impacted by their own histories of trauma?
- How do we understand commonly presenting symptoms to the clinic in the context of developmental trauma?
- How do we allocate resources in an efficient and equitable way?

II: Taking Action!

DYADIC DEVELOPMENTAL PSYCHOTHERAPY (DDP)

A family therapy model that integrates the latest science in attachment, intersubjectivity and interpersonal neurobiology to treat Developmental treatment needs

Elements of DDP

Therapist Use Of Self
Process Focused
Of Emotions
PACE
Meanings
Intersubjectivity
Reflective Capacity
Dialogue
Nonverbal- Verbal Dialogue
Experiential
Strength focused
their best

Coherent Narrative
Co-Regulation

Co-Creation Of

Repair
Affective - Reflective

Follow-Lead-Follow
Story Telling
Parents/Children doing

Goals of DDP

- The child will feel safer and more secure with their parents
- The child will understand their emotional experience better
- The child will regulate emotions more easily
- The child will be able to communicate their emotional experience more easily
- The child will be able to accept comfort and support more easily in relationships.

Goals of DDP (continued)

- The child will be able to respond to and receive initiatives to repair relationships better
- The child will want to be more like (identify with) parents
- The child will be able to reflect better on their experiences and have a more integrated autobiography
- The child will manage stress better
- The child will become more emotionally healthy as they heal from past traumas

III: A Fresh Look

Formulating common symptoms in the context of developmental trauma

Case Presentation: Avery

- Now 15 year old referred to GHC when 12 for residential treatment as a result of extreme verbal and physical aggression
- Engaged in provocative behavior such as racist and other judgmental comments that created conflict with peers and strangers
- Diagnosis of Asperger's Disorder, Oppositional Defiant Disorder, Generalized Anxiety Disorder, Attention Deficit Hyperactivity Disorder, attachment related difficulties and parent-child conflict.
- Rigid thinking, high anxiety, discomfort in social situations, hyper-vigilance
- High conflict divorce since Avery was 2

Avery: as defined by the DSM

- Asperger's Disorder (ie. Autism Spectrum Disorder)
- Oppositional Defiant Disorder
- Generalized Anxiety Disorder
- Attention Deficit Hyperactivity Disorder
- Learning Disability
- Parent-Child Relational Problem

The Clinical Features of Developmental Trauma

Anxiety

Disturbances in Mood

Dysregulated Affect

Interpersonal Difficulties

Developmental Trauma

Dysregulated Behaviours (impulsivity, etc)

Impairment in Executive Functioning

Inattention

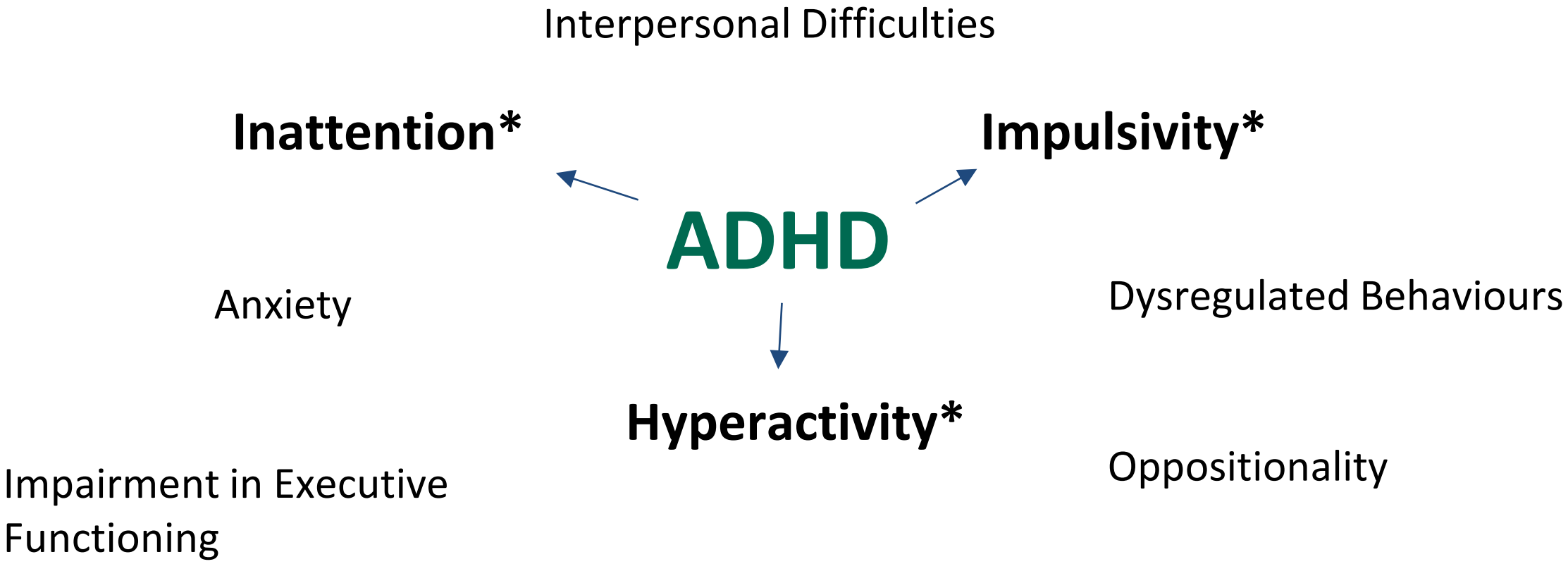
Distorted Thoughts/Negative Attributions

Dissociation

Common Psychiatric Diagnoses

- Attention Deficit Hyperactivity Disorder (ADHD)
- Learning Disabilities
- Anxiety Disorders
- Post Traumatic Stress Disorder (PTSD)
- Major Depressive Disorder (MDD)/Persistent Depressive Disorder
- Borderline Personality Disorder
- Adjustment Disorder
- Substance Use Disorders
- Oppositional Defiant Disorder, Conduct Disorder, etc. .

Attention Deficit Hyperactivity Disorder



Developmental Trauma and ADHD

- Study found that there is an increase in the presence of ACEs in children with the diagnosis of ADHD (50% of non-ADHD children had NO ACEs, while only 32% of those with ADHD; 3X more with 4 or more ACEs) (Brown NM et al., 2017)
- Minnesota Longitudinal Study of Risk and Adaptation (1975; 180 kids)
- How to approach assessment:
  - Do we see ADHD as an “either or” choice to developmental trauma and its clinical presentation
  - or do we see the potential for comorbidity
  - or are they two different pathways to similar changes in the brain, and therefore clinical presentations?

Developmental Trauma and Mood/Affect Dysregulation

- The challenge of understanding the experience of mood and affect (lability, episodes of change, etc) and how it is regulated in patients with histories of developmental trauma
- developmental trauma and its impact on a child's *reporting* of mood and affect
- common diagnoses of mood disorders, adjustment disorder and emerging personality disorders (ie. borderline personality disorder) based on prominent mood dysregulation

Treatment of Common Psychiatric Disorders in the Presence of Developmental Trauma

Lessons from Suzy and Noah

IV: Translating Knowledge into Practice

Noah Revisited

DDP Informed work

- Initial parent work; then alternating parent and parent-teen sessions.
- Parent-teen session: check in with mom; start with positive to engage Noah; develop rhythm of dialogue; follow-lead-follow.
- Therapist is active. PACE and matched affect to explore Noah's thoughts and feelings; Noah conveys these to mom or therapist talks for Noah while being aware of his nonverbal (deepens emotion); holding/building of the story.

DDP Skills cont.

- Helping mom respond with PACE – not problem solving, becoming defensive, or explaining/reassuring too quickly. Talking for her at times to Noah if she struggles.

- Encouraging mom to provide comfort to Noah with time together, empathy, acknowledgement of pain.

- Intersubjectivity – helping mom to see Noah's positive motives

- PACE for mom's experience of parent-child sessions e.g., empathy about how hard it is to hear Noah unhappiness; how it triggers immense feelings of responsibility and shame; attempting to help her manage her feelings of panic, fear, and anger in response to Noah's suicidal ideation.

Progress on DDP Goals

- Ultimately, mom could not tolerate Noah's symptoms and became rejecting. Noah decided to go back into care.
- Noah continued in individual therapy throughout 3 more foster placements. As a result, he could reflect better on experiences and developed a more coherent life narrative.
- Stabilized in foster home, pursued further consultation for gender dysphoria and treatment, and slowly reconnected with his mother.
- Mom now takes Noah's symptoms seriously and is able to provide some emotional support.

Noah

Nurturing Attachments Group Program

- Developed by Kim Golding based on Dan Hughes' DDP model, specifically for adoptive, foster and kin parents.
- Wendy Coetzee, a Chartered Principal Clinical Psychologist, has adapted the materials for biological families.
- George Hull made the decision to run 2 pilot groups – adoptive and biological from January 2016 - November 2016
- 18 weeks - 2 hours per session

Nurturing Attachments/Connections Group Aims

- Provide support to parents who can feel very isolated caring for children with trauma and attachment insecurities
- Increase understanding of the children and their behavioural and emotional needs through an increased understanding of Attachment Theory, child development and the impact of trauma
- Explore ways of applying this understanding to the parenting of the children
- Increase the skill and confidence of the parents

Avery, after PACE group

Quality Assurance – Implementation Evaluation

Dimension	Tools/Method	Outcome/Benefits
Quality and Impact of Training/Supervision	Training Surveys and Group Discussions	Ensure training goals met. Adjust according to needs.
Practice Case Review	Form to reflect on case – why referred, treatment, success challenge, reason for closure /withdrawn	Refinement of referrals – understanding what is good case
Fidelity Measurement	Tools that ask if we are implementing in the intended way - Family Tool and Clinical Reflective Tool - 3 and 6 months	6 month ratings very high from clients Clinicians to reflect on process
Program Commitment	Commitment Curve	High by Year 2 and maintained during Year 3
Practitioner Competence Measure	Tracking staff gains in “knowledge” of elements of DDP and their “confidence ” applying elements - 5 point scale – administered at 4 point since 2014	83% of the knowledge indicators are over 4.0 out of 5. 71% of confidence indicators over 4 on the 5 point scale - places of growth

Outcome Evaluation

DDP Family Therapy Cases		Nurturing Attachments Groups (2)	
Parent Stress Measure (PSI-4, SIPA)	Pre, Post	Parent Stress Measure (PSI-4, SIPA)	Pre, Post
Behavioural and Emotional Rating Scale, 2nd edition (BERS-2)	Pre, Post	Behavioural and Emotional Rating Scale, 2nd edition (BERS-2)	Pre, Post
Behaviour Rating Inventory of Executive Function (BRIEF)	Pre, Post	The Strengths and Difficulties Questionnaire	Pre, Post
Family Fidelity Measure	3 Months, 6 months	Feedback Questionnaire	Pre, Mid, Post

Knowledge and Outcome Indicators
Adoptive, Foster, Kin Group

	Strongly Agree	Agree	Disagree	Strongly Disagree
I understand the concepts of PACE (playful, accepting, curious, empathy) and how they are used.	56%	44%		
I learned how my own attachment history may impact my parenting.	44%	56%		
I was able to reflect on my own thoughts and feelings in parenting my child.	44%	56%		
I have learned ways to “repair” my relationship with my child after a conflict.	33%	67%		
I am better able to deal with conflict with my child.	22%	78%		
My relationship with my child has improved.	56%	44%		

SDQ Overall Distress Levels – Adoptive/Foster	Start of the Group	End of the Group
	# of children	# of children
Normal	.	4
Borderline	3	2
Abnormal	5	2

The Intensive Group - Overall Distress Levels did not show much change but 5 of the 6 showed improvement on the Behavioural Difficulties sub-scale.

Parenting Stress Index -4

Difficult Child		
	Pre	**Post**
Normal Range	5	6
High Range	0	2
Clinically Significant	3	0
Total	8	8

Total Stress		
	Pre	**Post**
Normal Range	5	8
High Range	0	0
Clinically Significant	3	0
Total	8	8

Learning to do the DDP

Clinical Benefits

Better Outcomes for Many Families

Improved Treatment Planning

Increased Understanding of Attachment

Increased Team Safety and Cohesion

Common Clinical Language

Increased Clinical Knowledge and Participation in Evaluation

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