PARENTING THE TRAUMATIZED CHILD

SOLOMON COUNSELING CENTER
CATHOLIC CHARITIES OF JACKSON
INTRODUCTION

• Solomon Counseling Center
  • Valerie McClellan, LCSW, ACSW
  • Diane Braman, LCSW
  • Dr. Miracle Paige, LPC
  • Kelli Leo, LPC
  • Matt Anderson, LMSW

• Solomon Counseling Center is a DMH certified community outpatient counseling center. Although SCC does specialize in the treatment of trauma, we treat the entire range of life challenging issues for children, adolescents, individual adults, couples and families.

• SCC therapists are all certified trauma therapists through the Trauma Focused-CBT National Therapist Certification Program.
OBJECTIVES

• Increase professional awareness of parental needs of families who have experienced childhood trauma.

• Provide professionals with an understanding regarding the clinical process as it involves support of parents and children as they engage in the healing process.

• Demonstrate ways to support caregivers through effective parenting strategies to promote safety, reduce trauma related stress symptoms and increase positive behavior of children in the family’s environment.
TRAUMA CHECKLIST
(TO GET IN A "TRAUMA" FRAME OF MIND)

1. Have you ever been in a hurricane, earthquake, tornado or flood?
2. Have you ever been in a fire?
3. Has there ever been a time when you were seriously hurt or thought you were going to die?
4. Have you or a close family member ever been in the hospital for something serious?
5. Has one of your parents or close family members been affected by a war?
6. Has there been a time you didn’t have enough to eat, didn’t have appropriate clothing or had no one to protect you?
7. Have you ever been in foster care or lived with someone other than your parents?
8. Have you even been homeless?
9. Has anyone in your family ever been depressed or had mental health issues?
10. Has a close friend or family member ever gone to jail?
11. Have you ever lived with anyone who drank or used drugs?
12. Has anyone ever hit you or beaten you up, or threatened to hurt you?
13. Have you ever been threatened with a weapon?
14. Have you ever seen or heard someone else being threatened, beaten, or seen someone who was badly hurt?
15. Have you ever seen someone who was dead or dying, or watched or heard them being killed?
16. Has anyone ever told you details of how someone you were close to was hurt or killed?
17. Has a parent or other adult you lived with ever pushed, grabbed, slapped, or hit you so hard that you had marks or were injured?
18. Have you ever seen a family member or someone else in the house being pushed, grabbed, slapped, hit in the face or threatened with or without a weapon.
19. Has someone close to you ever tried to kill or hurt him/herself?
20. Have you ever attempted to kill or hurt yourself?
21. Has anyone ever kept you somewhere against your will?
22. Has anyone ever stalked you or tried to kidnap you?
23. Have you ever seen something that no one should have to see?
24. Has anyone ever made you do sexual things you didn’t want to do, like touch you, make you touch them, or have any kind of sex with you?
25. Has anyone ever tried to make you do sexual things you didn’t want to do?
26. Is there anything else really scary or very upsetting that has happened to you that I haven’t asked you about?
27. Some people have something they are thinking about, but they’re not comfortable talking about the details yet. Is that true for you?
CAREGIVER’S EXPERIENCE

Before they get to our door what has happened?
Child has experienced sexual and/or physical abuse.
• Abuse is reported to DHS
• DHS begins investigation
• Determination is made for involvement of:
  - law enforcement
  - legal system – DA’s office
  - victim’s advocacy services
  - Children’s Safe Center (if available) – forensic medical exam
  - Children’s Advocacy Center (if available) - forensic interview

Process is very different in:
• Counties with a Children’s Advocacy Center
• Counties without a Children’s Advocacy Center
CAREGIVER’S CHALLENGES

• Loss of Income
• 68% of offenders are within the family
• Conflict in Families (see above)
• Interfere with Working Environment-
  law enf, CAC, CSC, therapy, DHS, attorney, etc
• Legal Status (undocumented)
• Having to move - home and/or school
• Uncertainty of how it will impact the child-
  emotionally & behaviorally
• Emotional impact (on caregiver)
Changing the Child Abuse System

WHAT USED TO HAPPEN WHEN KIDS NEEDED HELP FOR ABUSE

Typical Case—Robin, Age 5

Who talks to Robin? Nurse, Social Worker, Doctor
Who examines Robin? Doctor

Tells her teacher she is being hurt at home.

At School...Who talks to Robin? her Teacher, her Principal, a School Nurse, who also examines her.

Police Officer talks to Robin.

School calls Hotline and Police

“Why do I have to talk to SO MANY people?”

Detective is assigned and brings Robin to a specialized Hospital—where another Nurse, Social Worker, Doctor talks to her and is examined by another Doctor.

A Child Protection Investigator needs to talk to Robin.

A Lawyer needs to talk to Robin.

Robin had to talk to 15 people, but now...
HOW IT WORKS
WHERE THERE IS A CAC & MDT

HOW THE MULTIDISCIPLINARY TEAM Responds to CHILD ABUSE

- Law Enforcement
- Forensic Interview Services
- Medical Services
- Department of Human Resources
- Family and Victim Advocacy Services
- Mental Health Services
- District Attorney's Office

210 Pratt Avenue
Huntsville, AL 35801

National Children's Advocacy Center

256.533.KIDS
www.nationalcac.org
EMOTIONAL IMPACT ON CAREGIVER

- Inappropriate self-blame and guilt
- Inappropriate child blame
- Over protectiveness
- Over permissiveness
- Distorted thought process: I should have known, no one can be trusted, this has ruined our lives, my child is going to be gay, etc.
- Stress Symptoms: sleep problems, irritable, impatient, anger, grief, depression, etc.
CAREGIVER’S NEEDS

• Support with their own symptoms
• Understanding of why treatment is important
  ACE Study
• Understanding of the therapy process
  psychoeducation on Trauma Focused CBT
• the importance of their involvement
• Parenting skills they can use NOW
• Support as they move through the process
  DHS / legal / CAC / CSC / school
WHY GET TREATMENT FOR TRAUMA

Death

Birth

Early Death

Disease, Disability

Adoption of Health-risk Behaviors

Social, Emotional, & Cognitive Impairment

Adverse Childhood Experiences

The Influence of Adverse Childhood Experiences Throughout Life
WHAT ARE ADVERSE CHILDHOOD EXPERIENCES

• sexual abuse (by anyone)
• physical abuse (by a parent)
• psychological abuse (by a parent)
• exposure to domestic violence
• alcohol/drug abuse
• mental illness
• parental loss due to a crime
SO, WHY TREAT THE TRAUMA?

Left untreated, the consequences:
• Represent medical and social problems of national importance

• Strongest predictor of physical and mental health problems in adulthood

• Determine the likelihood of the 10 most common causes of death in the US
WHY TRAUMA FOCUSED CBT?

• 85% of children treated with TFCBT can expect to return to pre-trauma functioning or greater.

• Scientific support: 18 double blind studies to date
• Structured but flexible
• Applicable to diverse population
• Short term but can be incorporated into long term

• Increasing expectations for use of research based therapy by funding sources
TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (THE CLINICAL PROCESS)

- Psycho-education & Parenting Skills
- Relaxation skills
- Affective expression & Regulation skills
- Cognitive coping
- Trauma Narrative
- In-vivo Exposure
- Conjoint Sessions
- Enhanced future safety.

Caregiver is involved in every step of the therapy.
• **Psycho-education** – on trauma, trauma reactions
• **Parenting** – 1-2-3 Magic, Praise Parenting, emotional coaching
• **Relaxation skills** – teach parent & child so parent can practice with child (supports recovery for both)
• **Affective expression skills** – using games to teach to identify & label intensity of feelings
• **Cognitive Coping** – to address helpful & unhelpful thoughts
• **Trauma Narrative** – development & processing
• **In-vivo** – gradual exposure
• **Conjoint Sessions** – both the caregiver, and the child as needing help with the healing process.
• **Enhanced future safety** – body safety education
BENEFITS OF CAREGIVER INVOLVEMENT

• The most influential environment for children is their families
• Research tells us parents’ level of distress can significantly influence children’s reactions to trauma and treatment
• Caregivers:
  - are educated in ways to support their child
  - can help child practice new skills & transfer skills to life
  - can learn about their own behaviors and how these influence child behaviors
  - can learn strategies to manage problematic behaviors in their children – positive parenting skills
  - can learn about their own response to the traumatic event(s), referral for individual tx if needed
• Child can see improvement in PTSD symptoms even if caregiver does NOT participate
Evidence that treating parent is important:

- Deblinger et al. (1996): Treating parents resulted in decreased behavioral and depressive symptoms in child.
- Cohen and Mannarino (1996): Parents emotional reaction to trauma was the strongest predictor of treatment outcome (other than treatment type).
- Cohen and Mannarino (1997): At the 12 month follow-up, parental support was significantly related to decreased symptoms in child.
CASE CONCEPTUALIZATION

KELLI LEO, LPC AND DR. MIRACLE PAIGE, LPC
CLIENT HISTORY

- **Age/Gender**: 16 year old, female
- **Living situation**: with her mother who is very supportive of therapy
- **Date of TX/Length of treatment**: since January, 2015

**Trauma HX**: Client had been raped by her father in Jan., 2014. At 7 years old, her grandfather rubbed his genitals on her. grief over her GM’s death. a serious suicide threat by her sister who took a gun and retreated to the woods.

**Primary Concerns**: intrusive thoughts, avoidance symptoms (avoiding thoughts, feelings, activities, people) somatic symptoms, feelings isolated, anger, hypervigilance.

**Assessments**: UCLA PTSD Index (43). Mother completed the CAFAS and a CBCL. Client met diagnostic criteria for PTSD,

**Therapy Used**: Trauma Focused CBT. Client addressed challenges related to conflicting feelings about her father as well as her sexuality. She identified as LBGT.

**Success**: Client has been very successful in utilizing a variety of support networks and coping skills to assist her in addressing her symptoms.

**Plan**: Client is currently processing her trauma narrative in therapy.
CONJOINT THERAPY

Past conjoint sessions have included:
• Psychoeducation on trauma and trauma reactions
• Relaxation skills
• Psychoeducation on sexual abuse, specifically
• Support for mother’s reactions - exploring (briefly) her own feelings about her daughter’s rape- anger, disgust, fear….
• Facilitating communication between the child and mother

Future sessions will include:
• Sharing of the trauma narrative
CAREGIVER HISTORY

• **Age/Gender:** 41 year old, female
• **Living situation:** Client lives with daughter
• **Date of TX/Length of treatment:** 8 months

• **Presenting concerns:** Client reported having flashbacks, sleep problems, hypervigilance, appetite issues, forgetting, diminished interest, affected restrictions, and concentration issues. Client reported domestic violence in past relationship, being a child of a substances abuser, and ex-husband sexually abusing child as some of her traumatic events.

• **Assessments:** UCLA PTSD Index (67), STAI Trait (Anxiety assessment)-S-55/92%, T-50/93%, BDI-17-Borderline Clinically Depressed, and DMH Initial Biopsychosocial Assessment

• **TX Plan:** Client will gain a sense of mastery and control of life. She will be able to establish and maintain appropriate boundaries, safety planning, setting firm, consistent limits when in relationships. Reduce impact of trauma related symptoms while improving self-esteem, emotional well-being and use of healthy coping tools. Client will also use psychiatric services.

• **Therapy Used:** Cognitive Processing Therapy (includes CBT)

• **Success:** Client is able to sleep better with medication, non-drug sleep protocol, and relaxation techniques. She was able to return to work as a hairdresser and enroll in classes to become an instructor. Client is able to deal with stress related issues from daughter’s trauma event by using coping tools.

• **Future Plan:** continue to address treatment goals and after care plan
EFFECTIVE PARENTING STRATEGIES

- Praise Parenting,
- Emotional Coaching
- 1-2-3 Magic
- Appropriate boundaries; okay and not okay touch
- Psycho-education: developmental stages & age appropriate sexual health information.

- Remember: all behavior has a meaning – the child may not be defiant, he/she may be trying to tell the caregiver something for which he/she has no words.

- ADHD, ODD symptoms vs. PTSD (DSM-V)
CASE STUDY #1

• **Hx:** 7 year old boy, living with his grandmother for 10 months.
  GM supportive & consistent. She followed through with therapy, doctor, school, legal agencies.

• **Trauma HX:** Client had been sexually abused by his mother and her boyfriend, chronic neglect due to his mother’s substance abuse. No relationship with his father.

• **Presenting Concerns:** Client - sexually acting out on school bus, behavioral problems at school & home, PTS symptoms-re-experiencing, avoidance, hyper arousal
  Grandmother - overwhelmed due to missing work (no work=no pay) for appts with legal, DHS, therapy, school, unsure of how to address his sexually acting out, self-blame, worried he might not recover, stressed due to having to drive 1 hr for trauma services but committed to therapy

• **Assessments:** Trauma Hx Checklist, CBCL, CAFAS. Client was dx with Adjustment Disorder with disturbance of emotions and conduct. Previous dx of ADHD.

• **Therapy Used:** Trauma Focused CBT. Initially focused on stabilization, boundaries & safety.

• **Success:** 3 wks into tx-sexual acting out stopped, at 3 months bed wetting stopped; behavior stabilized; his resistance/avoidance deteriorated.

• **7 YR OLD TESTIFIED BEFORE 2 SEPARATE GRAND JURIES & IN TRIAL OF MOTHER’S BOYFRIEND WHO WAS CONVICTED!**
CASE STUDY #2: "ASYMPTOTIC" CHILDREN; WHY ARE THEY A CHALLENGE

- **Hx:** 12 year old male, lives with mother, stepfather, younger brother and stepsister. Mother very supportive but has her own lifelong trauma hx.

- **Trauma HX:** One week prior, client witnessed his father shoot at, but not kill, his stepmother in their home. Father arrested but released on bail.

- **Presenting Concerns:** Acute stress reaction by client. He primarily is asymptomatic though. Mother experiencing extreme stress due to incident triggering her own past trauma. After 2 sessions & 2nd wk of school, he brought a knife to school to defend against his father coming to the school to kidnap him. Mom & school decided alternative school would best suit his needs at this time.

- **Assessments:** Trauma Hx Checklist, CBCL, CAFAS, UCLA PTSD Index (28). Initial dx was Acute Stress Reaction. Previous dx of ADHD. After initial session with mom, she was referred for individual therapy. Initial dx updated to PTSD dx.

- **Therapy Used:** Trauma Focused CBT. Initial focus on helping child increase his understanding of personal safety & the responsibilities of the adults in his life; coping skills to regulate his emotions in any environment.

- **Success:** Mother is loving but tends to have extremely high expectations. After knife incident, she was able to understand that his reaction was from the trauma, not behavioral defiance. Therapist’s was able to write letter to help school understand client’s behavior as trauma related and to help mom make the best decision re: school placement for the child.

- Mom began her own trauma tx to address childhood abuse as well as DV hx with client’s father.
CASE STUDY #3

- **Hx:** 12 year old female, lives with mother and siblings. Father is absent.

- **Length of Tx:** 11 months

- **Trauma HX:** Client reported being gang raped.

- **Presenting Concerns:** Client reported having flashbacks, sleep problems, hypervigilance, appetite issues, forgetting, diminished interest, affected restrictions, avoidance, sexual acting out behaviors (sexting, inappropriate behaviors on social media) and concentration problems.

- **Assessments:** Trauma Hx Checklist, CBCL, CAFAS, UCLA PTSD Index (46). Dx is PTSD.

- **Therapy Used:** Trauma Focused CBT. Focus on client learning to establish and maintain appropriate boundaries, safety planning, setting firm, consistent limits when in a relationship, reduce impact of trauma related symptoms while improving self-esteem, emotional well-being and use of healthy coping tools. Therapy is ongoing.

- **Success:** Client is: able to sleep better and eat more; aware of body safety and is implementing safe behaviors; able to set boundaries and express feelings to safe people; able to participate in extracurricular activities such as basketball and cheerleading. She has goals for her future and uses positive “I” statements. She is no longer avoidant of talking about being raped and the effects it has had on her life. Her mother is able to practice breathing, relaxation and other safety components with her.
WRAP UP

• Caregivers with a trauma history: Interrupting the cycle of abuse/trauma

• Many trauma cases come in with previous dx of ADHD, Oppositional Defiant Disorder, etc: Treat the trauma then see what else shakes out; like panning for gold.

• Complex trauma can result in developmental holes

• Evaluations: Objectives: Parental Needs; Clinical Process; Parenting Strategies

• THERE IS HOPE!
FROM TRAUMA TO WELLNESS
RECOMMENDED READING & RESOURCES

- The Adverse Childhood Experiences Study; Center for Disease Control and Prevention.
- National Child Traumatic Stress Network: www.nctsn.org
- The Trauma Center: www.traumacenter.org
- CARES Institute: www.caresinstitute.org
- AGH Center for Traumatic Stress: www.ahn.org
- Materials to Teach Children Body Safety: www.hope4families.com