Trauma Informed Treatment with Youth in Foster Care
What is trauma?

• A traumatic event is one that threatens injury, death, or the physical integrity of self or others and also causes horror, terror, or helplessness at the time it occurs.

• Traumatic events include sexual abuse, physical abuse, domestic violence, community and school violence, medical trauma, motor vehicle accidents, acts of terrorism, war experiences, natural and human-made disasters, suicides, and other traumatic losses.

• In community samples, more than two thirds of children report experiencing a traumatic event by age 16.

(American Psychological Association, 2008)
Understanding trauma

- Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being.

- A traumatic experience can be a single event, a series of events, and/or a chronic condition.

(SAMHSA, 2014)
What we have learned...

- The Adverse Childhood Experiences Study (Centers for Disease Control and Prevention, 2013) was a large epidemiological study involving more than 17,000 individuals from United States; it analyzed the long-term effects of childhood and adolescent traumatic experiences on adult health risks, mental health, healthcare costs, and life expectancy.
Adverse Childhood Experiences have a tremendous impact on future violence victimization and perpetration and lifelong health and opportunity.
The lifetime impact...

- At least 1 in 7 children have experienced child abuse and/or neglect in the past year, and this is likely an underestimate.

- In the United States, the total lifetime economic burden associated with child abuse and neglect was approximately $124 billion in 2008. This economic burden rivals the cost of other high profile public health problems, such as stroke and type 2 diabetes.

- Exposure to violence in childhood increases the risks of injury, future violence victimization and perpetration, substance abuse, sexually transmitted infections, delayed brain development, reproductive health problems, involvement in sex trafficking, non-communicable diseases, lower educational attainment, and limited employment opportunities.

Trauma is prevalent with our youth...

- A national study asked 4,023 adolescents aged 12-17 if they had ever experienced sexual or physical assault or witnessed violence. Almost half (47%) had experienced one of these types of traumas. Specifically in their lifetime:
  - 8% experienced sexual assault
  - 22% experienced physical assault
  - 39% witnessed violence

Trauma can come from many places...

- Other acute and potentially traumatic events also affect large numbers of children. In 2006, 7.9 million U.S. children received emergency medical care for unintentional injuries (from motor vehicle crashes, falls, fires, dog bites, near drowning, etc.), and more than 400,000 for injuries sustained due to violence. Race and ethnicity, poverty status, and gender affect children’s risk of exposure to trauma.

(American Psychological Association, 2008)
The impacts also take many forms...

- Recent neurobiological, epigenetics, and psychological studies have shown that traumatic experiences in childhood can diminish concentration, memory, and the organizational and language abilities children need to succeed in school.

- This can lead to problems with academic performance, inappropriate behavior in the classroom, and difficulty forming relationships.

- Children exposed to violence, crime, and abuse are more likely to abuse drugs and alcohol; suffer from depression, anxiety, and posttraumatic stress disorder; fail or have difficulties in school; and become delinquent and engage in criminal behavior.

(Finkelhor, Turner, Ormrod, Hamby, and Kracke, 2009).
Symptoms of trauma often mimic other diagnoses...

- Nearly all children and adolescents express some kind of distress or behavioral change in the acute phase of recovery from a traumatic event.
  - the development of new fears
  - separation anxiety (particularly in young children)
  - sleep disturbance, nightmares
  - sadness
  - loss of interest in normal activities
  - reduced concentration
  - decline in schoolwork
  - anger
  - somatic complaints
  - Irritability

(American Psychological Association, 2008)
Trauma is prevalent in youth involved with Social Services...

- In 2011, child protective services in the United States received 3.4 million referrals, representing 6.2 million children. Of those cases referred, about 19% were substantiated and occurred in the following frequencies.
  - more than 75 percent (78.5%) suffered neglect
  - more than 15 percent (17.6%) suffered physical abuse
  - less than 10 percent (9.1%) suffered sexual abuse

Traumatized youth in foster care...

- Following a child's exposure to a traumatic event, social workers and foster parents are likely to observe the following symptoms:
  - **Reexperiencing** — constantly thinking about the event, replaying it over in their minds, nightmares.
  - **Avoidance** — consciously trying to avoid engagement, trying not to think about the event.
  - **Negative Cognitions and Mood** — blaming others or self, diminished interest in pleasurable activities, inability to remember key aspects of the event.
  - **Arousal** — being on edge, being on the lookout, constantly being worried.
Trauma often leads to more trauma...

- Children exposed to chronic and pervasive trauma are especially vulnerable to the impact of subsequent trauma. When children, adolescents, and families come to the attention of helping professionals, the identified trauma may not be the one that is most distressing to the child. For this reason, gathering a thorough, detailed history of trauma exposure is essential.

(American Psychological Association, 2008)
Awareness of the impact of trauma is relatively new...

- Many individuals who seek treatment in behavioral health settings have histories of trauma, but they often don’t recognize the significant effects of trauma in their own lives.

- Either they don’t draw connections between their trauma histories and their presenting problems, or they avoid the topic altogether.
Trauma is being recognized as a root cause of many social dysfunctions:

- The Justice Department launched Changing Minds in October 2016, a national campaign that seeks to raise awareness, teach skills, and inspire public action to address children's exposure to violence and the resulting trauma.

- Goals:
  - Raise awareness about the prevalence, urgency, and impact of children's exposure to violence and the trauma that may result.
  - *Change perceptions of adults who interact with children from viewing them as "angry, bad, and withdrawn" to recognizing that they are children who "have been hurt and need our help."*
  - Motivate adults who interact with children in schools, communities, and health settings to be caring, concerned, and supportive figures in the lives of our children.

- *One of the biggest predictors of children's ability to be resilient in the face of trauma is having loving and caring adults in their lives.*
Trauma treatment is also evolving...

- Many counselors do not have extensive training in treating trauma or offering trauma-informed services and may be uncertain of how to respond to clients’ trauma-related reactions or symptoms.
- Some counselors have experienced traumas themselves that may be triggered by clients’ reports of trauma.
- Others are interested in helping clients with trauma but may unwittingly cause harm by moving too deeply or quickly into trauma material or by discounting or disregarding a client’s report of trauma.
- Counselors must be aware of trauma-related symptoms and disorders and how they affect clients in behavioral health treatment.
According to SAMHSA, there are 4 tenets of trauma informed care. The treatment provider:

- *Realizes* the widespread impact of trauma and understands potential paths for recovery;
- *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively resist *re-traumatization*
What is resilience?

• The majority of children and adolescents manifest resilience in the aftermath of traumatic experiences. This is especially true of single-incident exposure. Youths who have been exposed to multiple traumas, have a past history of anxiety problems, or have experienced family adversity are likely to be at higher risk of showing symptoms of posttraumatic stress.

(American Psychological Association, 2008)
What is resilience?

- Many factors contribute to a person’s response to trauma:
  - Individual attributes
  - Developmental factors (including protective and risk factors)
  - Life history
  - Type of trauma (specific characteristics of the trauma, amount and length of trauma exposure)
  - Cultural meaning of traumatic events
  - Number of losses associated with the trauma
  - Available resources (internal and external, such as coping skills and family support)
  - Community reactions
The interaction between trauma and foster care:

- Environmental factors greatly influence emotional, physical, and social well-being.
  - Youth being placed in foster care are unlikely to have experienced sustained positive environmental factors.
- A fundamental determinant of *health versus illness* is the degree of fit between individuals’ biological, behavioral, and sociocultural needs and the resources available to them.
  - While foster care in the long run can provide needed resources to youth, the original environment likely did not.
- For youth in foster care, exposure rates to trauma approach 90% (Stein et al., 2001).
Foster youth with a history of trauma often present differently

- **Ages 5 and younger**: may fear being separated from parent, crying, whimpering, screaming, immobility and/or aimless motion, trembling, frightened facial expressions, and excessive clinging. May regress—return to behaviors exhibited at earlier ages (e.g., bed-wetting, fear of darkness). Children of this age are strongly affected by the parents’ reactions to the traumatic event.

- **Ages 6 to 11**: may show extreme withdrawal, disruptive behavior, and/or inability to pay attention. Regressive behaviors, nightmares, sleep problems, irrational fears, irritability, refusal to attend school, angry outbursts, and fighting are common. Child may complain of stomachaches or other bodily symptoms that have no medical basis. Schoolwork often suffers. Depression, anxiety, feelings of guilt, and emotional numbing or “flatness” are often present as well.

- **Ages 12 to 17**: may exhibit responses similar to those of adults, including flashbacks, nightmares, emotional numbing, avoidance of reminders of traumatic event, depression, substance abuse, problems with peers, and antisocial behavior. Also common are withdrawal and isolation, physical complaints, suicidal thoughts, school avoidance, academic decline, sleep disturbances, and confusion. May feel extreme guilt over his or her failure to prevent injury or loss of life, and may harbor revenge fantasies that interfere with recovery.
Quick interventions for foster parents...

1. **Don’t be afraid to talk about the traumatic event.**
   
   If children sense that caretakers are upset about the event, they will not bring it up. Don’t bring it up on your own, but when the child brings it up, don’t avoid discussion. Listen to the child, answer questions, and provide comfort and support.

2. **Provide a consistent, predictable pattern for the day.**
   
   Make sure the child has a structure to the day and knows the pattern. Try to have consistent times for meals, school, homework, quiet time, playtime, dinner, and chores. When the day includes new or different activities, tell the child beforehand and explain why this day’s pattern is different. Don’t underestimate how important it is for children to know that their caretakers are in control.

3. **Be nurturing, comforting, and affectionate, but be sure that this is in an appropriate context.**
   
   For children traumatized by physical or sexual abuse, intimacy is often associated with confusion, pain, fear, and abandonment. Providing hugs, kisses, and other physical comfort to younger children is very important. A good working principle for this is to be physically affectionate when the child seeks it.
Quick interventions for foster parents...

4. Discuss your expectations for behavior and your style of discipline with the child.
   Make sure that the rules and the consequences for breaking the rules are clear. Make sure that both you and the child understand beforehand the specific consequences for compliant and non-compliant behaviors.

5. Talk with the child.
   Give them age appropriate information. The more the child knows about who, what, where, why, and how the adult world works, the easier it is to make sense of it. Unpredictability and the unknown are two things that will make a traumatized child more anxious, fearful, and, therefore, more symptomatic.

6. Watch closely for signs of reenactment (e.g., in play, drawing, behaviors), avoidance (e.g., being withdrawn, daydreaming, avoiding other children) and physiological hyper-reactivity (e.g., anxiety, sleep problems, behavioral impulsivity).
   All traumatized children exhibit some combination of these symptoms in the acute posttraumatic period. When you see these symptoms, it is likely that the child has had some reminder of the event, either through thoughts or experiences. Try to comfort and be tolerant of the child’s emotional and behavioral problems.
Quick interventions for foster parents...

7. Protect the child.
   Do not hesitate to cut short or stop activities that are upsetting or re-traumatizing for the child. If you observe increased symptoms in a child that occur in a certain situation or following exposure to certain movies or activities, avoid them.

8. Give the child choices and some sense of control.
   When a child, particularly a traumatized child, feels that they do not have control of a situation they will predictably get more symptomatic. If a child is given some choice or some element of control in an activity or in an interaction with an adult, they will feel safer and more comfortable and will be able to feel, think, and act in a more mature fashion.

9. If you have questions, ask for help.
Assume that all children who have been adopted or fostered have experienced trauma.

<table>
<thead>
<tr>
<th>AGE</th>
<th>IMPACT ON WORKING MEMORY</th>
<th>IMPACT ON INHIBITORY CONTROL</th>
<th>IMPACT ON COGNITIVE FLEXIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant / toddler / pre-schooler</td>
<td>Difficulty acquiring developmental milestones</td>
<td>Frequent severe tantrums</td>
<td>Easily frustrated</td>
</tr>
<tr>
<td></td>
<td>Aggressive with other children</td>
<td>Attachment may be impacted</td>
<td></td>
</tr>
<tr>
<td>School-aged child</td>
<td>Difficulty with school skill acquisition</td>
<td>Frequently in trouble at school and with peers for fighting and disrupting</td>
<td>Organizational difficulties</td>
</tr>
<tr>
<td></td>
<td>Losing details can lead to confabulation, viewed by others as lying</td>
<td></td>
<td>Can look like learning problems or ADHD</td>
</tr>
<tr>
<td>Adolescent</td>
<td>Difficulty keeping up with material as academics advance</td>
<td>Impulsive actions which can threaten health and well-being</td>
<td>Difficulty assuming tasks of young adulthood which require rapid interpretation of information: ie, driving, functioning in workforce</td>
</tr>
<tr>
<td></td>
<td>Trouble keeping school work and home life organized</td>
<td>Actions can lead to involvement with law enforcement and increasingly serious consequences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Confabulation increasingly interpreted by others as integrity issue</td>
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</tbody>
</table>
## Interventions for social workers and foster parents

| Traumatized children will challenge the caretaker, often in ways that threaten placement. | Children come with negative beliefs and expectations about themselves (worthless, powerless) and about the caregiver (unreliable, rejecting). Children often reenact or recreate old relationships with new people. They do this to get the same reactions in caretakers that they experienced with other adults because these lead to familiar reactions. These patterns helped the child survive in the past, prove negative beliefs, help the child vent frustration, and give the child some sense of mastery. | Give messages that say the child is safe, wanted, capable, and worthwhile and that you as the caretaker are available, reliable, and responsive. Praise even neutral behavior. Be aware of your own emotional responses to the child’s behavior. Correct when necessary in a calm unemotional tone. Repeat, repeat, repeat. Do not take these behaviors personally. |
Things to focus on with youth in foster care:

- Have an understanding of trauma that includes an appreciation of its prevalence among young people in foster care and its common consequences.
- Individualize the young person.
  “I don’t want to be perceived as a foster care youth. I want to be known for me.”
- Promote the young person’s sense of trust and safety.
- Be prepared to assist the young person in reducing overwhelming emotion.
- Adopt a strengths-based approach.
  “Adults in my life have focused too much on the negative aspects of my past instead of focusing on the good.”
Foster Care-Specific Treatment Considerations
Period of Adjustment

• **Mourning**
  - Loss of parent(s)
  - Personal belongings
  - Friendships
  - Activities
  - Pets

• **Change** in environment
  - Rules
  - Discipline
  - Cultural

• **Fearing The Unknown**
  - Separation from siblings
  - Foster siblings
  - Visitation
  - New school
  - Making new friends
  - Never going home

• Adjustment to change takes time and differs from child to child

• Children look to adults for reassurance and predictability

• Don’t take rejection and/or limit testing personally
A FEW GOLDEN RULES

- Keeping your word
- Allowing choices
- Respecting their “stuff”
## Foster Care Goals

<table>
<thead>
<tr>
<th>Reunification</th>
<th>Termination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Continued visitation</td>
<td>• Continued visitation</td>
</tr>
<tr>
<td>• Parental assessments</td>
<td>• Parental assessments</td>
</tr>
<tr>
<td>• Therapy</td>
<td>• Therapy</td>
</tr>
<tr>
<td>• Additional services</td>
<td>• Additional services</td>
</tr>
</tbody>
</table>
Subject Matter Experts

We Need Your Help!!
Participants

- Child
- Parent
- Siblings
- Relatives
- Foster Parents
- Social Worker
- Case Manager or other Service Providers
- CASA and/or GAL
Give Feedback

• Behaviors

• Comments

• Observations

• Thoughts
COURT

- Contact
- Placement
- Abuse
- Reunification
- Termination
- Competency
Foster Care & Behavioral Health

Children's Mental Health Matters!
The AFCARS Report

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau

https://www.acf.hhs.gov/cb
Circumstances Associated With Child’s Removal

- Neglect 61% 166,679
- Drug Abuse (Parent) 34% 92,107
- Caretaker Inability To Cope 14% 37,857
- Physical Abuse 12% 33,671
- Child Behavior Problem 11% 28,829
- Housing 10% 27,871
- Parent Incarceration 8% 20,939
- Alcohol Abuse (Parent) 6% 15,143
- Abandonment 5% 12,889
- Sexual Abuse 4% 9,904
- Drug Abuse (Child) 2% 6,273
- Child Disability 2% 4,554
- Relinquishment 1% 2,694
- Parent Death 1% 2,212
- Alcohol Abuse (Child) 0% 1,242
## A Foster Care Alumni Study

**Casey Family Programs, 2003**

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>% of Foster Care Alumni</th>
<th>% of General Adult Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>21.5</td>
<td>4.5</td>
</tr>
<tr>
<td>Major Depressive Episode</td>
<td>15.3</td>
<td>10.6</td>
</tr>
<tr>
<td>Modified Social Phobia</td>
<td>11.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>11.4</td>
<td>3.6</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>9.4</td>
<td>5.1</td>
</tr>
<tr>
<td>Alcohol Dependence</td>
<td>3.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Drug Dependence</td>
<td>3.6</td>
<td>0.5</td>
</tr>
<tr>
<td>Bulimia</td>
<td>2.9</td>
<td>0.4</td>
</tr>
</tbody>
</table>
Good Morning
Let the Stress Begin...
Trauma Focused Cognitive Behavioral Therapy
Trauma Focused Cognitive Behavioral Therapy

• “TF-CBT” Drs. Anthony Mannarino, Judith Cohen and Esther Deblinger
• Evidence-based treatment
• Endorsed by U.S. Substance Abuse and Mental Health Services Administration
• Highly effective at improving youth posttraumatic stress disorder
• Also treats depressive, anxiety, cognitive and behavioral problems
• 8-25 sessions with both the child and his/her caregiver
• Addresses caregiver’s personal distress about trauma, parenting skills and supportive interactions
Foster Care Specific Considerations

• Involving biological parents
• Kinship Placements
• Termination of Parental Rights
• Managing Placement Changes
• Working with Young Children
• Psychotropic Medication Use
The Cognitive Triangle

THOUGHTS

FEELINGS

BEHAVIOR
## Core Components

![Figure 1: TF-CBT PRACTICE Components](image)

<table>
<thead>
<tr>
<th>PRAC:</th>
<th>Coping Skills Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>P:</td>
<td>Psychoeducation</td>
</tr>
<tr>
<td>P:</td>
<td>Parenting Skills</td>
</tr>
<tr>
<td>R:</td>
<td>Relaxation Skills</td>
</tr>
<tr>
<td>A:</td>
<td>Affective Modulation Skills</td>
</tr>
<tr>
<td>C:</td>
<td>Cognitive Coping Skills</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>T:</th>
<th>Trauma Narrative and Processing</th>
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<tr>
<td>T:</td>
<td>trauma Narrative and Processing</td>
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<table>
<thead>
<tr>
<th>ICE:</th>
<th>Treatment Consolidation and Closure Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>I:</td>
<td>In vivo Mastery of Trauma Reminders</td>
</tr>
<tr>
<td>C:</td>
<td>Conjoint Youth-Caregiver Sessions</td>
</tr>
<tr>
<td>E:</td>
<td>Enhancing Safety</td>
</tr>
</tbody>
</table>

(TG: Traumatic Grief Components as needed)
TF-CBT should be provided only to children who have clinically significant mental health problems and impairment in functioning related to a history of abuse or other potentially traumatic events.
Eye Movement Desensitization and Reprocessing

- “EMDR” Francine Shapiro Ph.D.
- Evidence-based treatment
- Endorsed by the World Health Organization, American Psychiatric Association and the Department of Veterans Affairs/Department of Defense
- Highly effective in treating youth with PTSD, complex trauma and single event traumas
• Also treats depressive, anxiety, cognitive and behavioral problems
• EMDR therapy is an eight-phase process
• Decreases or resolves the symptoms and emotional distress that are the result of disturbing life experiences
• In successful EMDR therapy, the meaning of painful events is transformed on an emotional level
• Eye movements (or other bilateral stimulation) are used
Bilateral Stimulation
Eye Movements
Tactile/Audio
Light Bars
Marching, Drumming, Coloring or Running
## EMDR Protocol

### Overview of eight-phase EMDR therapy treatment

<table>
<thead>
<tr>
<th>Phase</th>
<th>Purpose</th>
<th>Procedures</th>
</tr>
</thead>
</table>
| History taking| - Obtain background information  
- Identify suitability for EMDR treatment  
- Identify processing targets from events in client’s life according to standardized three-pronged protocol | - Standard history-taking questionnaires and diagnostic psychometrics  
- Review of the selection criteria  
- Questions and techniques to identify 1) past events that have laid the groundwork for the pathology, 2) current triggers and 3) future needs |
| Preparation   | Prepare appropriate clients for EMDR processing of targets                                                                               | - Education regarding the symptom picture  
- Metaphors and techniques that foster stabilization and a sense of personal control |
| Assessment    | Access the target for EMDR processing by stimulating primary aspects of the memory                                                         | Elicit the image, negative belief currently held, desired positive belief, current emotion, and physical sensation and baseline measures |
| Desensitization| Process experiences toward an adaptive resolution (no distress)                                                                            | Standardized protocols incorporating eye movements (taps or tones) that allow the spontaneous emergence of insights, emotions, physical sensations and other memories |
| Installation  | Increase connections to positive cognitive networks                                                                                           | Enhance the validity of the desired positive belief and fully integrate the positive effects within the memory network |
| Body scan     | Complete processing of any residual disturbance associated with the target                                                                  | Concentration on and processing of any residual physical sensations |
| Closure       | Ensure client stability at the completion of an EMDR session and between sessions                                                          | - Use of guided imagery or self-control techniques if needed  
- Briefing regarding expectations and behavioral reports between sessions |
| Reassessment  | Ensure maintenance of therapeutic outcomes and stability of client                                                                          | Evaluation of treatment effects  
Evaluation of integration within larger social system |

The table above has been adapted with permission from Francine Shapiro’s article “The Role of Eye Movement Desensitization and Reprocessing (EMDR) Therapy in Medicine: Addressing the Psychological and Physical Symptoms Stemming from Adverse Life Experiences,” published in the Winter 2014 issue of The Permanente Journal.
EMDR therapy involves attention to three time periods: the past, present, and future. Focus is given to past disturbing memories and related events.

Unlike talk therapy, the insights clients gain in EMDR therapy result not so much from clinician interpretation, but from the client’s own accelerated intellectual and emotional processes.
Questions

Confusion is a Prelude to Clarity