Trauma Specific Interventions for 0-6 Part 2: What do you need to do?

We Can't Wait

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Introduction

- Being Trauma Informed is good
- Knowing Trauma Specific Interventions that have been developed and tested as methods that are particularly effective in helping the child and caregiver recover from their traumatizing experiences and be better able to face life's challenges and experiences in the future is better

How Evidence Based Practices are used ”in the field”

- Learn the practice
- Learn the conditions under which they were developed
- Decide how you might use this practice, or elements of this practice with the case in front of you
- Knowing when to switch practices, methods, EBP Kernals
- Tracking changes in the child’s condition
  - Symptoms
  - Improvements

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Today's activity- What to Know

- A Complex Case
- Discussion of 5 treatment areas
  - Engagement, strength identification and joining
  - Method of methods- where do we start
  - Managing the session- attachment and attunement
  - Handing ourselves- boundaries, 2nd trauma, reflective supervision, supporting the therapist
  - Psychotropic medication for complex cases
- End with questions and comments

The case of 4 year old Maria

- Lives with adoptive parents and ½ brother. Attends pre-school
- Adopted at 2 ½ after chaotic early childhood- removal at 6 months, 10 placements before adoption. Neglect, abuse
- Multiple symptoms- attention, impulse, hyper, oppositional, stabbing, breaking, emotional dysregulation, aggression, mood quality & quantity, anxiety
- PTSD symptoms- memories, flashbacks, dissociation, startle, hypervigilance, sleep
- Self harm when dysregulated
- Eating- satiety problems
- Speech and language delay
- Attachment- anxious and also disinhibited
- Parental efforts at odds--> conflict and blow ups
- Temperamental mismatch
- Gross and fine motor delay

- Course- improvement, but frequency, duration, and intensity still high
- Cultural issues- children from mixed backgrounds (Latin, Polynesian, African American). Parents are White European
- Strengths- intelligent, charismatic, loving relationships, close sibling bond, financial stability, eager to get help

Engagement (Through Assessment) Identifying Strengths Joining with the Family

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What Do We Need to Do: Engagement/Assessment

- Assessment includes:
  - Engagement and building rapport
  - Earning trust
  - Getting on the same page
  - Getting familiar with the space
  - Speaking the unspeakable

Assessment is NOT:

- Paperwork we need to complete
- A hoop we need to jump through to get to the "good stuff"

Assessment *is* intervention

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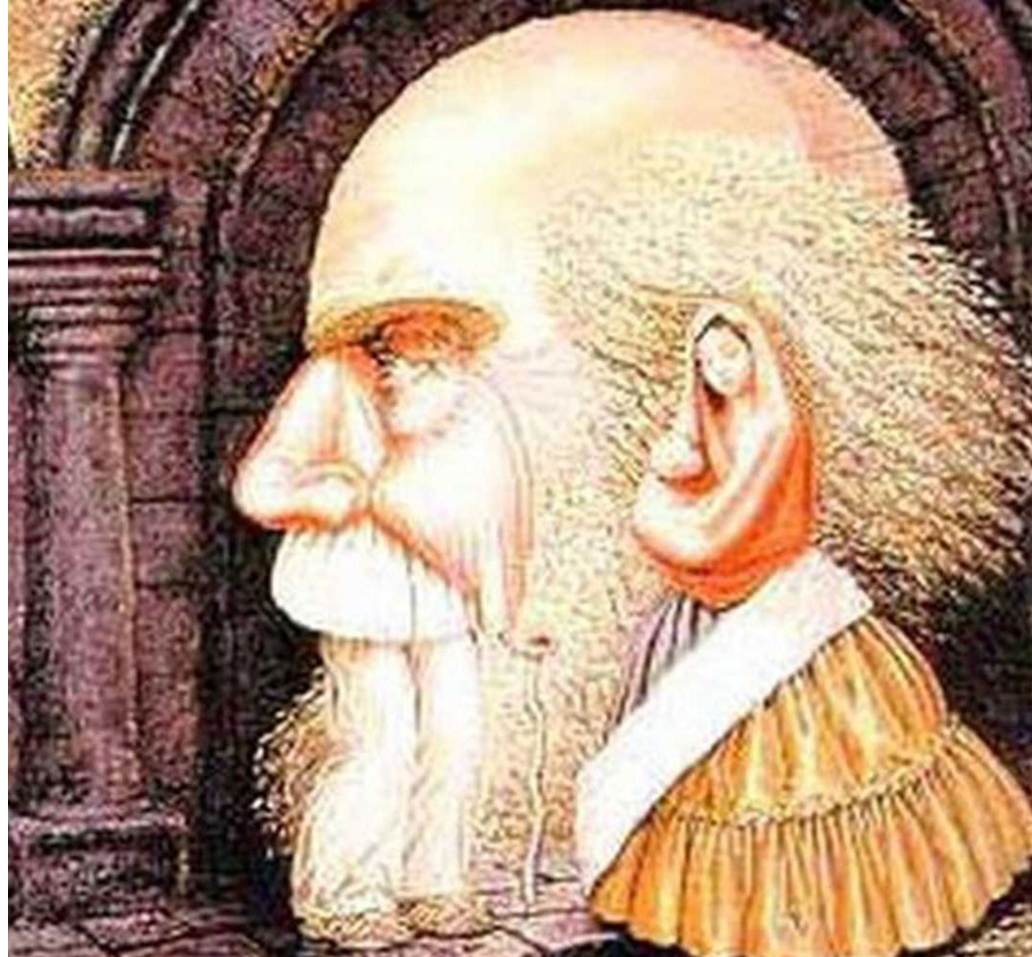
What Do We Need To Do:
Identifying Strengths



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Identifying Strengths

(if we just look)

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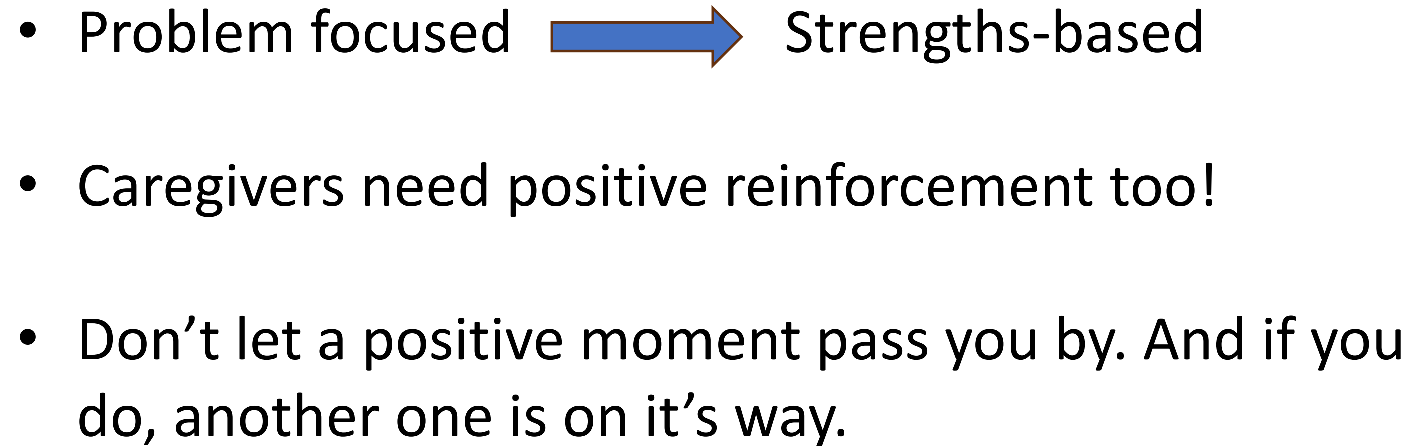
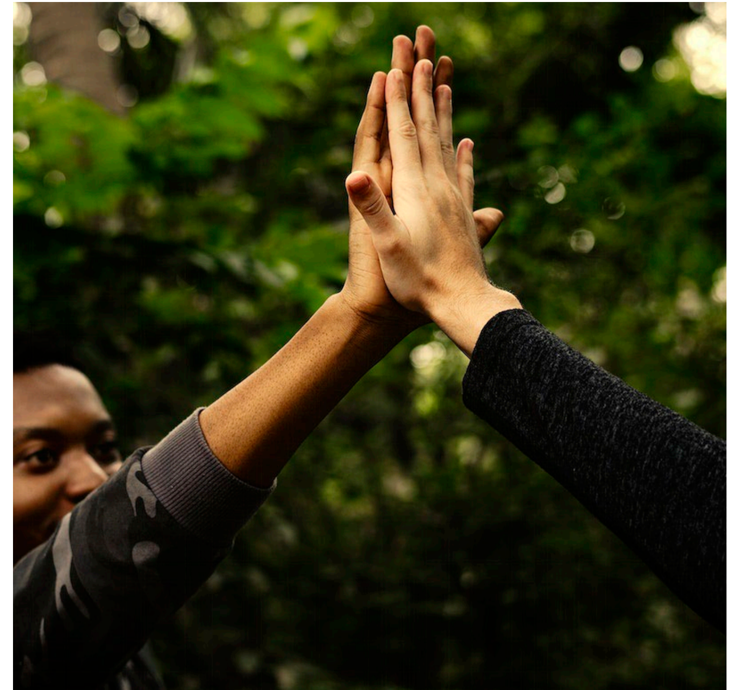
What Do We Need to Do:

Recognizing Strengths



- Problem focused → Strengths-based
- Caregivers need positive reinforcement too!
- Don't let a positive moment pass you by. And if you do, another one is on it's way.



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What Do We Need to Do :

Recognizing Strengths: Maria

- Maria is in school- there's a "village"
  - More adults for the child, and some time for the parents to regroup
- Financially stable
- Siblings are together and have a close bond
- Parents are loving, dedicated, and seeking support

How do we balance strengths and with identifying needs: the "Double Scoop"

What Do We Need to Do : (Joining with the family- use of self-modeling, holding space)

- Teamwork makes the dream work!
- Stay curious and observant
- Don't out-parent the parent
- Working with young children *is* working with caregivers
- Notice your own reactions during session, your desire to "save" or "fix."

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Using a Method of Methods

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Developmental Trauma & Attachment Program (DTAP)

"A method of methods"

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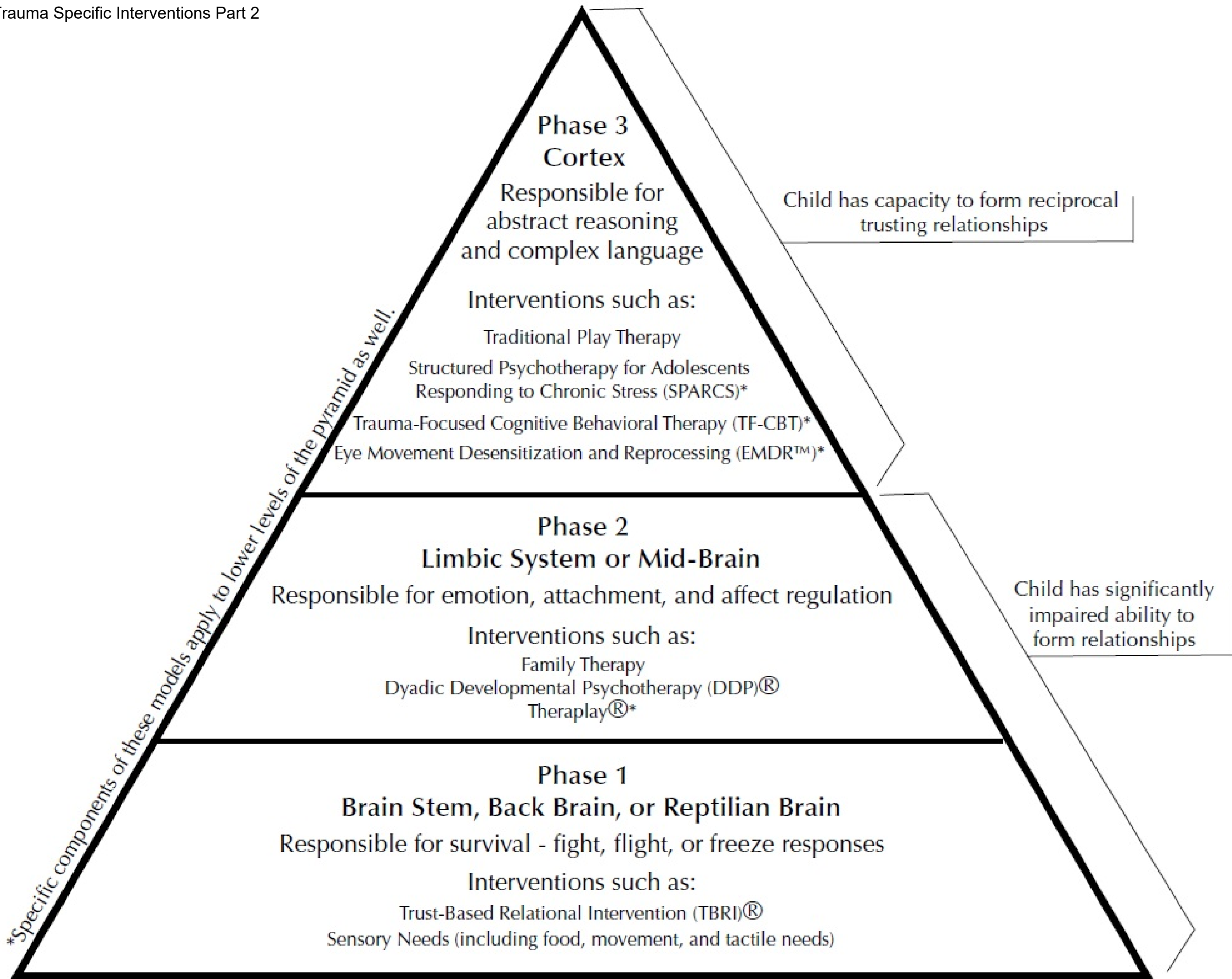

Figure 2.1. Developmental Trauma and Attachment Program (DTAP) Treatment Model®

Phase 1 approaches

…treatment needs to address not only the imprints of specific traumatic events but also the consequences of not having been mirrored, attuned to, and given consistent care and affection: dissociation and loss of self-regulation." (van der Kolk, 2014, p. 124)

- Occupational Therapy
- Trust Based Relational Interventions (TBRI)
- It is essential that therapists have a basic awareness of sensory issues
- Aim to support the most primitive part of the brain (the reptilian part) where automatic responses such as fight, flight, freeze responses originate
- The lower, earlier developing brain areas respond to the healing effects of rhythm, sound, movement and touch

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Phase 2 approaches

When trauma occurs within the context of a relationship, it often takes a healthy relationship to heal it.

- Theraplay
- Child-parent psychotherapy
- PCIT-TC
- Circle of Security (as an adjunctive support for caregivers)
- Aim to support moving attachment relationships toward security
- Children must have the experience of having the feeling identified and reflected back to them before learning feelings words and how to use them (the experience of feeling with)
- Models that help children put additional words to their inner experience and/or develop a coherent narrative of their story (through words or play like with CPP) can begin to be used from here
- Trauma processing can start in phase 2 but is further developed in phase 3 once attachment security has been established

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Theraplay

1. Relationship based; caregiver(s)-child relationship is the unit of treatment

2. Experiential in nature - provides dyad new experiences of safety and connection through attuned, attachment-based play

3. For children ages 0- 18 and their caregivers

Child-Parent Psychotherapy (CPP)

1. Relationship-based; dyad is the unit of treatment
2. Primary goal is to strengthen the relationship as a vehicle for restoring and healing the child's mental health post-trauma
3. For children ages 0-5 who have experienced a trauma and their caregivers

PCIT - TC

Parent Child Interaction Therapy for Traumatized Children

1. Behaviorally oriented and relationship based; caregiver(s)-child relationship is the unit of treatment

2. Experiential in nature - provides in-vivo coaching to parent who is engaging in play with their child

3. Dual aim to enhance the parent-child relationship while decreasing problem behaviors and relationship tension

4. For children ages 2- 7 and their caregivers

5. *Provider must have a trauma-informed and attachment-based orientation

Phase 3 approaches

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- EMDR
- Typical play therapy
- other more explicit and cognitive-based trauma processing approaches
- Effective therapeutic work is only possible when children feel safe both in their environment and in their bodies (phase 1) and in their relationships including with the therapist (phase 2 approaches)
- Represents the cortex and higher level cognitive functioning that allow for a different level of trauma processing and integration

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Trauma-focused Cognitive Behavioral Therapy (TF-CBT)

1. Conjoint child and caregiver psychotherapy model

2. Aims to reduce the severity of presenting trauma-related sxs by teaching/practicing coping skills, engaging in narrative processing and enhancing the parent's ability to support and communicate with their child around the trauma and related sxs

3. For children ages 3-18 who have experienced a trauma and their caregivers

4. *Provider must have a solid understanding of child development & play therapy

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Key elements and recommendations from DTAP model

(Buckwalter, Robinson, Ryan, & Knoverek, 2018)

- Get comfortable working with parents
- Prioritize safety & engagement in tx
- Attachment theory & trauma-informed approaches must be interconnected in tx
- Familiarize yourself with a number of different trauma-focused tx approaches
- Therapist’s way of being is just as, if not more, important than our way of doing
- Ongoing training, supervision and personal reflection are essential
- Match child’s treatment to their developmental age not their chronological age

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Predictability and Structure=Safety

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Managing the Session

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Rituals and Routines

Beginning

- Lotion check-up
- Owie check-up (cotton balls)
- Warm hands/cold hands
- Feeling check in
- Hello song

WALKING BACKWARDS

Ending

- Twinkle twinkle little star+ blanket rock
- Goodbye song
- Transitional Object
- Bridge to next activity

Attachment and Attunement

- Relationships are at every level
- You need knowledge of child and adult attachment patterns*
- Understand relationship patterns to support safety and engagement
- Think about Maria– her father was holding her, and Mother demanded father let go of her, and sat her on her lap.
  - What were the parent's attachment styles, and what was coming up for them?
  - How do you also maintain your own regulation during this?

Speak the Unspeakable* & Help to Feel the Unbearable

- How does it feel in your body to sit in a session where the child loses it?
- That may be an indication of the inner world of the child.
  - Helpless, out of control, scared, anxious…
- Parent/caregiver as a resource to the child. Actively involved in sessions. That is where the work is done (with exceptions when caregiver is not emotionally ready/safe for this work)
- "Dosing" the trauma work

**(Lieberman, 2017)

Applying to Maria's Session

- Taking child's perspective
- Bridging to child to include her in the circle, versus being an outsider
- Bridging behavior to parent to help with attunement to feelings and needs
- Deciding what is appropriate to share with child in age-appropriate way vs. what needs to be discussed as adults-only
- Establishing rituals and routines
- Linking back to attachment relationship
- Planning ahead→ Ultimate goal:
  - Trauma integration and ability for parents to continue this work, without me.

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Managing Ourselves

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Supervision Considerations

Secondary Traumatic Stress

Reflective Supervision and Support

Knowing Myself

Boundaries

“The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet.”

-Rachel Naomi Remen

The Question…

“What are you going to do with the emotional experiences that come with your work?”

Brian C. Miller, Reducing Secondary Traumatic Stress Skills for Sustaining A career in the Helping Professions.

Knowing Myself

What is an objective reaction to my client?

When does my reaction reflect my own family dynamics and history?

What is my Internal Working Model?

Understanding Interpersonal Neurobiology

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Reflective Supervision

- How do you feel working with this client?
- What is this situation bringing up for you?
- What are you worried about for this client?
- What do you wish for her?
- What does she need from her work with you?

-Brian C. Miller, Reducing Secondary Traumatic Stress Skills for Sustaining A career in the Helping Professions.
-Laura van Dernoot Lipsky with Connie Burk, Trauma Stewardship, An Everyday Guide to Caring for Self While Caring for Others

-San Diego Early Childhood Mental Health Leaders Collaborative, Dec 2015
Reflective Supervision: A resource for those supporting infants, toddlers, preschoolers and their families with Early Childhood Mental Health

Boundaries as Corrective Experiences

Session Boundaries

-Physical (personal space, touching/hugs)

-Time (going over session time, multiple phone calls, etc)

-Rituals and Routines

Psychological and Emotional Boundaries

-Am I trying to rescue or save my client from her reality

- Are my feelings reflective of my client's feelings or my own experiences

-What is in my realm of control/responsibility and what is my client's realm

Supporting the Therapist

- Regularly scheduled Supervision with Reflective Component
- Addressing Secondary Traumatic Stress/Vicarious Trauma
- Setting Realistic Expectations
- Grounding in the meaning of our work and our own story
- Pause to share healing and success stories
- Ongoing Training
- Personal psychotherapy/healing rituals
- Teamwork!!

Psychotropic Medication Treatment in a Young Child with Complex Problems

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What target symptoms do I aim at?

- Sleep
- Aggression
- Emotional dysregulation (excessive quantity of arousal, low stability)
- Hyperactivity/impulsivity
- Attention problems
- Depression, sadness
- Anxiety

- Does Maria have any of these?
  - Yes- sleep, aggression, hyperactivity, attention, and anxiety- so quite a few!

When do I use psychotropic meds in young children?

- High level of danger present (to the child or others)
- High level of suffering present
- High level of impaired function

- Does Maria have any of these?
  - Yes, all of them
    - Danger to herself and parents during her aggressive outbursts and attempts to run away
    - Suffering to her and her parents as no one in the family is happy about the outbursts and it limits Maria's opportunities, access to other children and activities
    - Impaired function as when she is in a dysregulated state, she can't learn, develop correctly, or find calmness- function is impaired.

Which symptom do I target first?

- Aggression or sleep are first
- The other 5 symptoms can be prioritized by the child or family

- What did we pick first for Maria?
  - Both, something that would decrease the aggression (F, I, D) and help with sleep
  - If we get more targets covered, that is a bonus

What helps sleep and aggression?

- Alpha-2 agonists- clonidine, guanfacine
- Atypical antipsychotics in low dose- Risperidone, Aripiprazole
- Sedatives- diphenhydramine (Benadryl)

- So, we tried guanfacine (Tenex) first. The dose started low, but quickly was increased to 2mg and given 3 times per day.
  - It helped somewhat with sleep onset
  - It helped somewhat with aggression and emotional dysregulation

What have we tried when that didn't work well enough?

- Risperidone
  - Some help with sleep and aggression
  - Big increase in appetite
  - Breast enlargement, galactorrhea
- Quetiapine
  - Very helpful for sleep, aggression, emotional dysregulation
  - Cause EPSE- truncal dyskinesias
- Ziprasidone
  - Some help at high doses with sleep, aggression, emotional dysregulation
  - No side effects
  - Dose is at top of range for her
- New trial of a mood stabilizer
  - Lamotrigine-rash
  - Gabapentin- new trial, not clear if it will be helpful at this point

So, how is she doing now?

- Some improvement in sleep- still a light sleeper and does OK if in contact with mother
- Still has aggressive outbursts, but some days doesn't (decrease in frequency)
- Moods still are up and down- maybe less with Lamotrigine.

- Maria is a 4-year-old child, with a complex set of problems, who is on 4 medications, and we still haven't addressed her attention, hyperactivity/impulsivity, and anxiety (very well).

Thank you!

Questions?