**Summary Outline – Presentation by Perkovitch and Sedam**

**The Impact of Trauma on Children – 12/19/18**

1. Learning Objectives
	1. A review of what is trauma
	2. Gain awareness of the frequency of trauma in our communities
	3. Become aware of the effects of trauma (Emotional, Physical, Community)
	4. Learn about Trauma Informed Care
	5. Become aware of resources to address trauma
2. A review of what is trauma - types
	1. Acute trauma – single traumatic event limited in time
		1. Examples - experiencing a crime, death of a loved one, car accident, pain or observed pain
		2. Generally people are around to address the trauma immediately, however people still experience effects of trauma even with support
		3. Many times people do not talk about the trauma, we may not know what to feel or say. This experience is very common, sometimes not talking about such things is a cultural issue
		4. Lack of support compounds the effects of the trauma
		5. Secondary trauma (observed pain, or the need to make decisions in a crisis)
	2. Chronic Trauma – the experience of multiple traumatic events
		1. Examples include domestic violence, relapses of a medical issue (multiple Baker Acts), longstanding trauma such as abuse, neglect, or war, community violence
		2. The effects of chronic trauma are often cumulative
		3. Chronic stress can affect the caregiver of someone experiencing trauma as well as other family members who are aware of the trauma
	3. Complex Trauma
		1. This is chronic trauma, but it’s different because the person experiencing the trauma has a personal relationship with the person inflicting the trauma. (Dr. Sedam asked attendees to imagine the difference between being slapped by someone you don’t know and being slapped by someone you thought loved and cared about you. The pain associated with each of those experiences is very different.)
		2. Simultaneous and sequential occurrences of child maltreatment constitute complex trauma.
		3. Complex trauma has profound effects on nearly every aspect of a child’s development and functioning.
		4. Child abuse and neglect are two of the most common types of complex trauma
		5. Other sources of ongoing stress include poverty, discrimination, separations from parent/siblings, frequent moves, school problems, traumatic grief and loss, refugee or immigrant experiences
3. Long Term Effects of Childhood Trauma
	1. High-risk or destructive coping behaviors
		1. These behaviors place children at risk for a range of serious mental and physical health problems including alcoholism, drug abuse, depression, suicide attempts, sexually transmitted diseases
		2. Often adolescents we see for mental illness or chronic physical disease will have been victims of trauma earlier in their lives
		3. Families taking care of traumatized children need help to care for them.
4. *Remembering Trauma* video – Dr. Sedam asked attendees to watch video and write down observations of main character (Manny) from the perspective of a GAL – what needs did he have and how/if they were met.
	1. Statistics from the video:
		1. 26% of children in the United States will witness or experience a traumatic event before they turn four according to the National Center for Mental Health Promotion and Youth Violence Prevention (2012).
		2. 1 in 6 children between 2-5 years receive a psychiatric diagnosis according the a Duke Early Childhood Study by Egger (2016)
		3. The majority of youth in juvenile detention have been exposed to 6 or more traumatic incidents by the time they are detained; the average number of exposures for detained youth is 14. (Abram, et al., 2004).
	2. Discussion after video:
		1. Graham Perkovitch pointed out the inability to control emotions in relation to trauma and failure to verbalize emotions.
		2. Attendees remarked on the misdiagnosis of ADHD. Dr. Sedam suggested this was a mistake due to the failure to make the underlying trauma diagnosis and pointed out that diagnoses such as ADHD and bipolar disorder share some of the same symptoms as trauma, such as inattentiveness and inability to control behavior. These children are focusing on the need to survive or “what is going to happen to me when I get home;” they are focused on the various triggers happening to them in the classroom.
		3. From a GAL perspective, Dr. Sedam remarked on the value of having GAL representation at the multi-disciplinary staffing hearings because GALs provide so much information about the situation to evaluate and serve the kids.
		4. Comments like Manny’s about “just wanting to give up” need attention and kids need to be given a different perspective.
		5. Graham Perkovitch noted that everyday occurrences can be triggers - even washing his hands could be a trigger.
		6. Complex trauma can result in a disorganized attachment style – children’s core beliefs are changed, they are “bad,” the world is not safe, they can’t trust people.
		7. Complex trauma requires a lot of work to help kids self-regulate and reflect because children learn to self-regulate by anticipating their caregiver’s response.
		8. Graham Perkovitch notes we must also study children who are doing well with trauma, and how they build resilience.
5. Discussion of ACES Study
	1. Philadelphia ACE study – children living in marginalized communities had an even higher rate of ACES than those in the original study
	2. ACE Pyramid shows long-term trauma impact
		1. 2001 study by economist James Heckman showed the vast savings for the country if we invested at the bottom of the period to combat complex trauma because we would avoid the disrupted neurodevelopment and other consequences shown in the pyramid.
		2. Frontal lobe of the brain is built on all experiences.
		3. New study by Dr. Bruce Berry coming out that shows how dramatic the impact of trauma is on early brain development by offering evidence that children who experience an “adversity package” from 0-2 months are more profoundly impacted than those who experience greater degrees of adversity between 2 months and 7 years of age.
		4. Maternal abandonment is the worst and most impactful form of trauma for children, even worse than the death of parents (with the exception of suicide).
		5. An ACE score of 6 or more can take 20 years off your life span.
6. Model for Intergenerational Transmission of Child Maltreatment
	1. Need for consistency in treating trauma is paramount; repetition is the key for the brain
	2. As an adult, you often pass on the same attachment style that you experienced with your caregivers
	3. Traumatized caregivers can be triggered by their own child and react the way they experienced it in childhood
7. Attachment trumps trauma
	1. Attachment is biological – it’s not choice; it’s about safety
	2. Traumatized children feel the world is not safe because they never know what will happen next.
	3. Relational trauma is a form of developmental trauma within the caregiving relationship.
		1. Involves combined effects of maltreatment by the caregiver.
		2. Overwhelming dysregulation occurs for children who do not experience safety or comfort.
			1. When you are removed and put in foster care, you are living with strangers, children do not feel safe and can act out.
	4. Effects of Trauma Exposure
		1. Inability to attach
		2. Biological effects – problems with movement and sensation
		3. Mood issues including problems controlling emotion and difficulty understanding, describing, or labeling feelings
		4. Dissociations – children experience a feeling of being disconnected from themselves; as if they are observing something happening to them and it doesn’t feel real (kids “numb themselves out”)
		5. Behavioral control – when children have a desire to do something, they have a hard time holding themselves back
		6. Cognition – problems focusing and completing tasks; cognition problems can mask IQ
		7. Self-concept – children often suffer from a distorted body image, low self-esteem, shame and guilt. (“Maybe I shouldn’t even try.” or “I must be a bad kid or my parents wouldn’t treat me so poorly.”)
		8. Development – trauma can disrupt developmental processes and interfere with mastery of age-appropriate tasks and skills
8. Traumatic Stress
	1. We will have little to no impact on kids until we build trust (How can this be done effectively in group homes for example with a 1 to 6 ratio?)
	2. Traumatic events overwhelm an individual’s capacity to cope
	3. Post-traumatic stress reactions include re-experiencing the event, avoidance, hyper-arousal, persistent difficult thoughts and emotions.
		1. Many kids in child welfare do not have the PTSD diagnosis but exhibit the behaviors.
	4. Dr. Sedam emphasized we must not forget that we are a social species: there is a central need for human connection. Kids have a need to feel seen and heard.
		1. When kids feel listened to it changes their physiologies.
		2. Central human needs for connection (Dr. Perry) – kids identify themselves in this way and they heal in relationship.
9. Influence of Developmental Stage
	1. Child traumatic stress reactions vary by developmental stage
	2. Responding to trauma may reduce children’s capacity to explore their environment and to master age-appropriate developmental tasks.
	3. The longer traumatic stress goes untreated, the farther children tend to stray from appropriate developmental pathways.
	4. Developmental screenings are needed for all young children in the child welfare system.
10. Influence on young children
	1. Express their distress through strong physiological and sensory reactions (i.e., if you pick them up and they scream or arch their backs; watch facial expression)
	2. Become passive, quiet, easily alarmed
	3. Become fearful, especially in new situations
	4. Experience confusion about assessing threats
	5. Engage in regressive behavior
	6. Experience strong startle reactions, night terrors
	7. Blame themselves due to poor understanding of cause and effect or or magical thinking.
	8. To heal from the trauma they need consistent, relationally safe developmental activities (“serve and return”).
11. Influence on school-age children
	1. Experience unwanted and intrusive thoughts and images
	2. Become preoccupied with frightening moments from the traumatic experience
	3. Replay the traumatic event in their minds
	4. Develop intense specific new fears linking back to the original danger
	5. Alternate between shy/withdrawn behavior and unusually aggressive behavior
	6. Become so fearful of recurrence that they avoid previously enjoyable activities
	7. Have thoughts of revenge
12. Influence on adolescents – they may feel:
	1. Weak, strange, childish or like they are “going crazy”
	2. Embarrassed by their bouts of fear or exaggerated physical responses
	3. That they are alone in their pain and suffering
	4. Anxiety and depression
	5. Intense anger
	6. Low self-esteem and helplessness
	7. Aggressive or disruptive behavior
	8. Self-harm (cutting) – done to make themselves feel something
	9. Over- or under- estimation of danger
	10. Expectations of maltreatment or abandonment
	11. Sleep disruption
13. Impact on behavioral, social and emotional functioning
	1. Hyperarousal (fear turns into terror; sadness turns into despair)
	2. Persistent Fear Response
14. Psychological safety
	1. Safety is all about perception – it differs for different people
	2. Be as predictable as possible for kids we deal with who are traumatized.
	3. Kids are conditioned to love their parents and want to go home even if maltreated.
		1. When maltreated, the perception of relationship changes
		2. Kids may expect to be maltreated
		3. They must be consistently shown positive models
	4. Trauma reminders (triggers) can be anything in the environment that reminds them of traumatic events
		1. This has to do with the amygdala in the brain – when it is repeatedly traumatized, a person can misread signals in the environment
15. Trauma affects many areas of life and can lead to secondary problems
16. Healing and best practices
	1. Slide about the Left Brain and the Right Brain is intended to provide context for the need to connect with traumatized children emotionally.
		1. Traditional discipline does not work with kids who have been with developmental or chronic trauma histories repeatedly traumatized – you need to connect right brain to right brain
		2. You need to help them self-regulate then you relate to them
17. PACE model of parenting (Playfulness, Acceptance, Curiosity, Empathy)
	1. Key is a deep respect for the child’s experience
	2. Consistency is critical
18. Four handouts
	1. 3 Core Concepts from Harvard
	2. Handout from Robert Wood Johnson Foundation, effects of trauma on health
	3. 12 core concepts for understanding impact of trauma
	4. Dr. Bruce Perry – overview for caregivers
19. Questions to ask Therapists and Agencies that provide trauma-specific or trauma-informed therapy
20. Questions and Answers
	1. Any tips on how to deal with teens on runaway status?
		1. Recognize that therapy itself could be traumatizing because they have to address the families’ problems and what happened to them.
		2. It is hurtful to recognize that the people who loved them also hurt them
		3. Running away is a way to avoid this but it can also be fun for teens
		4. Try to find out why the child is using running away as an outlet; why is running away a coping mechanism? Are there incentives that could make them stay?
	2. How specifically can you ground someone who is using dissociation as a coping mechanism?
		1. Focus on safety first so you can develop trust.
		2. Once they feel safe you can try and get them to develop different coping mechanism.
21. Comments after meeting
	1. Laurie Blades – advocate for services provided by trauma informed professionals to evaluate kids (CBHA sometimes has CAMS comprehensive but that is not always translated into recommendations).