A Developmental Trauma Approach to Helping Traumatized Children and Parents Achieve Resilience

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Parent-Child Interaction Therapy 2017 Summit
September 28, 2017
Disclosure

I, Julian D. Ford, am co-owner of Advanced Trauma Solutions (ATS), Inc., Sole Licensee of the University of Connecticut for the TARGET© Treatment/Training Model.
## Types of Potentially Traumatic Victimization

- Sexual abuse
- Physical abuse
- Neglect
- Emotional abuse
- Verbal abuse
- Bullying
- Dating Violence
- Witness to Murder
- Community Violence
- Hate Crimes
- War
- Torture
- Terrorism
- Rape/Sexual Coercion
- Kidnapping
- Assault/Mugging
- Robbery
- Ethnic Cleansing
- Property Destruction
- Witness to Family Violence
Exposure to Traumatic Stressors and PTSD are Prevalent and Associated with Internalizing/Externalizing in Childhood

- 61% of nationally representative sample of U.S. children exposed to victimization in the past year (Finkelhor et al., 2009)
- 62% of nationally representative sample of U. S. adolescents had lifetime histories of exposure to traumatic stressor(s), 5% had developed PTSD (McLaughlin et al., 2013)
Adverse Childhood Experiences and Serious Behavioral Health Problems in Adulthood

17,000 adults screened in medical clinic at Kaiser Permanente HMO (Anda et al., 2006)
Polyvictimized Children: A Large Sub-Group of Children and Adolescents Experience Multiple TYPES of Traumatic Victimization

- Nationally representative sample of 2,030 U.S. children, 22% had 4+ types of victimization in past year (Finkelhor, Ormrod, and Turner, 2007)

- Nationally representative sample of 3351 U.S. teens, 8% had experienced on average 5-10 (of 24 possible) types of victimization lifetime (Ford, Elhai, Connor, & Frueh, 2010)
Polyvictimized Children/Youth: Prevalence

- Nationally representative sample of 2,030 U.S. children, 10% were poly-victims: 9+ (age 3-6) to 15+ (age 15+) types (of 30 possible) of victimization lifetime (Finkelhor et al., 2009)

- Nationally representative sample of 3,351 trauma-exposed U.S. adolescents, LCA found 8% poly-victims (6-11 types traumatic events including physical or sexual abuse ➔ at risk for PTSD, depression, and delinquency (Ford et al., 2009)
Figure 1. Latent classes of adolescents identified based on self-reported exposure to psychological trauma: witnessing someone: 1, shot; 2, cut or stabbed; 3, sexually assaulted; 4, mugged or robbed; 5, threatened with a weapon; 6, physically assaulted; Personal exposure to: 7, serious accident; 8, natural disaster; 9, serious injury; and 10, incident involving fear of death. Unwanted sexual activity involving: 11, perpetrator’s penile penetration; 12, digital or object penetration; 13, oral sex; or 14, molestation; 15, victim’s forced touching of perpetrator’s sexual organs; and 16, victim’s forced penetration of perpetrator. Personal exposure to: 17, attack with a weapon; 18, attack without a weapon; 19, threat with a weapon; 20, physical assault with object; 21, physical assault with fists; 22, spanking requiring medical care; 23, physical assault leaving marks; and 24, being physically burned (Ford et al., 2010)
Types of Behavioral Health Problems Associated with Traumatic Poly-victimization

- Reactive Aggression
- Delinquency
- Delinquent Peer Affiliations
- School Problems/Failure
- Impulsivity
- Oppositionality-Defiance
- Withdrawal/Isolation
- Addictions
- Non-suicidal Self-harm
- Reckless/Extreme Risk Taking

- Unresolved Grief
- Suicidality
- Depression
- Panic
- Obsessions/Compulsions
- Sexual Problems
- Eating Problems
- Sleep Problems
- Self-blame/hatred and Shame
- Hopelessness
The Common Denominator in All Forms Of Adolescent Post-Traumatic Behavioral and Emotional Problems

*Chronic Survival Coping*

- Hypervigilance (Distrustful/On Edge)
- Reactive Aggression (Overt or Covert)
- Hopelessness Masked as Indifference
Posttraumatic Survival Coping – A Learning
Brain Shifts to Survival Mode

• Can’t stop and think, or think past the immediate problem or threat
• Can’t let go of grudges/resentments
  • Can’t set/stick with goals
• Can’t trust, especially caregivers
  • Can’t tell who is trustworthy
• Can’t remember to use anger management, skills, especially when very angry!
The Toll that Post-Traumatic Survival Coping Takes on Poly-victimized Children’s Lives

- School absence, suspension, disengagement, retention, drop-out
- Delinquent affiliations, attitudes, acts (including gang membership)
- Sensation seeking and coping via substance use, other risky behavior
- Depression, shame, hopelessness, self-as-damaged, self-harm, suicide
- Volatile, enmeshed, victimizing and/or enabling/rescuing relationships
Developmental Trauma Disorder

Criterion A.

Traumatic victimization (physical, sexual) +

Attachment disruption (primary caregiver separation/loss, or rejection (neglect, verbal abuse)
Developmental Trauma Disorder

Criterion B.

Affective/Physiological Dysregulation

B. 1. Inability to modulate or tolerate extreme affect states (e.g., fear, anger, shame, grief), including extreme tantrums, immobilization

B. 2. Inability to modulate/recover from extreme bodily states: aversion to (a) touch, (b) sound; (c) unexplained bodily problems
Developmental Trauma Disorder

Criterion B.

Affective/Physiological Dysregulation

B. 3. Diminished awareness/dissociation of emotional or bodily feelings

B. 4. Impaired capacity to describe emotions (alexithymia) or bodily states
Developmental Trauma Disorder

Criterion C.

Attentional/Behavioral Dysregulation

C. 1. Attention-bias toward or away from potential threats

C. 2. Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking
Developmental Trauma Disorder

Criterion C.

Attentional/Behavioral Dysregulation

C. 3. Maladaptive self-soothing

C. 4. Habitual (intentional or automatic) or reactive self-harm

C. 5 Inability to initiate or sustain goal-directed behavior
Developmental Trauma Disorder

Criterion D.

Self and Relational Dysregulation

**D. 1.** Persistent extreme negative self-perception—self-loathing or viewing self as damaged/defective

**D. 2.** Attachment insecurity: attempt to care for caregivers, or difficulty tolerating reunion after separation from primary caregiver(s)
Developmental Trauma Disorder

Criterion D.

Self and Relational Dysregulation

D. 3. Extreme persistent distrust, defiance or lack of reciprocal behavior in close relationships

D. 4. Reactive physical/verbal aggression
Developmental Trauma Disorder

Criterion D.

Self and Relational Dysregulation

D. 5. Psychological boundary deficits (excessive intimacy seeking or reliance on peers/adults for safety/reassurance)

D. 6. Dysregulated empathic arousal (intolerant/indifferent or overly reactive to others’ distress)
Developmental Trauma Disorder
Field Trial Clinician Survey

\[ S = 303 \text{ International, 1018 United States} \]

82% female, 82% White, 7% Hispanic

Median age = 45

34% Psychology, 29% Social Work, 27% Counseling, 13% MFT, 7% Psychiatry, 6% Child Welfare, 6% Educators, 4% Case Managers, 4% Pediatrics
Developmental Trauma Disorder Field Trial Interview Study

N = 236 ages 7-18 years old; 50% female

- 30% African American/Biracial, 17% Hispanic, 3% Asian American

- Trauma Histories: 9% No trauma, 11% one type trauma, 38% poly-victim, 62% traumatic loss, 45% family violence, 24.5% neglect, 21% sexual abuse, 21% emotional abuse, 17% community violence
“Briefly, the thalamus and sensory cortex process threat[s] … and convey this information to the amygdala. Prefrontal regions … modulate amygdala response, turning it down with the realization that something is not actually a threat or … irrationally amplifying it. The hippocampus also processes this information and plays a key role in retrieving relevant explicit memories ... [and] modulates ... response to psychological stressors. ... The amygdala integrates this information and signals [lower brain areas, e.g., locus ceruleus], which regulates autonomic, [HPA], and noradrenergic response.”
A Transtheoretical Transdiagnostic Framework

**Trauma Affect Regulation: Guide for Education and Therapy©** (TARGET)

1. **Psychoeducation:**
   - the brain’s stress response system becomes stuck in a survival “alarm” state in PTSD/DTD – our inner “Alarms” need a re-set

2. **Strengths-based self-regulation skills:**
   - Focusing (SOS) – building the ability to stop and (really) think
   - FREEDOM – 7 steps to thinking clearly under stress
normal stress
The Brain & Body Working Together

the brain

brain
spinal cord
nerves

the nervous system

Alarm System (amygdala) → Filing Center (hippocampus) → Thinking Center (prefrontal cortex)

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extreme stress / trauma
The Alarm Takes Control

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First Step to Re-Setting the Brain’s Alarm: SOS (Mental Focusing)

- **Step I: Stop, Slow Down, Sweep Your Mind Clear**
  - Notice how your body feels as you breathe in and out
  - Let your mind be a river that carries every thought away

- **Step II: Orient Yourself**
  - Focus your mind on just one thought that you choose
  - The hope, goal, or relationship that you value most in your life

- **Step III: Self Check Your Level of Alarm and Focus**
  - How Much Stress? How Much Focused Personal Control?
7 Steps to Re-Setting Adolescents’ Alarms & for Adults Working with Youths

**FREEDOM steps**

- **FOCUS**
  - Slow down, Orient, Self-Check
- **RECOGNIZE**
  - Stress Triggers
- **EMOTION**
  - One MAIN Emotion
- **EVALUATE**
  - One MAIN Thought
- **DEFINE**
  - One MAIN Personal Goal
- **OPTIONS**
  - Build On Your Positive Choices
- **MAKE A CONTRIBUTION**
  - Make the World a Better Place
TARGET Outcome Studies

Randomized Clinical Trial Effectiveness Studies


394 Juvenile Detention admissions (75% minorities; 91% male; 21% full/partial PTSD)
50% receive TARGET 50% receive Usual Services

For each group TARGET session received in first week:
- 54% fewer dangerous incidents in 2-week stay (p < .001)
- 72 minutes less seclusion in 2-week stay (p < .001)

Recidivism decreased (p < .001) in TARGET vs. Usual Services
65 System of Care DCFS Counselors Statewide Trained 2013-2015 — 90% achieved proficiency in 2+ cases

200 children in foster care randomized to TARGET or SAU 12-16 session in-home therapy w/child, foster & bio parents

Placement stability/reunification = primary outcomes in an independent evaluation by Northwestern University/Westat

Preliminary outcomes: Abbreviated Dysregulation Inventory

N = 36 foster children – Change between Sessions 4 and 10 (Completion)

• 20% reduction in emotional dysregulation
• 15% reduction in behavioral dysregulation
• 10% increase in cognitive self-regulation