

# The Challenging Process of Assessing Young Children exposed to neglect and abuse; aka: trauma and toxic stress.

Understanding the Impact of Toxic  
Stress on the Developing Child

Trauma Informed Care

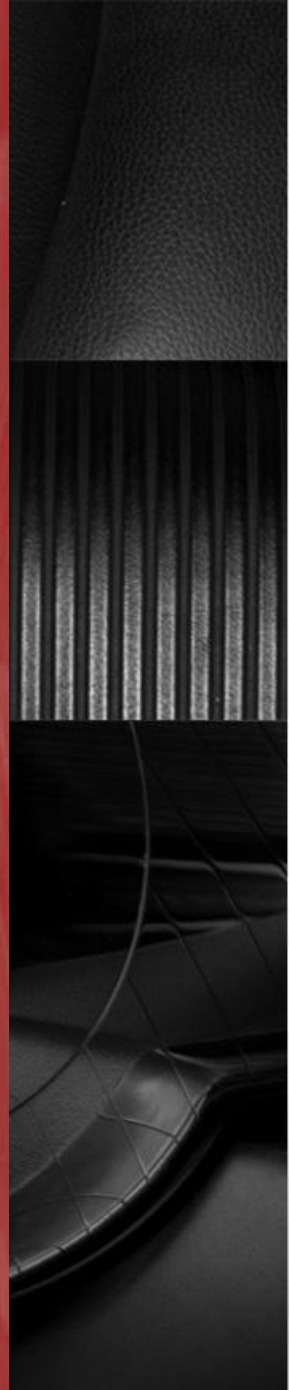
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Brains develop and organize  
in the context of relationships.



Positively and **Negatively**

- 
- “We are  
hardwired for  
relationship.”



# Imitation starts at birth

- Mirror neurons
- Ten-minute old newborn doing tongue-protrusion and mouth-opening, ala Meltzoff experiments.
- [Neonate imitation.wmv](#)
- “Micro events”
- [Still Face. Edward Tronick.wmv](#)

Three Core Concepts in Early Development

# 1 Experiences Build Brain Architecture

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# 2 Serve & Return Interaction Shapes Brain Circuitry

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# 3 Toxic Stress Derails Healthy Development

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# What is Trauma?


- An exceptional experience in which powerful and dangerous stimuli overwhelm the capacity to regulate emotions.
- Definition (*NASMHPD, 2006*)
  - – The experience of violence and victimization including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disasters
- DSM IV-TR (*APA, 2000*)
  - Person's response involves intense fear, horror and helplessness
  - Extreme stress that overwhelms the person's capacity to cope



# Definition of Trauma Informed Care

- Mental Health Treatment that incorporates:
  - An appreciation for the high prevalence of traumatic experiences in persons who receive mental health services
- A thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual


*(Jennings, 2004)*



# Prevalence of Trauma

## Mental Health Population – United States

- 90% of public mental health clients in have been exposed to trauma
  - (*Mueser et al., 2004, Mueser et al., 1998*)
- 51-98% of public mental health clients in have been exposed to trauma
  - (*Goodman et al., 1997, Mueser et al., 1998*)
- Most have multiple experiences of trauma
  - (*Mueser et al., 2004, Mueser et al., 1998*)
- 97% of homeless women with SMI have experienced severe physical & sexual abuse – 87% experience this abuse both in childhood and adulthood
  - (*Goodman et al., 1997*)



## Prevalence of Trauma Child Mental Health/Youth Detention Population - U.S.

- Canadian study of 187 adolescents reported 42% had PTSD
- American study of 100 adolescent inpatients; 93% had trauma histories and 32% had PTSD
- 70-90% incarcerated girls – sexual, physical, emotional abuse

*(DOC, 1998, Chesney & Sheldon 1991)*



## Other Critical Trauma Correlates: The Relationship of Childhood Trauma to Adult Health


- Adverse Childhood Events (ACEs) have serious health consequences
- Adoption of health risk behaviors as coping mechanisms
  - eating disorders, smoking, substance abuse, self harm, sexual promiscuity
- Severe medical conditions: heart disease, pulmonary disease, liver disease, STDs, GYN cancer
- Early Death (*Felitti et al., 1998*) [[www.acestudy.org](http://www.acestudy.org)]



# Adverse Childhood Experiences

- Recurrent and severe physical abuse
- Recurrent and severe emotional abuse
- Sexual abuse
- Growing up in household with:
  - Alcohol or drug user
  - Member being imprisoned
  - Mentally ill, chronically depressed, or institutionalized member
  - Mother being treated violently
  - Both biological parents absent
  - Emotional or physical abuse

*(Fellitti et al, 1998)*




# Adverse Childhood Experiences (ACE) study by Kaiser Permanente and the Centers for Disease Control and Prevention (initial phase 1995 to 1997)

- 17,337 adult health maintenance organization (HMO) members responded to a questionnaire about adverse childhood experiences
  - 11% reported emotional abused as a child,
  - 30.1% reported physical abuse, and
  - 19.9% sexual abuse.
  - 23.5% reported being exposed to family alcohol abuse,
  - 18.8% were exposed to mental illness,
  - 12.5% witnessed their mothers being battered, and
  - 4.9% reported family drug abuse.
- The ACE study showed that adverse childhood experiences are vastly more common than recognized or acknowledged and that they have a powerful relationship to adult health a half-century later.

Demographic Categories		Percent (N = 17,337)
Gender		
	Female	54%
	Male	46%
Race		
	White	74.8%
	Hispanic/Latino	11.2%
	Asian/Pacific Islander	7.2%
	African-American	4.6%
	Other	1.9%
Age (years)		
	19-29	5.3%
	30-39	9.8%
	40-49	18.6%
	50-59	19.9%
	60 and over	46.4%
Education		
	Not High School Graduate	7.2%
	High School Graduate	17.6%
	Some College	35.9%
	College Graduate or Higher	39.3%



Born in 1935 or before



# What does the prevalence data tell us?

- Growing body of research on the relationship between victimization and later offending
- Many people with trauma histories have overlapping problems with mental health, addictions, physical health, and are victims or perpetrators of crime
- **Victims of trauma are found across all systems of care**

(Hodas, 2004; Cusack et al, Muesar et al, 1998, Lipschitz et al, 1999; NASMHPD, 1998).



Therefore...

- We need to presume the clients we serve have a history of traumatic stress and exercise “universal precautions” by creating systems of care that are *trauma-informed*

*(Hodas, 2005)*





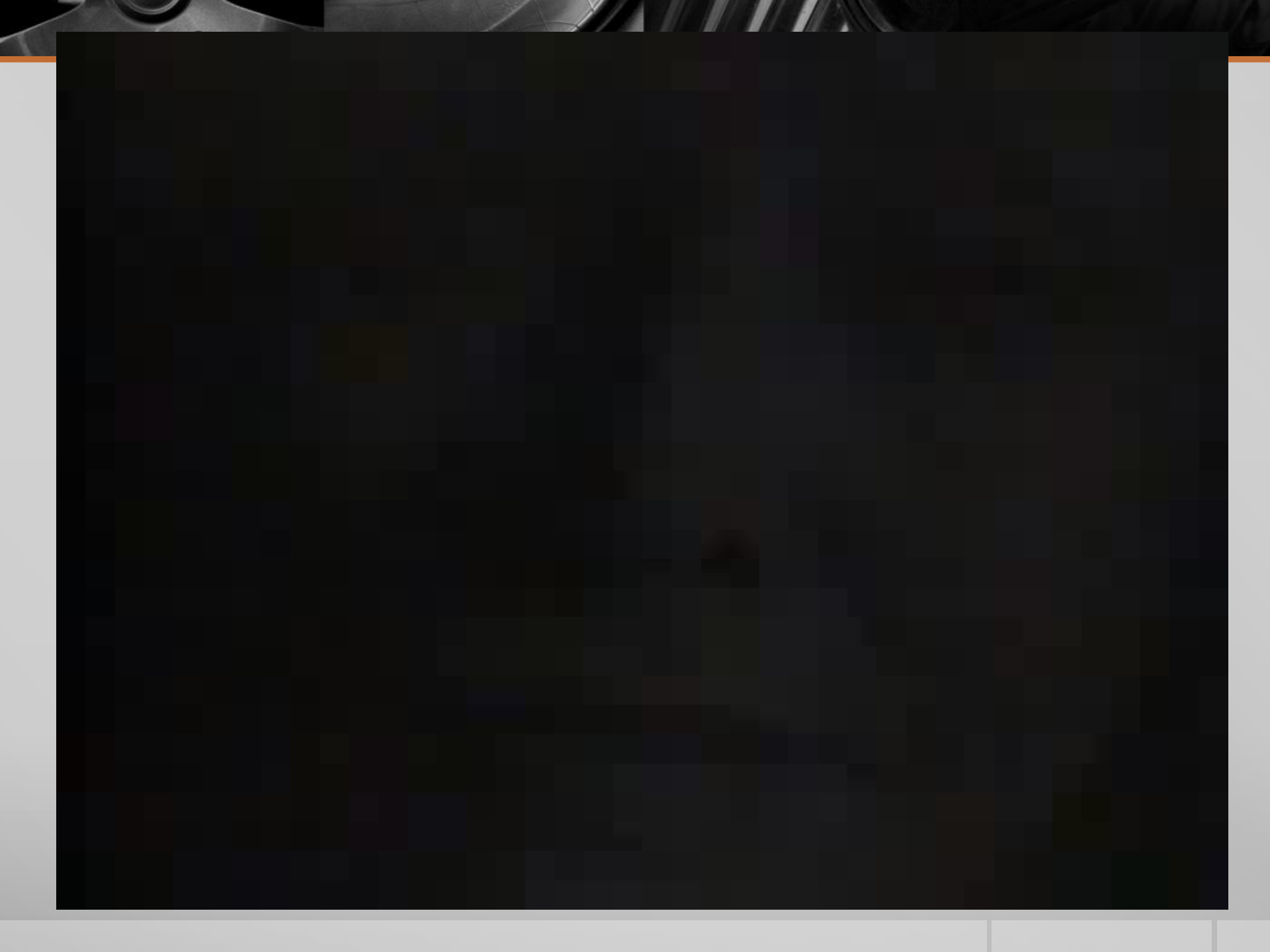
# How are Children Traumatized?

- Exposure to community violence in their neighborhoods and homes.
- Exposure and witnessing domestic violence.
- Exposure to or hearing about unusual traumatic events such as accidents, terrorist attacks, wars, natural disasters (hurricanes, tornados, fires).
- Exposure to media.
- Abuse: emotional, physical, sexual.
- Medical Trauma



# Broad types of Trauma


- Single incident trauma
  - World Trade Center
- Chronic toxic stress
  - Exposure to neglect and abuse
  - Alcoholic parent





# Trauma in Early Childhood

- [Negative Effects of Domestic Violence on Children.wmv](#)
- Children exposed to domestic violence are at risk for depression, anxiety, aggressive behavior, and academic problems.
- It is estimated that between 3.3 million and 10 million children in the U.S. witness domestic violence annually.
- Very young children are more likely to be exposed to domestic violence than older children.
- Very young children exposed to domestic violence may experience extreme stress that can have a potentially serious impact on brain development.
- Children who witness domestic violence are at high risk for child abuse or neglect.

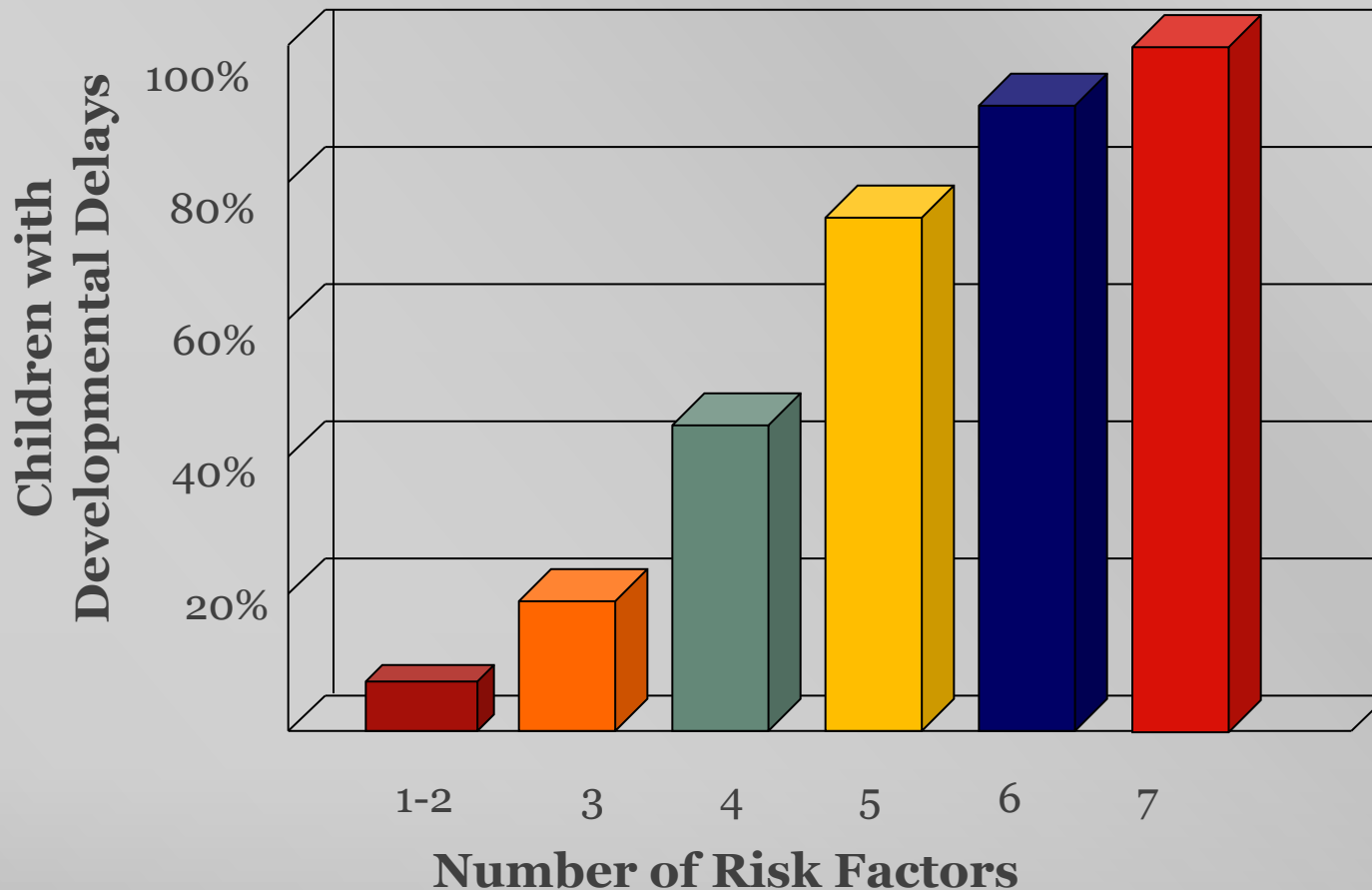
- 
- [..\Domestic Violence and Children \(PSA\).wmv](#)
  - [..\Domestic Violence PSA.wmv](#)
  - [..\10 Shocking domestic violence statistics on children and mot.wmv](#)
  - [..\911 domestic violence call from a child witnessing abuse.wmv](#)

# Relationships Buffer Toxic Stress

- Learning how to cope with moderate, short-lived stress can build a healthy stress response system.
- Toxic stress—when the body's stress response system is activated excessively—can weaken brain architecture.
- Without caring adults to buffer children, toxic stress can have long-term consequences for learning, behavior, and both physical and mental health.
- Hardwired for relationships.



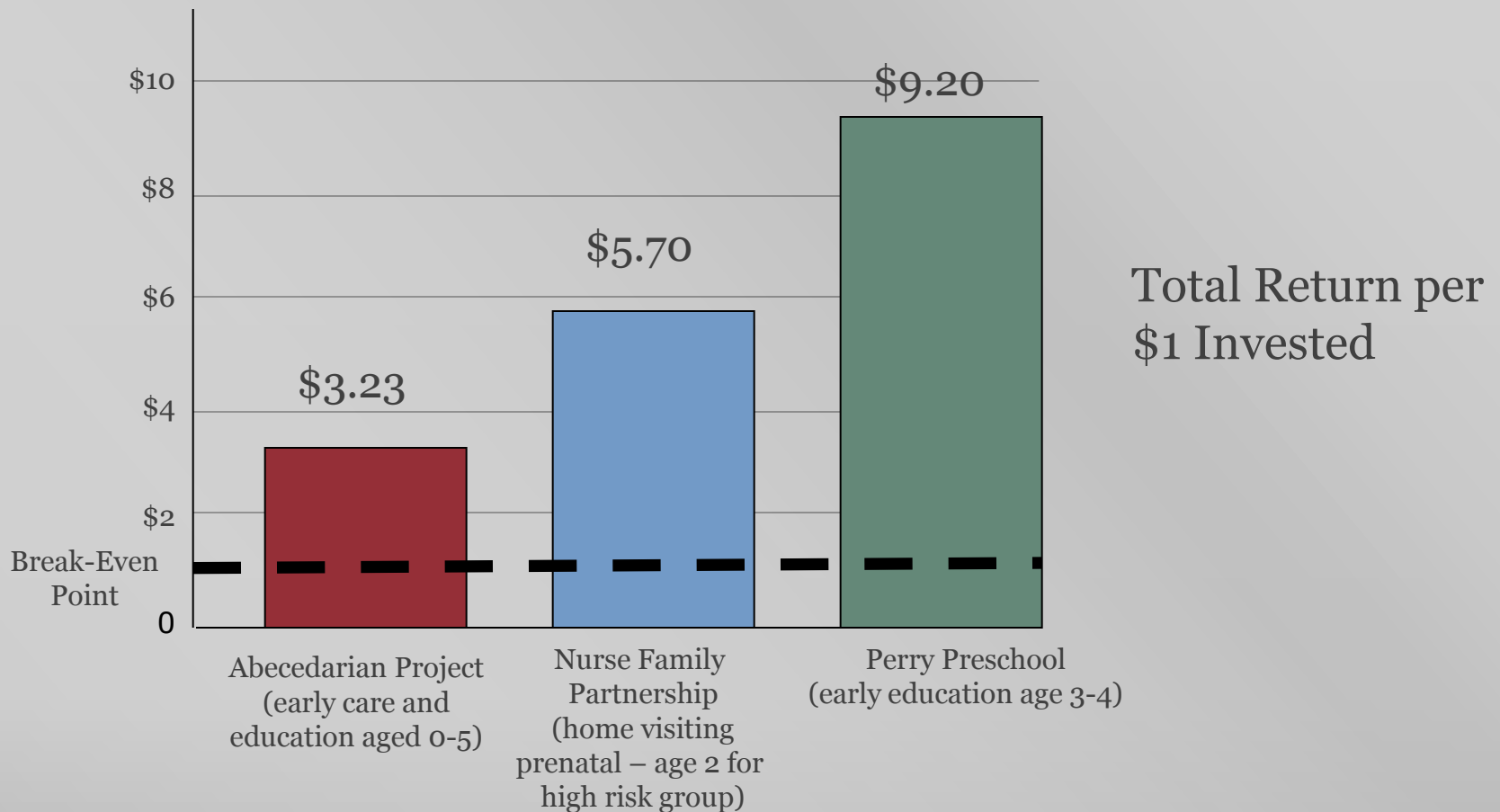
# Significant Adversity Impairs Development in the First Three Years



Data Source: Barth, et al. (2008)

Graph Courtesy: Center on the Developing Child at Harvard University

# Quality Early Care and Education Pays Off: Cost/Benefit Analyses Show Positive Returns



Data Sources:

Karoly et al. (2005)

Heckman et al. (2009)

Graph Courtesy: Center on the Developing Child at Harvard University

# Keys to Healthy Development



A balanced approach to emotional, social, cognitive, and language development, starting in the earliest years of life.

Supportive relationships and positive learning experiences that begin with parents but are strengthened by others outside the home.




Highly specialized interventions as early as possible for children and families experiencing significant adversity.

*For more on the science:*

[www.developingchild.harvard.edu](http://www.developingchild.harvard.edu)

*For more on business champions:*

[www.ReadyNation.org](http://www.ReadyNation.org)



Maltreated children develop as if the entire world is chaotic, unpredictable, violent, frightening and devoid of nurturing.

Unfortunately, the systems designed to help these children continue to expose these children to neglect, unpredictability, fear, chaos and, all too often, more violence.

# ***Trauma and Altered Neurodevelopment***

Altered cardiovascular regulation

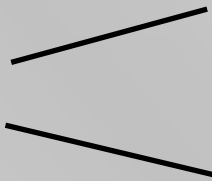
Behavioral impulsivity

Increased anxiety

Increased startle response

Sleep abnormalities

# MEMORY

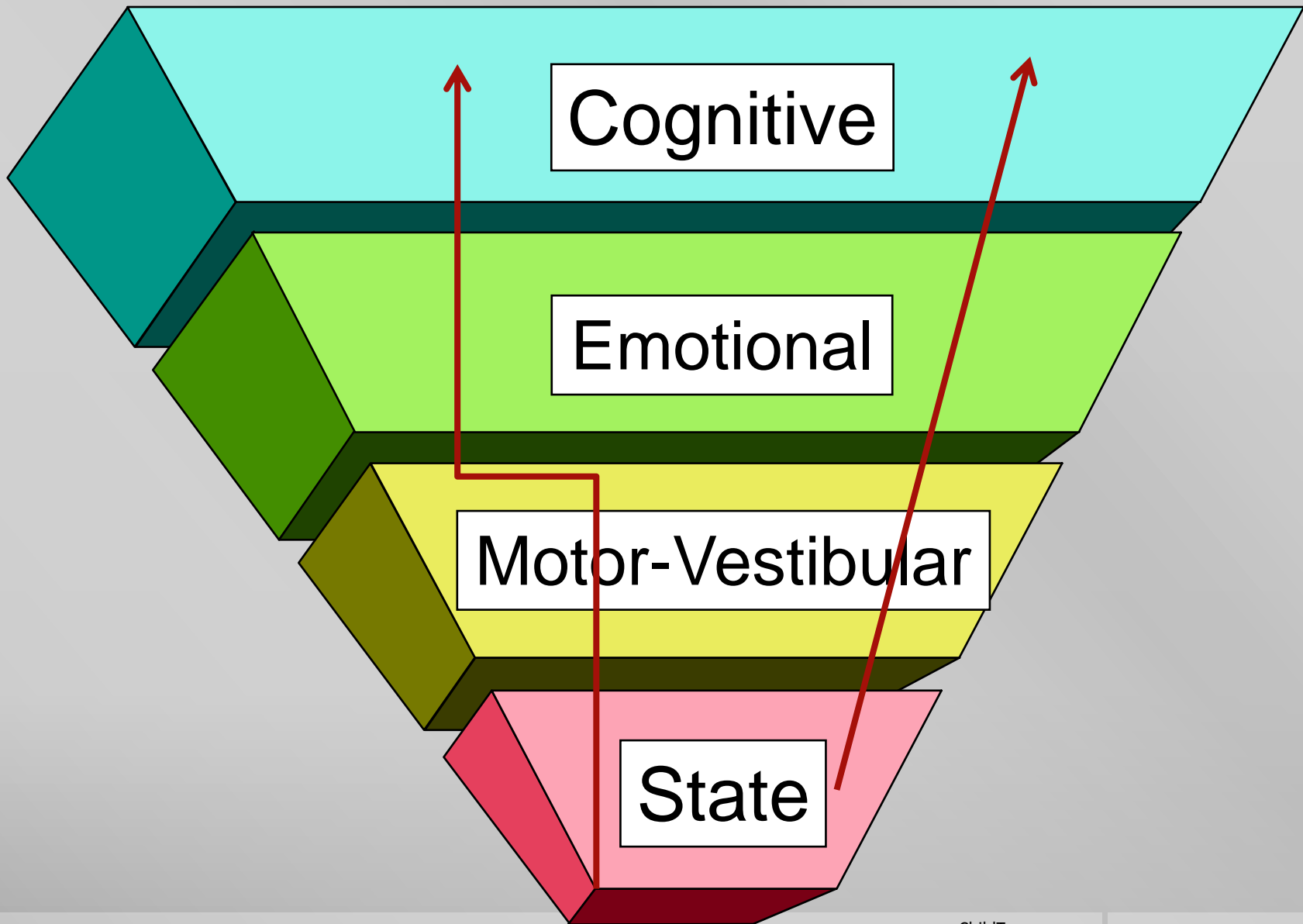
Cognitive  **Implicit**  
**Explicit**


**Affective/Emotional**

**Motor/Vestibular**

**“State”**

# MEMORY





- Children who have been traumatized have emotional and state memories indelibly burned into their brainstem and midbrain!

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- *Once you know how to ride a bicycle...*
  - *can you unlearn it?*



# Consequences of Maltreatment


- Increases in violent behavior
- Increases in neuropsychiatric disorders
- Increased risk of substance abuse
- Increased risk for teenage pregnancy
- Increased risk for anti-social/criminal actions
- Increased risk of becoming perpetrators of abuse
- Increased risk of becoming victims of other abuse



# A Public Health Crisis

- *If anxiety, impulsivity, aggression, sleep problems, depression, vulnerability to substance abuse, antisocial and criminal behavior, retardation, school failure, respiratory and heart problems in 8 million people every year were caused by a virus, we would consider it a national public health crisis.*
- *Yet over 8 million maltreated children each year are vulnerable to these problems. Our society has yet to recognize this epidemic, let alone develop an 'immunization' strategy.*

**B.D. Perry**

- 
- “If you can't feed a hundred people, then feed just one.”  
- Mother Teresa



# Abnormal Brain Development due to Child abuse and Neglect

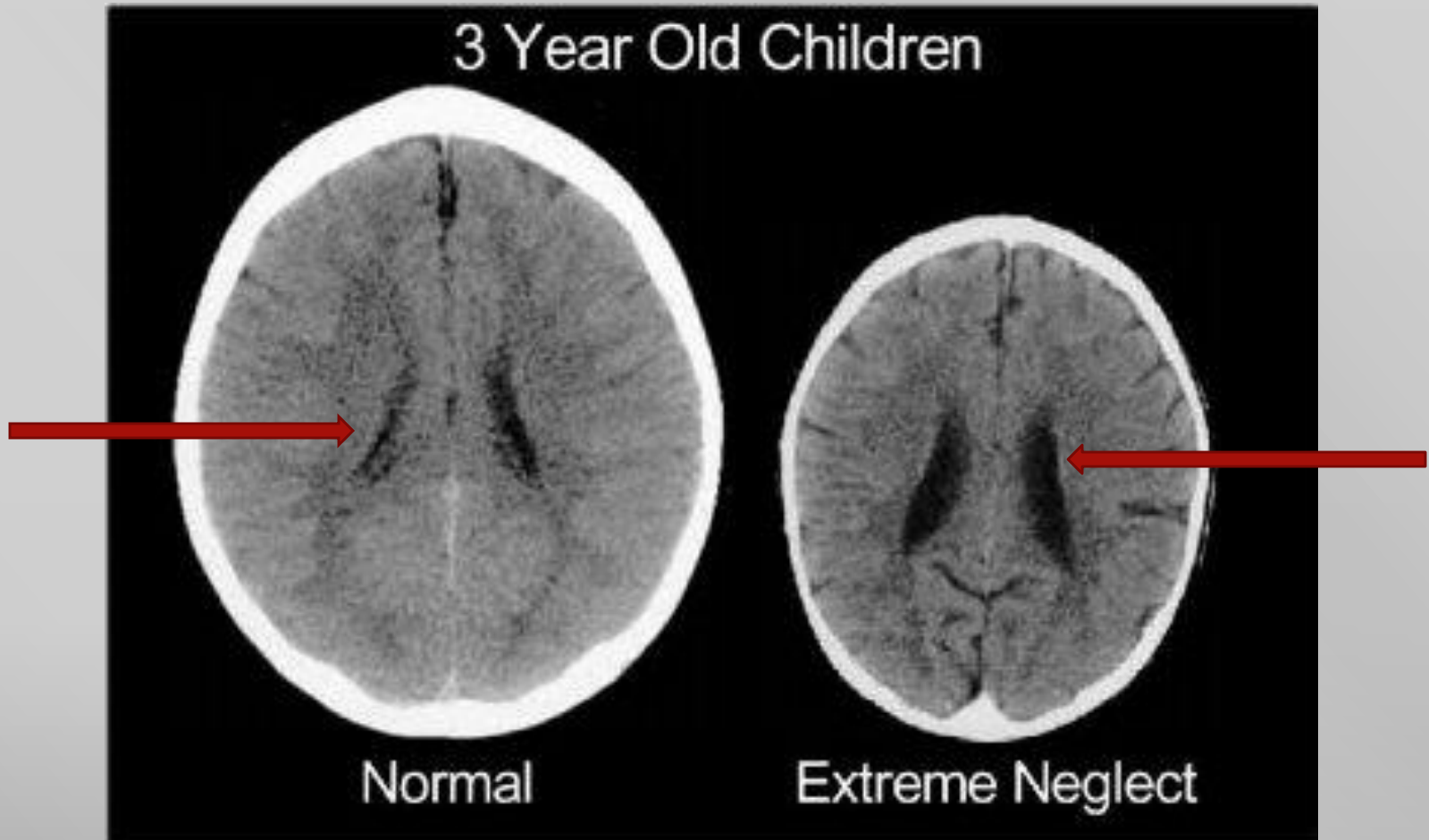
- Abnormal Cortical Development
- Diminished Corpus callosum size
- Diminished left-hemisphere development
- Diminished left hippocampal volume and development
- Decrease right-left cortical integration
- Increase EEG abnormalities



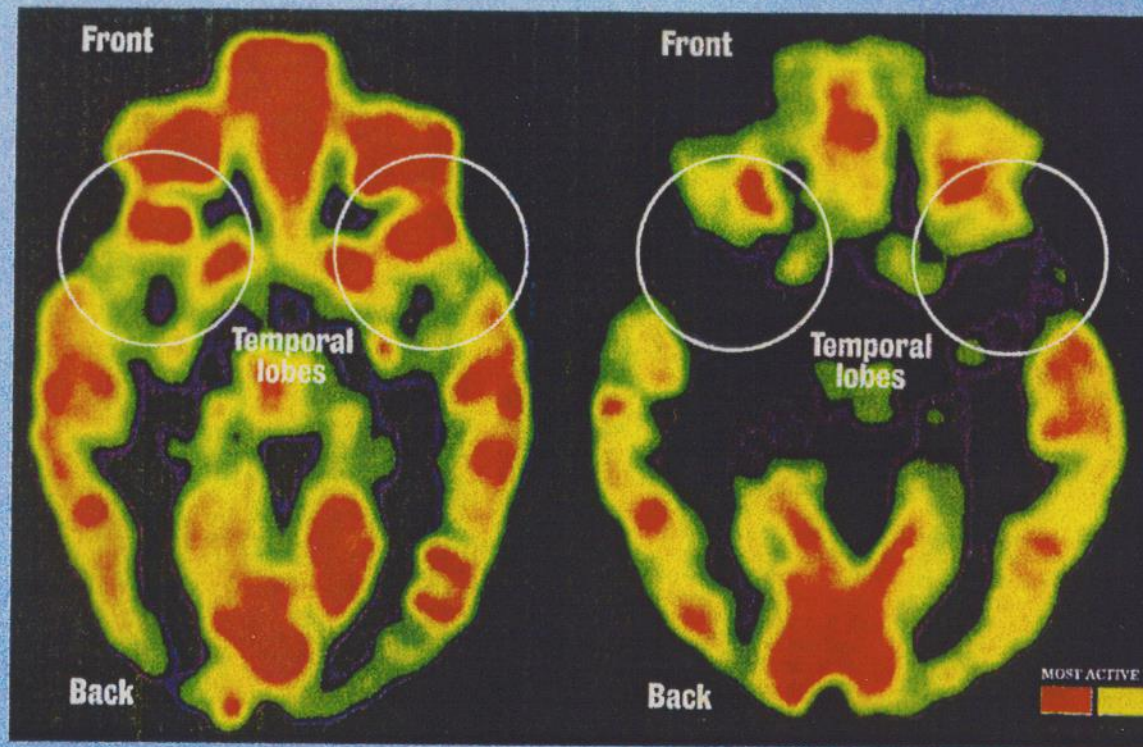
# Neuro-imaging evidence

- “These images illustrate the negative impact on the developing brain.
- The CT scan on the left is from a healthy three year old with an average head size (50<sup>th</sup> percentile).
- The image on the right is from a three year old child following severe sensory deprivation neglect since birth.
- The brain is significantly smaller than average and has abnormal development of cortical, limbic, and midbrain structures.”

From studies by Bruce D. Perry , MD PhD at the  
ChildTrauma Academy



# Effect of extreme deprivation



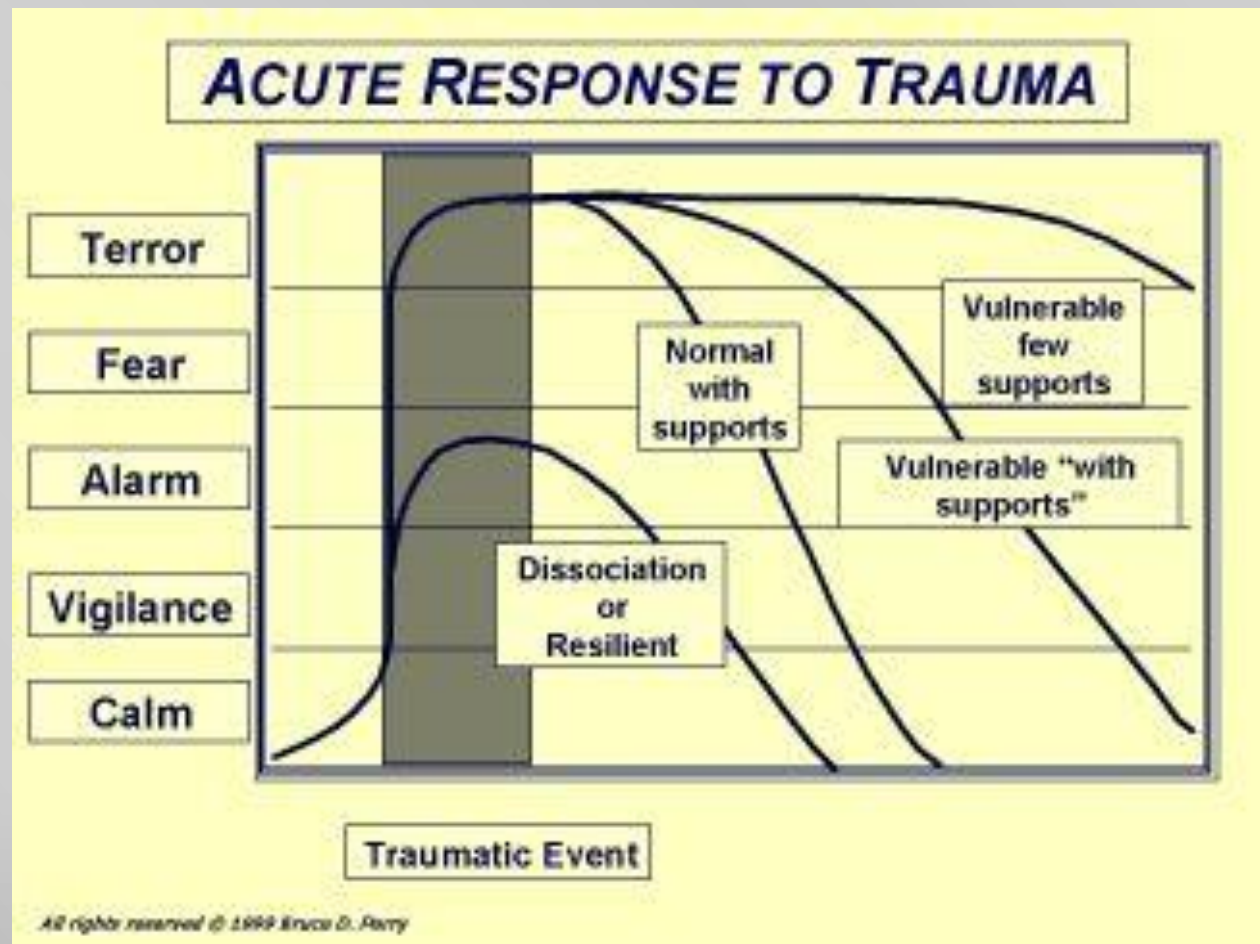
Healthy Brain

Abused Brain

# Arousal continuum, Bruce Perry, MD PhD, 2006

<b>Sense of Time</b>	<b>Extended Future</b>	<b>Days Hours</b>	<b>Hours Minutes</b>	<b>Minutes Seconds</b>	<b>Loss of Sense of Time</b>
Hperarousal Continuum	Rest Male child	Vigilance	Resistance Crying	Defiance Tantrums	Aggression
Dissociative Continuum	Rest Female child	Avoidance	Compliance Robotic	Dissociation Fetal rocking	Fainting
Primary Secondary Brain Areas	Neocortex Subcortex	Subcortex Limbic	Limbic Midbrain	Midbrain Brainstem	Brainstem Autonomic
Cognition	Abstract	Concrete	Emotional	Reactive	Reflexive
<b>Mental Status</b>	<b>Calm</b>	<b>Arousal</b>	<b>Alarm</b>	<b>Fear</b>	<b>Terror</b>

# The Alarm Phase



# Bonding and the Brain

- Critical periods occur during the first year when bonding experiences must be present for the brain systems responsible for attachment to develop normally.
- If missed → impaired bonding
- Severe emotional neglect during early childhood can be devastating causing children to lose the capacity to form any meaningful relationships for the rest of their lives.
- Aka: neurons that fire together wire together.



# Attachment

"lasting psychological connectedness between human beings" (Bowlby, 1969, p. 194)

"The propensity to make strong emotional bonds to particular individuals is a basic component of human nature" (Bowlby, 1988, 3)

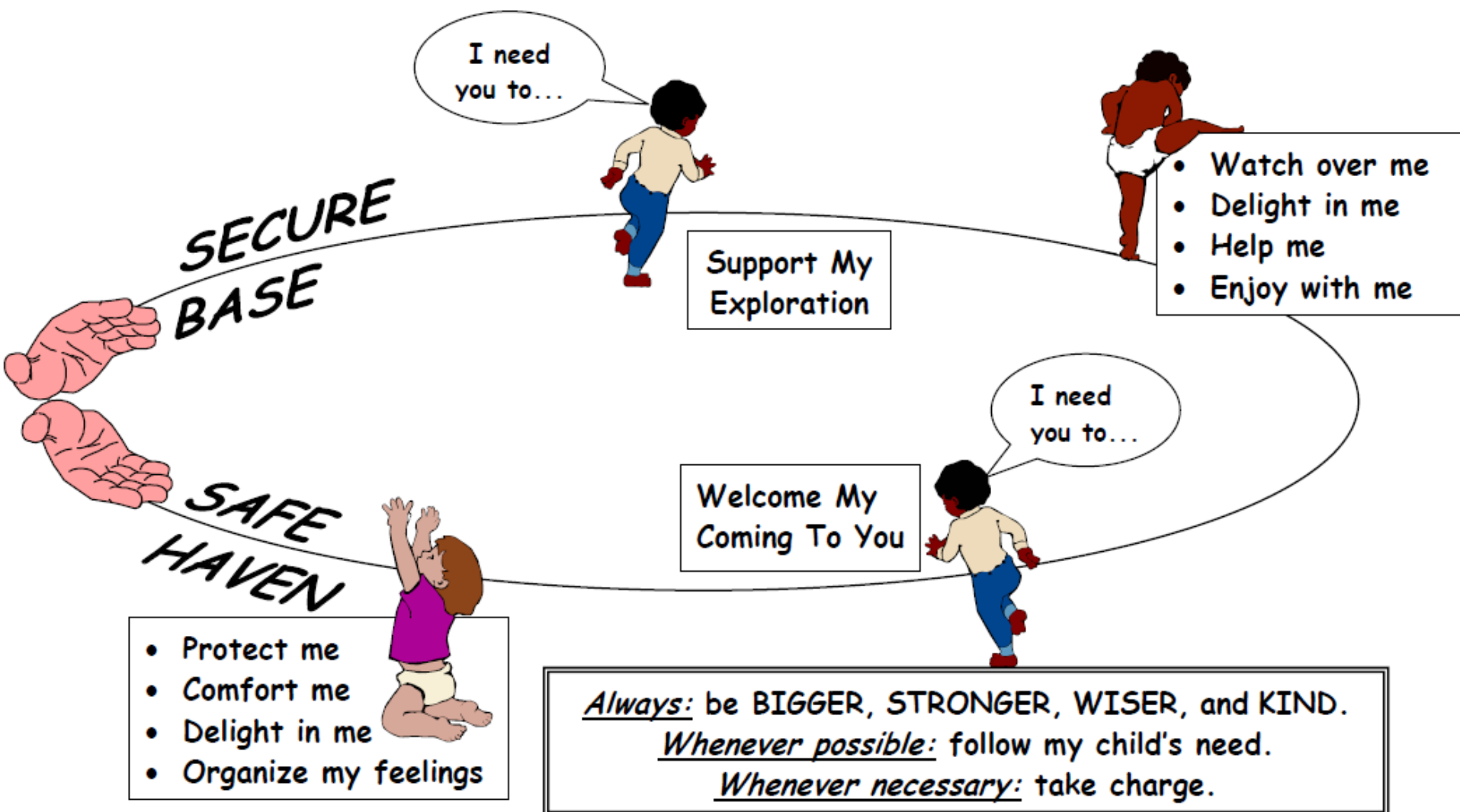


# Characteristics of Attachment

- **Proximity Maintenance** - The desire to be near the people we are attached to.
- **Secure Base** - The attachment figure acts as a base of security from which the child can explore the surrounding environment.
- **Safe Haven** - Returning to the attachment figure for comfort and safety in the face of a fear or threat.
- **Separation Distress** - Anxiety that occurs in the absence of the attachment figure.
- [separation anxiety.wmv](#)

# CIRCLE OF SECURITY


PARENT ATTENDING TO THE CHILD'S NEEDS

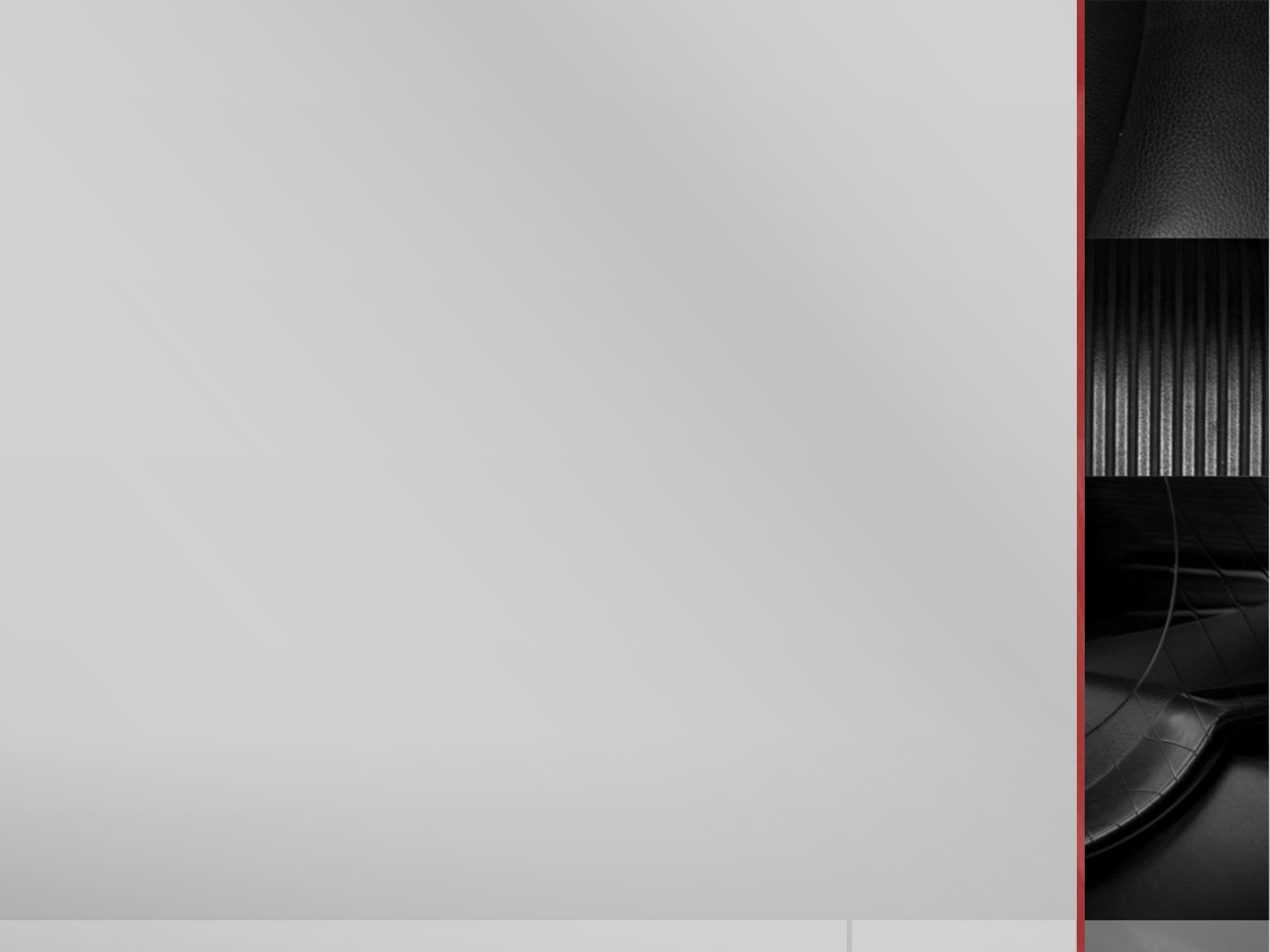




# Power of a secure base/safe haven.

- [Visual Cliff Experiment.flv.wmv](#)
- [Circle of Security Trailer 1.14.10.wmv](#)

- 
- “If you think you are too small to be effective, you have never been in bed with a mosquito.”  
- Betty Reese





# What is Infant Toddler Mental Health?

- Infant and toddler mental health can be defined as the social and emotional well-being that results when infants and toddlers are supported by nurturing relationships.
- Infant mental health is the developing capacity of the child from birth to age 3 to:
  - experience, regulate, and express emotions;
  - form close and secure interpersonal relationships; and
  - explore the environment and learn –



## What is? ...

- all in the context of family, community, and cultural expectations for young children.
- Infant mental health is synonymous with healthy social and emotional development.




## “the relationship”

- Infants and toddlers **come to experience the full range of human emotions.**
- Initially, they depend heavily on adults to help them **regulate their interaction, attention, and behavior** as they experience emotion.
- Increasing self-monitoring by the young child contributes to the emotional regulation that is a sign of mental health.



## “the relationship”

- Through **relationships with parents and other caregivers**, infants and toddlers learn what people expect of them and what they can expect of other people.
- **Nurturing, protective, stable, and consistent relationships are essential to young children’s mental health.**
- Thus, the state of adults’ emotional well-being and life circumstances profoundly affects the quality of infant/caregiver relationships.



## ***What signs indicate that a significant social-emotional delay may exist?***

**Family risk factors include:**

- Maternal depression;
- Caregivers with substance abuse and or mental illness;
- Domestic Violence;
- Foster care;
- Poverty;
- Adoption; and
- Exposure to maltreatment.



## CAPTA

- *The Child Abuse Prevention and Treatment Act requires a referral of a child under the age of 3 who is involved in a substantiated case of abuse or neglect to Early Intervention Services.*



## Indicators that a significant social-emotional delay may exist?

- Specific Infant and Toddler Behaviors
- Lacking emotional display, such as cooing, babbling, or whimpering;
- Having a sad affect;
- Resisting being held or touched;
- Being difficult to sooth or console;
- Appearing fearful;
- Rarely making eye contact;
- Clinging to caregiver.



# Warning Signs of **Mental Health** Issues

- The following behaviors may be indicative of **mental health** concerns:
  - frequent crying or excessive irritability
  - frequent requests or hints for help
  - constant anxiety, worry, or preoccupation
  - fears or phobias that are unreasonable or interfere with normal activities
  - inability to concentrate on age-appropriate activities



## Warning signs continued

- loss of interest in playing
- isolation from other children
- low self-esteem and/or lack of self-confidence
- hurting younger children or animals
- setting fires
- sexual acting-out that is not age appropriate
- decline in school performance that does not improve
  - (American Psychiatric Association, 2002)



# Social – Emotional Assessment

- The use tools that have been demonstrated to be valid and reliable is key.
- The input of parents, teachers and others who know the child is invaluable.
- Observations of the child add great detail to the assessment information.
- An evaluation team member with expertise in infant – toddler mental health is needed to help interpret and support the teams evaluation decision making, e.g.,
  - school psychologist,
  - licensed psychologist,
  - LMHP/LIMHP



# Social – Emotional Assessment Domains

- Child behavior development
- Child and family risk factors
- Temperament
- Self-regulation
- Attachment
- Relationships
- Coping skills
- Social/Emotional development
- History
  - Pre/postnatal, mothers health, environment,



# Assessment and Screening Instruments:

- Infant-Toddler Social and Emotional Assessment – (ITSEA) (Carter, 1998).
- Tabs Assessment Tool: Temperament and Atypical Behavior Scale (Neisworth & Bagnato, 1999).
- The Ages and Stages Questionnaire: Social Emotional (2002)
- Behavioral Assessments of Baby's Emotional and Social Style (BABES) (1994).
- Devereux Early Childhood Assessment Program (DECA) (LeBuffe & Naglieri, 1998).
- Bayley III Behavior Rating Scale (Bayley).
- Early Coping Inventory (Zeitlin & Williamson, 1988).
- Child Behavior Checklist, Ages 2-3 (1986).
- AIMS: Developmental Indicators of Emotional Health (1990).
- Parental Developmental Questionnaire (Messina & Messina, 1999).
- Vineland Social Emotional Early Childhood Scales (Sparrow, Balla, & Cicchetti, 1998).
- Behavioral Assessment System for Children (2 ½-5)



# Clinical Evaluations

- Many sources of information.
- Clinical information from psychologist, LMHP, or psychiatrist
- Understanding conceptualization of data using the DC: 0-3R will be very helpful.
- DC: 0-3 R would be a helpful resource for school psychologists as well as other mental health professionals.

REVISED

# DC:0-3R

Diagnostic Classification  
of Mental Health and  
Developmental Disorders  
of Infancy and Early  
Childhood:  
REVISED EDITION



ZERO TO THREE



# Diagnosis... DC: 0-3R

- **Diagnostic Classification  
of Mental Health and Developmental Disorders of  
Infancy and Early Childhood™**
- **Revised Edition 2005**
- **Published by Zero to Three**



## Diagnosis... DC: 0-3R Axis I

- **Primary Diagnoses:**
- 100 Traumatic Stress Disorder
- 200 Disorders of Affect
- 300 Adjustment Disorder
- 400 Regulatory Disorders of Sensory Processing
- 500 Sleep Behavior Disorder
- 600 Feeding Behavior Disorder
- 700 Disorders of Relating and Communicating



# Diagnosis... DC: 0-3R

## Axis II: Relationship Classification

- Relationship disorders include several patterns. Each highlights a relational pattern that includes descriptors of behavior, affect, and psychological involvement for the caregiver and the child.
- Two tools for evaluating
- 1. Relationship Problems Checklist (RPCL)
  - 901 Overinvolved
  - 902 Underinvolved
  - 903 Anxious/Tense
  - 904 Angry/Hostile
  - 905 Mixed Relationship Disorder
  - 906 Abusive (verbal, physical, sexual)



## Diagnosis... DC: 0-3R

### Axis II: Relationship Classification

- 2. The Parent-Infant Relationship Global Assessment Scale (PIR-GAS)
  - 91-100 Well Adapted
  - 91-90 Adapted
  - 71-80 Perturbed
  - 61-70 Significantly Perturbed
  - 51-60 Distressed
  - 41-50 Disturbed
  - 31-40 Disordered
  - 21-30 Severely Disordered
  - 11-20 Grossly Impaired
  - 1 to 10 Documented Maltreatment



# Diagnosis... DC: 0-3R

**Axis III: Medical and Developmental Disorders and Conditions**


**Axis IV: Psychosocial Stressors**

- Child's primary support group
- Social environment
- Educational/child care challenges
- Housing Challenges
- Economic Challenges
- Occupational Challenges
- Health Care Access
- Health of the child
- Legal/criminal justice challenges



# Diagnosis... DC: 0-3R

- **Axis V: Emotional and Social Functioning**
  - Attention and regulation
  - Forming relationships/mutual engagement
  - Intentional two-way communication
  - Complex gestures and problems solving
  - Use of symbols to express thoughts/feelings
  - Connecting Symbols logically / abstract thinking



# Clinical Interaction Checklist: / Free Play

## Relationship: Positive Sharing in Play

### ■ Child

- +Looks to caregiver for approval.
- +Seeks physical closeness to caregiver

### ■ Caregiver

- +Uses friendly tone of voice
- +Demonstrates affections

### Together

- +Mutual Positive Affect
- +Play *with* each other



# Clinical Interaction Checklist: / Free Play

## Caregivers Awareness of Child's developmental Needs

- Caregiver:
  - +Lets child choose toys
  - +Lets child choose ways to play
- Caregiver:
  - -Physical or verbal intrusiveness
  - -Ignores child's preferences
  - -Overly directive in play



# Clinical Interaction Checklist: / Free Play Caregiver Rejection

- Caregiver:
- -Ignores child
- -Speaks to child in harsh tone
- -teases child
- -handles child harshly



## Clinical Interaction Checklist: / Free Play Child Negativity toward Caregiver

- Child
- -Maintains physical distance from caregiver
- -rejects caregiver's attempts to engage child
- -Overly compliant (doesn't show typical, age-appropriate assertiveness)
- -Non-compliant
- -Aggressive



# Clinical Interaction Checklist / Free Play

## Mutual Positive Affect

- Is there any mutual positive affect present.
  - Yes or NO
  
- Osofsky, JD, Kronenburg, ME, & Hogan, AE (2004). Clinical interaction rating scales & checklist. LSUHSC, New Orleans. Copyright material; Do not copy without permission of authors.




# Clinical Interaction Checklist / Clean up Caregivers Limit Setting

- Caregiver:

- +Explains reason for cleanup
- +makes sure clean up is completed
- +makes clean up fun
- +uses praise
- +gives clear directives

- Caregiver:

- -speaks harshly to child
- -Physically harsh to child



# Clinical Interaction Checklist / clean up

## Child's response to clean up

- |  |                     |
|--|---------------------|
| ■ <u>Child:</u>                          | ■ <u>Child:</u>     |
| ■ +completes task with little difficulty | ■ -Overly compliant |
|  | ■ -non-compliant    |

### Rating:

- Area of Strength
- No/little Concern
- Mild Concern
- Serious Concern



# Rambling thought

- Ambiguity.
- Social emotional assessment is not a clean simple process.
- Trust among team members.
- Trust for community resources: get to know them.
- Be proactive.
- Be an advocate for children and families.



## ***How do I talk with parents about social and emotional delays?***

- Early intervention supports and services are strengths based, and practitioners already have at hand the best way to approach concerns about social and emotional development.
- Clearly understanding and using the strengths of the family and the child is the best foundation for talking with parents about problems.



## ***How do I talk with parents about social and emotional delays?***

- Remember that motivation can be a strength.
  - a. Understand that a child's difficult behavior as being motivated by wanting to communicate, connect and learn or to cope with his or her own difficult experience of the world because of sensory or other problems.
  - b. Understand that a parent's frustration and anger may come out of motivation of wanting their child to succeed, to be happy and capable, to learn the rules of social interaction and be respectful of others helps when confronting difficult relationships.
  - c. Understand that parents have been practicing ways of relating to their child that don't work for a long time and it will take time to learn different ways of relating that might be more effective with this particular child, just like you might have to find new ways of feeding a child with oral issues or adapting the environment in other ways for a child with special needs.



## *How do I talk with parents about social and emotional delays?*

- Remember that the tension and negativity that you may see in a parent-child relationship may be the result of social and emotional delays rather than the cause, and that parents want a way to improve these difficult interactions.



## *How do I talk with parents about social and emotional delays?*

- Help parents understand that their reactions are shared by other parents.
- Parents may tend to feel blame and guilty when any social and emotional problem is addressed, even more than when there is a physical problem.



## *How do I talk with parents about social and emotional delays?*

- Offer hope that things can be better and that identifying and talking about the problems is the first step towards improving things for the child and the family.
- Stay focused on the family's wishes for their child and help them see a path to move towards those ultimate goals.



## ***How do I talk with parents about social and emotional delays?***

- Be especially careful not to use blaming or judgmental language, but rather describe the concerning behavior or lack of expected behavior.
- Be sensitive to the families grieving process at not having the child they expected.
- Be sensitive to the cultural explanations of developmental differences.
- Parents may need to hear information several times at varying levels of detail as they come to terms with their child's issues.

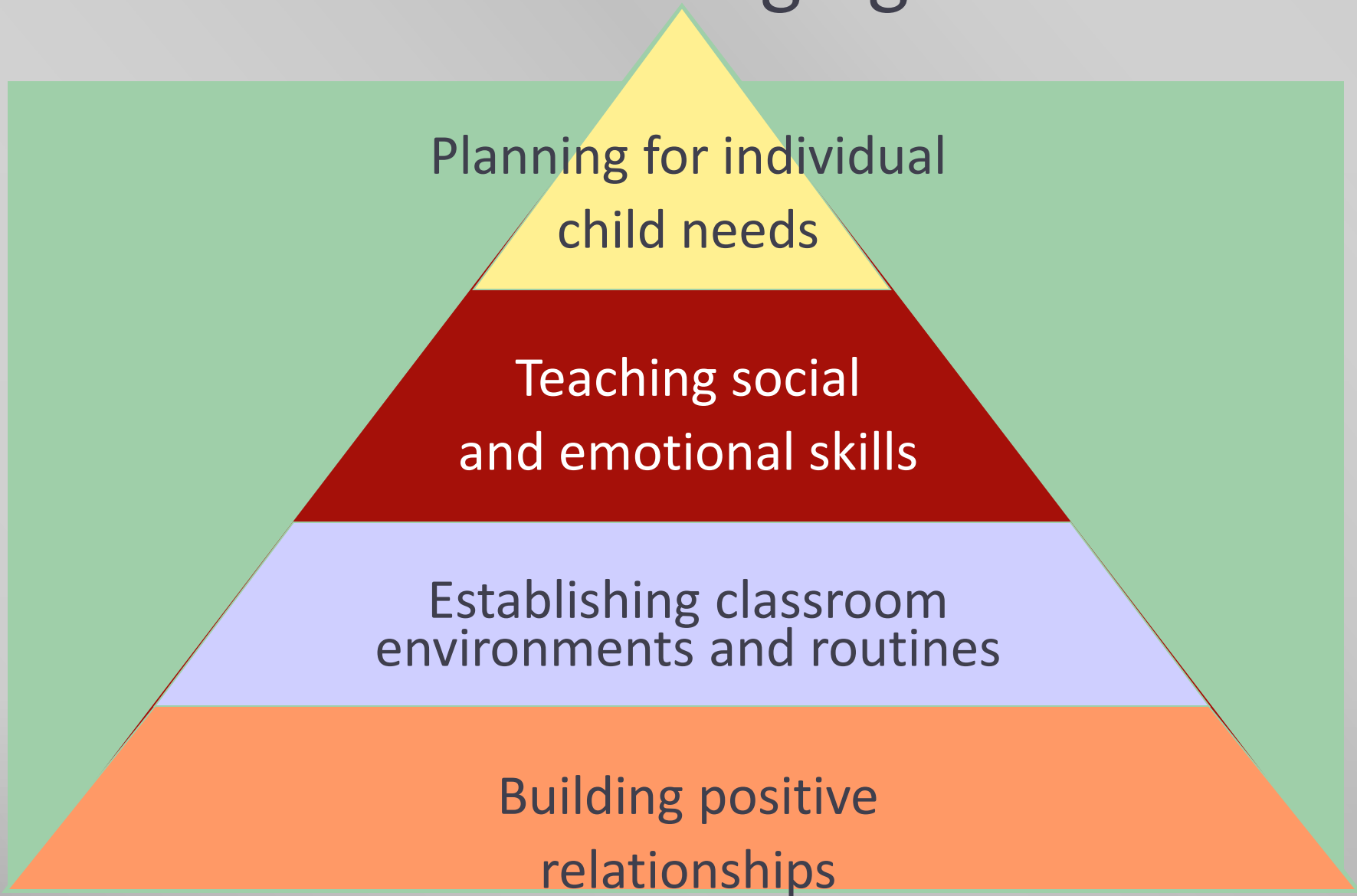


# “partnerships”

## who are your community resources?

- Parents and Parent Networks
- Community/Agency Caregivers (Head Start, Daycare Providers, Preschool Programs, etc)
- Early Childhood Specialists
- Speech/Language Pathologists
- School Psychologists / School Counselors / School Social Workers
- School Nurses / Home health / Visiting nurses
- Mentors
- Pediatricians, Family Practice Physicians
- Parents
- Mental Health Professionals (child psychiatrist, child psychologists, LMHP's)
- Services Coordinators—Early Development Networks
- Professional Partners Program
- Child Welfare Agencies/ CPS/NDHHS
- 1184 Teams...
- Business Community

# Framework for managing behavior





# Shift in thinking

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## Traditional Approach

- Same response for all behavior problems
- Act after problem occurs
- Focus on stopping the behavior
- A quick fix

## New Approach proactive

- Planned, individual response
- Act to prevent problem
- Focus on teaching new skills
- Maintained changes in behavior pattern

With the old approach . . .

you could say that  
you won the battle  
but lost the war.

But also damaged the relationship

