Impact of Abuse and Neglect on Development

Mellicent Blythe, LCSW
Laura Phipps, LCSW

NC Child Treatment Program
Center for Child and Family Health
mblythe@email.unc.edu
lgphipps@email.unc.edu

UNC
SCHOOL OF SOCIAL WORK

Agenda

- Trauma basics
- Effect of trauma on brain development
- Effect of trauma on attachment
- Psychological safety and resilience
- Trauma assessment and treatment
- Family visitation and services

Video

https://vimeo.com/73172036

Breakout #1

- What parts of this story would you typically have heard when this case was brought before you?
- What parts of the story would you not typically know?
- Does this additional information change how you would typically respond to a request for the siblings to be placed together?
- What would you need to ask and who would you ask to find out those typically hidden parts?

Trauma Basics

Trauma

What is Trauma?

Events that threaten the life or physical integrity of the child or of someone critically important to the child, such as a parent or sibling.

Trauma is an event that overwhelms a person's ability to cope.

What is Child Traumatic Stress?

*The **physical** and **emotional** responses of a child to traumatic events.*

NCTSN, 2008

Types of Trauma

Acute Trauma:

- Single event
- Natural disaster
- Serious accident
- Sudden or violent loss of loved one
- Physical or sexual assault
- Community violence

Chronic Trauma:

- Same trauma repeated or
- multiple different trauma

Complex Trauma:

- Repeated traumatic events, often caused by the child's caregiver

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Race and Trauma

Disproportionate rates of…

- Trauma, abuse, violence, & ACEs
- Police brutality (e.g., unarmed shootings)
- Involvement in child welfare & juvenile justice

Race and Trauma: Child Welfare

- Black and Brown children compared to White
  counterparts have higher rates of:
  - Substantiation
  - Removal
  - Foster care/out of home placements
- Black and Brown children compared to White counterparts are:
  - Less likely to be reunited
  - More likely to spend a longer duration in care
  - More likely to have caregivers with limited access to economic and service resources

(Lee et al., 2015; Hill, 2004; CW Information Gateway, 2016; Church, Gross, & Baldwin, 2005)

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Race and Trauma: JJ

- Black and Brown children compared to White counterparts have higher rates of:
  - Arrests
  - Incarceration

- Black and Brown children compared to White counterparts are:
  - 5X more likely to be committed
  - 4X more likely to be certified for adult courts
  - More likely to have longer sentences
  - More likely to be presumed guilty and dangerous
  - Less likely to be diverted to a rehabilitation program
  - Less likely to receive mental health services

- Black Children Five Times More Likely Than White Youth to Be Incarcerated (eji.org)

Race and Trauma: Schools

- Systematic barriers to equal opportunity
- Racial disparities in educational attainment, placement, discipline
- The effects of race-related trauma on student learning, adjustment, adaptation, and overall well-being
- Systemic Policies: Gun Free Zones/Zero Tolerance Policies
  - Increase use of school resources officers (SROs)
  - Increased rates of suspension and expulsions for AA and Latinx youth

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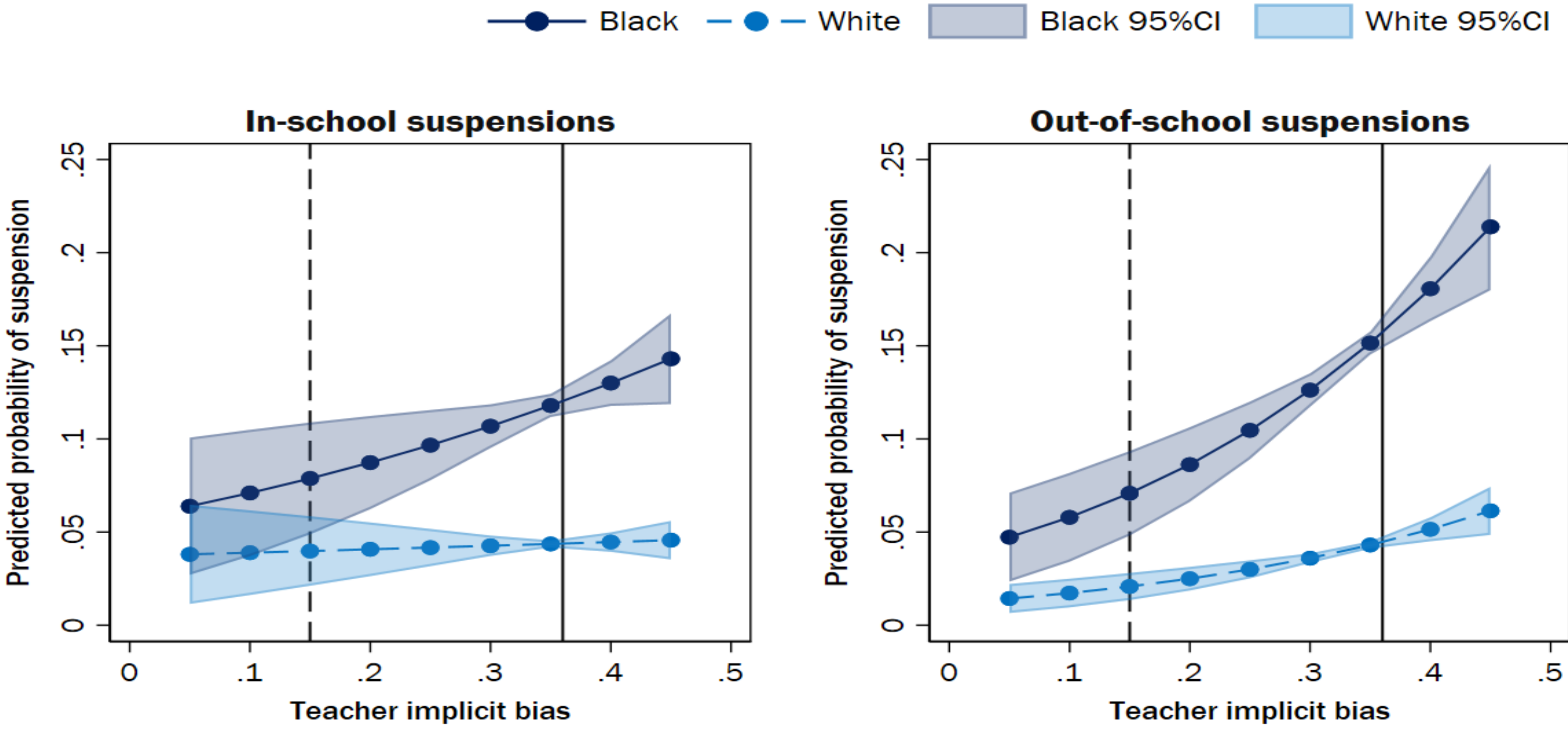
Figure 2: County-level white-Black disciplinary differences by bias



Source: Chin, M. J., Quinn, D., Dhaliwal, T. K., & Lovison, V. (forthcoming). Bias in the air: A nationwide exploration of teachers' implicit racial attitudes, aggregate bias, and student outcomes. Educational Researcher.

BROWN CENTER on Education Policy at BROOKINGS

Race-Based Trauma or Racial Trauma

- Ongoing individual and collective injuries due to exposure and re-exposure to race-based stress
- The physical and psychological symptoms people of color often experience after being exposed—directly or indirectly—to stressful experiences resulting from racism

(Comas-Diaz, Hall, & Neville, 2019)

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COVID-19: Disparities

People of color were more likely to…

- Be exposed/get sick
- Have a severe course
- Die from COVID-19
- Suffer secondary adversities (economic, social, & health consequences)

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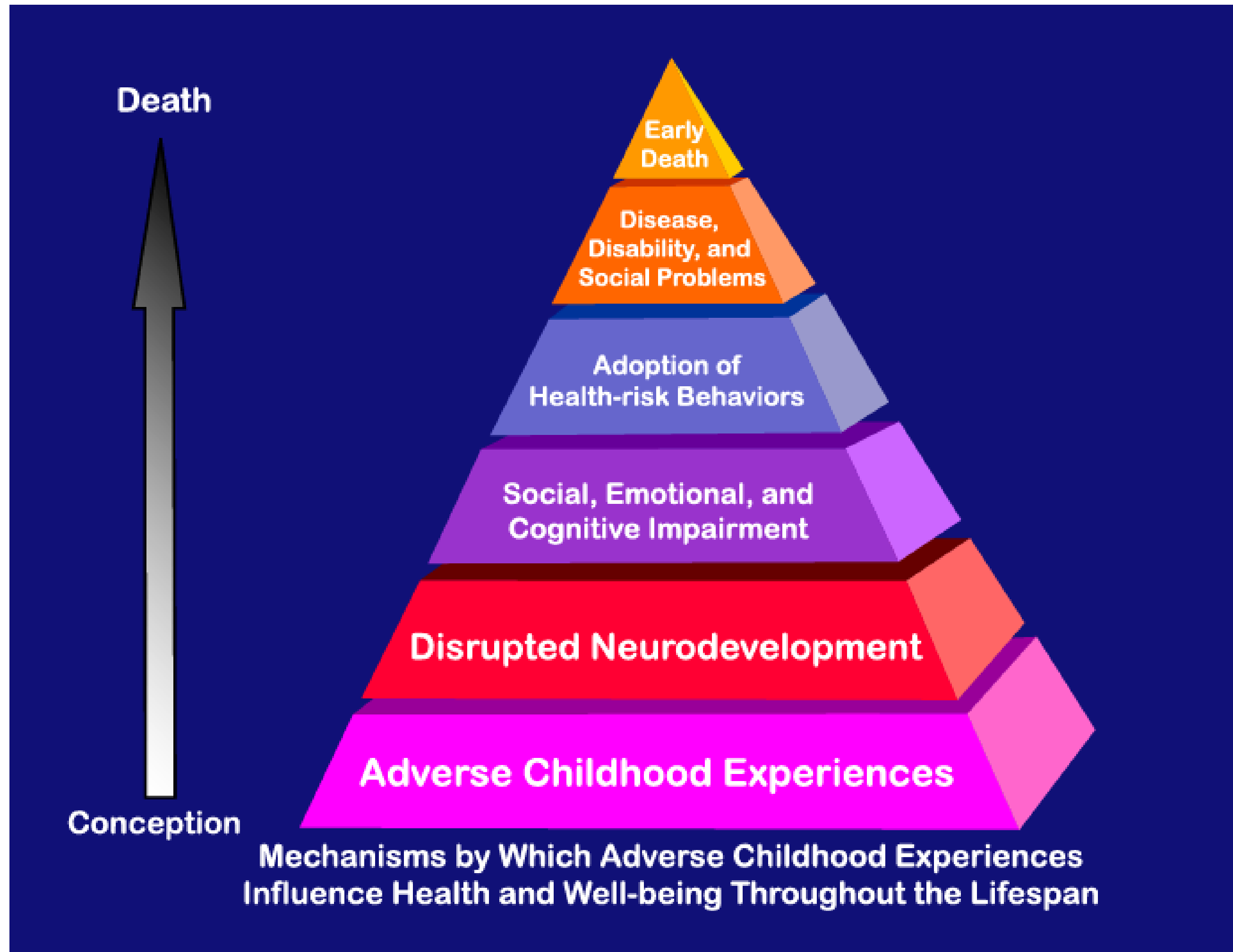
Degree of Trauma

- Age/developmental level
- Temperament
- Understanding of danger
- Previous traumas
- One time or chronic
- Adversities faced following the trauma
- Availability of adults who can help, reassure, protect

Brown, 1999; Widom, 2000

Collective Impact of Trauma



http://www.canarratives.org/

Feletti, 2012

Being Cautious About ACE Scores

- In 2020, one of the ACES original study lead authors published this paper:
- “Inferences about an individual’s risk for health or social problems should not be made based upon an ACE score, and no arbitrary ACE score, or range of scores, should be designated as a cut point for decision making or used to infer knowledge about individual risk for health outcomes.”

ARTICLE IN PRESS

American Journal of
Preventive Medicine
CURRENT ISSUES

Inside the Adverse Childhood Experience Score: Strengths, Limitations, and Misapplications

Robert F. Anda, MD, MS,[1] Laura E. Porter, BA,[2] David W. Brown, DSc, MScPH, MSc[3]

INTRODUCTION

Despite its usefulness in research and surveillance studies, the Adverse Childhood Experience (ACE) score is a relatively crude measure of cumulative childhood stress exposure that can vary widely from person to person. Unlike recognized public health screening measures, such as blood pressure or lipid levels that use measurement reference standards and cut points or thresholds for clinical decision making, the ACE score is not a standardized measure of childhood exposure to the biology of stress. The authors are concerned that ACE scores are being misappropriated as a screening or diagnostic tool to infer individual client risk and misapplied in treatment algorithms that inappropriately assign population-based risk for health outcomes from epidemiologic studies to individuals. Such assumptions ignore the limitations of the ACE score. Programs that promote the use of ACE scores in screening and treating individuals should receive the same rigorous and systematic review of the evidence of their effectiveness according to the standards applied to other screening programs by the U.S. Preventive Services Task Force (USPSTF).

INSIDE THE ADVERSE CHILDHOOD EXPERIENCE SCORE

The ACE study, a collaborative effort between the U.S. Centers for Disease Control and Prevention and Kaiser Permanente to examine the relationships among 10 childhood stressors and a variety of health and social problems, has demonstrated how abuse, neglect, witnessing domestic violence, and childhood exposure to household dysfunctions are common and highly inter-related.[1] This interrelatedness led the investigators to develop the ACE score, an integer count of 10 adverse experiences during childhood (range, 0−10), which has repeatedly demonstrated a strong, graded, dose-response relationship to numerous health and social outcomes (e.g., mental illness, illicit drug use, suicide risk, and risk for chronic diseases).[1] As a result, the ACE study has attracted significant scientific and policy attention.[2–5] More recently, the ACE score has gained attention through lay press and websites,[6,7] and the ACE score is increasingly being used and promoted as a screening tool for use at the individual level.[8,9]

Because the ACE score has a powerful relationship to the risk of many public health problems, it is useful for research and public health surveillance. ACE score use has expanded to most states in the U.S. via the Centers for Disease Control and Prevention−supported Behavioral Risk Factor Surveillance System[10] and internationally through the efforts of WHO.[11] The findings from these applications are similar to those of the ACE study and have raised awareness of the childhood origins of public health problems for policymakers and legislators.

However, the questions from the ACE study cannot fully assess the frequency, intensity, or chronicity of exposure to an ACE or account for sex differences or differences in the timing of exposure. For example, 2 people, each having an ACE score of 4, may have different lifetime exposures, timing of exposures (during sensitive developmental periods), or positive experiences or protective factors that affect the biology of stress. A person with an ACE score of 1 may have experienced intense, chronic, and unrelenting exposure to a single type of abuse, whereas another person who has experienced low-level exposure (intensity, frequency, and chronicity) to multiple adversities will have a higher ACE score. As a result, projecting the risk of health or social outcomes based on any individual's ACE score by applying grouped (or average) risk observed in epidemiologic studies can lead to significant underestimation or overestimation of actual risk; thus, the ACE score is not suitable for screening individuals and assigning risk for use in decision making about need for services or treatment. Researchers are actively working to modify, improve, and expand the set

From the [1]ACE Interface LLC, Peachtree City, Georgia; [2]ACE Interface LLC, Shelton, Washington; and [3]BCGI LLC/pivot-23.5°, Cornelius, North Carolina

Address correspondence to: David W. Brown, DSc, MScPH, MSc, BCGI LLC/pivot-23.5°, 19701 Bethel Church Road, Suite 103−168, Cornelius, NC 28031. E-mail: david.brown@pivot235.org.

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Anda et al., 2020

New NCTSN Resource On ACES Screening

Beyond the ACE Score: Perspectives from the NCTSN on Child Trauma and Adversity Screening and Impact

Amaya-Jackson, L., Absher, L.E., Gerrity, E.T., Layne, C.M., & Halladay Goldman, J. (2021)

WHAT THE SCORE CAN AND CAN'T TELL YOU

What Counting ACEs Can Tell You	What Counting ACEs Can't Tell You
ACEs allows us to talk about prevalence, risk, and related outcomes of 10 common traumas, adversities, and household difficulties that occur within families.	Other traumas are not included as standard ACEs and are therefore unaccounted for. Many types of trauma not typically included in ACEs checklists have high prevalence rates and are strongly associated with negative outcomes.
The ACE Study demonstrated that adverse childhood experiences (focused on those that occur in one's household) carry significant risks for a broad range of major long-term physical and mental health consequences.	Counting ACEs using ACE score checklists do not allow consideration of frequency, duration, severity, age of onset, synergy between ACEs, current distress and functioning, or interrupted developmental tasks, that are often critical mediators of short and long-term consequences.
The ACE Study showed that ACEs have a cumulative impact with a stepped increase with each additional ACE, such that the higher the ACE score, the higher the risk with a broad range of negative physical and mental health outcomes. Thus, an ACE score (total number of ACEs types) provides useful information in surveys about general risk in a large community, state, or national population.	Simple screens generating ACE scores are not clinically useful, as they are incomplete trauma profiles and leave out information regarding distress (e.g., posttraumatic stress reactions), risky behavior, and functioning. This information is needed to determine next steps, including assessment, treatment, referral, or legally mandated child abuse reporting.
In provider-client discussions about ACEs, obtaining ACE histories can "open the door" to helping parents and child clients understand that adverse household (intrafamilial) experiences carry some risk of negative physical and mental health outcomes.	Risks identified in large-scale epidemiologic studies do not necessarily generalize to, or support the use of, individual ACE scores to gauge risks for specific individuals. Serious questions have been raised over the use of ACE scores for individual screening, assessment, or eligibility thresholds for services (e.g., scores of 4 or more ACEs qualify).[20,21,22]
Asking about ACEs can provide some clients with the language to articulate what they have experienced and why it is important. Labeling their experiences in this manner can be empowering. For some individuals, "ACEs" as a concept also carries less stigma than "trauma."	Some family, youth, and adults don't know what to do with the idea of an ACE score. Resistance to labeling, e.g., *"I am not a score,"* and feeling doomed are concerns clients express that require appropriate processing about what the score means or assisting them when action is warranted.

Amaya-Jackson et al, 2021

Is Neglect Trauma?

- Threats to psychological well-being lead to same responses in the brain as other forms of trauma
- Neglected children develop symptoms of PTSD at similar rates
- Neglect puts children at risk for other forms of trauma

NCTSN, 2008; DeBellis, 2005; Milot et al., 2010

Video

InBrief: The Science of Neglect

http://developingchild.harvard.edu/resources/multimedia/videos/inbrief_series/inbrief_neglect/

Trauma and Behavior

- Children who have experienced trauma often exhibit extremely challenging behaviors and reactions.
- Labeling behaviors as “good” or “bad” overlooks the fact that they developed to help the child survive in an unsafe and unpredictable world
- The same behaviors that allowed them to survive abusive or neglectful caregivers now work against them

(NCTSN, 2008)

Behaviors Associated with Overwhelming Emotions

- Aggression
- Oppositional defiant behavior
- Sexual acting out
- Self-harm/suicidality
- Anxiety
- Substance abuse

*"Even in a new 'safe' setting, traumatized children may exhibit behaviors that evoke in their new caregivers some of the same reactions they experienced with other adults (e.g., anger, threats, violence)…These **'reenactment behaviors'** can cause the new adults in their lives to feel negative and hopeless about the child."*

- NCTSN, 2008

Three Areas of Concern

1. Brain development

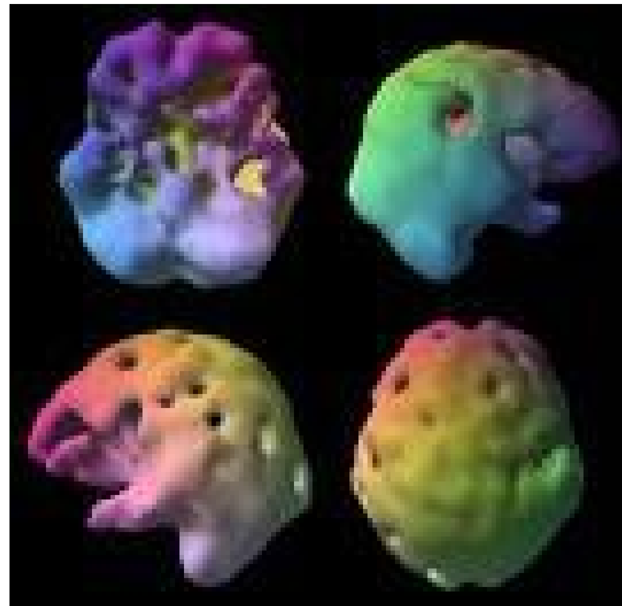
2. Attachment

3. Psychological safety and trauma triggers

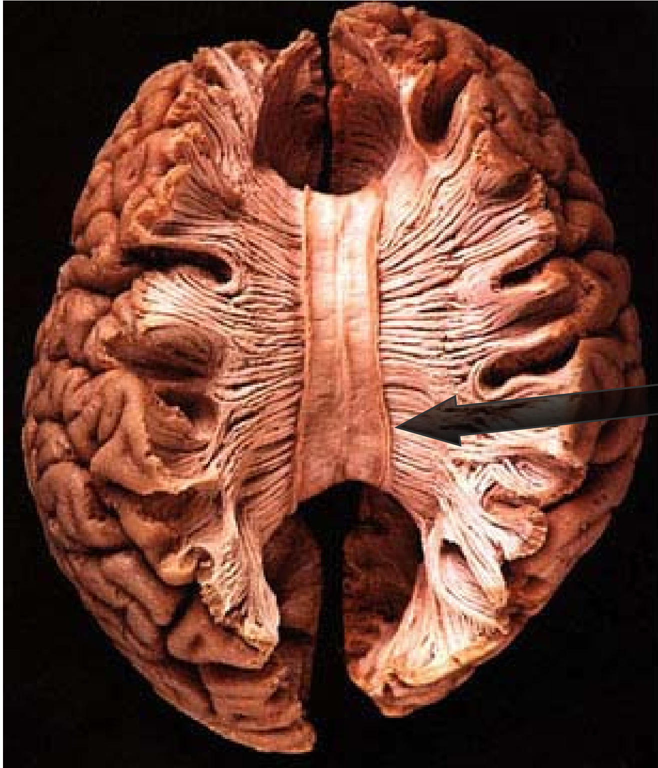
Effect of Trauma on Brain Development

Childhood trauma affects the brain in 3 ways

1. Causes structural changes
2. Changes stress response system
3. Creates deficits in normal learning



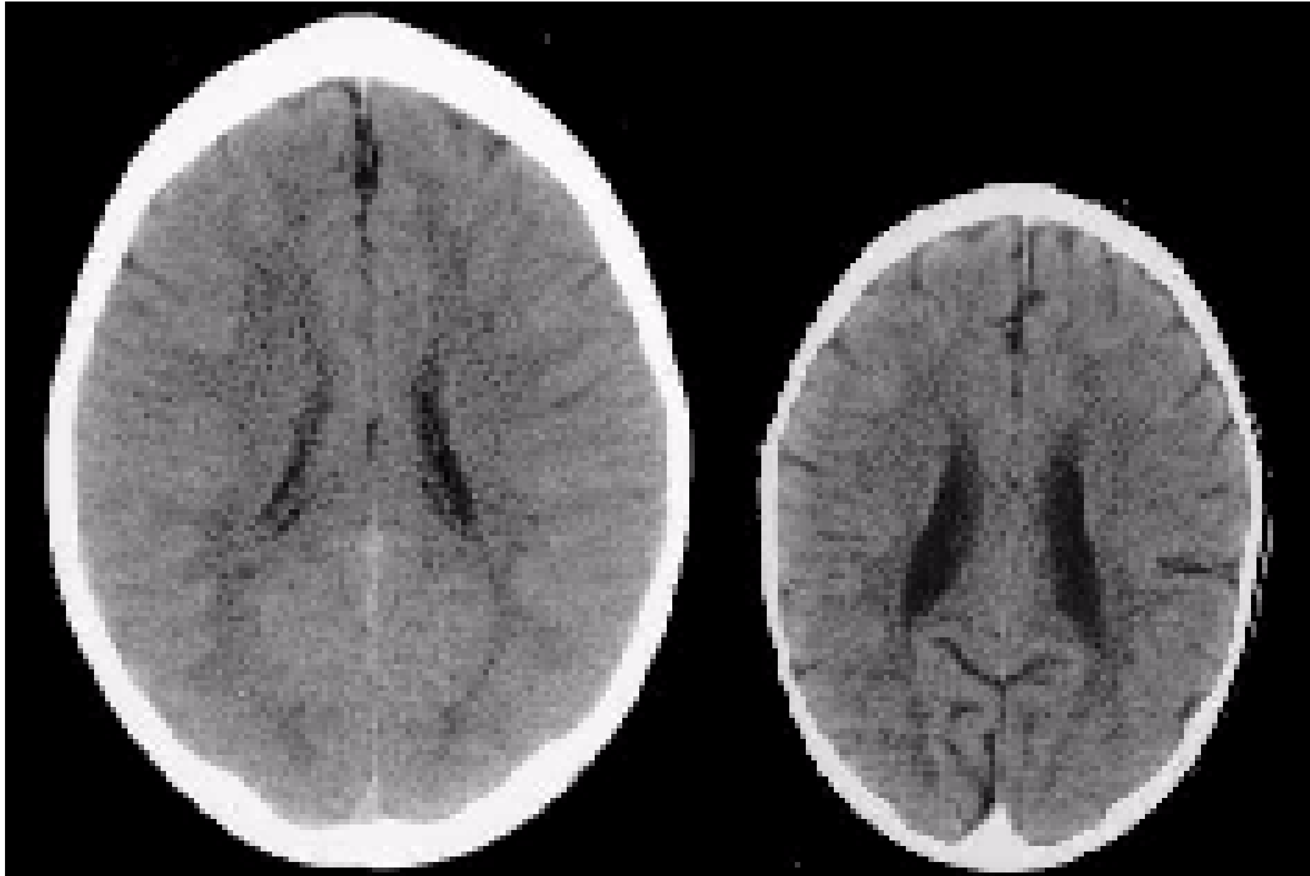
1. Structural Changes in the Brain



- Head injuries
- Corpus callosum
- Smaller brain volume (equals lower IQ)

Block, 2009; DeBellis, 2002; Teicher, 2000

Structural Changes in the Brain



Normal Development

Severe Neglect

Child kept in cage for three years

Perry& Pollard. 1997

2. Stress Response System

- Extreme fear = "fight, flight, or freeze"
  - cascade of stress hormones
  - temporary, emergency response
- When continuously exposed to situations - hormones stay "on" - result in damage to brain
- Brain "hardwired" for danger; body "on alert"
- Can permanently alter brain chemistry; resulting in anxiety, impulsivity, depression, aggression

DeBellis, 2002

3. Deficits in normal learning

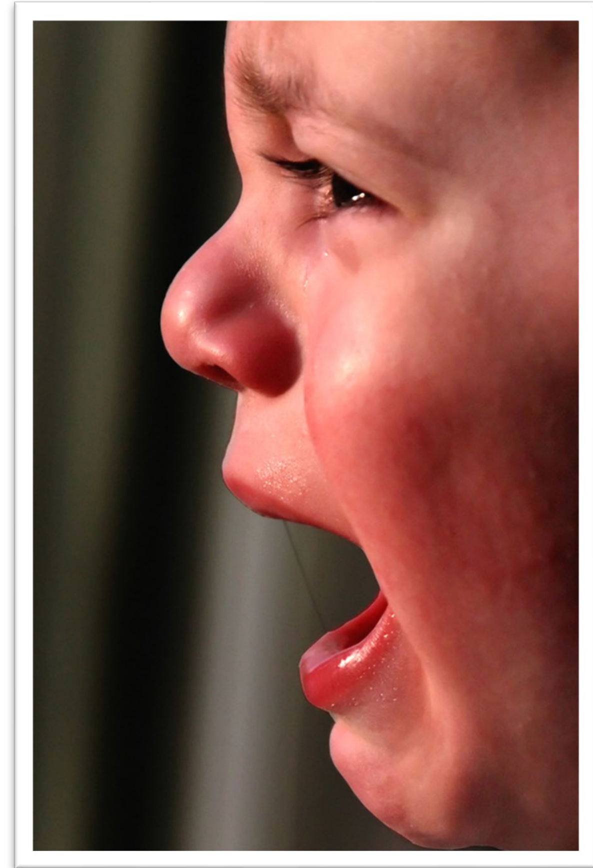
- Not just what happened to them, it's what didn't happen
- Repeated experiences of pain, anxiety, fear, neglect - taking place of normal play, exploration, socialization
- Development "holes" in language, social skills, and reasoning
- Stimulation years later cannot make up for this deprivation; some ability is lost
- Over-arousal of the body's stress system can block cognitive processing, even years later

Ziegler, 2002

Video

Rage of Innocents: Stress and Maltreatment

http://fod.infobase.com.libproxy.lib.unc.edu/p_ViewVideo.aspx?xtid=9184#



Effect of Trauma on Attachment

Secure Attachment

- Reciprocal relationship between child and caregiver
- Secure attachment develops based on consistently available, responsive, nurturing care giving
- Caregiver serves as "secure base“
- Groundwork for all future relationships

(Bowlby, 1988)

Outcomes of Secure Attachment: Childhood

- Learn reciprocity in relationships
- Learn to trust others
- Develop healthy identity and self-worth
- Strengthens development of:
  - ✓ Empathy
  - ✓ Language and cognitive skills
  - ✓ Emotional regulation
  - ✓ Positive world view

(Benoit, 2004)

Outcomes of Secure Attachment: Teens

- Less likely to:
  - ✓ drink alcohol
  - ✓ use drugs
  - ✓ engage in risky sexual behavior
- Fewer mental health problems
- More constructive coping skills
- Girls have fewer:
  - ✓ weight related concerns
  - ✓ teenage pregnancy

(Moretti & Peled, 2004)

Quality of Attachment

Secure ⟷ Insecure

Organized ⟷ Disorganized

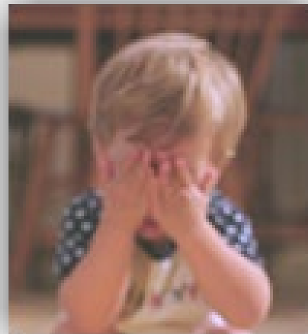
RAD:
Disorder of non-attachment
Extremely rare

"Attachment develops even in the face of maltreatment and severe punishment. It is the quality of the attachment relationship that is compromised in these circumstances, not the presence or strength of the attachment"

Carlson et al., 2003

Outcomes of Insecure Attachment: Childhood

- Lack of trust
- Developmental delays in language and social skills
- Inability to regulate and self-soothe
- More negative view of oneself and the world



(Moullin et al., 2014)

Outcomes of Insecure Attachment: School Age & Teens

Externalizing behaviors (aggression)

Internalizing behaviors (depression, anxiety

Associated with

- ✓School failure
- ✓Suicidality
- ✓Drug use
- ✓Delinquent behavior

(Moretti & Peled, 2004)

Promoting Secure Attachment

1. Responsive, consistent, nurturing primary caretaker
2. Support/treatment for caregiver to address their own trauma and attachment history
3. Opportunities to build or maintain positive connections outside the family

(Moretti & Peled, 2004; NCTSN, 2012)

Psychological Safety and Resilience

Psychological Safety

- Physical safety and psychological safety are different
- **Psychological safety:** the experience of feeling safe, secure, and protected from danger and harm
- Children and caregivers often have different perceptions of safety
- Components of psychological safety:
    1. Protection from harm
    2. Capable
    3. Lovable

SAFE

- Observe and eliminate trauma triggers
- Make a safety plan
- Have clear expectations and set limits
- Be flexible

CAPABLE

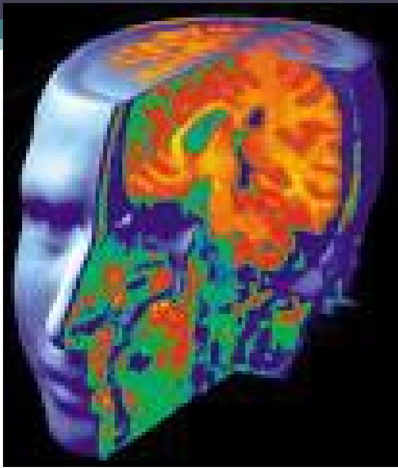
- Nurture strengths
- Give children choices and responsibilities
- Teach strategies for managing intense emotions
- Provide opportunities for kids to learn new skills

LOVABLE

- Provide affection
- Praise positive behaviors
- Accept and validate all emotions
- Maintain connections with important people in the child's life

Threats to Psychological Safety: Trauma Triggers

- Reminders of traumatic events: sights, smells, sounds, touches, people, places or things
- Child becomes overwhelmed by physical and emotional reactions
- Seems to come "out of the blue"
- Hyper vigilance, social isolation, refusal to comply with requests can all be attempts to avoid trauma trigger



Traumatic Memory Imprinting

Memory early in life stored in limbic system

- Good: helps survive trauma without reasoning
- Bad: Not stored in neocortex where reasoning can have impact - stored in limbic system. Means not available for cognitive processing; deeply embedded physiologically.

Younger the child is, more extensive the trauma, becomes "hard-wired"; less likely to change significantly without intervention

Benefits of Psychological Safety

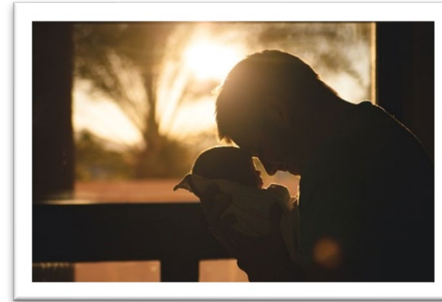
- Without psychological safety, stress responses continue to disrupt normal development
- With psychological safety:
  - Allows children to engage in activities that support healthy development
  - Supports relationships that can counter negative internal messages
  - Prevents re-traumatization

Factors that Enhance Resilience

Protective Factors

Individual characteristics:

- Cognitive ability
- Self-efficacy
- Internal locus of control Temperament
- Social skills



Family characteristics:

- Family cohesion
- Supportive parent-child interaction
- Social support (e.g., extended family support)

Protective factors

Cultural protective factors:

- Strong sense of cultural identity
- Spirituality
- Connection to cultural community
- Protective beliefs and values
- Cultural talents and skills

Community characteristics:

- Positive school experiences
- Community resources
- Supportive peers and/or mentors

Cornerstone of Psychological Safety and Resilience: Positive and Stable Relationships

- Separation from primary attachment figures has significant impact regardless of the quality of attachment
- Maintaining positive connections enhances psychological safety and resilience.
- Stability and permanency are critical for forming new positive attachments
- Child welfare workers can play a huge role in promoting positive relationships in children's lives and helping them maintain connections.

Breakout #2

- Using the NCTSN Bench Cards, what questions would you want to ask about the family in *Removed* before making any placement decisions?
- What would you want to put in place or ask about to support these children's psychological safety and resilience?

Trauma Assessment & Treatment

Enhance Child Well-Being and Resilience: Treatment and Services

- Enhance resilience by ensuring access to evidence-based, trauma-informed treatments.
- Treatment can help children manage overwhelming emotion related to trauma, cope with trauma triggers, and build resilience and protective factors.

What Does This Really Mean?

- *Trauma-informed:* Is the treatment specifically designed to address trauma history and symptoms in the child and the family?
- *Evidence-Based:* Is there evidence showing that this treatment is effective? Evidence-based treatment is integration of
  - *Clinical expertise*
  - *Best research evidence*
  - *Patient values and preferences*

Sackett, D. 1996

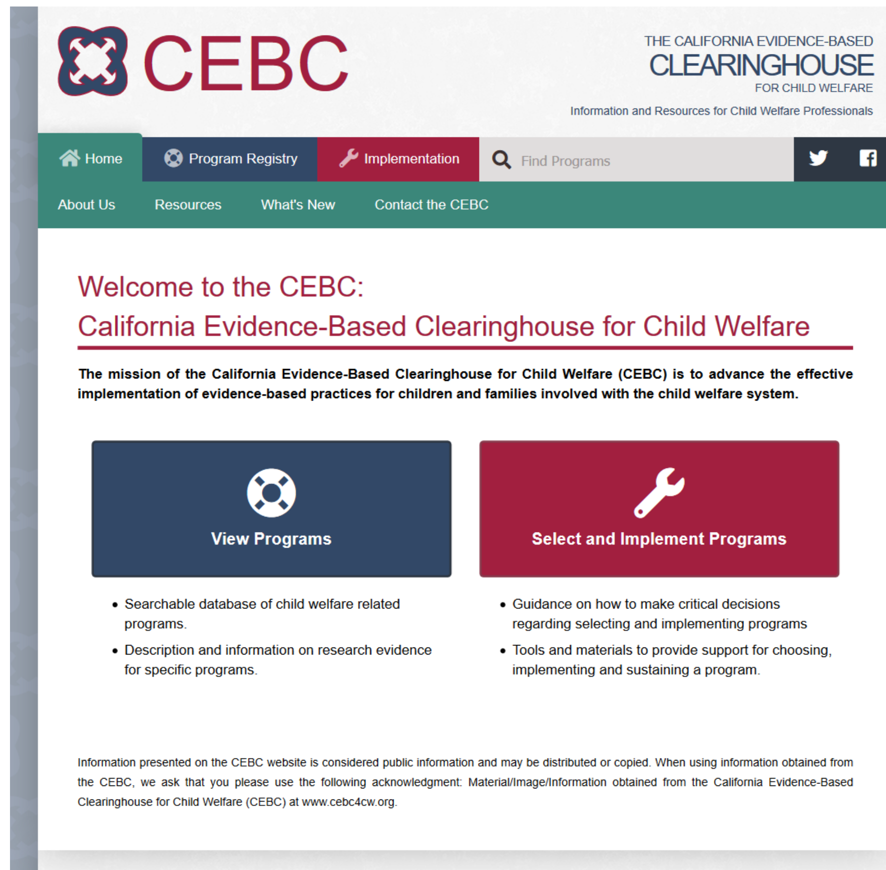
Core Components of Trauma-Focused, Evidence-Based Treatment

- Building a strong therapeutic relationship
- Psychoeducation about normal responses to trauma
- Parent support, conjoint therapy, or parent training
- Emotional expression and regulation skills
- Anxiety management and relaxation skills
- Trauma processing and integration
- Personal safety training and other important empowerment activities
- Resilience and closure

Key Questions for Judges to Ask

- Has this child been assessed for trauma exposure and trauma reactions?
- If we find that trauma is a factor, how is the current or proposed treatment addressing this? Why do we think this will be helpful?
- Has this child been assessed for pre-natal drug or alcohol exposure?
- If we find exposure is likely, have we done neuro-psychological testing and implemented any recommendations?

Finding Evidence-Based Treatments



http://www.cebc4cw.org/

Examples of Trauma-Informed, Evidence-Based Treatments in NC

- AF-CBT (ages 5-17)
  Alternatives for Families: A Cognitive-Behavioral Therapy
- CPT (ages 14+)
  Cognitive Processing Therapy
- CPP (ages 0-5)
  Child-Parent Psychotherapy
- MST (ages 12-17)
  Multi-Systemic Therapy
- PCIT (ages 2½-6½)
  Parent Child Interaction Therapy
- TF-CBT (ages 3–18)
  Trauma-Focused Cognitive Behavioral Therapy
- *New: PSB-CBT*
  Problematic Sexual Behavior-Cognitive Behavioral Therapy

Finding Child Trauma Clinicians in NC

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Treatment Models

- Any Model
- Attachment and Biobehavioral Catch-up (ABC) *
- Child-Parent Psychotherapy (CPP)
- Parent-Child Interaction Therapy (PCIT)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Resource Parent Curriculum (RPC)
- Problematic Sexual Behavior Cognitive Behavioral Therapy (PSB-CBT)

Additional Language Spoken

- Spanish
- Other

https://ncchildtreatmentprogram.org

Family Visitation and Services

Placement Considerations

- Maintaining child's existing attachments should be a critical consideration in initial placement and subsequent moves
- Ask that the quality of parent-child attachment be included in mental health assessments/evaluations to guide decision-making
- Maintain school, neighborhood, activities as much as possible when placed
- Provide as much time as possible for planning and transition from one placement to another

Visitation

- Maintaining child's attachments should also be critical consideration in determining visitation
- Younger children need shorter, more frequent visits
- Beware of reducing visits as a consequence of "bad" behavior; instead increase pre- and post-visit support
- Visits should be used as an opportunity for parents to practice and demonstrate new skills and knowledge
- Ensure safe, child-friendly, natural visitation sites
- Cast a wide net: explore visits with siblings, fictive and legal kin, previous foster parents, friends, etc.

Don’t Forget the Parents!

- Address parents’ trauma history
  - Remember: “What happened to you?” instead of “What’s wrong with you?”
- Ensure or advocate for trauma-informed and evidence-based treatment and parenting programs in your community
- Birth Parents with Trauma History: A Guide for Judges and Attorneys