TRAUMA-INFORMED COMMUNITY-BASED OCCUPATIONAL THERAPY: A PRACTICE MODEL USED WITH CHILDREN AND YOUTH RECEIVING OUT-PATIENT PSYCHOLOGICAL SERVICES

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1. Describe complex trauma and impacts on the child's developing neurobiology.
2. Integrate understanding of sensory and neurobiological models of arousal modulation and its application in psychological trauma recovery.
3. Reflect on and discuss multifaceted roles of occupational therapy in community-based pediatric complex trauma recovery and parallels to commonly used sensory and participation-based pediatric treatment approaches.

OBJECTIVES

WORKING WITH CHILDREN WITH DIFFICULT BEHAVIORS

CHILDREN WITH TRAUMA HISTORIES

My clinical work at the Village Counseling Center, Gainesville, FL

BEHAVIOR MANAGEMENT APPROACHES

Preventing challenging behavior

- Minimizing aversive events
- Sharing control
- **Providing an environment that promotes successful engagement**
- Increasing communication effectiveness
- Clarifying expectations
- **Supporting self-regulation**
- **Matching demands to abilities**

HOW DO PRACTITIONERS PREPARE FOR CHALLENGING BEHAVIORS?

Being prepared for problem behavior

1. Rule out pain or illness
2. Establish predictability and consistency
3. Create a calm atmosphere
4. Attend to appropriate behaviors
5. Use ‘do’ statements
6. Keep perspective
7. Consider potential for trauma exposure

TRAUMA

AOTA Information Sheet:
https://www.aota.org/~/media/Corporate/Files/Practice/Children/Childhood-Trauma-Info-Sheet-2015.pdf

COMPLEX (TYPE II) TRAUMA

- Repetitive or prolonged exposure to traumatic stressors
- Involve harm or abandonment
- Developmentally adverse
- Most often interpersonal in nature

(Snedden, 2010; van der Kolk, 2005)

- New Category DSM-5: Trauma and Stress Related Disorders (TSRD)
  - Under DSM-IV: PTSD - anxiety disorder

RESPONSE DURING TRAUMA

- Inhibition of hippocampus (Karl et al., 2006)
  - Hippocampus: Memory & Learning; stores memory in time and place
  - Inhibition = recollection of traumatic event(s) not placed in the past
  - Continued experience of anxiety, dread – perceptions of immanent threat
- Verbal memory (Bremner, Vermetten, Afzal, &Vythilingam, 2004)
- Frontal-limbic system – regulates emotional responses to stress & fear (Karl et al., 2006)
- Neuro-endocrine system -hypothelamatic-pituitary-adrenal axis (Caffo, Forresi & Lievers, 2005)

RESPONSE DURING TRAUMA, CONT.

- Develop maladaptive behaviors (Sar & Ozturk, 2006)
  - Purpose: protect self from further trauma
  - Hypervigilance
  - Altered sense of control
  - Impaired concentration

- Fight, Flight or Freeze (Rothschild, 1998)
  - Freezing: Child not able to fight or flee
  - Freezing: Dissociated state = depersonalization; distorted reality where time slows down and fear & pain are markedly reduced

- Act withdrawn
- Demand attention through both positive and negative behaviors
- Demonstrate poor verbal skills
- Display excessive temper tantrums
- **Exhibit aggressive behaviors**
- **Exhibit memory problems**
- **Exhibit regressive behaviors**
- Experience nightmares or sleep difficulties
- Fear adults who remind them of the traumatic event
- Have a poor appetite, low weight and/or digestive problems
- Have poor sleep habits
- **Scream or cry excessively**
- Show irritability, sadness and anxiety
- **Startle easily**

POTENTIAL SYMPTOMS IF EXPOSED TO TRAUMATIC STRESS (0-2 YEARS)

http://www.nctsn.org/trauma-types/early-childhood-trauma/Symptoms-and-Behaviors-Associated-with-Exposure-to-Trauma

POTENTIAL SYMPTOMS IF EXPOSED TO TRAUMATIC STRESS (3-6 YEARS)

- **Act out in social situations**
- Act withdrawn
- Demand attention through both positive and negative behaviors
- **Display excessive temper**
- **Be anxious and fearful and avoidant**
- Be unable to trust others or make friends
- Be verbally abusive
- Believe they are to blame for the traumatic experience
- **Develop learning disabilities**
- Exhibit aggressive behaviors
- Experience nightmares or sleep difficulties
- Experience stomachaches and headaches
- Fear adults who remind them of the traumatic event
- Fear being separated from parent/caregiver
- **Have difficulties focusing or learning in school**
- **Have poor sleep habits**
- Imitate the abusive/traumatic event
- Lack self-confidence
- Show irritability, sadness and anxiety
- Wet the bed or self after being toilet trained or exhibit other regressive behaviors
- **Startle easily**
- **Show poor skill development**

http://www.nctsn.org/trauma-types/early-childhood-trauma/Symptoms-and-Behaviors-Associated-with-Exposure-to-Trauma

Most common (in order of frequency)

1. Separation anxiety disorder
2. **Oppositional defiance disorder**
3. Phobic disorders
4. PTSD
5. **ADHD**

(Ackerman et al., 1998)

CHILDHOOD TRAUMA & PSYCHIATRIC ILLNESS

LINGERING PROBLEMS POST TRAUMA

- Early experiences occur within the context of a developing brain – neural development and social interactions are intertwined
- Interferes with ability to create understanding of a cohesive whole from sensory, emotional and cognitive experiences
  - Dissociated sensory fragments – difficulty comprehending what is happening
  - Difficulty executing appropriate adaptive responses

(van der Kolk, 2005)

- Hypervigilance
- Sleep disturbance
- Difficulty concentrating
- Anxiety & obsessive thoughts

LINGERING PROBLEMS POST TRAUMA

INSTRUMENTS FOR ASSESSING (1) TRAUMATIC STRESS IN YOUNG CHILDREN & (2) PARENT STRESS/STRENGTHS

- **Child Behavior Checklist (CBCL):** Achenbach, and Rescorla (2001)—aged 1½–5; 6-18
- **Trauma Symptom Checklist for Young Children (TSCYC):** Briere et al. (2001)—aged 3–12
- **Life Stressor Checklist—Revised (LSC-R):** Wolfe, Kimerling, Brown, Chrestman, and Levin (1996)
- **Parenting Stress Index (PSI):** Abidin (1995)

ADULTS CAN HELP RE-ESTABLISH SECURITY & STABILITY FOR CHILDREN POST TRAUMA

- **Answering children's questions in language they can understand, so that they can develop an understanding of the events and changes in their life**
- Developing family safety plans
- Engaging in age-appropriate activities that stimulate the mind and body
- Finding ways to have fun and relax together
- **Helping children expand their "feelings" vocabulary**
- Honoring family traditions that bring them close to the people they love, e.g., storytelling, holiday celebrations, reunions, trips
- Looking for changes in behaviors
- Helping children to get back on track
- **Setting and adhering to routines and schedules**
- **Setting boundaries and limits with consistency and patience**
- Showing love and affection

http://www.nctsn.org/content/helpi

MODEL OF RECOVERY

- Herman's (1997) Tri-Phasic model of recovery from complex trauma

1. Safety & Stabilization
2. Remembrance & Mourning
3. Reconnection

TRI-PHASIC MODEL OF RECOVERY

1. Safety & Stabilization
   - Goal: shift from state of "unpredictable danger" to "reliable safety"

(Herman, 1997)

2. Remembrance & Mourning
   - Processes traumatic memories
   - How events shape survivor's life

3. Reconnection
   - Reshaping identity
   - Participation in meaningful relationships & activities

UNDERSTANDING THE PHYSIOLOGIC TRAUMA RESPONSE

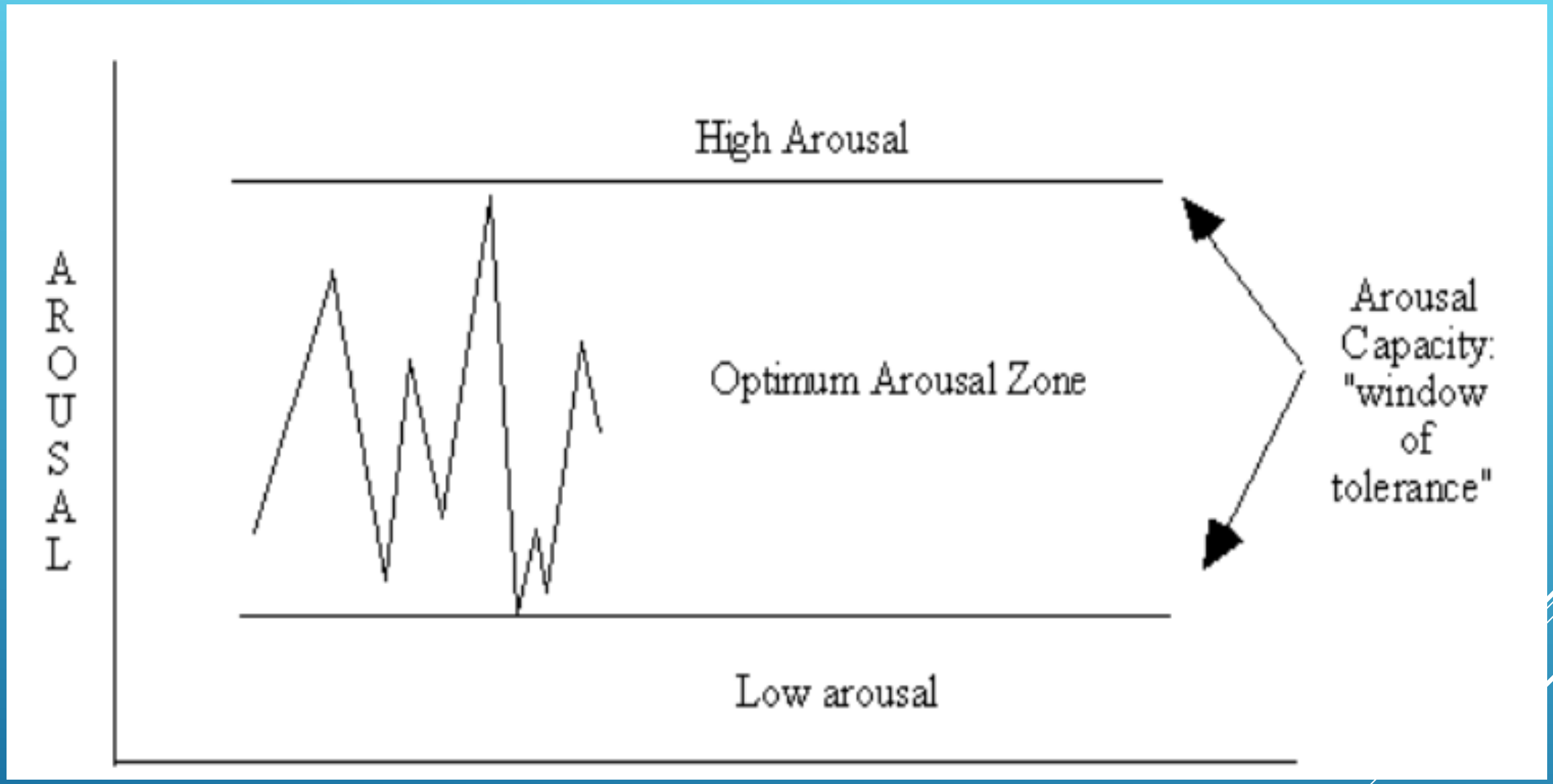
States become traits

UNDERSTANDING STATES

- "Developmental experiences determine the organizational and functional status of the mature brain."

- "…if the neurobiology of a specific response, Hyperarousal or Dissociation, is activated long enough, there will be molecular, structural and functional changes in those systems."

- Putnam, 1995 https://doi.org/10.1002/1097-0355(199524)16:4%3C271::AID-IMHJ2280160404%3E3.0.CO;2-B

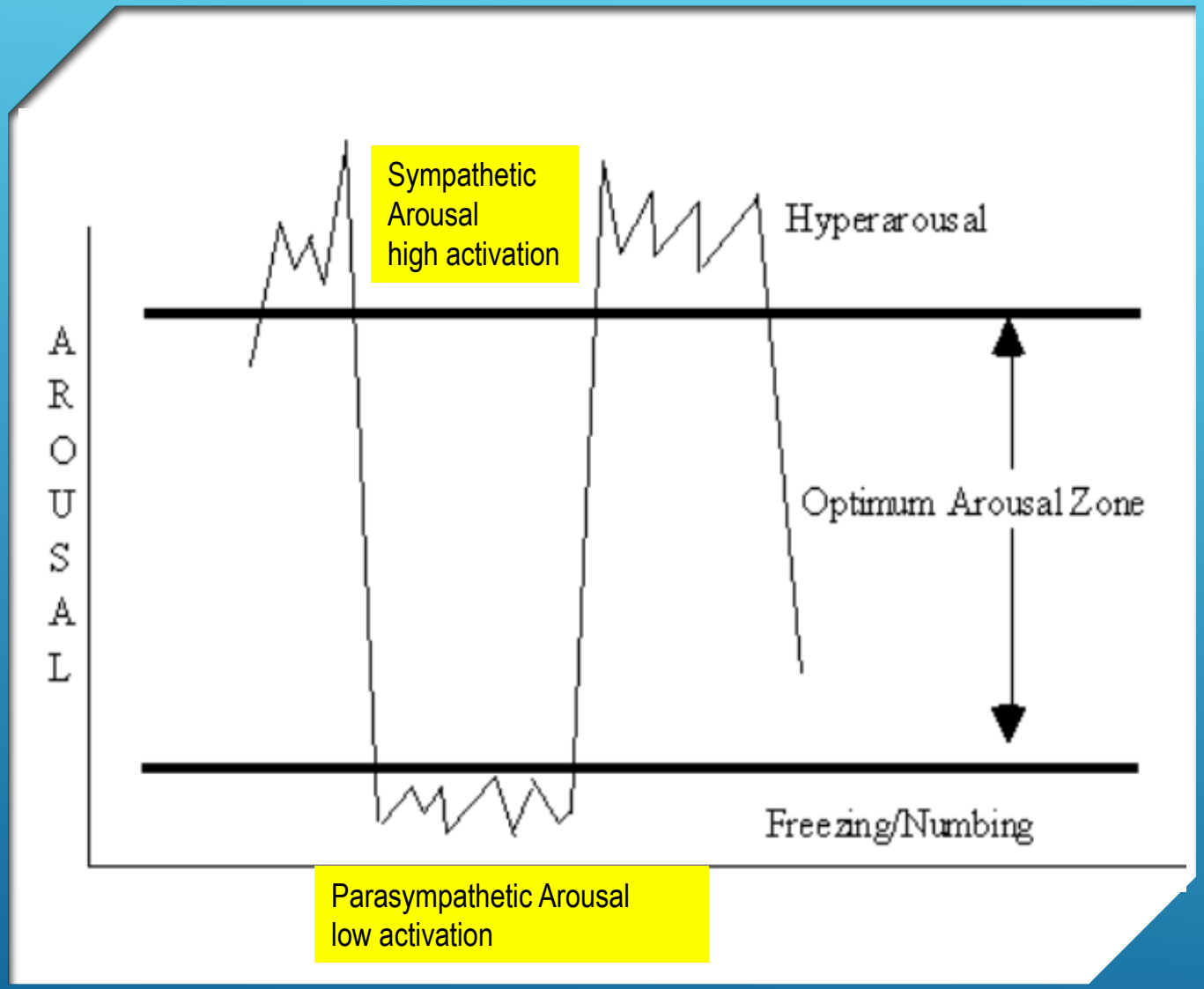


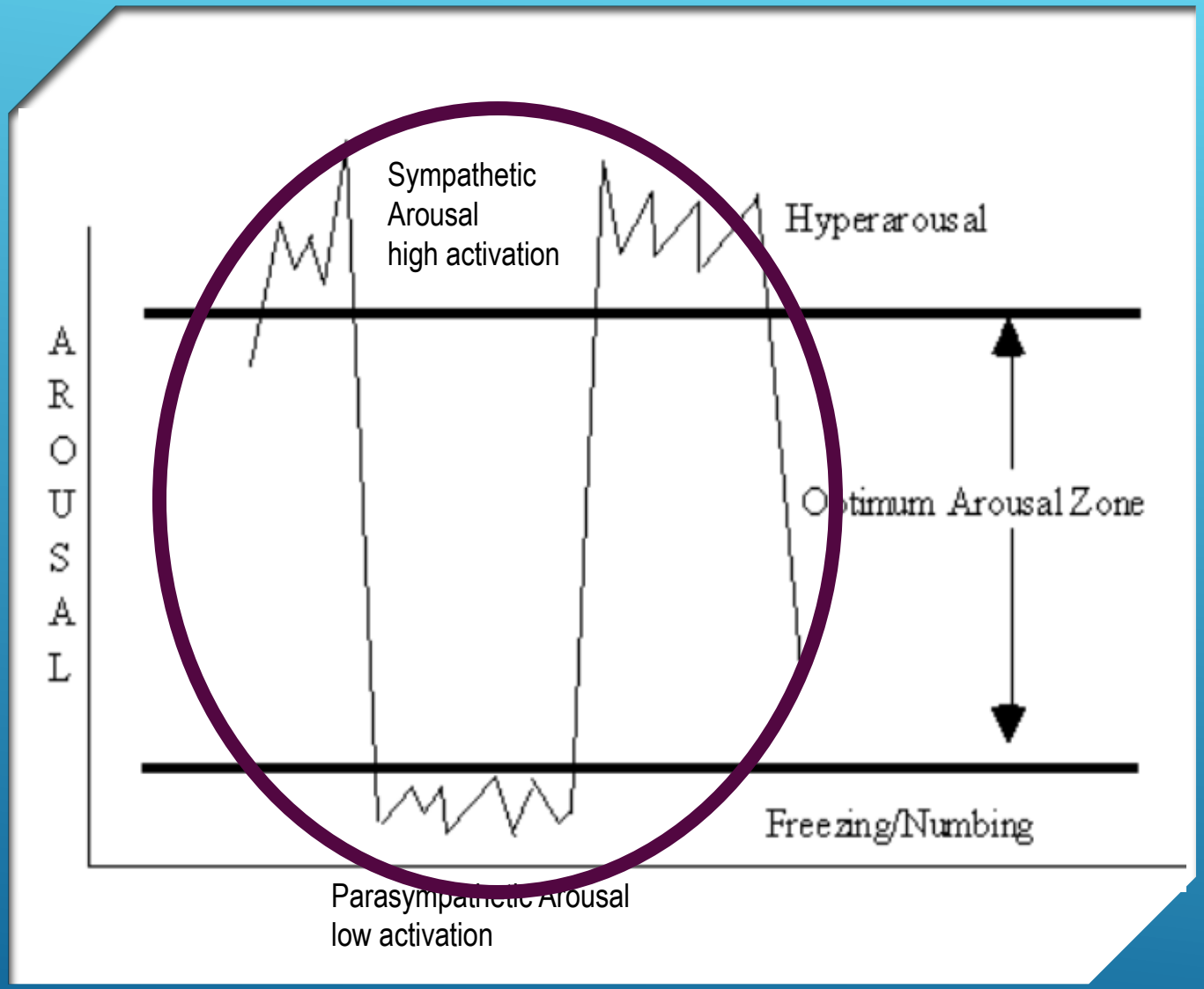
MODULATION MODEL

Ogden and Minton, 2000 https://www.sensorimotorpsychotherapy.org/articles.html

BI-PHASIC MODULATION RESPONSE TO TRAUMA

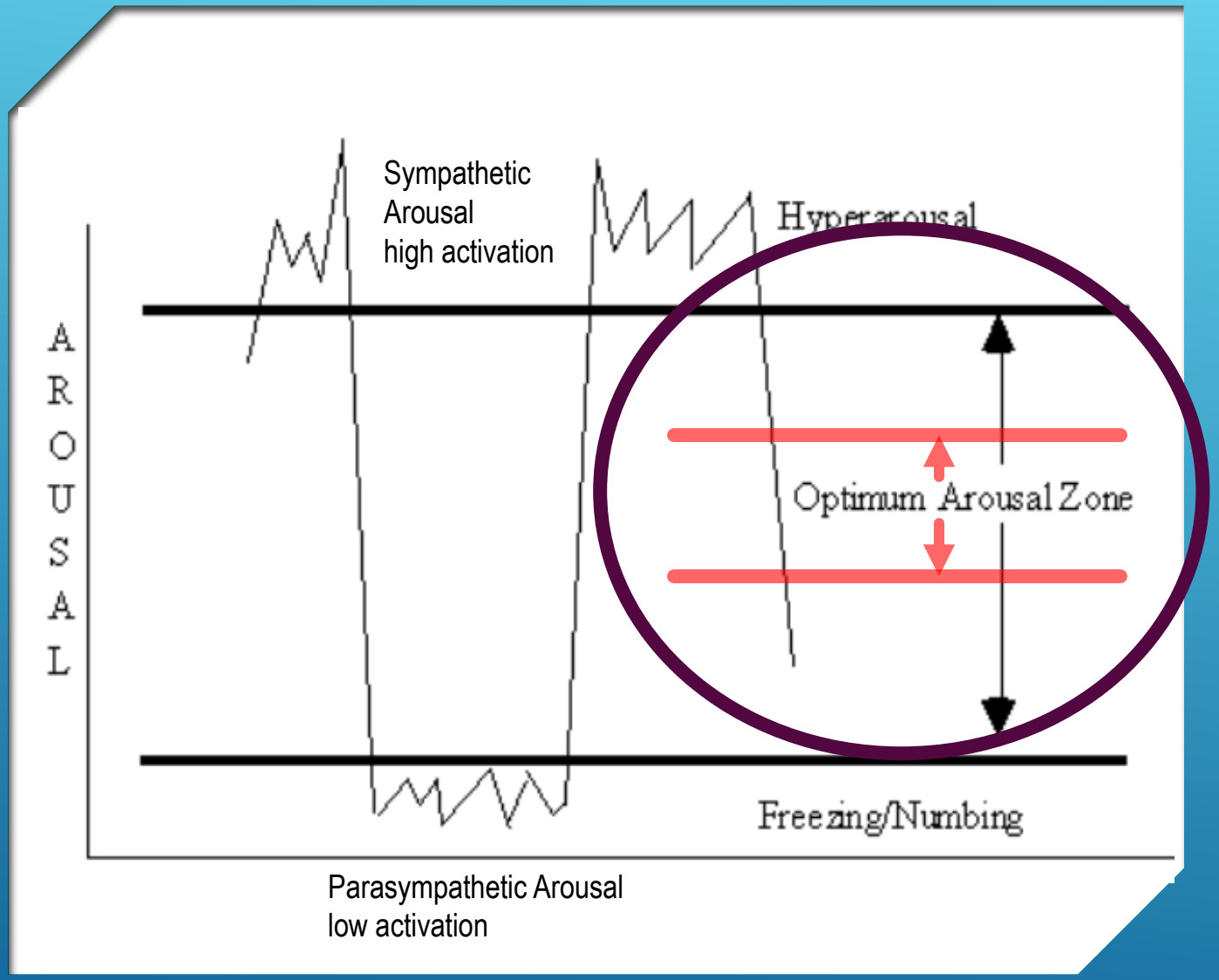
Ogden and Minton, 2000





POST-TRAUMA DYSREGULATION: 1) RAPID OSCILLATIONS

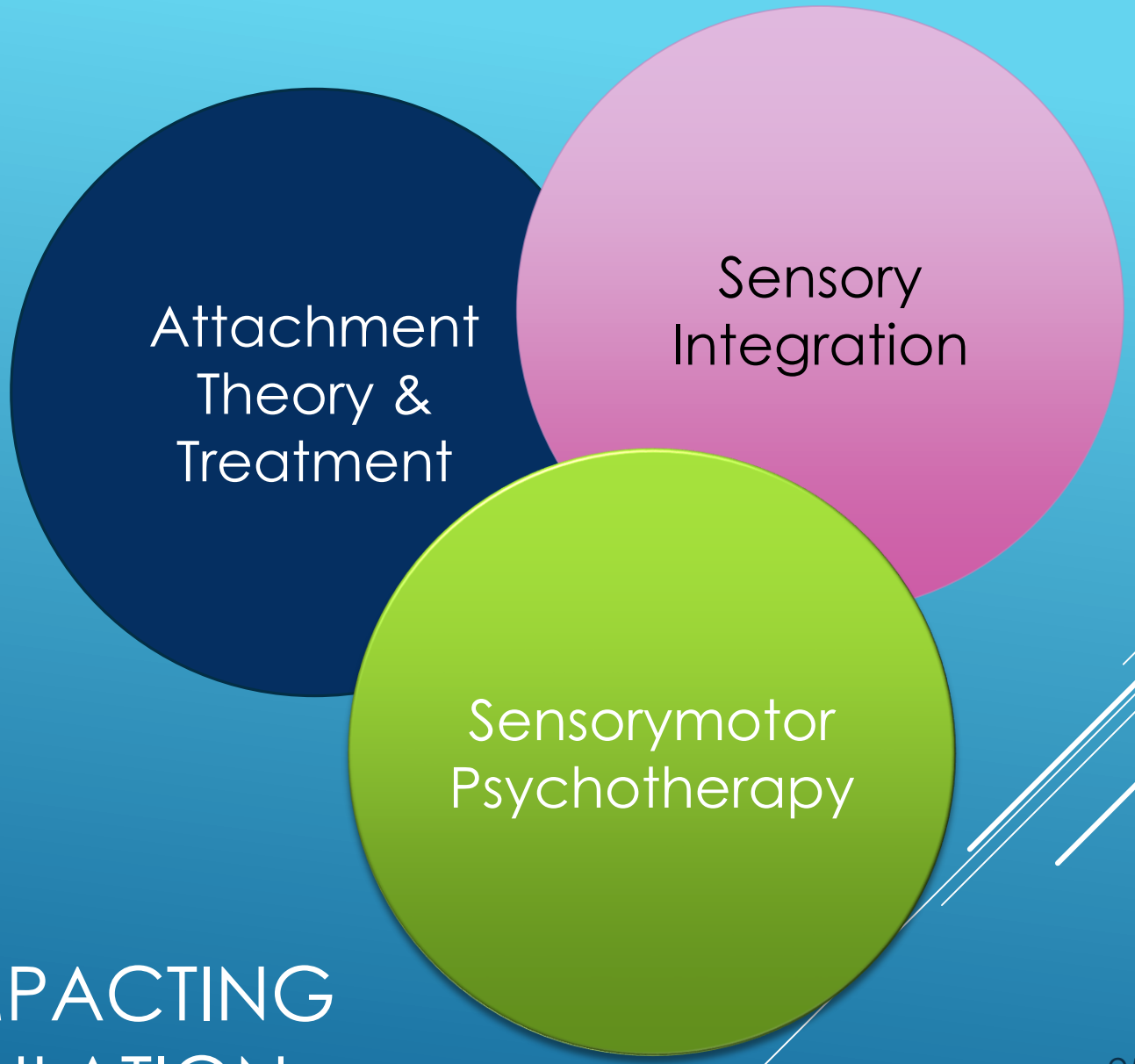
Dysregulation isn't just behavioral or dysregulated within their relationships; post-trauma dysregulation is also physiologic.



POST-TRAUMA DYSREGULATION: 1) RAPID OSCILLATIONS 2) NARROW WINDOW

Dysregulation is physiologic, behavioral and relational.

TX PARADIGMS FOR IMPACTING CHILD AROUSAL MODULATION



- Relationship with caregiver
  - Sense of well-being: safe, basic needs met
  - Balance of protection and nurture
- Parent's have issues too
- Social experience of disability
- Abuse or neglect

ATTACHMENT
WHAT YOU NEED TO REMEMBER…

ATTACHMENT THEORY & TX WISDOMS

- **Co-regulation** of arousal & affect

  Video address:
  https://www.youtube.com/watch?time_continue=137&v=apzXGEbZht0

- Humans have a biological imperative to attach
- Attachment provides both protective and healing against trauma
- When the caregiver is source of fear & danger >> devastating effects

- Match affect
- Match tone
- Match cadence
- Match intensity
- Match movement intensities
- Match prosody
- Do NOT match emotion

USE OF SELF IN CO-REGULATING CHILD'S AROUSAL:

(1) THERAPEUTIC USE OF SELF
(2) PARENT EDUCATION

Adapted from Hughes et al., 2015 https://doi.org/10.1177/0308575915610943

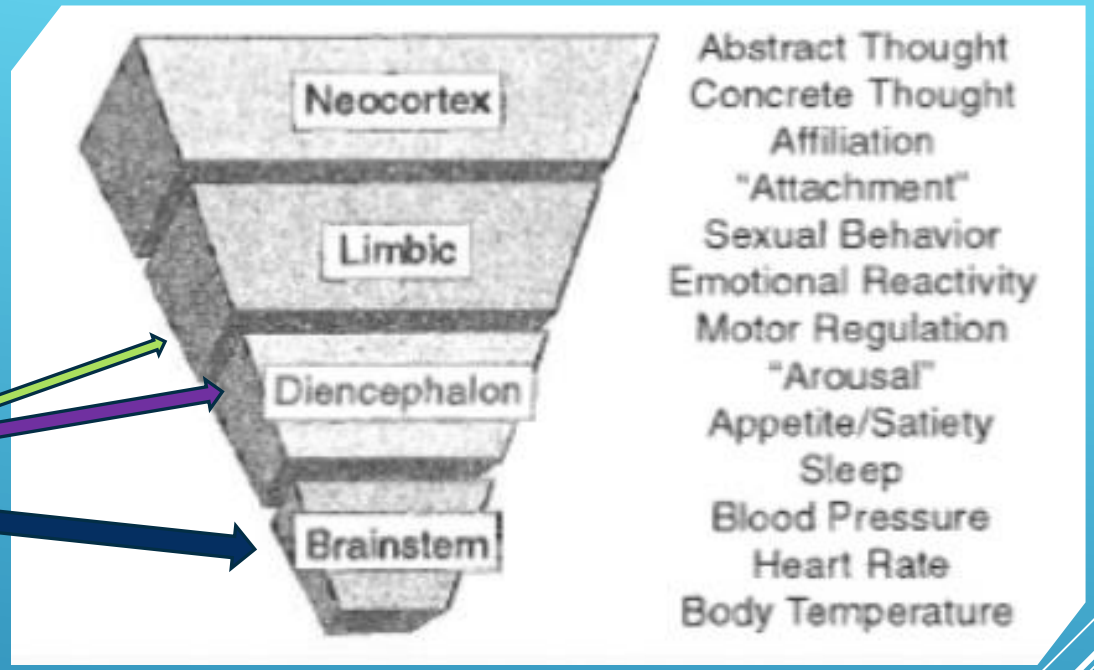
SENSORYMOTOR PSCYHOTHERAPY (SP) WISDOMS

- Premise: Changes at the sensorimotor level results in higher level change within the system
- Brings sensorimotor processes into awareness using both cognitive and sensorimotor processes "to interrupt autonomic somatic narratives embedded in procedural memory". Masero, 2017 https://doi.org/10.1002/anzf.1267 (excellent article on SP)
- Focus: Facilitated state change using
  - **Sensorimotor strategies**
  - **Cognitive strategies**

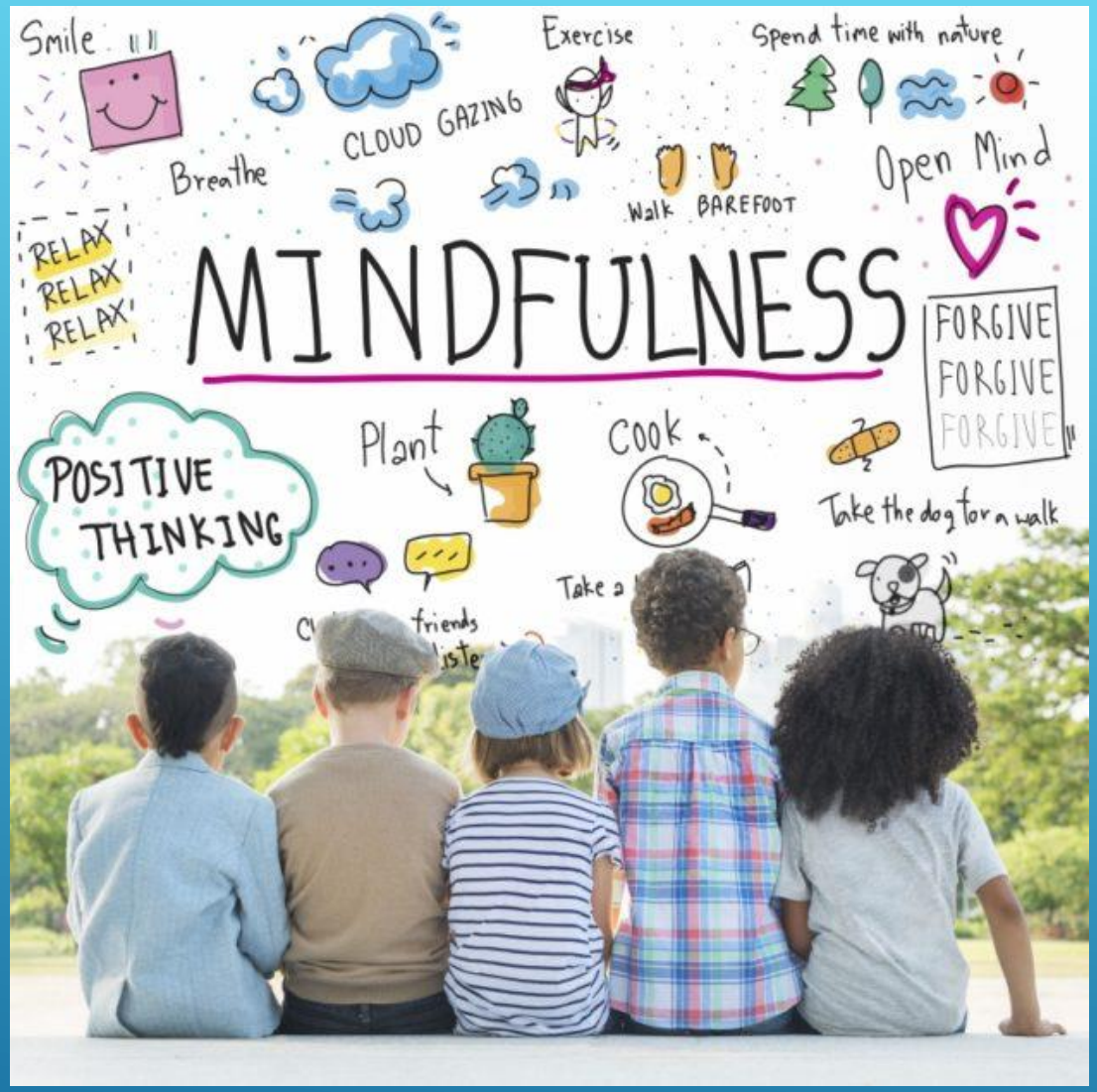
- How: Bring the body into focus in arousal regulation
  - Observe & describe (e.g., mindfulness)
  - ⟶ ❖ Sensory processing & integration
  - Support new actions
  - Name and frame – focus on awareness and labeling of body sensations & feelings (don't try to interpret them)
  - Increase cognition – engage cortex for down regulation

SENSORYMOTOR PSCYHOTHERAPY (SP) WISDOMS

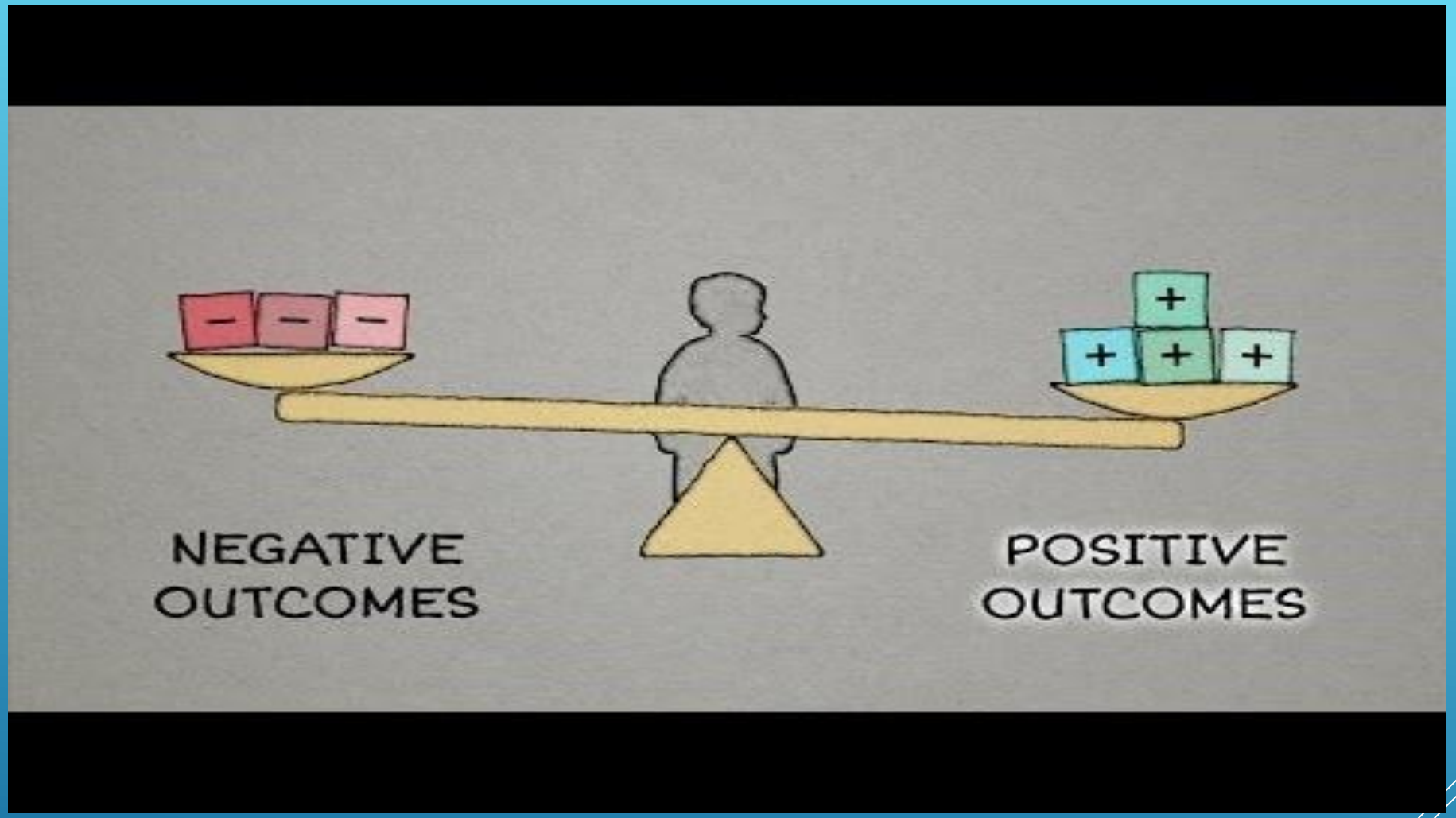
- Sensorimotor interventions that reflect normal development
- Regulation challenges
  1. Physical
  2. Sensory
  3. Emotional



SENSORY PROCESSING & INTEGRATION



MINDFULNESS



OT'S ROLE IN TRAUMA RECOVERY INTERVENTION?

HTTPS://YOUTU.BE/1R8HJ72BFGO

Secure base	
I have…	▪ People around me I trust and who love me no matter what ▪ People who set limits for me so I know when to stop before there is danger or trouble ▪ People who show me how to do things right by the way they do things ▪ People who want me to learn to do things on my own ▪ People who help me when I am sick, in danger, or need to learn.

RESILIENCE – 3 BUILDING BLOCKS

Source:
http://www.gov.scot/Topics/People/Young-People/gettingitright/national-practice-model/resilience-matrix

Self esteem	
I am…	▪ A person other people can like and love ▪ A person who is happy to do nice things for others and able to show my concern ▪ A person who is respectful of myself and of others ▪ A person who is willing to be responsible for what I do ▪ A person who is sure that in the end things will be alright.

Self efficacy	
I can…	▪ Talk to other people about the things that frighten or bother me ▪ Find ways to solve the problems I might face ▪ Control myself when I feel like doing something that's not right, or that's dangerous ▪ Figure out when it is a good time to talk to someone, or to take action ▪ Find someone to help me when I need it.

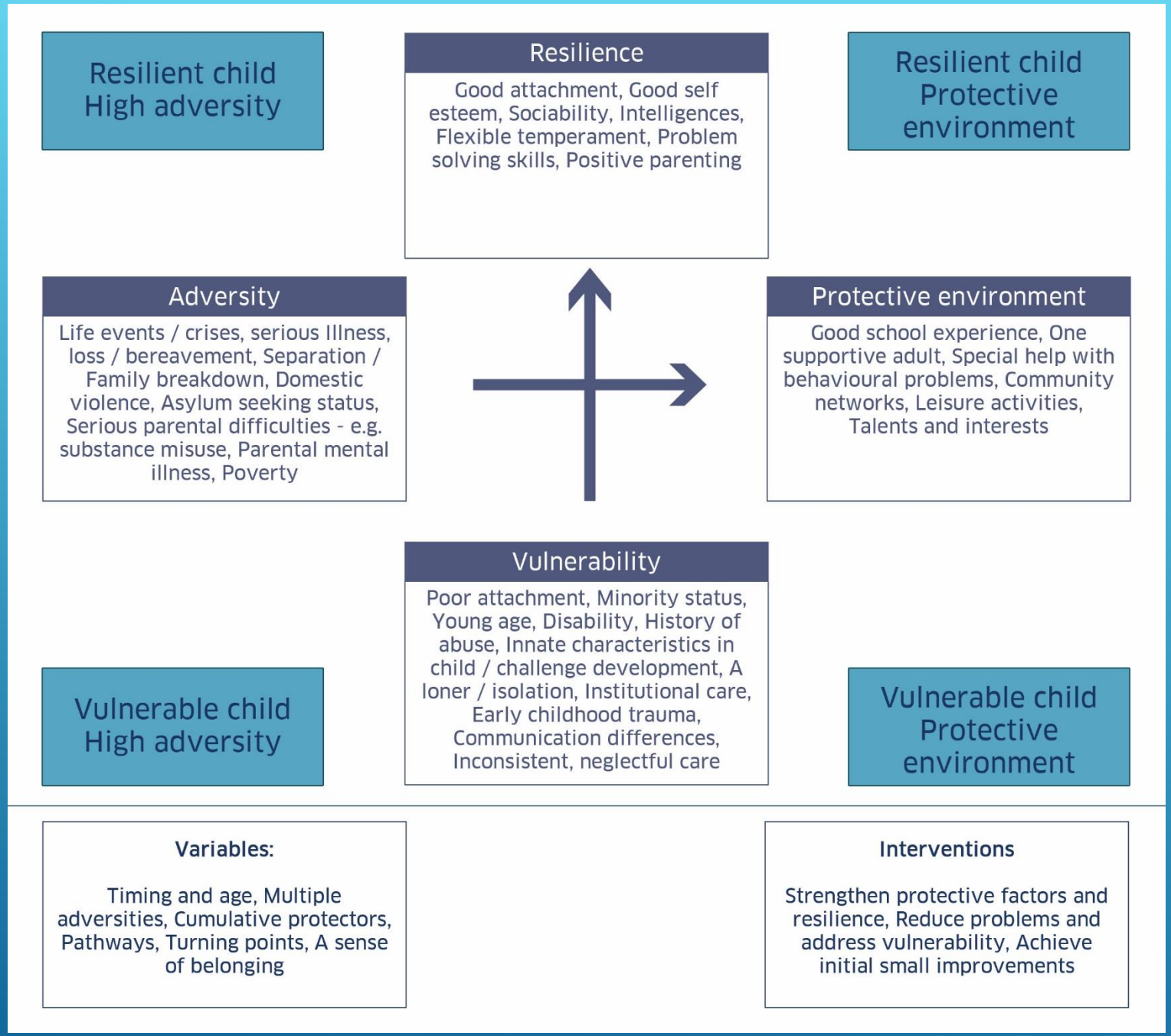
Groteberg, 1997

CHILD-LEVEL ASSESSMENTS OF CHILD'S RESILIENCE

- **Preferences for Activities for Children** (PAC); King et al., 2005
  - Self-report measuring range of child's preferred activities
- **Resiliency Scales for Children and Adolescents** (RSCA); Prince-Embury, 2005)
  - Self-report of child's perceived resourcefulness and vulnerability
- **Behaviour Assessment System for Children**, 2nd Edition BASC2 — Self-Report, Teacher report, Parent report; Reynolds & Kamphaus, 2009
  - Self-report to assess perceptions of the child's social, emotional, and behavioral functioning

WHAT IS OT'S ROLE IN RESILIENCE INTERVENTION?

Resilience/Vulnerability Matrix source: *Scottish Government, Better Life Chances Unit* *http://www.gov.scot/Topics/People/Young-People/gettingitright/resources*



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