# Identifying and managing trauma responses in young children

Mary Margaret Gleason MD FAAP
Tulane University School of Medicine
Webinar hosted by the
National Health Collaborative on Violence and Abuse
January 25, 2013

Tulane University

## Faculty Disclosure Information

In the past 12 months, I have no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in this CME activity.

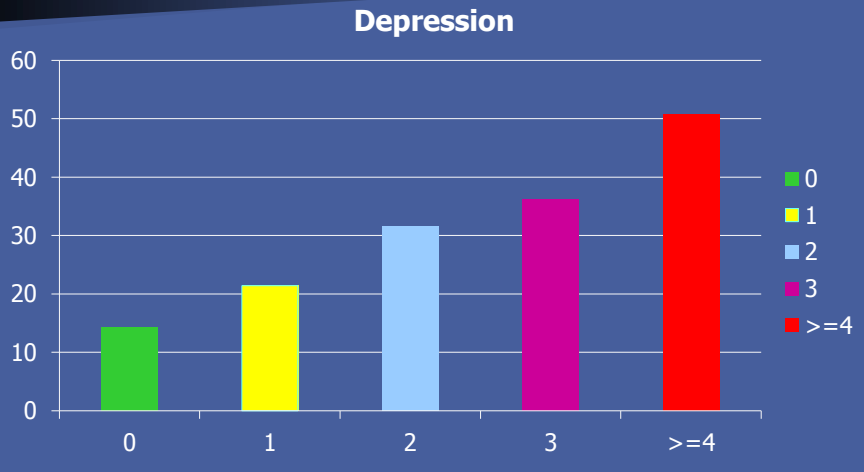
I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

# Overview

- Why pay attention to trauma in young children?
- Identifying trauma responses in young children
  - Red Flags
  - Structured assessment
  - Specialty care
- Treatment approaches
  - Primary care interventions
  - Evidence Based Treatments
  - Role of pharmacotherapy

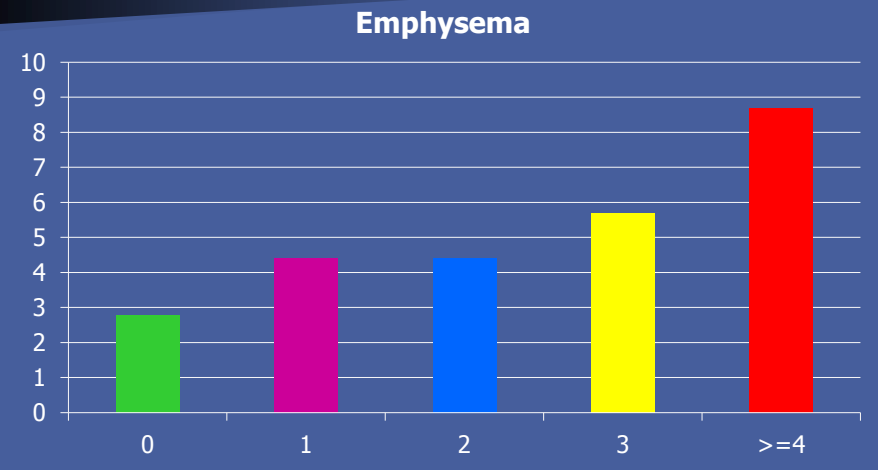


# Why early adversity matters




Felletti et al 1998

# Why early adversity matters




Felletti et al 1998



# Why focus on trauma in early childhood?

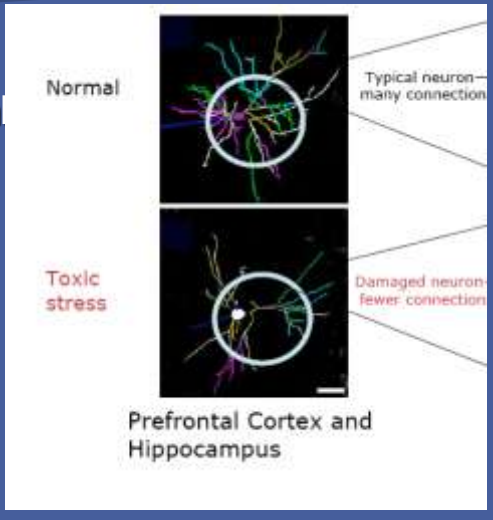
- Experiences in early childhood provides foundation for
  - Healthy brain development
  - Healthy family relationships
  - Peer relationships
  - Language development
  - Motor development
  - School readiness

# Early Experience and Brain Development

- Brains are built over time, from prenatal period to adulthood
- Interactions between genes and experience shape brain architecture
- Capacity for change decreases with age
  - Shonkoff 2003

# Early stress is toxic!

- Decreased synaptogenesis
- Smaller hippocampal volume
- Differential pruning
- Clear behavioral correlates



# Developmental issues preschoolers

- Rapid brain development
- Cognitive, language, represent capacity
- Parent child relationship as buffer or risk factor
  - Quality of relationship
    - Moderates effect of DV on child PTSD (Lieberman 2005)
    - moderates association between temperament and biological reactivity *(Nachmias et al. 1996)*
- Adult/society minimizes trauma reactions



# Early childhood trauma in clinical practice

- Part of the chief complaint
  - New pt adopted from institutional care
  - Pt newly placed in foster care
  - Pt with new foster caregiver, seen with CPS worker
- Part of the history
  - Multiple caregiving disruptions
  - Family, community, or other violence exposure
  - Discrete event (e.g. MVA)
  - Medical trauma
- Disclosed or identified through exam
  - Sexual abuse
  - PE indicating child maltreatment
  - Child disclosure of maltreatment or other events

# Early childhood trauma in clinical practice

- NEED TO ASK!



# Clinical surveillance ("red flags")

- Impairment > 2 weeks
- Preoccupation with death
- Playing out elements of the trauma
- New behavioral disturbances – especially in specific contexts
- New onset sleep problems and nightmares
- New school or child care problems

# General Screening Tools

- Brief Infant Toddler Social Emotional Assessment *(Briggs Gowan, Carter 2002)*
- Ages and Stages Social Emotional *(Squires 2002)*
- Early Childhood Screening Assessment *(Gleason et al 2006)* (12-60 month)
- Pediatric Symptom Checklist (4-18 yo) (Murphy 1992)

- *http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf*

# Modified Child Behavior Checklist–PTSD Scale (Dehon 2009)

- 1. Argues a lot
- 2. Cannot concentrate or cannot pay attention for long
- 3. Cannot get his/her mind off certain thoughts, obsessions
- 4. Clings to adults or too dependent
- 5. Fears certain animals, situations, or places other than school. Feels others are out to get him/her
- 6. Nightmares
- 7. Nervous, high-strung, or tense
- 8. Nightmares
- 9. Too fearful or anxious
- 10. Feels too guilty
- 11. Headaches
- 12. Nausea and feels sick
- 13. Stomachaches and cramps
- 14. Vomiting and throwing up
- 15. Secretive and keeps things to self
- 16. Stubborn, sullen, or irritable
- 17. Sudden changes in mood or feelings
- 18. Trouble sleeping
- 19. Unhappy, sad, and depressed
- 20. Withdrawn and does not get involved with others

# Preschool PTSD

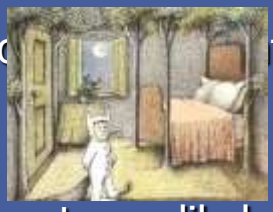
(Scheeringa et al)

- Exposure to traumatic event
- Re-experiencing (≥1)
  - intrusive recollections/play, recurrent dreams, flashback, distress at reminders
- Avoidance (≥1)
  - Avoid thoughts, feelings, conversations, places, people, activities; inability to recall, decreased interest, detachment/social withdrawal, restricted affect, foreshortened future
- Arousal (≥2)
  - Sleep problems, irritability/extreme tantrums, concentration problems, hypervigilance, hyperstartle



# Trauma causes more than PTSD

- PTSD
- Disruptive behavior
- Mood disorders
- Other anxiety disc tio anxiety)
- Sleep disorders
- But if has new symptoms, likely has PTSS's *(Scheeringa et al unpublished)*



# Primary care first line intervention

- Protect child/Develop team
  - Child protection services
  - Ensure access to DV services
  - Mobilize appropriate support services for child/children and family
  - Ensure relevant caregivers are aware of potentially traumatic events
  - Educate caregivers re: potential for secondary traumatization
  - Plan for follow-up



# EARLY CHILDHOOD TRAUMA TREATMENTS

Trauma Webinar 1/25/13 MM Gleason mgleason@tulane.edu

# Early Childhood Mental Health Treatments: PTSD

- Child Parent Psychotherapy *(Lieberman et al 2005)*
  - 52 week dyadic therapy
  - Attachment based treatment
  - Increased resilience, decreased symptoms
- Cognitive Behavioral Therapy *(Cohen et al 96, Deblinger et al 2001, Scheeringa et al 2011)*
  - Adapted for preschoolers' development
  - Learn relaxation skills, rate distress, practice exposure
  - Reduces PTSD as well as other internalizing and externalizing symptoms
  - Parents do not need to get better for child to improve



# Early Childhood Mental Health Treatments: Disruptive behaviors

- Parent Child Interaction Therapy *(Eyberg 1988)*
  - Based on behavioral principles, social learning theory and attachment
  - In-vivo parent coaching
  - Positive reinforcement for positive behaviors, clear directions and consistent consequences
- Reduces aggression with sustained effects x years
- In maltreated children: Equal efficacy in decreasing child behavior symptoms in children in foster care and non-maltreated children *(Timmer 2006)*

# Randomized Controlled Trials of Medications for Trauma-Exposed Preschoolers



# Pharmacological treatments school age children

- 2 randomized controlled trials of sertraline
  - No effect vs. placebo *(Robb et al 2010, Cohen 2007)*
- Prevention of acute stress disorder
  - Morphine reduces risk of acute stress disorder *(Stoddard 2009)*
  - Negative findings for propranolol *(Sherri 2010)*

# Family interventions

- Parental mental health care/referral as appropriate
- Enhance community supports



# Summary

- To identify trauma, must consider it
- Co-morbid conditions are the norm after trauma
- Treatments targeting PTSD and behavioral dysregulation are effective but not always available
- No rigorous evidence supporting use of pharmacotherapy

# THANK YOU!

Trauma Webinar 1/25/13 MM
Gleason mgleason@tulane.edu