Vulnerable Youth and Trauma: How to Leverage Evidence-Based Care and Resources in North Carolina

September 30, 2023
Case 1 Presentation

• TM is a 15 yo Black/African American girl presents with a Foster Care SW to her primary care clinic for first time

• Foster Care SW is working in place of co-worker and provides history: Past Dx: ODD, ADHD, Depression Unspecified, r/o bipolar disorder; Medications: Concerta 36mg daily, fluoxetine 20mg daily; No ongoing therapy. Previous medication included Abilify, Lexapro, Adderall, Risperidone.

• Foster parent called her Foster Care SW to report she was “acting manic”, not sleeping, and she has been increasingly defiant, including a recent altercation with the school resource officer. The placement was no longer working.

• On evaluation using PHQ-9, TM endorsed suicidal ideation, some sadness about not being with her family and moving frequently. No history of panic symptoms but appeared anxious. She was tearful discussing the recent placement disruption.
Primary Care Physician Calls NC PAL

• Primary Care Questions
  • What do we do with this medication list?
  • Do we restart Abilify for the “aggression”?
  • What therapy resources are available?
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• TM states she changed placement day before appointment because foster parent did not feel it was a good fit. Behavior such as coming home late from school, trouble waking up in the morning, and staying up late on social media caused frequent disagreements that included slamming doors, yelling, and not completing chores. After one of these arguments, parent took her hair products as a form of punishment. The argument escalated.

• Foster parent called her Foster Care SW to report she was “acting manic”, not sleeping, and she has been increasingly defiant, including a recent altercation with the school resource officer. The placement was no longer working.

• On evaluation using PHQ-9, TM endorsed suicidal ideation, sadness about not being with her family and moving frequently. No history of panic symptoms but appeared anxious. Tearful discussing recent placement disruption. She did not want to talk much about biological family and did not feel connected to friends due to school changes. She feels race played a role in her disruption because she told her foster parent it was racist to take her hair products. She does not feel medication has been helpful. No thought disorganization or perceptual disturbance. Appearance notable for fashionable details of clothing and hair. She wants to be a stylist in the future. She is on track to graduate from high school. She is very active on social media and has a huge following.
Connecting with the NC Child Treatment Program
Difficulties Addressed by TF-CBT

**CRAFTS**

- **C**ognitive Problems
- **R**elationship Problems
- **A**ffective Problems
- **F**amily Problems
- **T**raumatic Behavior Problems
- **S**omatic Problems
Core Values of TF-CBT

**CRAFTS**

- Components-Based
- Respectful of Cultural Values
- Adaptable and Flexible
- Family Focused
- Therapeutic Relationship is Central
- Self-Efficacy is emphasized
Treatment Research for TF-CBT

• Trauma-Focused CBT is the most rigorously tested treatment for abused children
  • 21 randomized controlled trials supporting TF-CBT

• Improved PTSD, depression, anxiety, shame and behavior problems compared to supportive treatments

• PTSD improved more with direct child treatment

• Improved parental distress, parental support, and parental depression compared to supportive treatment

• 80% of children show significant improvement in < 16 weeks
The Power Threat Meaning Framework

- Developed by Johnstone et al. and coproduced with community members.
- The framework provides a new perspective for explaining behavioral concerns and is an alternative to models based on a psychiatric diagnosis.
- It integrates evidence about the role of various kinds of power in people’s lives; the kinds of threat that misuses of power pose to us; and the ways we have learned as human beings to respond to threat. In traditional mental health practice, these threat responses are sometimes called ‘symptoms’.
- The Framework explores how we make sense of difficult experiences, and how messages from wider society can increase our feelings of shame, self-blame, isolation, fear and guilt.

The main aspects of the Framework are summarized in these questions, which can apply to individuals, families or social groups:

- *What has happened to you?’ (How is Power operating in your life?)*
- *How did it affect you?’ (What kind of Threats does this pose?)*
- *What sense did you make of it?’ (What is the Meaning of these situations and experiences to you?)*
- *What did you have to do to survive?’ (What kinds of Threat Response are you using?)*

In addition, the two questions below help us to think about what skills and resources people might have and how we might pull all these ideas and responses together into a personal narrative or story:

- *What are your strengths?’ (What access to Power resources do you have?)*
- *What is your story?’ (How does all this fit together?)*
List of Tools to Support Interventions

- Ethnic matching\(^1\)
- Multicultural training\(^1\)
- Changing practice manuals to be inclusive\(^1\)

- Skills-based changes (focused on provider characteristics)\(^2\)
- Process-based changes (focused on the provider-client dynamic)\(^2\)
- Adaptation-based (focused on the infusion of culture into the practice)\(^2\)

- Bottom-up – grounded in culture\(^3\)
- Top-down – outside groups making decisions\(^3\)

- Based on a meta-analysis, a robust effect size was found for interventions that were culturally adapted.\(^4\)
Discussion

• Assessment
  • Who’s making the decisions?
  • What is the source of the history provided for the assessment?

• Diagnosis
  • Has the impact of trauma been assessed?
  • Is conceptualization culturally-sensitive, trauma-informed, and historically accurate (as possible)?

• Treatment
  • What are we treating?
References


