Trauma Through the Lens of Foster Care System

Donna Potter, LCSW
Review evidence-based trauma informed treatments for children
According to a study published by Finkelhor, Turner, Shattuck, and Hamby in 2015, of a nationally-representative survey of 4000 children (10-17) and their caregivers (0-9) asking about experiences in the past year:

- 37.3% experienced physical assault
  - 9.3% of these resulted in injury
- 5% experienced a sexual offence
- 1.4% experienced a contact sexual assault
  - Lifetime for 14-17 year old girls: 14.3% (completed rape for 4.5%)
  - Lifetime for 14-17 year old boys: 6%
- 15.2% experienced child maltreatment (physical or emotional abuse, neglect or custodial interference
  - Lifetime for 14-17 year olds was 38%
- 24.5% had witnessed family or community violence
  - 8.4% witnessed family assault
  - 5.8% witnessed parent assaulted by partner
    - Lifetime for 14-17 year olds witnessing family assault was 32%
    - Lifetime for 14-17 year olds witnessing parent assaulted by partner was 25%
- 18.4% had witnessed community violence
  - Lifetime for 14-17 year olds witnessing community violence was 57.9%
Children need trauma-informed evidence-based care

The impact of trauma exposure is cumulative

- 40.9% had more than 1 direct exposure to violence
- 10.1% had 6 or more direct exposures to violence
- 1.2% had 10 or more direct exposures to violence
  - Finkelhor, Turner, Shattuck, and Hamby (2015)
Children in the Child Welfare System need trauma-informed evidence-based care

- In utero and environmental exposure to drugs and alcohol
- Interpersonal violence exposure
- Disorganization of attachment relationships
- Structural racism
What is evidence-based practice?

• “Evidence-based practice refers to a clinical decision-making approach in which the practitioner, in consultation with the client “explicitly, conscientiously, and judiciously” selects the evidence-based treatment options best suited to meet the client’s needs and obtain optimal outcomes.” (Sackett, Rosenberg, Gray, Haynes, and Richardson, 1996)

• Assessment driven

• Outcomes oriented

• Different from evidence-based treatment which refers to a specific researched intervention
What is trauma-informed care?

https://www.chcs.org/media/Infographic-TIC-1.pdf
For more information on becoming trauma informed

Being Trauma-Informed Means Being Anti-Racist

- ACE Study (almost 75% white, middle to upper class, 75% advanced education):
  - 50% of the population had experienced >1 ACE
  - 25% of the population had experienced 2+ ACE
- Philadelphia Urban ACE (61% Black, Latino, Asian, or Biracial, 44% advanced education)
  - 33.2% of PU ACE vs 10.6% of ACE experienced emotional abuse
  - 35% of PU ACE vs 28.3% of ACE experienced physical abuse
  - 16.2% of PU ACE vs 20.7% of ACE experienced sexual abuse
• ACE Study (almost 75% white, middle to upper class, 75% advanced education):
  • 50% of the population had experienced >1 ACE
  • 6.8% of the population had experienced 4+ ACE
• Philadelphia Urban ACE (61% Black, Latino, Asian, or Biracial, 44% advanced education)
  • 70% of the population had experienced >1 ACE
  • 21.5% of the population had experienced 4+ ACE
Core Elements Of Evidence-Based Treatment For Child Trauma

- Psychoeducation about trauma and goals of treatment
- Management of trauma symptoms and reminders
- Trauma narration
- Cognitive and affective processing
- Safety and relationships
- Parenting
- Addressing grief and loss
- Emotion regulation
- Resumption or assumption of healthy developmental trajectory

How do clinicians and agencies know which interventions are evidence based?

- National Child Traumatic Stress Network
- California Evidence Based Clearinghouse
Trauma-Focused Cognitive Behavioral Therapy

Deblinger, Cohen, and Mannarino
Who benefits from TF-CBT:

- Youth between the ages of 3 and 18
- Memory of trauma
- Corroborated by an unbiased adult
- Diagnosis of PTSD or PTS symptoms
- Behavioral concerns not the primary reason for referral
- Child currently safe (e.g., not exposed to perpetrator)
- Non-offending caregiver must participate in model
Difficulties Addressed by TF-CBT

**CRAFTS**
- Cognitive Problems
- Relationship Problems
- Affective Problems
- Family Problems
- Traumatic Behavior Problems
- Somatic Problems
TF-CBT Outcomes in 21 Randomized Controlled Trials (RCTs)

Decrease in:

• Child PTSD symptoms
• Child depressive symptoms
• Child anxiety symptoms
• Child behavioral problems (including PSB)
• Parental distress
• Parental depression
TF-CBT Outcomes in Randomized Controlled Trials (RCTs)

**Improvements in:**
- Parental support
- Child self esteem
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
PRACTICE TF-CBT

- Psychoeducation and Parenting Strategies
- Relaxation
- Affect expression & regulation
- Cognitive coping
- Trauma narrative and processing
- In vivo exposure
- Conjoint parent child sessions
- Enhancing personal safety and future growth

https://tfcbt.org/about/

Cohen, Mannerino, Deblinger
Cultural Adaptations Are Necessary

- Culturally-Modified Trauma-Focused Treatment: Making TF-CBT Culturally Relevant for Hispanic Families by Susana Rivera, October 2008 (available on NCTSN website)
- Information sheet on NCTSN – https://www.nctsn.org/interventions/culturally-modified-trauma-focused-treatment
- TF CBT with American Indian and Alaska Native families
  - http://www.icctc.org/
- Information sheet on NCTSN – https://www.nctsn.org/interventions/culturally-modified-trauma-focused-treatment
- Group trauma-focused cognitive-behavioral therapy with former child soldiers and other war-affected boys in the DRC
- Implementing TF-CBT Among Formerly Trafficked –Sexually Exploited Girls in Cambodia
- Spotlight on culture – many resources for working with cultural concerns
  - http://www.nctsn.org/resources/topics/culture-and-trauma
- Trauma-Focused CBT for Children and Adolescents: Treatment Applications edited by Judith A. Cohen, Anthony P. Mannarino, Esther Deblinger
Child Parent Psychotherapy

Lieberman, Van Horn, and Ghosh-Ippen
Who benefits from CPP?

• Children ages birth through five years:
  • Who have experienced a traumatic event (e.g., exposure to domestic violence, child maltreatment)
  • Who are struggling with emotional, behavioral, and attachment difficulties

• Children’s primary attachment figures (including foster parents):
  • Who may or may not have also suffered the same or other traumatic events (e.g., domestic violence)
  • Who are struggling with additional psychosocial stressors (e.g., maternal depression)
CPP Outcomes in 5 Randomized Controlled Trials (RCTs)

Decrease in:

• Child and caregiver PTSD symptoms
• Child and caregiver depressive symptoms
• Child behavioral problems
• Caregiver general distress
• PLACEMENT DISRUPTIONS FOR CHILDREN IN FOSTER CARE*
CPP Outcomes in 5 Randomized Controlled Trials (RCTs)

**Improvements in:**
- Child attachment security and organization
- Child perceptions of self and caregiver
- Caregiver perceptions of self and child
- Child cognitive functioning
How does CPP work?

WEEKLY, 60-MINUTE DYADIC (CAREGIVER AND CHILD) SESSIONS

AVERAGE COURSE OF TREATMENT: APPROXIMATELY ONE YEAR OR 30-50 SESSIONS

WE USE TOYS AND PLAY TO HELP FAMILIES COMMUNICATE ABOUT TRAUMATIC EXPERIENCES

WE HELP CAREGIVERS AND CHILDREN UNDERSTAND EACH OTHER, RESPOND TO DIFFICULT FEELINGS AND BEHAVIORS, AND CREATE A FAMILY STORY THAT LEADS TO HEALING

https://childparentpsychotherapy.com/about/

Lieberman, Van Horn, and Ghosh-Ippen
How do clinicians and agencies implement evidence-based trauma informed treatments?

- EPIS Framework (Aarons, Hurlburt, and Horwitz)
  - Exploration
  - Preparation
  - Implementation
  - Sustainment
The roles of team members in supporting trauma informed care
What can psychiatry do to help?

• Be trauma informed
• Ask what happened?
  • To the child
  • To the family
  • To past generations
  • To the cultural group
• Advocate for evidence-based treatments
• Communicate with and participate in Child and Family Team Meetings
• Differentiate what is psychiatric from what is neurological, medical, and environmental
• Utilize the North Carolina Child Treatment Program
How to make evidence-based trauma treatments accessible across North Carolina
Developing And Sustaining An Evidence-based Treatment Array
OVERALL IMPACT

10 Years of Improving NC Children’s Lives

- 1,750 clinicians trained
- 425 senior leaders trained
- 750 clinicians active on roster
- 3,000 EBT clients served*
  by rostered clinicians per year

Demonstrated Clinical Outcomes

Over 100,000 children are affected by abuse and neglect in NC each year. NC Child Treatment Program’s array of evidence-based treatments have been shown to:

Decrease
- Placement disruptions
- Defiance and aggression
- PTSD and depression
- Problematic sexual behaviors

Increase
- Parenting skills
- Child cognitive ability
- Positive behaviors at school and home

"The TF-CBT Learning Collaborative changed my life. Not only how I work with clients, but with my entire approach in how I work with families and how I supervise my staff. It has changed our entire agency.”

-Sarah Roethlinger, clinician and senior leader
DON’T HAVE ALL THE NC COUNTIES MEMORIZED?
# MODELS DISSEMINATED BY NC CTP

<table>
<thead>
<tr>
<th>Model</th>
<th>Age Range</th>
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<tbody>
<tr>
<td>Child-Parent Psychotherapy (CPP)</td>
<td>0-5</td>
</tr>
<tr>
<td>Cognitive Processing Therapy (CPT)</td>
<td>14+</td>
</tr>
<tr>
<td>Parent-Child Interaction Therapy (PCIT)</td>
<td>2-6</td>
</tr>
<tr>
<td>Problematic Sexual Behavior – Cognitive Behavioral Therapy (PSB-CBT)</td>
<td>3-18</td>
</tr>
<tr>
<td>Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)</td>
<td>12-21</td>
</tr>
<tr>
<td>Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)</td>
<td>3-18</td>
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</tbody>
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"Having gone through CTP, I've been able to do so much [as a program manager and a clinician]. I've been through other collaboratives with model developers, but CTP does such a fantastic job bridging the gap between research and practice. Just one example is learning how to do a really good Functional Behavior Analysis for my TF-CBT clients. Now I do that with all my clients, and I've helped my clinicians do them. Now it's reached way beyond just one model and has all these ripple effects."

Stephanie Mueller, clinician and senior leader
ADDRESSING BARRIERS: THE ROLE OF NC CHILD TREATMENT PROGRAM

High quality training, fidelity monitoring, and outcomes tracking through NC CTP can provide the quality assurance that Medicaid and public program dollars are well-spent and have the greatest possible impact.

The goal of NC CTP is to have clinicians and agency leaders join our mission. Learning what to do is easy. Learning how to do it well takes practice.

Implementing treatment well is an evidence-based strategy for retaining the Mental Health workforce. We can take care of our clinicians while they care for kids.

"I can attest as a counselor who has been providing TFCBT since 2019 that it keeps me in the field. When I would first meet with kids, their symptoms would be the highest they could be. By the time we finished, their symptoms would be close to or at zero. The pride they would have in themselves made my heart beam with joy knowing I gave them the tools to achieve this. It's a hard job doing trauma counseling, but every kid that I helped made it worth it ten times over."

- EBT Trained Clinician
Medicaid serving agency in Eastern NC
THANK YOU

https://www.ccfhnc.org
https://www.ncchildtreatmentprogram.org

Address:
NC Child Treatment Program
c/o Center for Child and Family Health
1121 W. Chapel Hill St.
Ste. 100
Durham, NC 27701

Phone Numbers:
919-699-4400-Margaret
Phone: 1-844-NCCTP-4U
(1-844-622-8748)
Fax: (919) 419-9353
References


