Terrorized families: Understanding and treating trauma in a family setting

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  - thousands of traumatized children and military families in MN

Overview

- Traumatic and stressful events
  - Effects on children
- Adult stress responses & posttraumatic stress disorder
  - Effects of PTSD and stress on parenting
  - Impact of parenting on children's adjustment
- Evidence-based practices for children and families affected by trauma
  - Trauma-informed PMTO
  - (Statewide implementation of trauma-focused cognitive behavioral therapy)

Defining trauma

- In its definition of posttraumatic stress disorder, the Diagnostic and Statistical Manual uses this definition of trauma: an event or events the person experienced, witnessed, or was confronted with that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

Types of traumatic events

- Family violence
  - Abuse and neglect
  - Domestic violence
- War
  - War in country of origin, refugee status
  - Combat exposure
- Terrorism
  - Single or episodic incidents (e.g. Norway)
  - Ongoing attacks (e.g. Israel-Gaza border)
- Community violence
- Also: medical trauma, motor vehicle accidents, other accidents

Trauma exposure is common: USA data

- 15 to 43% of girls and 14 to 43% of boys have experienced at least one traumatic event in their lifetime.
- Maltreatment incidence is 12 per 1,000 children
- 1.8 to 4 million American women are physically abused each year.
- It is estimated that 7-14 million children witness family violence each year (Edleson et al., 2007)
- USA has the highest level of homicide of any developed country in the world.
  - Homicide is the third-leading cause of death for children ages 5-14, the second-leading cause of death for those aged 15-24, and has been the leading cause of death for African-American youth from the early 1980s into the early twenty-first century

The cycle of violence

- Both follow-up and follow-back studies have consistently shown a direct link between exposure to violence and subsequent perpetration of violence.
- For example, Widom (2001) reported that child victims of maltreatment were 59% more likely to be arrested as juveniles, 28% more likely to be arrested in adulthood, and 30% more likely to be arrested for a violent crime.

The impact of trauma on children
Short Term Effects: Acute Disruptions in Self Regulation

- Eating
- Sleeping
- Toiletting
- Attention & Concentration
- Withdrawal
- Avoidance
- Fearfulness
- Re-experiencing /flashbacks
- Aggression; Turning passive into active
- Relationships
- Partial memory loss

Long Term Effects:
Chronic Developmental Adaptations

- Depression
- Anxiety
- PTSD
- Personality
- Substance abuse
- Perpetration of violence

Trauma and Developmental Psychopathology

Trauma & Cumulative Risk Overlap

- Risks 'pile up' (Rutter, 1985)
- Secondary adversities during trauma events (Pynoos et al., 1996)
- Multi-problem families risk for trauma (Widom, 1989; 1999)
- Other risks contribute to PTSD

Traumatized parents

Why be concerned with trauma and posttraumatic stress in parents?

- Associations between adult trauma and:
  - Child distress and child PTSD
  - Parenting impairments
- How might parents respond differently to other adults (e.g. service providers) when they are dealing with traumatic stress?
- And most important, how might they deal differently with their children?

Parents who are traumatized may be:

- Suffering from PTSD and related disorders (e.g., depression, anxiety)
- Using drugs to mask the pain
- Disempowered
- Parents of children who have become “parentified” (i.e. responsible beyond their years)

How might parents' trauma histories affect their parenting?

- A history of traumatic experiences may:
- Compromise parents' ability to make appropriate judgments about their own and their child's safety and to appraise danger; in some cases, parents may be overprotective and, in others, they may not recognize situations that could be dangerous for the child.
- Make it challenging for parents to form and maintain secure and trusting relationships, leading to:
  - Disruptions in relationships with infants, children, and adolescents, and/or negative feelings about parenting; parents may personalize their children's negative behavior, resulting in ineffective or inappropriate discipline.
  - Challenges in relationships with caseworkers, foster parents, and service providers and difficulties supporting their child's therapy.

Trauma history can:

- Impair parents' capacity to regulate their emotions.
- Lead to poor self-esteem and the development of maladaptive coping strategies, such as substance abuse or abusive intimate relationships that parents maintain because of a real or perceived lack of alternatives.
- Result in trauma reminders—or "triggers"—when parents have extreme reactions to situations that seem benign to others.
- NCTSN, 2011: http://www.nctsn.org/products/birth-parents-trauma-histories-and-child-welfare-system

Traumatized parents may…

- Find it hard to talk about their strengths (or those of their children)
- Need support in managing children's behavior
- Have difficulty labeling their children's emotions, and validating them
- Have difficulty managing their own emotions in family communication
  - When posttraumatic stress symptoms interfere with daily interactions with children, parents should seek individual treatment

Posttraumatic stress disorder

- Diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters:
- intrusive recollections
  - Includes nightmares, flashbacks & associated physiologic reactivity
- avoidant/numbing symptoms
  - Avoiding thoughts, feelings, conversations, activities etc, associated with the traumatic event
  - Inability to recall an important aspect of the event
  - Diminished interest or participation in activities, estrangement or detached feelings
  - Restricted range of affect, sense of foreshortened future
- hyper-arousal symptoms
  - Sleep problems, hyper vigilance, exaggerated startle, irritability or anger, concentration difficulties

How does adult posttraumatic stress disorder affect parenting?

- Growth in fathers' PTSD is associated with self-reported impairments in parenting one year after return from combat

- Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, (2010), Journal of Consulting and Clinical Psychology, 78, 5, 599-610

Traumatized parents

- Trauma and adversity affect children's adjustment because they impair parenting:
  - Disrupt emotion socialization of parents
    - Increase experiential avoidance
    - Increase emotion dismissing
    - Increase withdrawal and coercion, bids for attention and other atypical family processes
  - emotion socialization includes:
    - discussion of emotions,
    - teaching about and responding to children's emotions
    - responding to own emotions
  - increase coercive parenting

Parenting & Trauma

- Trauma elicits proximity-seeking in children (Bowlby, 1969)–(parents proximal)
- Much research on effects of parental functioning on child outcomes following traumatic events
- Little research on effects of *parenting* practices on child outcome following traumatic events
- Yet, parenting practices have more influence than parent's functioning on children's behavior!

Parenting practices predict children's recovery from a traumatic incident

- Mothers' observed effective parenting is associated with steeper reductions in child-reported traumatic stress over a period of four months following a domestic violence incident
- Gewirtz, Medhanie, & DeGarmo, (2011), Journal of Family Psychology, 25, 29-38.

Interventions that buffer parenting show improvements to child internalizing and stress regulation

- Parent training directed at mothers only resulted in improvements to child internalizing (later associated with reductions in externalizing) (DeGarmo, Patterson, &Forgatch 2005)
- Foster parent training associated with changes in children's cortisol levels (Fisher et al., 2000; 2006)

Interventions to address trauma in a family context

Strengthening parenting: trauma-informed PMTO

Examining PMTO with families exposed to traumatic events

- Stages:
  - Modifications
  - Feasibility test
  - Effectiveness trials

- Populations:
  - Parents exposed to domestic violence
    - Gewirtz & Taylor, 2009
  - Homeless families with high trauma exposure
    - Randomized controlled trial of PMTO groups in family supportive housing (NIMH funded)
  - Immigrant families fleeing war (SAMHSA funded)
    - Completed feasibility trials with 10 Somali moms in public housing
  - Military families with parents deployed to combat
    - Underway: An RCT of After Deployment, Adaptive Parenting Tools (NIDA funded)

Trauma-informed PMTO (Gewirtz & Davis, in press)

- Theoretical framework II:
  - Social interaction learning: Patterson, Gottman
    - Gottman & Katz – meta emotion philosophy: dismissing, rejecting, or invalidating parenting practices may impede children's emotion regulation; emotion coaching may enhance it.
  - Mindfulness: e.g. Kabat-Zinn
    - Emotionally uncontrolled and coercive interactions may be overlearned and automatic (i.e., mindless; Langer & Imber, 1979)
    - Mindfulness interventions have been used with success in a variety of contexts (e.g. Kabat-Zinn, 1992; Linehan, 1993; Hayes et al., 2000).

Population presenting problems

- Complex trauma
  - Exposure to domestic violence
  - Maltreatment
  - Homelessness
- Exposure to combat – military families

Homeless families - Early Risers study

- We implemented PTC in the context of an RCT of the Early Risers prevention program, in 8 housing agencies (N=16 in the sample; 134 families).
- At baseline we found that mothers' parenting self-efficacy was associated with observed effective parenting – and with child adjustment (Gewirtz et al., 2009)
- At two-year follow-up, the Early Risers program had a significant effect on parenting self-efficacy. In turn, self-efficacy was associated with improved parenting practices (observed), and parenting was associated with improved child adjustment (teacher ratings); Gewirtz et al., under review).

Extending PMTO for military families

ADAPT

After Deployment: Adaptive Parenting Tools

Background and rationale

- National Guard and Reserves (NG/R) are USA's 'civilian soldiers'
- Dispersed with no common support system
- Now face multiple deployments
  - Unprecedented reliance on NG/R troops
  - Typical deployment is 12 months in Army Guard (mean – 2.2)
  - Multiple, shorter deployments in Air Guard
- Balance multiple daily demands: work, family, military
- Higher rates of PTSD, substance use disorders

Combat deployment is a family stressor

- Separations from family and children
  - Intense work conditions
  - Exposure to potentially traumatic events
- Associations between combat deployment and family functioning (e.g. Karney, 2007; Jensen & Shaw, 1996; McCarroll et al, 2000; Chandra et al., 2010)
  - Depression in spouses
  - Child adjustment problems
  - Domestic violence (also associated with children at home)
- Combat related stressors (not just deployment) also affect families
  - Combat-related PTSD associated with marital disruption, spousal abuse, parenting skills & satisfaction (e.g. Glenn et al, 2002, Prigerson et al., 2001; Solomon et al., 1992)

Reintegration is a key transition point

- Stressful for families – longer and more complex than previously thought (MacDermid, 2006)
- Yet more complex if service member was injured (Cozza et al., 2005)
- Key transition times offer special opportunities for prevention (e.g. as parents are readjusting parenting roles)

Effectiveness of a web-enhanced parenting program for military families

- 5 year study (2010-2015) funded by National Institutes of Health/ National Institute on Drug Abuse
- 400 NG/R families recruited and followed over a 2 year period beginning summer 2011
  - Random assignment to a parenting program (ADAPT) or parenting services-as-usual (web and print resources)
  - Parents and teachers complete online questionnaires, and observational, self-report, and physiological data are gathered from families at baseline, 12, 18, and 24 months.
  - Outcomes: child substance use risk, behavior & emotional problems, parent adjustment (mental health, substance use), parenting, parent emotion regulation, parent emotion socialization

Modifications to PMTO for military families: ADAPT

- Attention to emotion regulation in family communication (emotion socialization)
  - Mindfulness training (to address experiential avoidance associated with PTSD symptoms)
  - Emotion coaching (esp. responding to children's fears)
- Attention to military culture and values
- Emphasis on united parenting front (for two-parent families)
- Addressing common barriers to participation
  - Web-component to increase involvement in group program by other caregivers, spouses, etc.
  - Stand alone online ADAPT is under development

Measurement

- Multi-method, multi-informant measures gathered at baseline, 6, 12, & 24 months
- Online data gathering
  - Parent(s) enter through online portal & consent
- In-home assessment
  - Parent, child self-report (online, with tablets)
  - Observational data (family interaction tasks)
  - Physiological data (vagal tone, heart rate)
- Teacher report
  - online

Descriptive data on families recruited to date

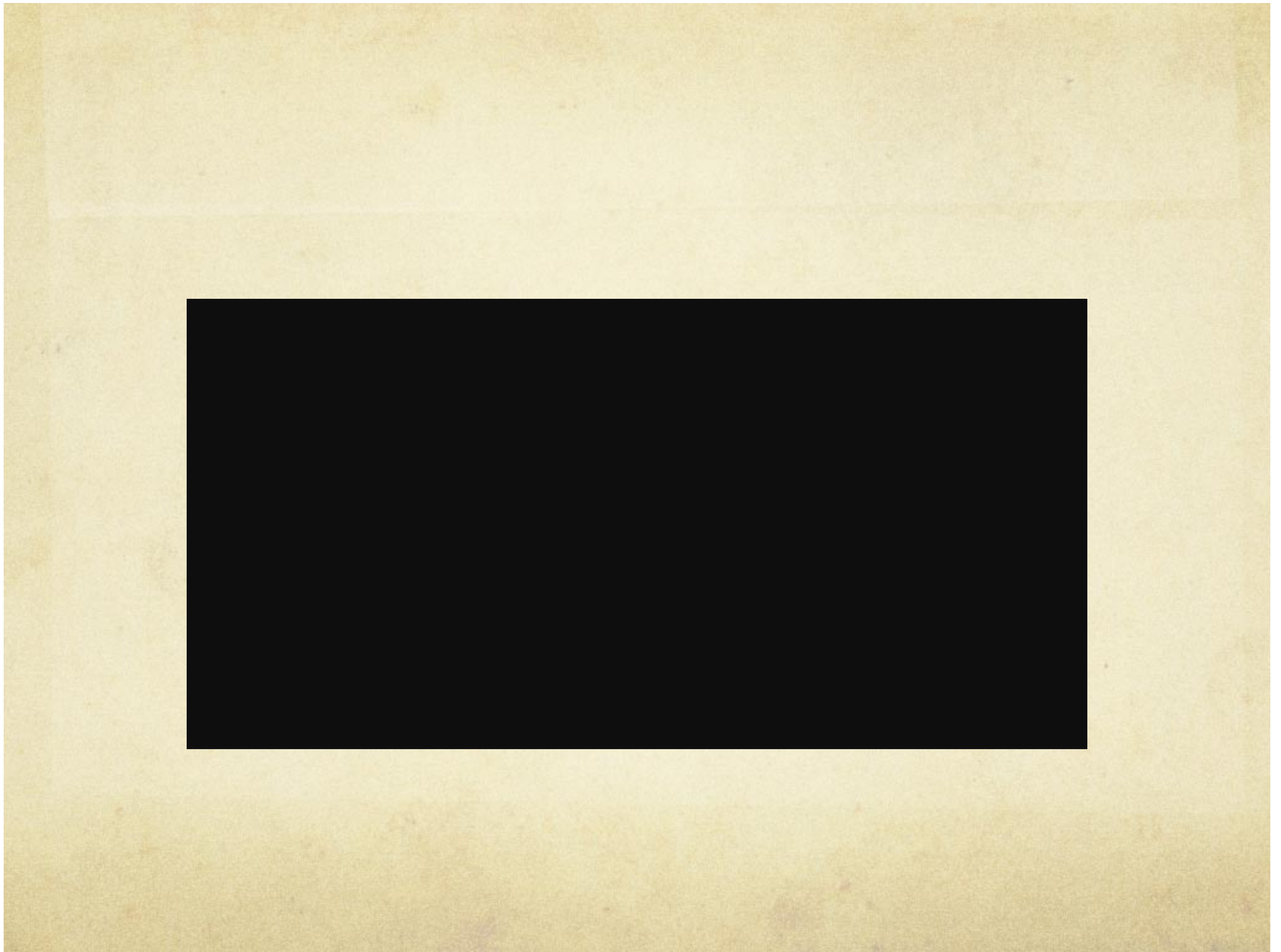
- N=260 families; 80% 2-parent families
- Average annual income range $60-70,000
- Mean length of marriage: 8.9 years
- Average number of children: 2.4
- Number of deployments: 1-6 for women, 1-11 for men (mean = 3.1 men, 1.6 women)
- 15% deployed moms; 93% deployed dads

ADAPT: After Deployment Adaptive Parenting Tools

- A 14-week long, web-enhanced, group-based program that will be offered to NG and Reserve troops returning from deployment who have at least one child aged 5-12yrs
- Weekly, provided in the community, 2hrs long, groups began Sept 2011
- Online ADAPT is available to participants for 12 months

ADAPT

- Groups include standard PMTO plus mindfulness training in each session.
- Problem solving component adds emotion coaching (3-4 sessions)
- Online ADAPT consists of skill videos demonstrating each parenting tool, plus practice videos, mindfulness exercises that are downloadable to MP3s and cellphones, and home practice worksheets



6-month follow up data - preliminary

- 43 participants in 27 families with baseline and Time 2 (post intervention data)
  - 16 Couples (32 moms and dads)
  - 8 single mothers/mother-only data
  - 3 Single fathers/father-only data
  - 23 controls, 20 intervention participants

- Outcomes
  - Parenting practices (self report of discipline; APQ)
  - Parenting self-efficacy (PLOC)
  - Couple satisfaction (DAS)

Using ITT analyses, families assigned to ADAPT reported:

- Significantly less poor discipline than control families (p=.01; D=.291)
- Significantly better parenting self-efficacy (p=.002; D=.598)
- Significantly improved couple adjustment (p=.000; D=.399); mothers reported greater marital adjustment than fathers
- All effects were consistent across baseline levels of variables (i.e. regardless of whether participants started out at low or high levels of a variable)

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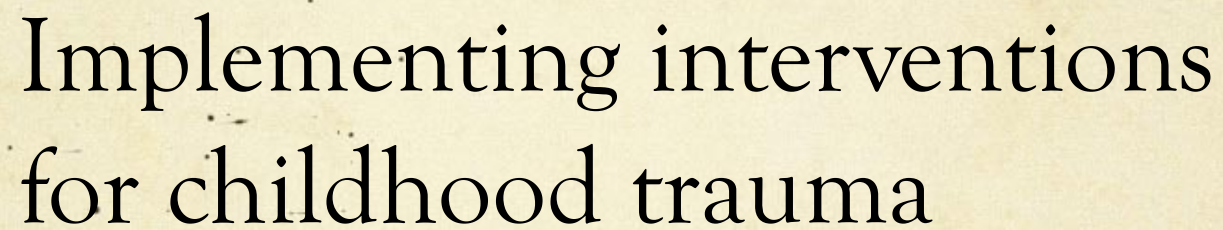

Implementing interventions
for childhood trauma

Trauma treatment

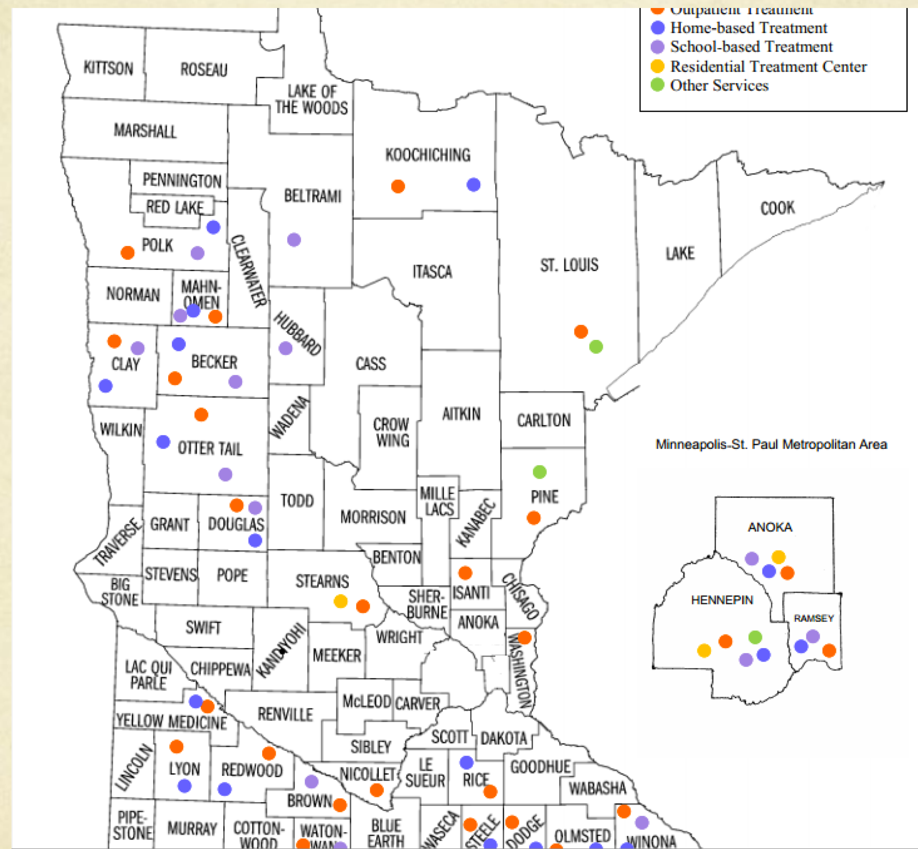
- Trauma-focused cognitive behavior therapy (Cohen, Mannarino, Deblinger, 2006)
  - See http://tfcbt.musc.edu
  - Validated for 3-18 year olds
  - Essential components:
    - Establishing and maintaining therapeutic relationship with child and parent
    - Psycho-education about childhood trauma and PTSD
    - Emotional regulation skills
    - Individualized stress management skills

TF-CBT contd.

- Connecting thoughts, feelings, and behaviors related to the trauma
- Assisting the child in sharing a verbal, written, or artistic narrative about the trauma(s) and related experiences
- Encouraging gradual in vivo exposure to trauma reminders if appropriate
- Cognitive and affective processing of the trauma experiences
- Education about healthy interpersonal relationships
- Parental treatment components including parenting skills
- Joint parent-child sessions to practice skills and enhance trauma-related discussions
- Personal safety skills training
- Coping with future trauma reminders

Implementation of TFCBT across Minnesota

- Training requires 10 days of face-to-face training plus tfcbt web completion
  - Trauma assessment (2 days)
  - Introduction to trauma (1 day)
  - TF-CBT (7 days)
  - Plus, bimonthly consultation calls for 18 months
- Since 2006, 210 therapists trained in TF-CBT across MN
- Over 1000 children screened and treated for trauma-related disorders
- Statewide certification underway (1st in USA)

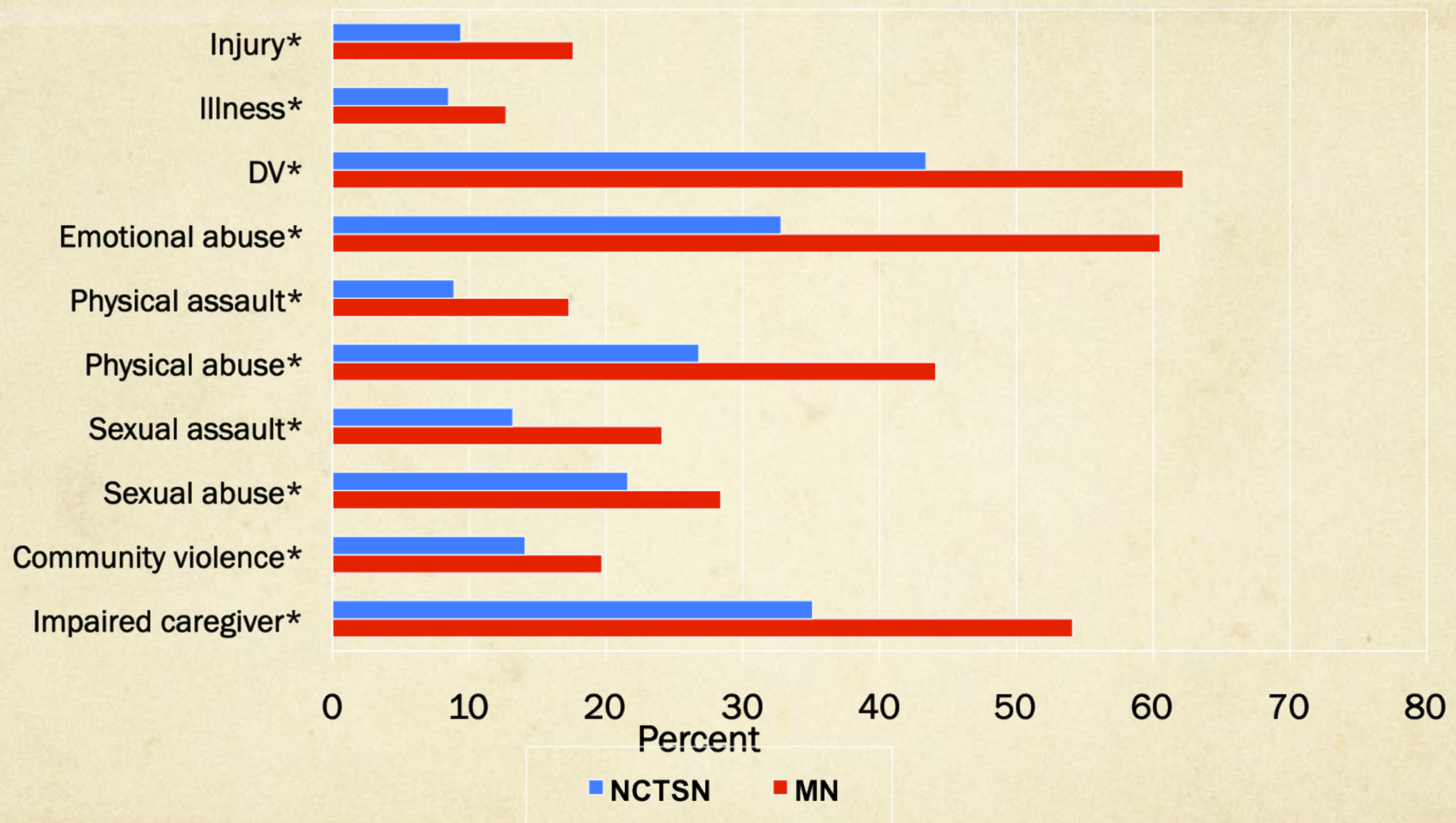


Home-based Treatment
School-based Treatment
Residential Treatment Center
Other Services
KITTSON
ROSEAU
LAKE OF THE WOODS
MARSHALL
KOOCHICHING
PENNINGTON
RED LAKE
BELTRAMI
POLK
COOK
LAKE
ITASCA
ST. LOUIS
NORMAN
MAHN-OMEN
CLEARWATER
HUBBARD
CLAY
BECKER
CASS
WADENA
CROW WING
AITKIN
CARLTON
WILKIN
OTTER TAIL
Minneapolis-St. Paul Metropolitan Area
TODD
MORRISON
MILLE LACS
KANABEC
PINE
GRANT
DOUGLAS
TRAVERSE
ANOKA
BENTON
STEVENS
POPE
STEARNS
BIG STONE
SHER-BURNE
ISANTI
CHISAGO
HENNEPIN
RAMSEY
SWIFT
ANOKA
KANDIYOHI
MEEKER
WRIGHT
WASHINGTON
LAC QUI PARLE
CHIPPEWA
McLEOD
CARVER
YELLOW MEDICINE
RENVILLE
SCOTT
DAKOTA
SIBLEY
LINCOLN
LYON
REDWOOD
NICOLLET
LE SUEUR
RICE
GOODHUE
WABASHA
BROWN
PIPE-STONE
MURRAY
COTTON-WOOD
WATON-WAN
BLUE EARTH
WASECA
STEELE
DODGE
OLMSTED
WINONA

Comparison of subsample of children served by Ambit Network vs. NCTSN nationwide data

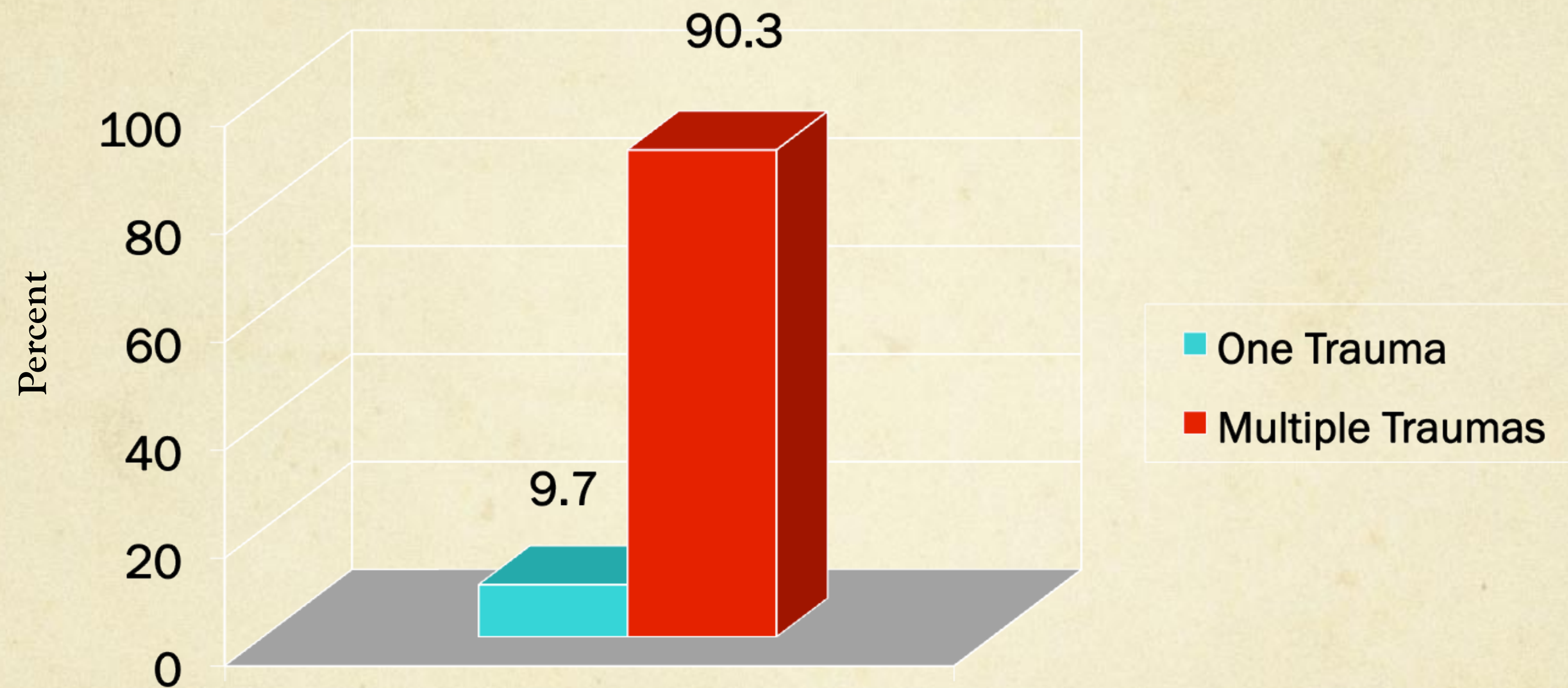
	Minnesota (N=836)		Network (N=12,462)
Age at Baseline (Tx Entry)	Mean = 12.2; Range = 4-18		Mean=10.47 ; Range=4.3
Race	Caucasian	62.2%	52.3%
	African American	21.1%	30.4%
Ethnicity	Hispanic/Latino	8.5%	28.6%
Sex	Female	53.1%	52%
	Male	46.9%	47.9%
Living Situation	Parent(s)	53.5%	53.5
	Other Relatives	8.1%	12.9
	Foster care	7.3%	8.2
Insurance Coverage	Any insurance	70%	70.4%
	Public	50.7%	60.8%
	Private	20.3%	11%

Most commonly reported traumas: MN vs NCTSN children



*p ≤.000

Single VS. Multiple Traumas (MN)



M= 4.6 Range 1-20

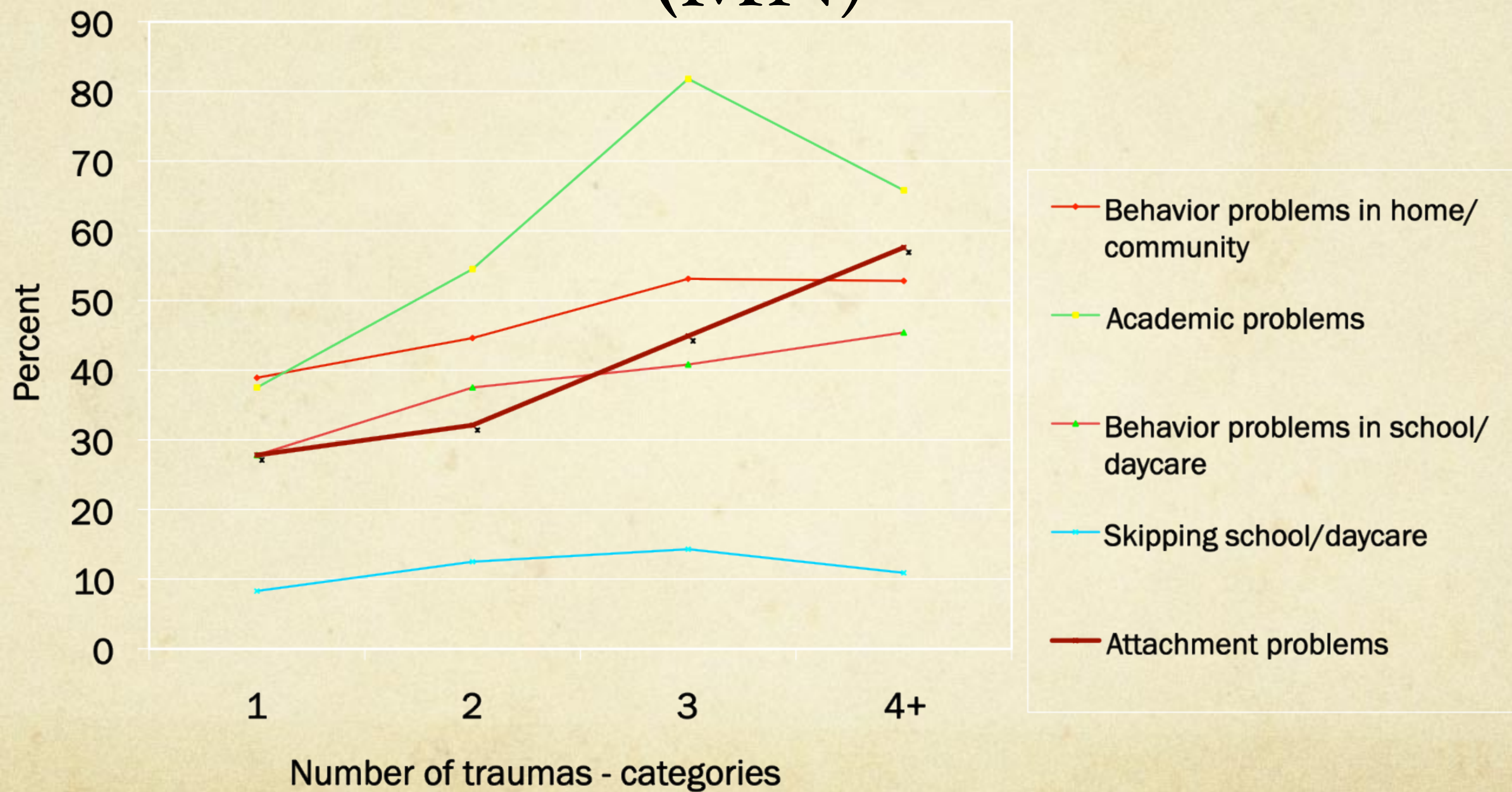
Clinical Evaluation (MN; N=836)

	% of children with a probable or definite diagnosis
Generalized Anxiety	35.3%
Depression	45.7%
ADHD	25.8%
ODD	24.9%
Gen. Behavioral Problems	38.8%
PTSD	52.2%
Attachment problems	33.4%
Traumatic grief	25.3%
Acute stress disorder	14.8%

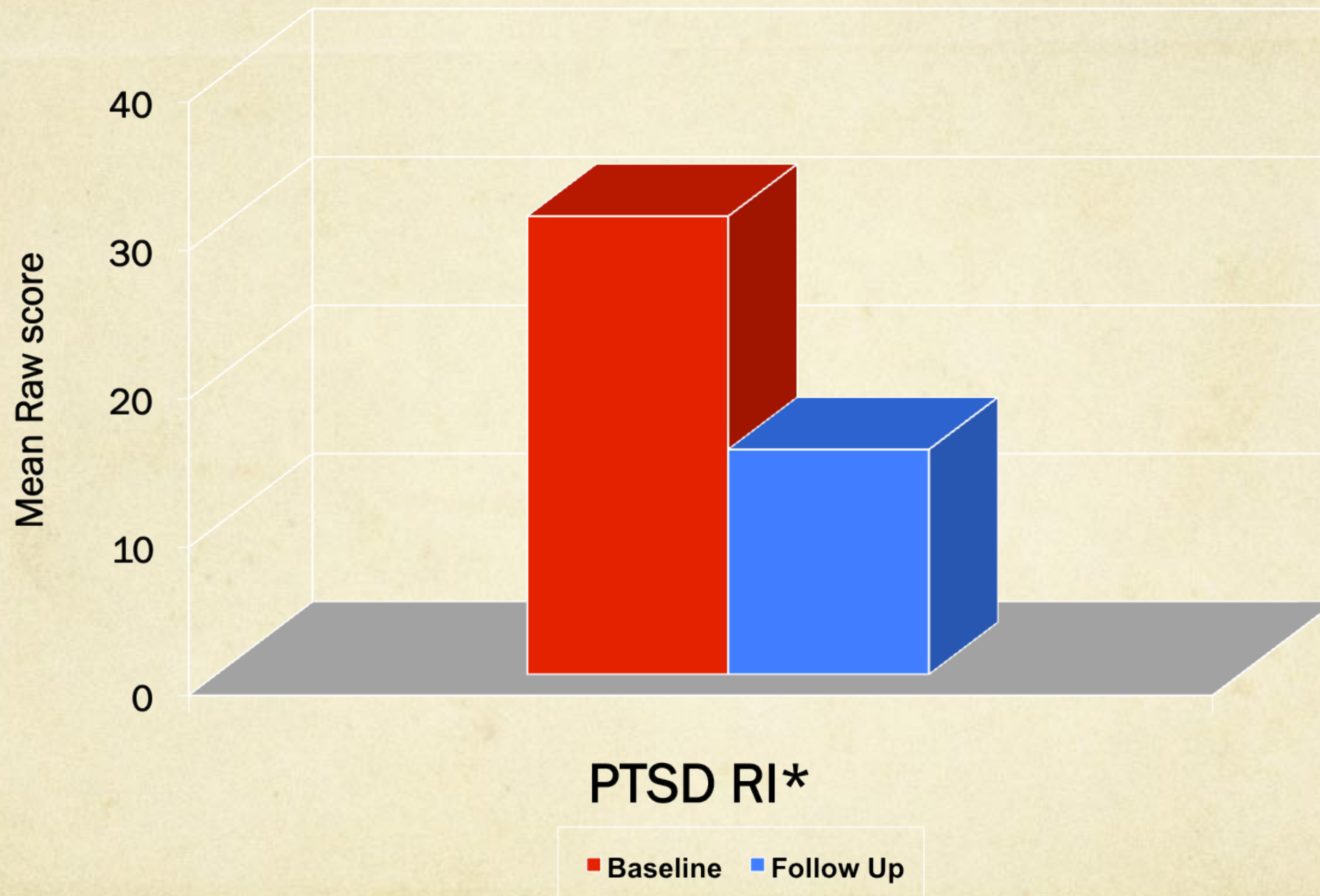
Functional Impairments (MN)

	Somewhat and very much a problem
Problems in the Home/Community	
Behavior problems at home/comm.	50.3%
Attachment problems	49.2%
Running away from home	5.9%
Criminal activity	7.6%
Social and School Functioning	
Academic problems	47.8%
Behavior problems in school	41.9%
Problems skipping school	11.4%
Risk Taking Behaviors	
Self injury	13.8%
Suicidality	18.1%
Inappropriate sexual behaviors	15.9%

Multiple Traumas & Problems in Other Domains of Functioning (MN)



Clinical Outcomes at End of Tx Follow Up on the UCLA PTSD-RI (MN)



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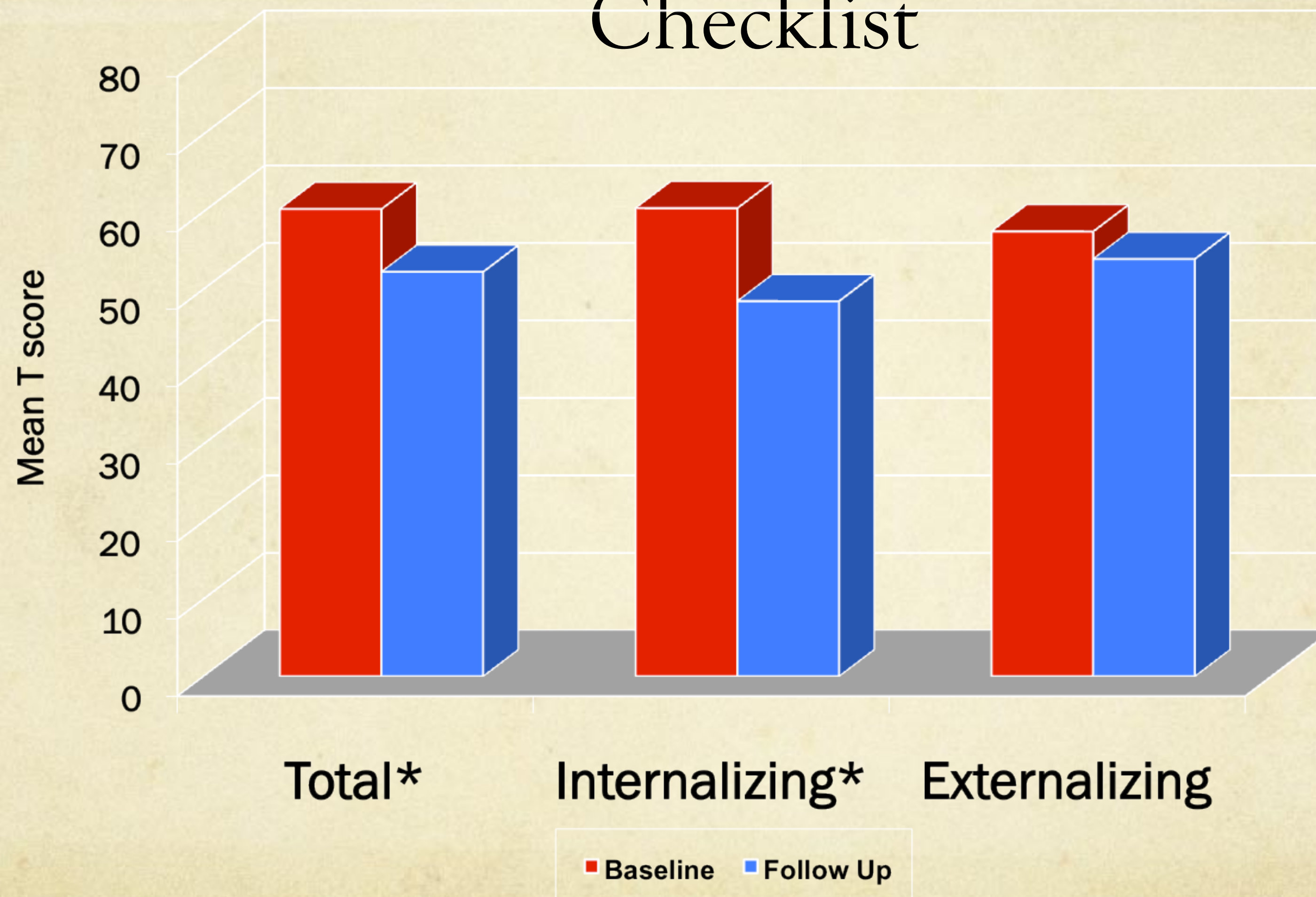
Pre and post-treatment changes for MN children on the Child Behavior Checklist



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