CHILDHOOD TRAUMA

DISCUSSION

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PREFACE

Research shows that adverse traumatic experiences in childhood can not only affect a child's perception of his or her environment and the child's role in it, but trauma can also affect a child's brain development, making it all the more challenging to reach successful adulthood. Understanding the sources and impact of trauma should guide our approach to children's services and to the training of personnel in all child serving systems, including health care providers, school staff, juvenile courts, DFCS staff).

Our goal at Voices for Georgia's Children is to help decision-makers craft and implement policies that ensure Georgia's children grow up to be healthy, educated and productive citizens. To that end, we have developed a comprehensive policy agenda focused on early childhood, child health and disconnected youth, which, if followed, can effectively prevent and offset some of the damaging experiences faced by our children. Many of our recommendations are aligned with those included in this policy brief. Please read on.

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DISCUSSION

What is trauma?

How does trauma during childhood affect both brain and social development throughout a person's lifetime? What are recommendations for policies aimed at reducing the occurrence of childhood trauma as well as alleviating its effects later in life? Traumatic experiences in childhood increase the risk of a variety of mental and physical health issues in adolescence and adulthood.[1] These experiences may cause negative stimulation in the maturing brain that will determine the functional capacity of the brain.[2] Policies that consider the effects of childhood trauma and promote healthy child and youth development are crucial to creating a foundation for educational success, healthy relationship developments, and economic productivity.[3]

Trauma is another way of referring to a person's emotional and physiological response to adverse childhood experiences (commonly known as "ACE's"). These adverse experiences include exposure to parental separation, parental alcohol or drug abuse, witness to injury or murder, sexual abuse or assault, physical assault, physical abuse, serious neglect, removal from home, and being threatened or held captive.[4] A recent study of over 1000 high school seniors, examining the prevalence of these experiences and their effects throughout a person's life, found that the most commonly reported adverse childhood experience was parent separation, i.e. divorce, with 27.5%.[5] One in seven respondents (14.2%) reported living with an unemployed parent, a parent with a drinking or drug problem, or witnessing an injury or murder.[6] 11.7% of girls in the study reported sexual abuse, compared to 1.4% of boys.[7] Furthermore, girls reported much higher rates of physical abuse (5% compared to 3.3%) and serious neglect (3.3% compared to 1.7%).[8]   The study found that boys reported higher rates of witnessing an injury or murder (19.7% compared to 13.8%), physical violence (10.8% to 4.5%), and being threatened, held captive, or kidnapped (15.5% v. 4.3%) than their female counterparts.[9]

Child sexual abuse in particular has been the subject of numerous studies of negative childhood experiences. A 2002 study of over 17,000 adult health care plan members found that 21% of participants reported being sexually abused during their childhood (25% of females and 16% of males).[10] Sexual abuse rarely occurs as an isolated event; it clearly overlaps with other types of negative childhood experiences.[11] In fact, the presence of childhood sexual abuse significantly increased the likelihood of experiencing further adverse childhood experiences, including emotional abuse, household dysfunction, and emotional neglect.[12]

How is trauma related to post-traumatic stress disorder?

Research has shown that childhood abuse, particularly sexual abuse, may be linked to post-traumatic stress disorder (PTSD).[13] A recent study compared rates of PTSD diagnoses of nearly 500 sexually abused, physically abused, non-abused (neglected) foster children.[14] The study found that more than 60% of sexually abused foster children were diagnosed with PTSD, compared with approximately 40% of the physically abused group of children and nearly 20% of the non-abused foster children.[15] A 2004 study found that rates of PTSD in juvenile justice-involved youth are estimated between 3-50%, compared to the PTSD of soldiers returning from deployment in Iraq (12-20%).[16] Not all children who experience trauma develop PTSD, however some children may experience partial symptoms of PTSD, other forms of anxiety or depression, or other significant impairments in their ability to meet the demands of daily life.[17] Consequently, addressing and attacking the roots of childhood trauma may be an important method of preventing the development of PTSD.[18]

How does trauma affect childhood development?

Children respond to stress in one of three ways: Positive stress response, Tolerable stress response, and Toxic stress response.[19] Characterized by brief increases in heart rate and mild elevations in hormone levels, the positive stress response is a normal and essential component of a child's development.[20] A tolerable stress response, on the other hand, activates the body's alert systems to a greater degree and is the result of more severe, longer-lasting difficulties, such as the loss of a loved one, a natural disaster, or an injury.[21] If this response is time-limited and a child has relationships with adults helping him adapt, the brain and other organs recover from what might otherwise lead to damaging effects.[22] Finally, and most importantly, is the toxic stress response, which can occur when a child experiences strong, frequent, and prolonged adversity, including physical and emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and family economic hardship.[23]

All of the adverse childhood experiences ("ACE's") mentioned above have been associated with at least one adverse health outcome.[24] Increasing the frequency of a given adverse childhood

experience significantly increases impact on depressive symptoms, drug use, and antisocial behavior.[25] This effect becomes even stronger when a respondent has experienced multiple types of adverse childhood experiences.[26]

The intensity and duration of a child's response to trauma is dependent upon a variety of factors, including the child's age, the meaning of an event for the child, the nature of the trauma, the presence of a supportive caretaker, and the presence of an aggravating loss (particularly the loss of a caretaker).[27] There can be mitigating factors, such as early intervention, after the traumatic experience, which are discussed in the Policy Solutions section of this document.[28] Events throughout a person's life are likely to result in a different combination of adaptive responses, depending upon the time during a person's life where it occurs.[29]

Health

There is extensive evidence of a strong relationship between early trauma and a wide range of health-threatening behaviors.[30] Adolescents with a history of multiple risk factors and adverse childhood experiences are more likely to begin drinking alcohol at a younger age and are more likely to use alcohol as a means of coping with stress.[31] Increased exposure to adverse childhood experiences is also linked with tobacco use, drug use, sexual promiscuity, and obesity.[32] Furthermore, adolescents (and adults) who display higher rates of risk-taking behaviors are also more likely to have trouble maintaining supportive social networks and are at a higher risk of incarceration, violent crime, failure in school, gang membership, unemployment, poverty, homelessness, and single parenthood.[33] Ultimately, this often leads to a cycle of significant adversity that spans generations.[34]

Behavioral Health

Because of the effect some adverse experiences have on a child's stress system, traumatized children have been found to be at later risk for their own mental illness and behavioral health challenges. Older youths in foster care have disproportionately high rates of lifetime and past-year psychiatric disorders compared to youths not in the foster care system. Some, but not all, psychiatric disorders result from traumatic experiences.[35] 61% of foster youths qualified as having at least one psychiatric disorder during their lifetime, with 62% of these youths reporting the onset of their earliest disorder before entering into the foster care system.[36]

Nutrition

Lack of adequate nutrition is a form of neglect and can have a traumatic effect on a child's development.[37] Adequate nutrition before birth (for pregnant women) and after birth (for both the primary caregiver and the baby) are fundamental to the promotion of healthy child development, particularly given the large number of preventable threats to brain development early in life.[38] Toxic stress in childhood is possibly associated with the adoption of unhealthy lifestyles as a coping mechanism.[39]

Eduction

Recent research has shown that childhood trauma can diminish concentration, memory and the language abilities that children need to succeed in school. To teachers and other school staff, these inattentive, disorganized or hyper behaviors may look very much like ADHD (Attention Deficit Hyperactivity Disorder), which in reality, they are a result of a heightened arousal system due to trauma.

Why should policy makers care about childhood trauma?

There are deep cultural and public policy implications that arise from understanding the critical role of a child's early experiences in determining their functional capacity as an adult.[40] It is commonly thought that children are resilient, when in reality, they are impressionable and very vulnerable.[41] In the process of coping with traumatic experiences, without appropriate supports, critical elements of a child's emotional, behavioral, cognitive, and social potential are diminished, and a piece of the child can be lost forever.[42]

POLICY SOLUTIONS

The following recommendations address childhood stress from a variety of points. In order to adequately tackle childhood trauma, policies must focus on a child's developmental needs from birth.[38] In addition, an adequate support system for each child should be at the center of any child policy platform.[39] Furthermore, policies should focus on community-based services, including programs that work to eliminate the underlying causes of childhood trauma, such as efforts made to reduce domestic and neighborhood violence, substance abuse, and poverty.[43] Cohesive policies that attack childhood trauma from several different angles, all the while fostering a supportive environment for children, will see the most success in reducing both its individual and societal costs.[44]

Early Care and Learning

- Counter childhood trauma by creating an environment where the effects of toxic stress are buffered with appropriate supports helping children adapt and enhancing child cognitive and social development.[45]

- Increase participation of children from low-income families in high-quality early education centers.

  ◊ Economists advocate for early and sustained investments in early childcare and education programs, particularly for children whose parents have limited education and low income, on the basis of cost-benefit analyses that reveal even higher costs with incarceration and reduced economic productivity associated with poor educational outcomes.[46]

  ◊ Effective programs provide a combination of the following characteristics: 1) highly skilled teachers who are trained in child development and are knowledgeable about the effects of stress and trauma on behavior and development; 2) small class sizes and high adult-to-child ratios; 3) age-appropriate curriculum and stimulating materials in a safe physical setting; 4) a language-rich environment; 5) warm, responsive interactions between staff and children; and 6) high and consistent levels of child participation.[47]

- Increase participation of families, quality teachers and child care centers in the Georgia Department of Early Care and Learning's (DECAL) Quality Rated System

  ◊ Despite the existence of national health and safety performance standards for out-of-home childcare programs, many unlicensed childcare settings, particularly those for toddlers and infants, do not follow even the basic safety provisions.

  ◊ DECAL's Quality Rated System is a systematic approach to assess, improve, and communicate the level of quality in early and school-age care and education programs. Similar to rating systems for other service- related industries, Quality Rated assigns a quality rating to early and school-age care and educational programs that meet a set of defined program standards.[48]

- Increase the resources allocated to support implementation of Positive Behavior Intervention and Supports in early learning environments and childcare centers to establish the positive climate needed for healthy development.

Early Intervention

- Increased access to health care and home visiting support helps to prevent threats to healthy development and also provides early diagnoses, appropriate care, and intervention when problems emerge.[49]

    ◊ Increased access to basic medical care for children and pregnant women.

        - Benefits include positive effects of adequate prenatal and early childhood nutrition on healthy brain development, and improved outcomes for young children with developmental delays or vision or hearing impairments, when their difficulties are detected and early intervention begins. [50]

- Home visiting programs with skilled personnel who provide intensive family support.

    ◊ Home visiting is shown to reduce instances of abuse and neglect and therefore can reduce the instances of childhood trauma.[51]

    ◊ Highly skilled personnel, with the proper training and program resources to reduce the impact of stressors on the home environment, will improve the long-term physical and mental health of the children.[52]

- Develop a comprehensive and coordinated three-year child and adolescent behavioral health state plan.

    ◊ From birth to adolescence, prevention to high end intervention, this plan would include input from policy maker, provider and consumer stakeholders.

    ◊ The plan would identify strategies that coordinate resources from all child serving systems and create sustainable models to address all behavioral health needs, including evidence based trauma therapies.

- Increase access to basic medical care for children through improved insurance enrollment practices and start up support for school-based health services

    ◊ 189,000 children in Georgia do not have health insurance, and it is estimated that nearly 130,000 of them are eligible for Medicaid or Peachcare, yet remain uninsured.

    ◊ School-based health centers provide primary and behavioral health care to children who would otherwise struggle to get their basic health needs met. With 320,000 of Georgia's children missing more than 10 days per year of school due to illness, school-based health services are critical to keeping children healthy and in class. In Georgia, SBHCs have been demonstrated to improve both health and education outcomes, including significantly reduce emergency room visits and hospitalization for asthma and reducing absences from school. On average, SBHCs become independently financially sustainable, but start-up costs are needed.

Parental Health

- Addressing parental mental and behavioral health can prevent or minimize a child's exposure to traumatic environments.

    ◊ Adverse experience and neglect resulting from unmet mental and behavioral health needs of adults (particularly mothers) can impact children in their presence. Mental illness or addictive disease in a caregiver or close adult can result in physical injuries as well as trauma to a child.

        - Children rely greatly on healthy caregivers and mentors. Diminished access to all kinds of health services for care-giving and mentoring adults can affect access to those adults by children. Loss of a caregiver is a leading source of trauma in children.

Afterschool Programs

- Increase funding and prevalence for quality after-school programs like the Boys & Girls Clubs of America.[53]

  ◊ After-school programs provide a safe place for children after school hours have ended with nutritional snacks and supportive adults who assist in mentoring children.

  ◊ Promote the use of Georgia's new Afterschool and Youth Development (ASYD) Quality Standards.

Foster Youth Care

- Department of Family and Child Services (DFCS) and Care Management Organizations should develop procedures that enable continuity of behavioral health and primary care while youth are in foster care and after their transitioning out of the system. Strategies could include use of telehealth for behavioral health services as children are placed in different regions on the state, a medical passport to ensure new providers know the child's medical history, ability for providers to talk with previous providers to better understand the child's current medication and history.

  ◊ Initial and periodic mental health assessments should be conducted for children and adolescents in the foster care system, and mental health services should continue for young adults transitioning out of the foster care system.

  ◊ For children and youth with significant prior trauma histories, trauma-focused behavioral health therapies that are evidence-based or evidence-informed should be made available, and provided by professionals trained in these treatments.[57] Trauma-focused therapies can be very beneficial, and more behavioral health professionals are needed to offer these therapies.

  - There were no differences in prevalence rates for youths in kinship care and those in non-kin foster families.[54]

- Georgia's Division of Family and Children Services (DFCS) should strive to maintain placement stability, which appears to have a large, positive effect on mental health outcomes when the foster youth become adults.[55]

Juvenile Justice/School Discipline

- Juvenile courts must work to provide environments that are safe and services that do not increase the level of trauma that youth and families experience.

  ◊ The provision of or referral to evidence-based, trauma-responsive treatment is essential within a trauma-informed system. Children and adolescents are less likely to benefit from rehabilitation services if the system they are involved in does not respond to their issues. This non-response can increase the level of trauma that youth and families experience.[56]

  - A recent study conducted by the Minnesota Department of Public Safety found that 53% of children in correctional facilities reported exposure to trauma, whereas only 28% of youth outside the justice system reported exposure to trauma.[57]

- Support and increase funding for Georgia's Juvenile Justice Incentive Grants , which use evidence-based programs to reduce incarceration by addressing social-emotional challenges for children at medium to high risk to re-offend.

- Support development and improvement of protocols and practices for Children in Need of Services (CHINS) programs for children committing status offenses.

- Raise the age of juvenile court jurisdiction to include youth who are 17 years old.

  ◊ Juvenile courts are more likely to mandate a 17 year old to attend school, make restitution to victims an attend community-based rehabilitative

programs that focus on the causes of the problem behavior, all of which are likely to reduce trauma for youth who's brain is still in development.

- Eliminate shackling of youth in juvenile court

- Eliminate solitary confinement for youth in detention.

- Implement PBIS in all school settings, including early learning.

Workforce and Systems Development

- Caregivers and child-serving professionals should receive training on the effects of trauma and stress on children and youth, so that they can respond appropriately to behaviors and initiate effective interventions.[58]

  ◊ This includes childcare providers, school personnel as well as physical, mental or behavioral health professionals

- Parental leave policies which promote enhanced bonding and responsive caregiving can not only build a

strong foundation for healthy development but they can also provide families with sufficient time to adjust to the arrival of a new child.[59]

- Train adults who work with children and youth across all state agencies to be trauma responsive.

- Compensate adults appropriately compared to market salary rates to improve staff retention, and thereby improve continuity of care for children and youth engaging with these systems.

Nutrition

- Increased funding for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

  ◊ That said, up to 40% of early deaths have been estimated to be the result of behavioral or life-style patterns such as low levels of physical activity, high consumption of fast food, and low consumption of nutritious foods.[60]

  ◊ Mothers who participate in WIC are less likely to have babies with low birth-weight or who were

born prematurely, both of which are associated with lower educational achievement, lower probability of employment, and lower earnings as an adult.[61]

  ◊ For every dollar the government spent on WIC, it saved $3.50 on reduced payments for Medicaid, Supplemental Security Income, special education services, and unneeded medical costs in the first year of life. [62]

OTHER STATE POLICIES AS EXAMPLES

Texas Children Recovering from Trauma, Texas Department of State Health Services

- The funding for this initiative began in 2012 and will continue through 2016, making it difficult to presently evaluate the success of the program.[63]

- The initiative aims to transform children's mental health services in Texas into a trauma-informed care system that fosters resilience and recovery.[64] The target populations are children and adolescents aged 3–17 who are from military families and/or who have experienced or witnessed trauma.[65]

- The initiative will train the Texas mental health workforce, enhance policies and practices, and increase the number of mental health professionals trained in Trauma-Focused Cognitive Behavior Therapy (TF-CBT) and Parent-Child Interaction Therapy (PCIT).[66]

Compassionate Schools, State of Washington, Office of Superintendent of Public Instruction

- Provides training, guidance, referral, and technical assistance to schools that adopt the Compassionate Schools Model.[67]

  ◊ These schools create compassionate classrooms, with the goal of keeping students engaged and learning through the creation and support of a healthy climate and culture within the school, where all students can learn.[68]

  ◊ Every staff member is trained in trauma and its effects on a child's learning.[69]

  ◊ The Heart of Learning and Teaching: Compassion, Resiliency, and Academic Success, one of many resources to be used by those schools wishing to adopt a compassionate approach to learning and teaching, provides current information about trauma and learning, self care, classroom strategies, and building parent and community partnerships that work.[70]

  ◊ Whether or not the Compassionate Schools process is successful depends on each individual school's implementation because it is not "one size fits all", allowing each school to develop its own compassionate "personality".[71]

Multiplying Connections, Health Federation of Philadelphia

- Works with and through public organizations that regularly serve children and families, training professionals in trauma-informed techniques that build resilience in children and reduce harm, while collaborating with administrators and managers to change practices and policies.[72]

- Builds partnerships among organizations to ensure that children have opportunities for optimal development and enter school ready to learn.[73]

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS), Los Angeles, CA

- In 1999, RAND [74] researchers joined colleagues at the Los Angeles Unified School District and the University of California Los Angeles to confront one of the saddest realities in the U.S.—the large number of children who go to school weighed down by experiencing or witnessing some form of violence, trauma, or maltreatment.[75]

- CBITS provides mental health screening and a brief standardized series of therapy sessions in schools aimed at reducing a child's symptoms related to existing traumatic experiences and enhancing skills to handle future stresses. CBITS is founded on cognitive-behavioral therapy, which is recognized by the U.S. Task Force on Community Preventive Services as the only approach with strong evidence of effectiveness.

  ◊ CBITS is designed to be delivered by school mental health clinicians such as social workers, psychologists, and other clinicians. CBITS is being implemented in many school districts nationally, with many training and support activities supported by the National Child Traumatic Stress Network.

  ◊ In addition, a CBITS adaptation—called Support for Students Exposed to Trauma (SSET)—allows teachers and school counselors with no mental health training to deliver a modified program.

Seeking Safety

- Seeking Safety is a present-focused therapy to help both adults and adolescents attain safety from trauma/PTSD and substance abuse.[76]

  ◊ The treatment is designed to be used in a variety of ways for adults and adolescents. Treatment therapies include individual and group formats as well as women, men, and mixed-gender group formats in a variety of settings (outpatient, inpatient, residential). It has also been used with people who have a trauma history, but do not meet criteria for PTSD.[77]

- Seeking Safety meets criteria in the field as an effective treatment for PTSD/substance abuse for adults and a promising treatment for adolescents.[78]

- Seeking Safety shows positive outcomes and is the only treatment outperforming a control on both PTSD and substance use disorder (SUD).[79]
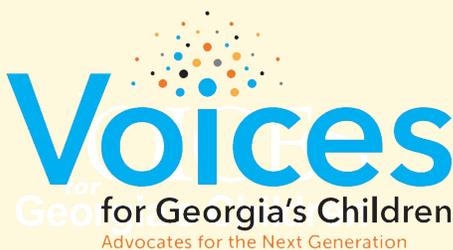
FURTHER READING

- Center on the Developing Child, Harvard University, Early Childhood Program Evaluation: A Decision-Maker's Guide, NATIONAL FORUM ON EARLY CHILDHOOD PROGRAM EVALUATION (2007).

- The National Child Traumatic Stress Network, http://www.nctsn.org

- National Children's Advocacy Center, http://www.nationalcac.org

- University of Albany School of Social Work & Prevent Child Abuse America, Adverse Childhood Experiences Response, http://www.aceresponse.org

- United States Department of Health & Human Services, Administration for Children & Families, Child Welfare Information Gateway, http://www.childwelfare.gov

- World Health Organization, Child Development & Child Maltreatment, http://www.who.int/topics

*End notes for this document can be found at http://bit.ly/2OMILSj

ABOUT VOICES

Established in 2003, Voices for Georgia's Children is a nonpartisan, nonprofit child policy and advocacy organization that envisions a Georgia where children are safe, healthy, educated, employable, and connected to their family and community. It is our mission to be a powerful, unifying voice for a public agenda that ensures the well being of all of Georgia's children.

To fulfill our mission and, ultimately, make life better for Georgia's children, we provide the necessary research-based information, measures, collective voice and proposed legislation to help guide decision makers in the right direction – that is, supporting policies that ensure Georgia's children grow up to be healthy, educated and productive citizens. Learn more at www.georgiavoices.org/about/, and find us on Facebook, Twitter and Instagram.