Using PMTO with children and parents affected by family violence

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  - MN's Department of Human Services, Children's Mental Health and Child Welfare divisions
  - And, thousands of traumatized kids and families in MN

Overview

- Traumatic and stressful events – impact on children's development
- Related resources – the Core Curriculum on Child Trauma, National Child Traumatic Stress Network
  - Geraldine
- Modifying PMTO for family violence
- (What is trauma-informed practice?)

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.

What do we mean by family violence?

- Abuse
  - Sexual
  - physical
- Neglect
- domestic violence/intimate partner violence
- Overlap of other types of violence with domestic violence or child abuse

Family violence is the most common source of children's exposure to violence in USA

- Debates around mandatory reporting of child witnessing of DV/IPV
  - Minnesota experience
- Children may be victims, witnesses, or even perpetrators


trauma & development

Child Development and Trauma

INFANTS AND YOUNG CHILDREN

Expected development

-need protection and nurturing

-need reliability and consistency in care-taking

to respond to situations of uncertainty

-caregiving is basis for secure attachment

Child Development and Trauma

INFANTS AND YOUNG CHILDREN

Stress and Trauma

- disturbances of sleep and eating
- inability to be soothed
- constant crying
- more generalized fears such as stranger or separation anxiety
- avoidance of situations that may or may not be related to the trauma

Child Development and Trauma

PRESCHOOL CHILDREN

(18 months to 3 years old)

Expected development

- rely on natural clues that elicit responses and seek the company of attachment figures to diminish apprehension.
- Increased capacities: physical, cognitive, language development
- normal struggles around separation

Child Development and Trauma

PRESCHOOL CHILDREN

(18 months to 3 years old)

Stress and Trauma

- disruption of expectations of protective figures (attachment difficulties)
- agitated motor behavior or extreme passivity.
- eating and/or sleeping disturbances
- inconsolable crying

Child Development and Trauma

4-6 years old

Expected development

- play: to express feelings and ideas
- increased cognitive capacities
- increased sophistication of language
- less action
- reality and fantasy

Child Development and Trauma

4-6 years old

Stress and Trauma

- regression: loss of previously attained milestones (e.g. toilet training)
- preoccupation with words or symbols that may or may not be related to the trauma.
- posttraumatic play in which themes of the trauma are repeated
- nightmares
- temper tantrums

Child Development and Trauma

School age

Expected development

- rely less on cues from caretakers and understand situations of potential threat . They invoke fantasies of superhuman powers to protect themselves
- mastery and control, separation - individuation, self awareness - self esteem, energy directed to school and learning, increased language sophistication, reality - fantasy, etc.

Child Development and Trauma

School age

Stress and Trauma

- Disillusionment with the outside world
- poor academic performance
- lying
- stealing
- fighting
- sleep and eating disturbances
- clinging
- false bravado

School age contd.

- experience "time skew" and "omen formation" regarding the trauma
  - Time skew refers to a child mis-sequencing trauma related events when recalling the memory.
  - Omen formation is a belief that there were warning signs that predicted the trauma. As a result, children often believe that if they are alert enough, they will recognize warning signs and avoid future traumas.

School age contd.

- posttraumatic play -a literal representation of the trauma, involves compulsively repeating some aspect of the trauma, and does not tend to relieve anxiety. An example of posttraumatic play is an increase in shooting games after exposure to a school shooting.
- reenactment of the trauma - more flexible than PT play- involves behaviorally recreating aspects of the trauma (e.g., carrying a weapon after exposure to violence).

Child Development and Trauma

Puberty/Early Adolescence

Expected development

- psychological concomitant to physical changes
- preoccupation with body
- sense of distinctiveness
- change in relationship with parents
- peer pressure

Child Development and Trauma

Early Adolescence

Stress and Trauma

- feelings of inadequacy
- unrealistic feelings of guilt
- exaggerated preoccupation with body
- somatic manifestations
- acting out:
  - unsafe sex, criminal and illegal activities, drugs, pregnancies, etc.

Child Development and Trauma

Adolescence

Expected development

- revival and culmination of previous developmental issues
- sexual and aggressive urges foster autonomy and independence
- adult physical and cognitive maturation without the emotional component
- identity definition and personality resolution (2nd opportunity)

Child Development and Trauma

Adolescence

Stress and Trauma

- can act as younger children
- inadequate solutions that can be physically dangerous to self and others
- 2nd opportunity for separation and individuation experienced as threatening

Adolescence contd

- Symptoms more closely resemble PTSD in adults
- Traumatic play still evident
- Traumatic reenactment still evident
- More likely than younger children or adults to exhibit impulsive and aggressive behaviors.

Traumatized parents

- May see the perpetrator in their child
- May experience an action of the child's as a trauma trigger
- May depend upon the child for some aspect of their safety or safety plan
- What might it be like to have to manage a child's behavior in the context of the above three considerations?
  - Ideas?

What is the moment-by-moment experience of a child exposed to family violence?

- Development of the Core Curriculum on Childhoood Trauma as an educational tool to 'see through the eyes of the child'.
- Through case-based presentations, those learning to work with traumatized children and families understand trauma reactions, and can explore what trauma-informed practice means.

Geraldine case study

CASE VIGNETTE WORKSHEET

FACTS	HUNCHES	NEED TO KNOW
LIST FACTS	STATE HUNCHES	LIST WHAT NEED TO KNOW IDENTIFY NEXT STEPS

MOMENT-TO-MOMENT TRACKING FORM

Objective				
Sights	**Sounds**	**Smells**	**Physical Sensations**	**Taste**

Subjective	
Cognitive Appraisals	**Acute Emotional Responses**

Available Protective Actions

Potential Traumatic Reminders

PMTO as a trauma-informed practice

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: 400 families to be recruited into a RCT (NIDA funded)

Overview

- Homeless families
  - Need for interventions to reduce maltreatment
  - Challenges for research
  - Challenges for empirically supported interventions
- Supportive housing as a portal for prevention
- Early Risers – Healthy Families study
  - Parenting Through Change

Families experiencing homelessness

- Multiple challenges
  - Mobility
  - Lack of basic needs
  - Challenges to parenting
    - Parents' own trauma histories
    - Parents' histories in the child welfare system
    - Lack of effective parenting models

Parenting interventions for homeless families

- Many empirically supported practices for maltreatment prevention and parenting
  - California Clearinghouse
  - NREPP, OJJDP, etc.
- But extreme dearth of data (i.e. none!) on program outcomes for homeless families
- Why not?
  - Research challenges
  - Service delivery challenges

Working with homeless families: intervention research challenges

- Finding homeless families
  - Shelters ('3 hots and a cot')
  - Supportive housing (transitional and permanent)
  - Cars, doubled-up, streets
- Mobility
- Parents' fears of child protective services
- Agencies that are underfunded and overburdened
  - High staff turnover
  - Vulnerable, small, often grassroots agencies that nonetheless have GOOD reach into the community

Implementing evidence-based parenting interventions for homeless families

- Stage 1: Feasibility study in a shelter (Gewirtz & Taylor, 2009)
  - Implementation of Parenting Through Change (Forgatch, 1994) for women in a domestic violence shelter
    - Delivered by two shelter advocates (trained by PI)
  - Successfully recruited and retained 10 women over 14 weeks of the program
    - 8/10 women attended average 12 sessions
    - None still in shelter by end of program
  - Excellent satisfaction ratings
  - Shelter continued to implement the program

Supportive housing as an opportune prevention portal (Gewirtz & August, 2008)

- Supportive housing is an increasingly popular approach to addressing homelessness
  - Provides subsidized housing + services to individuals and families
  - Single site or scattered site
- Somewhat addresses challenges of recruitment and retention
  - Local average length of stay is 18 months (range: 6 – indefinite)
- Supportive housing agencies are seeking empirically supported services but often don't have the resources to access them
  - Services usually involve case management, but many agencies provide or refer to parenting supports

Parenting interventions contd.

- Stage 2: randomized controlled trial of an empirically supported family-based prevention program in family supportive housing sites in a large Metro area (Gewirtz, 2007)
  - Early Risers-Healthy Families Network study
    - NIMH-funded prevention trial (MH074610-01 to Gerald August (PI), Abigail Gewirtz, & George Realmuto (Co-Is)
    - Partnership between U of MN and the Family Housing Fund (a nonprofit intermediary distributing federal and state housing funds) and its partners: 16 supportive housing agencies known as the Healthy Families Network
      - Private non-profit agencies that provided 95% single site supportive housing in the Twin Cities Metro area

Early Risers Program

- Comprehensive targeted prevention program to promote resilience (social, academic and emotional functioning) and reduce behavior problems among at-risk children, and promote parenting and family functioning.
- Originally designed as a targeted prevention intervention with two prior RCTs (efficacy & effectiveness) showing positive effects
- Adapted as a selective prevention program for formerly homeless families
  - Levels of service intensity based on need
  - Families recruited over a year period as they enter housing

ER-HFN

- Comprehensive prevention program includes:
  - Child components
    - After school and summer camp programming (2 years) using PATHS program (Promoting Alternative Thinking Strategies; Kusché & Greenberg, 1993) + reading curriculum
    - School-based monitoring and mentoring program
  - Parenting components
    - Case management
    - Parenting Through Change
  - Referrals for mental health assessment and treatment as needed

Participants

- Families with 5-12 year old children living in single site supportive housing in Twin Cities metro area
- Agencies randomly assigned to ER or treatment-as-usual condition
- 152 families initially recruited (across 16 HFN agencies)
  - 253 children
  - Almost 100 schools
- Parent, child, and teacher reported assessments, and observational measures of parenting
- Yearly assessments thereafter (3 follow up assessments)

Children's backgrounds of adversity

- Average number of times families had moved in the past year—over two.
- Mother reports of involvement in a relationship characterized by domestic violence: three quarters reported ever being in such a relationship. 60% mothers reported that their children had witnessed domestic violence.
- Child report of exposure to traumatic events: 98% reported exposure to at least one of the events described. Most common: watching somebody being arrested (more than 80%).
- One quarter of families reported a currently open child protection case.

Child Adjustment

- Reading, math, IQ, overall school functioning all lower than same-age peers
- Teacher report of behavioral and emotional problems were similar to a group of housed Minneapolis children referred to a prior Early Risers study for aggression and conduct problems
- 40% received special services in school

Recruitment and retention

- 10% families were consented but couldn't be reached for baseline assessment
- 50% families left supportive housing in the first year of the study
- By the end of the study (4 yrs) only 2% families were still in supportive housing

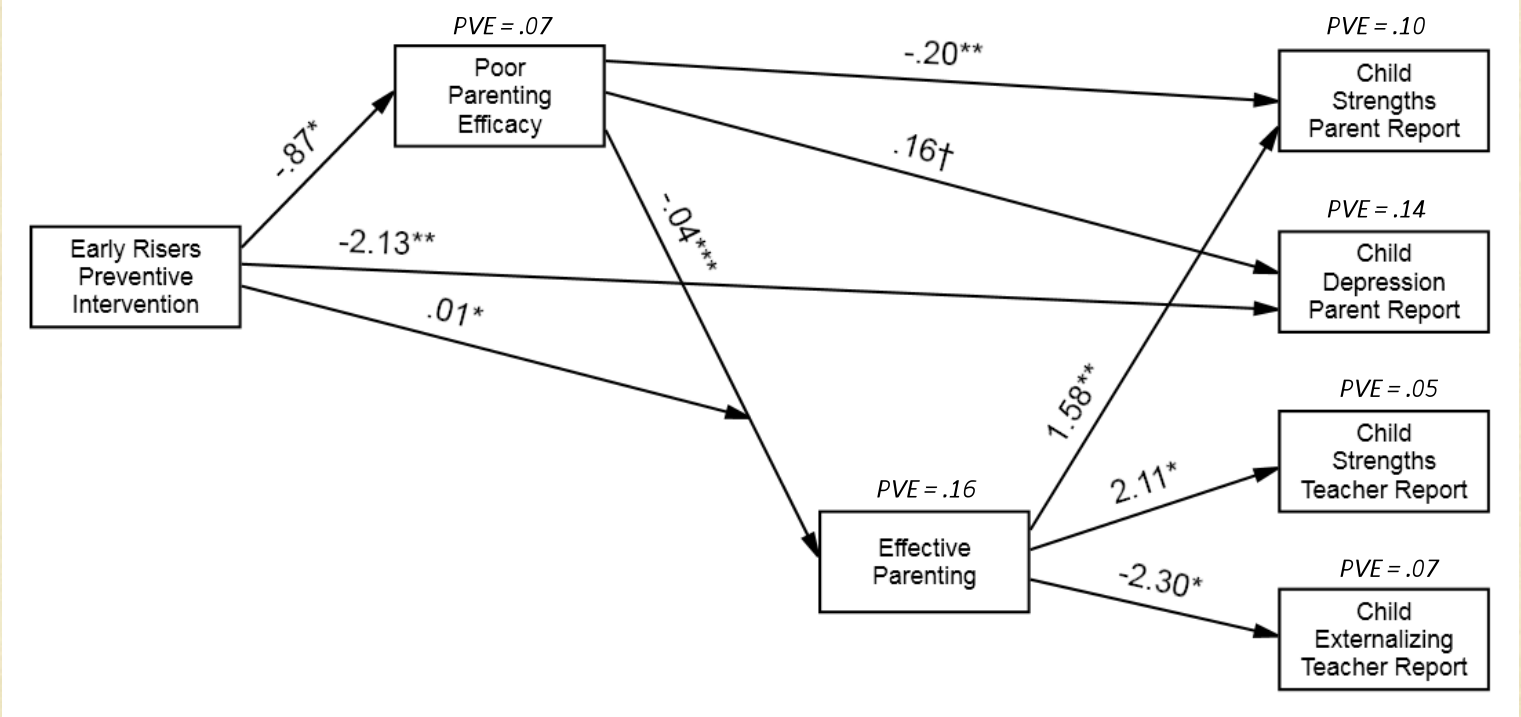
Implementation of programs

- Program implementers were advocates hired to deliver Early Risers and its components, including Parenting Through Change
  - Observational fidelity measures indicated good adherence and competence in delivering the program components

Outcomes at two year follow-up

- 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).

Summary of study findings illustrating the unstandardized four-level model-based effects for the Early Risers preventive intervention and relations among study outcomes.



What is trauma-informed practice?

Overview

- Defining trauma-informed care
- Care systems serving traumatized children
- Assessment
- Intervention
- Building trauma-informed systems
  - A Minnesota example

Defining trauma-informed care

- What is trauma?
- Trauma-informed care
  - Practitioner knowledge about impact of traumatic events on children, adults, and families
  - Practitioner use of this knowledge in delivering care (skills)
    - E.g. 'what happened to you?' vs. 'why did you do this?'
  - Agency and system use of knowledge in training staff and implementing interventions

Practitioner knowledge

- How did you learn about trauma?
- What did you learn?
- Developing trauma curricula for students as well as community professionals
  - National Child Traumatic Stress Network Core Curriculum in Child Trauma

Practitioner skills

- Trauma assessment
- Delivering
  - evidence-based trauma treatments
  - trauma-informed interventions

The assessment process

- Assessing trauma in context of 'regular' assessment?
  - Becoming 'trauma-informed' in organization
- Who does the assessing?
  - E.g., triage unit, therapists, front line providers
- Types of assessment tools
  - Trauma history assessment
  - Assessing trauma symptoms
  - Other symptoms/issues
  - Other information: e.g. prior services history

Assessing exposure to trauma and violence

- Two key variables to assess:
  - Exposure history
    - Violence exposure scale (Fox)
    - Things I have seen and heard (Richters & Martinez)
  - Symptoms related to the trauma event(s)
    - PTSD reaction index (PTSD-RI; Pynoos et al.)
    - Trauma symptom checklist for children (Briere)
    - Levonn (Richters & Martinez)

Assessing PTSD

- Standardized instruments vs. clinical interview in assessing PTSD diagnostic criteria.
- You should directly ask children (ages 7 and older) about PTSD symptoms relating to a traumatic event. If they are not asked, they are less likely to talk about them!

Notes on the reporting of trauma exposure and symptoms

By children

- Underreporting consistent with posttraumatic symptoms (i.e. denial)
- Fear of disclosure; shame; stigma

By their caregivers – underreporting well documented

- Guilt
- Denial
- Concern about child protection involvement

Discrepancy between parent and child report of both history and symptoms

Thank you!

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