TRAUMA AND ATTACHMENT

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Objectives
Attendees will be able to:

• Understand the healthy development of child-caregiver attachment
• Identify and understand the various attachment styles
• Identify different types of trauma, including acute trauma, chronic trauma, and complex trauma.
• Increase understanding of how trauma impacts attachment in children and adolescents
• Understand trauma/stressor related attachment disorders from DSM5, including reactive attachment disorder and disinhibited social engagement disorder
• Discuss treatment approaches for addressing trauma (e.g., Trauma-Focused Cognitive Behavioral Therapy)
What is Attachment?

Attachment is the emotional relationship between a child and the “regular caregiver”

APA Online—Psychology Matters: Glossary
John Bowlby—Father of Attachment Theory

- Attachment work really began to take shape in the 1950’s
- John Bowlby was the first attachment theorist, describing attachment as a "lasting psychological connectedness between human beings."
- Bowlby believed that the earliest bonds formed by children with their caregivers have a tremendous impact that continues throughout life.
Attachment Types

- Mary Ainsworth—expanded on Bowlby’s work
- In the 1970s, Ainsworth devised a procedure called a "Strange situation", to observe attachment relationships between a caregiver and child.
• On the basis of their behaviors, the children were categorized into three groups, with a fourth added later.
• Each of these groups reflects a different kind of attachment relationship with the caregiver.
Secure Attachment

Parenting styles related to secure attachment:
• Consistently respond to needs
• Respond in a loving/caring way
• Feeds hungry child in timely manner
• Comforts child when scared, nervous, upset
• Joins child in his/her excitement.

As children:
• Child feels he/she can depend on parent/caregiver
• Child usually plays well with other children
• May cry when parent leaves but will settle down if a friendly adult is there to comfort
• Happy to see parent(s) when they return
• Child learns that he/she can trust and rely on caring adults

As adults
• Has trusting, lasting relationships
• Tend to have high self-esteem, better self-reliance
• Are comfortable sharing feelings
• Seek out social support
• May experience less depression and anxiety
Avoidant Attachment

Parenting styles related to avoidant attachment:
• May respond to needs, but not in a timely fashion
• Child may wait a lot time to be fed
• Fear is dealt with alone
• Parent does not share in child’s excitement

As children:
• Have learned that depending on parents won’t get them the secure feeling they want
• These children may learn to take care of themselves
• May be too independent, won’t ask for help, but get frustrated
• May have peer relational problems and may be aggressive at times
• Usually do not build strong relationships with other providers (e.g., daycare)
• Don’t seem to mind when parents leave, don’t seem happy when parents return; May even seem to ignore parents

As adults:
• May have intimacy problems
• Do not invest much in relationships
• Unwilling/unable to share feelings with others
Ambivalent Attachment

Parenting styles related to ambivalent attachment:
- Parents sometimes respond to crying infant and sometimes do not
- May feed a hungry child, but may feed the child when not hungry
- May overly comfort a scared child, other times may ignore
- Doesn’t understand a child’s excitement or responds inappropriately

As children:
- Ambivalence = “not sure”
- Sometimes needs are met, and sometimes they are not
- Child is always looking for that feeling of security (e.g., may behave inappropriately because the behavior consistently gets parent’s attention)
- Clingy
- Immature and over-emotional, baby talk
- Attention-seeking
- Will latch onto everyone for short periods of time; Wary of strangers
- Hard letting parents go and may cry for long time; Not comforted upon return

As adults:
- Reluctant to get close to others
- Worried that partner does not love them
- Becomes very distraught when relationships end
Disorganized Attachment

Parenting styles related to disorganized attachment:
• Parents rarely meets infants needs
• Responses do not match the needs
• Possible neglect, maltreatment, abuse
• Possible parental depression

As children:
• They don’t know what to expect from their parents
• They don’t learn any consistent way (positive or negative) to get their needs met
• Behaviors may not make sense; may speak fast and be difficult to understand; May freeze up for no apparent reason
• Struggles with empathy
• There are two types of disorganized attachments:
  • Controlling-Disorganized: Child is bossy and controlling
  • Caregiving-Disorganized: Child acts as parent to peers or caregivers

As adults:
• Detached from self and relationships
• No clear connection with others
• Sense of self is incoherent
• May be insensitive or abusive
Why is Attachment Important?

- Early relationships (e.g., child-caregiver) are the prototype for future relationships
- We learn how relationships work... what can we expect? Should I trust others? Are people dependable?
- Early attachments aids in the development of emotional regulation, social skills, empathy
- Having a secure attachment before, during, and after a traumatic event is a resiliency factor
Trauma and Attachment

The relationship, generally speaking...

Increased exposure to danger/trauma during early development

Increased distortion in the attachment response

Less resilience in face of future trauma; Possible increased future trauma
In other words:
Trauma experiences can disturb the development of healthy attachments and may create a cycle of trauma.
Childhood Trauma

- Reaction to trauma may vary in different ages groups
- Younger children may not be able to verbalize their feelings or reactions; Behaviors are indicators of how they are affected
- Young children are particularly vulnerable as their brains are still developing
- Young children struggle to understand cause and effect--may believe that their thoughts or wishes can make things happen
- Young children are less able to keep themselves safe
Sometimes adults say, “They're too young to understand.” However, young children are affected by traumatic events, even though they may not understand what happened.

Types of Childhood Traumatic Experiences

- Medical neglect
- Physical and emotional abuse
- Witnessing domestic violence
- Being physically attacked
- Being in a serious accident
- Being sexually assaulted or molested
- Being in a fire or a disaster like a hurricane or a tornado
- Painful medical procedures
- Loss of caregiver

- Bullying (?)
Acute, Chronic, Complex Trauma

- Acute: Single incident
- Chronic: Repeated, prolonged (e.g., domestic violence, war)
- Complex: Chronic and of an interpersonal nature; Severe and pervasive, such as abuse or profound neglect; Early onset; May disrupt many aspects of the child’s development and the very formation of a self; Usually in context of child-caregiver relationship and interferes with child’s ability to form secure attachment
Reaction to Trauma is Affected By:

- The child’s age and developmental level
- Whether the child was a witness or victim
- The child’s perception of danger
- Who is the perpetrator and what is his/her relationship to the child
- Previous trauma experiences
- Memory of the trauma
- Support from a caring/trusting/consistent adult
  - Type of attachment as well
Possible Reactions and Effects of Early Trauma

- Demonstrate poor verbal skills
- Memory problems
- Have difficulties focusing/learning in school
- Develop learning disabilities
- Show poor skill development
- Display excessive temper
- Demand attention through positive/negative behaviors
- Exhibit regressive behaviors
- Exhibit aggressive behaviors
- Act out in social situations
- Imitate the abusive/traumatic event
- Are verbally abusive
- Scream or cry excessively

- Show irritability, sadness, and anxiety
- Act withdrawn
- Lack self-confidence
- Have a poor appetite, low weight, and/or digestive problems
- Experience stomachaches and headaches
- Have poor sleep habits
- Experience nightmares or sleep difficulties
- Wet the bed or self after being toilet trained
- Fear being separated from parent/caregiver
- Startle easily
- Are unable to trust others or make friends
- Believe they are to blame for the traumatic experience
- Fear adults who remind them of the traumatic event
Assessing and Treating Trauma
Example Instruments/Procedures for Assessing Traumatic Stress in Young Children and also Parents

- Semi-Structured Interviews
- Behavioral observations
- Child Behavior Checklist (CBCL)
- Posttraumatic Symptom Inventory for Children (PT-SIC)
- PTSD Symptoms in Preschool Aged Children (PTSD-PAC)
- Traumatic Events Screening Inventory-Parent Report Revised (TESI-PRR)
- Trauma Symptom Checklist for Children (TSCC) (young children version also)
- Violence Exposure Scale for Children-Preschool Version (VEX-PV)
- Violence Exposure Scale for Children-Revised Parent Report (VEX-RPR)
- Life Stressor Checklist—Revised (LSC-R)
- Parenting Stress Index (PSI)
- Davidson Trauma Scale (DTS)
Trauma- and Stressor-Related Disorders: DSM5

- www.dsm5.org
- Adjustment Disorders (used to be in own residual category)
- Acute Stress Disorder (used to be under anxiety disorders)
- PTSD (used to be under anxiety disorders)
- Attachment disorders (used to be under other disorders of infancy, childhood, or adolescence)
  - Reactive attachment disorder
  - Disinhibited social engagement disorder

Of course other disorders may be linked to trauma experiences, including depression, anxiety, behavior problems, personality disorders, etc.
Adjustment Disorders

Changes in DSM-5:

- Re-conceptualized as a group of stress-response syndromes
- Occurs after exposure to a distressing (traumatic or non-traumatic) event
- Subtypes marked by depressed mood, anxious symptoms, or disturbances in conduct, or combination (this is unchanged)
Acute Stress Disorder

Changes in DSM-5:

- The stressor criterion for acute stress disorder is changed from DSM-IV. The criterion requires being explicit as to whether qualifying traumatic events were experienced directly, witnessed, or experienced indirectly.
- Old criterion regarding the subjective reaction to the traumatic event (e.g., “the person’s response involved intense fear, helplessness, or horror”) has been eliminated (reactions have been found to be very heterogeneous).
- Criteria met with 9 of 14 listed symptoms in these categories: intrusion, negative mood, dissociation, avoidance, and arousal.
Posttraumatic Stress Disorder

Changes in DSM-5:

• The stressor criterion is more explicit with regard to how an individual experienced “traumatic” events.
• Also, subjective reaction has been eliminated.
• Old: three major symptom clusters (re-experiencing, avoidance/numbing, and arousal); New: four symptom clusters (avoidance/numbing now two distinct clusters: avoidance and persistent negative alterations in cognitions and mood)
• The final cluster—alterations in arousal and reactivity—retains most of the DSM-IV arousal symptoms.
  • It also includes irritable or aggressive behavior and reckless or self-destructive behavior.
• Increased developmental sensitivity. Threshold lowered for children. New subtype for 6 years or younger called “Preschool subtype”
• Also “Dissociative Subtype” for those with prominent dissociative symptoms (e.g., feeling detached from self, word seems unreal, dreamlike, distorted)
Attachment Disorders

• Old: two subtypes of Reactive Attachment Disorder: emotionally withdrawn/inhibited and indiscriminately social/disinhibited
• New: these subtypes are defined as distinct disorders: reactive attachment disorder and disinhibited social engagement disorder
• Both are result of neglect or other situations that limit opportunity for healthy attachments
Attachment Disorders, Continued

- Reactive attachment disorder more closely resembles internalizing disorders; it is essentially equivalent to a lack of or incompletely formed preferred attachments to caregiving adults.
- Disinhibited social engagement disorder more closely resembles ADHD; child treats strangers as they would parental figures; may be cuddly with strangers or seek comfort from them; would go with stranger with no hesitation.
Hope
Treatments for Children and Families

- Importance of age-appropriate treatment
- Focus on relationships, particularly the child-caregiver relationship

- The following treatment approaches have been empirically supported
Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) for Preschoolers

- Designed to help physically abused children and their offending parents
- Addresses underlying contributors to maltreatment (e.g., parental hostility)
- Abused children are helped to view abuse as wrong and illegal
- They are taught emotional comprehension, expression, and regulation as well as social skills.
- Parents learn proper emotion regulation skills, how to avoid potentially abusive situations, and healthy child management and disciplinary techniques
- Dyadic work gives families an opportunity to measure progress, to help identify and clarify family miscommunication, and to establish a family no-violence agreement
Attachment, Self-Regulation and Competency (ARC)

- Designed for youth and families who have experienced multiple and/or prolonged traumatic stress
- Three core domains that impact traumatized youth and that are relevant to future resiliency
- Within the three core domains, ten building blocks of trauma-informed treatment and service are identified
Parent-Child Interaction Therapy (PCIT)

- Teaches parents/caregivers targeted behavior management techniques as they play with their child
- Focus on increasing children’s positive behaviors; It has been adapted for children who have experienced trauma
- Parents/caregivers are coached live by the therapist
- PCIT is a short-term, mastery-based treatment that typically runs for 16 to 20 weeks, based on the needs of the family
Preschool PTSD Intervention

- Protocol-specific cognitive-behavioral treatment that is combined with parent/caregiver involvement in every session.
- Treatment is for 12 weeks, and it can be focused on PTSD symptoms from any type of trauma.
- Includes relaxation training, systematic exposure, and homework.
- Addresses parent-child relational issues.

- The manual for this intervention is available for free online at http://www.infantinstitute.org/MikeSPDF/PPTManual6.pdf
Child-Parent Psychotherapy (CPP)

- Integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories
- Dyadic treatment approach designed to restore both the child-parent relationship and the child’s mental health and developmental progression
- Specific trauma is family violence
- Child-parent interactions are the focus of the intervention
Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)
TF-CBT

• Developed by Drs. Judith Cohen, Anthony Mannarino, (Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents, Pittsburgh, PA) and Esther Deblinger (New Jersey Child Abuse Research Education and Service (CARES) Institute)

• Based on principles of CBT and trauma treatment

• Originally developed and tests for sexually abused boys and girls and their non-abusive parent(s)

• Goal: address biopsychosocial needs of children with problems related to traumatic life experiences

• Short-term treatment; 12 to 16 weekly sessions (number of sessions is flexible, depends on family’s needs)
TF-CBT, Continued

- Involves individual sessions with children for 30 to 45 minutes followed by parallel sessions with parent for 30 to 45 minutes
- Program includes 3 (or more) joint parent-child sessions
- Designed for ages 3 to 18
- Has a manual, designed to be delivered in a structured sequence, but not a "cookbook"; Requires close therapeutic alliances
- Adaptable for use with children who have other problems in addition to PTSD symptoms, depression, and behavior problems
- Can be used by a variety of mental health professionals including psychologists, social workers, professional counselors, psychiatrists, or clinical counselors with basic training in working clinically with distressed children and their families, a sound theoretical understanding of CBT, and a working knowledge of child development
TF-CBT Works!

- There is strong scientific evidence that TF-CBT helps children, adolescents, and their parents overcome many of the difficulties associated with abuse and trauma.
- Multiple randomized, controlled clinical trials by different research groups have found that TF-CBT is better than no treatment or good comparison treatments in reducing common symptoms related to trauma. This is the highest level of evidence for treatment efficacy.
- TF-CBT was given a ranking of "1", the highest level of empirical support in the U.S. Department of Justice sponsored report Child Physical and Sexual Abuse: Guidelines for Treatment.
- TF-CBT was selected as a “Best Practice” for cases of child abuse in the Kaufman Best Practices Final Report, sponsored by the National Child Traumatic Stress Network.
- TF-CBT has been named a Model Program by the National Registry of Evidence-based Programs and Practices of the Substance Abuse and Mental Health Services Administration.
Psychoeducation

- Child and parent sessions providing psychoeducation
- Helping parents and children learn about trauma, its effects, and treatment
- Information provided depends on type of trauma and child’s developmental level
- Normalize PTSD-like symptoms
- Explain that treatment is collaborative and prepare them for what will happen in treatment
- Provide psychoeducation initially and throughout treatment
Psychoeducation, Continued

In this module, the therapist provide information to the child and caregiver about:

• The different types of trauma
• Why this type of trauma occurs
• Effects of trauma
• Why children may not like to talk about trauma

• Training site has example scripts for various types of trauma

• The therapist may also provide written handouts of recommend books to reinforce information
Stress Management

Techniques for helping children control their feelings
• Controlled breathing
• Relaxation training (progressive muscle relaxation)
• Thought stopping

• Parent session teaches parents these skills as well
• Encourage child to teach skills to his/her parent

• Homework: practice skills at home
Affect Expression and Modulation

A technique to increase children's emotional awareness

- Identify emotions
- Differentiate intensity of emotions
  - Subjective Units of Distress (SUDS, for older youth)
  - Emotions Thermometers (for younger youth)
- Express emotions appropriately (e.g., role-play using I-statements)

- Homework: Name the Feelings Worksheet, Emotional Thermometers, Rating Feelings Worksheet
Affect Expression and Modulation, Continued

Parent session:

• Encourage parent to help child label emotions
• Encourage parent to reinforce the child, offering praise when the child appropriately manages difficult emotions
• May have to teach parent to identify and express his/her own feelings
• If parent is overly distressed about the child’s trauma, he/she may need a referral for individual treatment
Cognitive Coping

A technique to help children alter unhelpful thoughts

- Help parents and child identify and change inaccurate beliefs/thoughts about every day events (not the trauma, yet)
- Recognize and understand the difference between helpful and unhelpful cognitions
- Teach the relationship between thoughts, feelings, and behaviors (apply the cognitive triangle to different scenarios)
- Generate alternative thoughts that are more accurate and helpful

- Homework: use skill in real life
Cognitive Coping, Continued

Parent session:
• Encourage positive self talk
• Teach parents the cognitive triangle
• Help parents identify inaccurate or unhelpful thoughts occurring in their daily lives and how to feel better by examining and challenging them
Creating the Trauma Narrative

A technique to help children manage trauma symptoms
- Helps to control intrusive and upsetting trauma related images
- Helps reduce avoidance of cues, situations, and feelings associated with trauma
- Identifies unhelpful cognitions about trauma events
- Helps child recognize, anticipate, and prepare for reminders of trauma
Creating the Trauma Narrative, Continued

- Decide on the best format for narrative (book, picture, song, poem, etc.)
- Decide where to start narrative
- Have child fully describe perception of event (may take multiple sessions)
- Child reads narrative
- Child adds thoughts and feelings
- Child includes worst memory of event, may even be encouraged to draw a picture of memory
- Employ cognitive processing techniques learned in Cognitive Coping Module
- If child continues to be highly reactive, employ techniques learning in Stress management Module (e.g., breathing, PMR, thought stopping)
- Praise child, reward child, and encourage child to create optimistic ending to narrative
Creating the Trauma Narrative, Continued

Parent session:
• Explain rationale for approach
• Work closely with the parent, addressing their concerns and preparing them
• Ensure parent responds in a helpful/supportive manner
• Remind that sharing narrative is ongoing
• Devote parallel parent session to parent reading child’s book
• Praise the parent, too
Cognitive Processing

A technique to help alter trauma-related cognitions

• Challenges unhelpful thoughts/feelings regarding shame, blame, trust, self-esteem, personal safety, etc. (may take many sessions)
• Therapist assesses issues relatively directly and openly with child and parent
• Techniques include Socratic questioning, role-playing, perspective-talking activities, “best friend role play,” “’’responsibility pie,’’ “talk show host role play,’’ etc.
• Homework: Practice challenging trauma-related dysfunctional cognitions
Cognitive Processing, Continued

- Parent session: Restructuring parent’s cognitive distortions regarding event, such as:
  - I should have known this would happen
  - I should have kept my child safe
  - My child will never be happy again
  - Our family is destroyed
  - My child's childhood is ruined
  - The world is terribly dangerous
  - My child can never recover
Behavior Management Training

- Strategies for helping parents of traumatized children
- Parents may feel guilt about disciplining a traumatized child
- Help parents develop a “toolkit”
  - Praise
  - Ignoring
  - Timeouts
  - Behavior charts
- Role play with parent and observe use of skills with the child

- Homework: correctly and consistently use toolkit at home
Parent-Child Sessions

Facilitating open communication about trauma

• Evaluate readiness for joint session
• Help parents develop skills to respond appropriately when child discusses trauma
• Promote positive, healthy communication about trauma
• Encourage parent to model effective coping
• Train family to continue therapeutic work at home
• End sessions on a positive note
Online TF-CBT Training

- http://tfcbt.musc.edu
- Medical University of South Carolina in partnership with The National Child Traumatic Stress Network. TF-CBT Web: An On-Line Learning Course for Trauma-Focused Cognitive-Behavioral Therapy.
And Take Care of Yourself

• Working with those that are traumatized can be rewarding but also difficult work.
• Engage in self-care
• Know your limits and stick with them
• Watch for burnout, compassion fatigue, vicarious trauma
  • Exhaustion
  • Numbing
  • Desensitization
  • Distancing or over involvement
  • Sleep/appetite changes
• Any symptoms of post-traumatic stress
• Seek consultation or supervision as indicated
Recommended Resources


Questions or comments?

Please email if you have additional questions/comments or to receive PDF of this PowerPoint.
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