Cumulative Exposure to Early Life Stress and Trauma

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Center on Family Violence

For copy of presentation:

An ordinary day for some youths

Credit: Freedom Writers
What Are Children Exposed To?

Physical Aggression
“He threw hot coffee at her face, choked her, shoved her into walls, kicked her, punched her – gave her a black eye, put her in the hospital. One time he tried to run her over with the car”
– 11-year-old boy

Psychological Aggression
“Sometimes everything seemed good. We would go to McDonalds, he would make jokes and stuff. Then he would accuse my mother of something. He like controlled her every move. There’d be screaming and cursing. I’d put my headphones on to ignore the yelling. Once I heard my father threaten to take me and my brother away from her. That scared me.”
– 13-year-old girl

Sexual Aggression
“It was disgusting. He would grab her in places right in front of me. He was constantly telling my mother that she needed to …you know, have sex – one time I heard my mother – I thought she was hurt and I walked right into him on top of her.”
– 15-year-old girl

Children’s Reactions

– “My children would not come near us; they would stay in their room, paralyzed with fright.”
– “I screamed so loud… I couldn’t breathe…my daughter hit her father on the head and said, Let Go of Momma” (6 y.o. girl)
– “My daughter and son grabbed their father and said, Let momma alone! Let momma alone! They would stand next to me so that he wouldn’t hit me. The time he hit me, my daughter told her father: Momma is good, momma is very good. Why did you hit her?” (3 y.o. girl)
– I would look at my oldest son, and he would understand me. At age five, he’d take his brother by the hand, and they’d go outside. From the street, they could hear the screams…” (5 y.o. boy)

“My son never goes out; he only goes to class. He has no friends, so he doesn’t go out.” (17 y.o. boy)

“My daughter...stops laughing. She never smiles and never goes out alone after 6pm. When her father is out of prison...she does not sleep and she has nightmares...” (10 y.o. girl)


“His father used to beat me in the mornings... so every time I took my son to the park after the beatings, he used to slap the faces of little girls... he transmitted to the little girls what he saw at home.” (2 y.o. boy)

“My son accepted it as normal and reacted the same way [as his father]. When my son didn’t get what he wanted, he would hit me.” (9 y.o. boy)

Children As Silent Victims

- Children can be exposed to DV in a number of ways
- Children can display a variety of behaviors while witnessing DV
- Children need not directly witness DV nor display distress to suffer consequences

Consequences

- Posttraumatic Stress Disorder
- Depression
- Anxiety
- Conduct problems
- Alcohol and substance abuse
- Impaired social and occupational functioning
Children Exposed to DV are also likely to Experience Direct Aggression

- DV in the home exponentially raises the risk of emotional and physical violence towards the child as well as neglect.
- The prevalence of child physical, sexual, and emotional maltreatment in families with DV is estimated to range from 30% to 60% (Appel & Holden, 1998; Colletti et al., 2008).
- Perpetrators can behave towards children as they do their partners and can exploit the children to hurt victims.
- Victimized caregivers are also likely to exhibit harsh or non-optimal parenting, including behavior that crosses the line of abuse (Edelson, 1999; Hartley, 2002; Levendosky & Graham-Bermann, 2000).

DV and Maltreatment Overlap in a Sample of Preschool Children

Co-Occurring Victimization
Nat’l Survey of Children’s Exposure to Violence


Children’s Early Exposure to DV can be a Gateway to Subsequent Victimization and Poly-Victimization

Exposure to chronic, pervasive, and multiple forms of violence, trauma, and loss in multiple contexts and across multiple developmental stages
Research Supports a Dose-Response Relationship between the Number of Types of Adversities and Impairment

Adverse Childhood Experiences (ACE) Study
Anda et al., 2006

1. Did a parent or other adult in the household often or very often … swear at you, insult you, put you down, or humiliate you? -or- Act in a way that made you afraid that you might be physically hurt?

2. Did a parent or other adult in the household often or very often… push, grab, slap, or throw something at you? Ever hit you so hard that you had marks or were injured?

3. Did an adult or person at least 5 years older than you ever… touch or fondle you or have you touch their body in a sexual way? Attempt or actually have oral, anal, or vaginal intercourse with you?

4. Did you often or very often feel that… no one in your family loved you or thought you were important or special? Your family didn’t look out for each other, feel close to each other, or support each other?

5. Did you often or very often feel that… you didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6. Were your parents ever separated or divorced?

7. Was your mother or stepmother often or very often pushed, grabbed, slapped, or had something thrown at her? Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

10. Did a household member go to prison?
Adverse Childhood Experiences (ACE) Study, cont.

- $N = 17,000$ middle-class adults seeking preventive care
- 2 out of 3 reported at least 1 type
- 1 out of 6 reported 4 or more types
- Dose-response relationship between ACE scores and health risk
- Smoking, obesity, physical inactivity, depression, suicide, alcoholism, drug abuse, sexual promiscuity, STD, heart disease, cancer, stroke, chronic bronchitis, COPD, diabetes, hepatitis, skeletal fractures
- Accounting for depression, alcoholism, and drug abuse, those with ACE scores of 7 or more were 17 times more likely to attempt suicide.


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Poly-Victimization in the CT Juvenile Justice System

Navy Families Study, cont.


National Child Traumatic Stress Network (NCTSN) Core Data Set (N=3,485)

- Poly-victimization in 0-5 period largely defined by DV and adversity in caregiving environment

National Child Traumatic Stress Network (NCTSN) Core Data Set (N=3,485)

- Poly-victimization in 0-5 period largely defined by DV and adversity in caregiving environment
- > 80% of poly-victims in the 13-18 y.o. age range had been classified as poly-victims in the earlier time period
- Poly-victims > PTSD, internalizing and externalizing problems in adolescence


Violence Exposure Can Interrupt Child Development in a Number of Ways

Early Childhood
- Developing a secure attachment with caregiver
- Recognize/Respond to emotional cues (empathy)
- Capacity to assess danger
- Beginnings of self-concept/self-esteem
- Motor/language development

Middle Childhood
- Sustained attention for learning and problem solving
- Increase emotional/behavioral control
- Increased self-concept and self-esteem
- Development of stronger peer relations

Adolescence
- Physical body and hormonal changes
- Develop more mature peer-related social skills
- Ability to modify/ control emotion and behavior to meet long-term goals
- Capacity for abstract thinking
- Develop independent self-identity
Learning Brain vs. Survival Brain

Safe/Secure Environment
- Exploration
- Mastery of skills

Adverse/Harsh environment
- Anticipating, preventing, or protecting self against potential or actual danger


The Stress Response: Sensory
The Stress Response: Alarm

The Stress Response: Evaluation

Fight or Flee (or freeze)

Thinking Center

Filing/Memory Center
The Stress Response: False Alarm

Thinking Center

Filing/Memory Center

False Alarm

The Stress Response: Imminent

Auto-Pilot Mode

Filing/Memory Center

Fight or Flee (or freeze)
The Stress Response: Trigger

Filing/Memory

Trauma Memory

Auto-Pilot Mode

Fight or Flee (or freeze)

Credit: Channel 5 News Texas
Brain Correlates

Structural and functional abnormalities

- Amygdala
- Hippocampus
- Anterior Cingulate Cortex
- Corpus Callosum


DV Can Sensitize Children to Respond Less Adaptively to Subsequent Stressors
This is the first study to link family violence with attention bias in children as young as 4 years of age and symptoms of anxiety. Briggs-Gowan MJ, Pollak SD, Grasso D, et al. (In press). Attention bias and anxiety in young children exposed to family violence. Journal of child psychology and psychiatry, and allied disciplines.

PTSD as a Fear Disorder

- Symptoms are defined by four primary domains
  - Intrusion symptoms
  - Avoidance
  - Changes in cognition and mood
  - Alterations in arousal and reactivity
Developmental Trauma Disorder (DTD)

- Dysregulation
  - Affective
  - Somatic
  - Cognitive
  - Behavioral
  - Interpersonal
  - Self-identity

Triggers

- Things, events, situations, places, sensations, and even people that a youth consciously or unconsciously connects with a traumatic event.
Through Their Eyes

Clips from Office for Victims of Crime – Through Our eyes: Children, Violence, and Trauma

Treating Trauma-Related Problems
Exposure Therapy

- PTSD develops when there is failure to process traumatic memory because of extensive avoidance of reminders
- Avoidance maintained by negative reinforcement
- Exposure serves to promote emotional engagement of traumatic memories in a safe environment to facilitate **habituation** and **trauma memory processing** (i.e., modify erroneous underlying cognitions)

Habituation in therapy
Trauma Memory Processing

Common Emerging Themes

- Abandonment
- Mistrust
- Shame
- Social isolation
- Incompetence
- Vulnerability
- No identity
- Failure

- Entitlement
- Acceptance of lack of self-control
- Self-sacrifice
- Self-punishment
- Lack of self-efficacy
- Pessimism
- Emotional inhibition
- Perfectionism
Exposure Based Models

- Prolonged Exposure
- Cognitive Processing Therapy
- Eye Movement Desensitization and Reprocessing
- Trauma-Focused Cognitive Behavioral Therapy
Goals for Treating Youth with Complex Trauma

- **Safety**: Recognize and prevent trauma and reenactments
- **Affect Dysregulation**: Enhance ability to manage extreme arousal states
- **Somatic Dysregulation**: Repair the Mind-Body Split
- **Cognitive Dysregulation**: Enhance self-determination and autonomy
- **Behavioral Dysregulation**: Enhance personal control and self-efficacy
- **Relational Dysregulation**: Enhance attachment security
- **Self Dysregulation**: Enhance sense of self and personal identity
- **Resilience**: Maintain functioning and overcome comorbidities