Transforming Trajectories for Traumatized Children

Judith A. Cohen, MD, Jeanette Scheid, MD, PhD, Ruth Gerson, MD

When 13-year-old Alice came for an evaluation, she was suspicious and sarcastic. She had been in therapy for oppositional-defiant disorder for more than 5 years. Her psychopharmacologic history was almost as lengthy, starting with stimulants for attention-deficit/hyperactivity disorder the following year. Now she was taking a cocktail of psychotropic medications for attention-deficit/hyperactivity disorder, oppositional-defiant disorder, bipolar disorder, and dysthymia, but her anger and aggression were worsening, and she was starting to use illicit drugs and engage in risky sexual activities. Alice's relationship with this foster mother (her 10th in 8 years) was deteriorating because of these behaviors, and if this placement failed, Alice would go to a residential treatment facility (RTF). Alice had been sexually and physically abused by her birth father during her first 5 years, often after he beat her heroin-addicted mother. She also had been sexually abused in 2 foster homes.

Alice had a right to be angry and mistrustful. Despite years of treatment, no mental health professional had connected her current symptoms to her past trauma, and she had never received trauma-focused treatment. The system had repeatedly let her down. After a careful evaluation, Alice endorsed several trauma symptoms and her diagnosis was changed to posttraumatic stress disorder (PTSD) to more concisely account for all of her difficulties, including aggression, anger, and newly emerging risky behaviors.[1]

Alice is not alone. Trauma affects more than two thirds of American children; one third experience multiple, often chronic, traumas such as child maltreatment (child sexual, physical, or emotional abuse; child neglect; or domestic violence). Yet efforts to identify and effectively treat the potentially serious and long-term negative impacts of these experiences lag far behind. For example, virtually all children in America's child welfare systems are affected by trauma (having been placed in care owing to parental abuse or neglect), but without access to systematic trauma-informed assessment or evidence-based trauma treatment, less than an estimated one tenth of the children in these systems receive optimal treatment.

The cost of ignoring trauma for children like Alice is staggering. Trauma exposure in childhood leads to significantly higher rates of medical and mental health disorders and health care usage; and in a large national study, untreated child abuse and neglect alone accounted for more years lost to disability than all mental disorders combined.[2]

Child and adolescent psychiatrists and other child-serving professionals can take important and meaningful steps to help children like Alice avoid these negative outcomes and live healthy, productive lives. These include developing personal proficiency to provide and advocating for others to provide:

1. early and effective identification of trauma impact in children and adolescents
2. evidence-based trauma-focused psychotherapeutic interventions for traumatized children
3. evidence-based psychopharmacologic treatments for traumatized children as these become available
4. integrated, trauma-informed systems of care
5. outreach and collaboration with primary care providers
6. training to the next generation of child and adolescent psychiatrists about all of the above

EARLY IDENTIFICATION

PTSD symptoms are often mistaken for other *DSM-5* disorders, leading to children receiving

incorrect diagnoses and less than optimal treatments. When children do not respond to a prescribed treatment, rather than removing the original diagnosis and rethinking the underlying etiology, a common response is paradoxically to retain the original (incorrect) diagnosis and to add another inaccurate diagnosis. Often this problem is compounded by adding additional ineffective or inappropriate treatments, thus further obscuring the underlying trauma etiology. Early identification of trauma-related etiology contributes to optimal outcomes by protecting the child from ongoing trauma exposure, providing earlier effective intervention, preventing ineffective or harmful interventions, and/or preventing longer-term negative medical, psychological, educational, occupational, and interpersonal sequelae. It is incumbent on all mental health professionals to learn the new *DSM-5* PTSD diagnostic criteria, including for young (<7-year-old) children, and to gain the skills needed to sensitively and effectively elicit information about exposure to diverse types of traumatic experiences and trauma symptoms from children across the developmental spectrum and from their parents or caregivers. The American Academy of Child and Adolescent Psychiatry (AACAP) Child Maltreatment and Violence Committee sponsors yearly workshops and symposia at the annual meeting in this regard. It is also important to understand that PTSD is not the only diagnostic outcome of child trauma; assessing for trauma-related depression, anxiety, substance abuse, and other outcomes is also essential. Moreover, questions about trauma exposure and impact should be included when conducting a mental health assessment of every child and adolescent, not only those for whom the evaluator has a high suspicion of trauma impact.

EVIDENCE-BASED TRAUMA PSYCHOTHERAPY

Trauma-focused psychotherapy is currently the first-line treatment for children and adolescents with PTSD.[3] Many trauma-focused treatment models are available, including individual and group trauma-focused cognitive-behavioral therapy, psychodynamic dyadic child–parent psychotherapy for young children, school-based and other group formats for children of different developmental levels, and treatment approaches that have been developed specifically for adolescents with complex trauma. Trauma-focused psychotherapy is increasingly available in community settings with initial Web-based training freely available in several models available to licensed master's level clinicians (e.g., www.musc.edu/tfcbt; www.afcbt.org; www.cbitsprogram.org; http://pcitextensiondlc.net/logon/). Mental health providers who are interested in documenting their proficiency can obtain national certification in 2 of these treatment models. AACAP provides training in some of these psychotherapeutic treatments at its annual meeting. Any child and adolescent psychiatrist treating traumatized youth should pursue at least basic training in evidence-based trauma-focused psychotherapy for 3 reasons. First, child and adolescent psychiatrists who provide psychotherapy as part of their practice should receive training in at least 1 evidence-based trauma-focused treatment to offer such treatment to traumatized children within their psychotherapy practices. Second, child and adolescent psychiatrists who do not personally provide psychotherapy should become familiar with core features of evidence-based trauma-focused treatment to be conversant about these treatments with other mental health professionals in their practice and community, to appropriately recognize mental health providers in their area who have proficiency in these treatments, and to refer traumatized children to these providers. Third, advocating for other mental health providers in one's community to become proficient in these models is another important and effective strategy for improving the quality of care for traumatized children.

EVIDENCE-BASED PSYCHOPHARMACOLOGIC TREATMENTS

The child and adolescent psychiatrist's specialized expertise is most critically needed to incorporate evidence-based pharmacotherapy into traumatized children's integrated care. Unfortunately, at the current time, there are no evidence-based psychopharmacologic treatments available because the extant research has failed to demonstrate the effectiveness of any medication for improving pediatric PTSD. Matthew Friedman, MD, PhD, Director of the National Center for PTSD, issued a plea for "rational psychopharmacology" for PTSD 25 years ago, referring

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