ADVERSE CHILDHOOD EXPERIENCES, TRAUMA, AND PLAY THERAPY

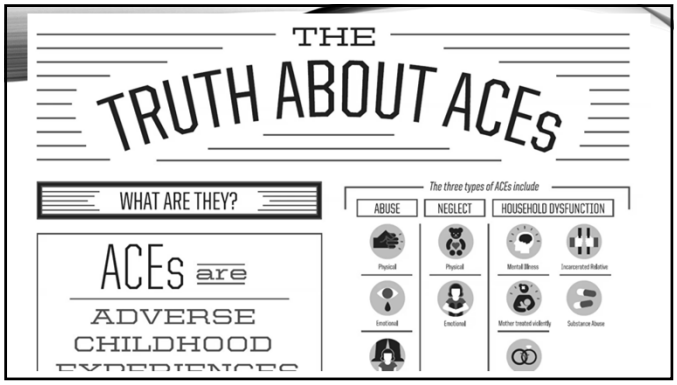
Dee Ray, PhD, LPC-S, NCC, RPT-S, Certified CCPT-S, Certified CPRT-S
dee.ray@unt.edu
University of North Texas

Anything is preferable to that godforsaken sense of irrelevance and alienation…Kids will go to almost any length to feel seen and connected

(Van Der Kolk, 2014, p. 117)

WHAT ARE ADVERSE CHILDHOOD EXPERIENCES (ACES)?

- Adverse childhood experiences (ACEs) can be defined as traumatic and stressful experiences occurring in childhood (Murphy et al., 2014).
- ACEs occur prior to the age of 18.
- ACEs include experiences of maltreatment, neglect, and household dysfunction.



ORIGINAL CATEGORIES OF ACES

Mental Illness	Substance Abuse
Caregiver Separation	Domestic Violence
Incarceration	Physical Abuse
Sexual Abuse	Emotional Abuse
Physical Neglect	Emotional Neglect

Felitti et al., 1998

CATEGORIES OF EXPANDED ACES

- Witness Violence
- Felt Discrimination
- Adverse Neighborhood Experience
- Bullied
- Foster Care

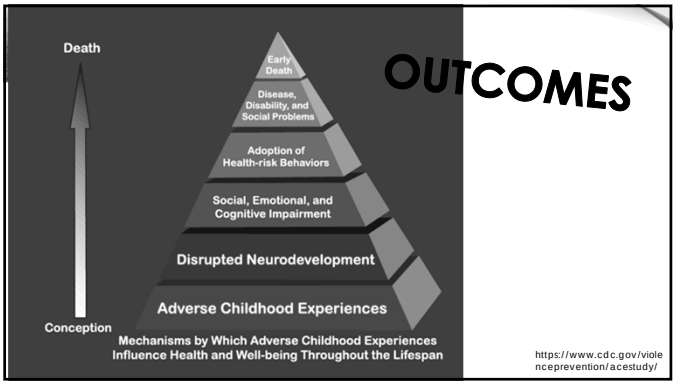
Wade et al., 2016

FREQUENCY AMONG WOMEN & MEN

Number of Adverse Childhood Experiences (ACE Score)	Women	Men	Total
0	34.5	38.0	36.1
1	24.5	27.9	26.0
2	15.5	16.4	15.9
3	10.3	8.6	9.5
4 or more	15.2	9.2	12.5

https://acestoohigh.com/

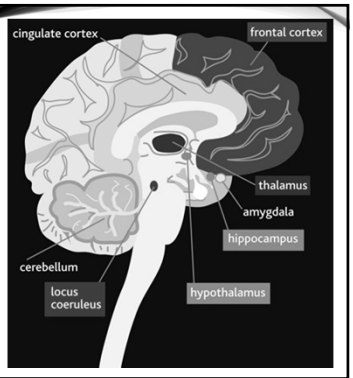
OUTCOMES

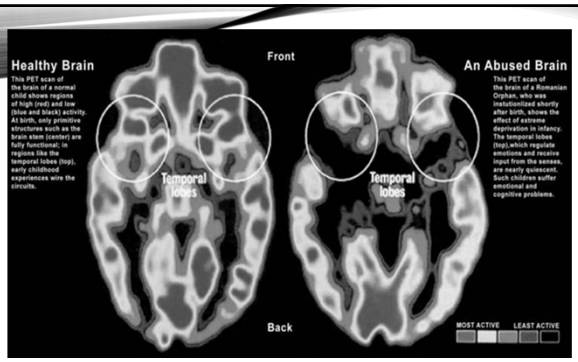


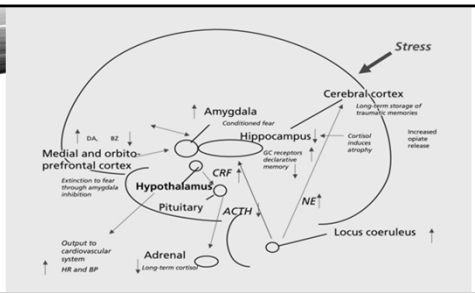
https://www.cdc.gov/violenceprevention/acestudy/

How Trauma Affects the Brain

Sensory information converges on the thalamus. 1st neural pathway passes information on to amygdala to interpret emotional significance. If amygdala detects threat, sends message to hypothalamus to secrete stress hormones to defend against threat. 2nd neural pathway sends information to the prefrontal cortex for refined interpretation. Trauma increases the potential for misinterpretation of threat leading to overly intense reaction of amygdala, likely to overtake prefrontal cortex. (Van Der Kolk, 2014)

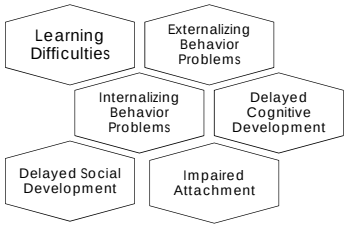






Lasting effects of trauma on the brain, showing long-term dysregulation of norepinephrine and Cortisol systems, and vulnerable areas of hippocampus, amygdala, and medial prefrontal cortex that are affected by trauma. GC, glucocorticoid; CRF, corticotropin-releasing factor; ACTH, adrenocorticotropin hormone; NE, norepinephrine; HR, heart rate; BP, blood pressure; DA, dopamine; BZ, benzodiazapine; GC, glucocorticoid (Bremner, 2006)

ACES EFFECTS ON CHILDREN



Clarkson Freeman, 2014; Escueta et al., 2014; Marie-Mitchell, Studer, & O'Connor, 2016

RECENT RESEARCH

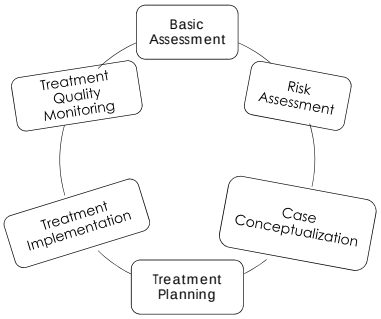
- 60 children; Ages 4-12; Grades K-5; 71% Male, 28% Female
- Ethnicity: 25% African American; 41% White; 28% Latino/a; 1.7% Multiracial; 3.3% not reported
- ACEs Expanded Checklist; Social Emotional Assets and Resilience Scales; Strengths & Difficulties Questionnaire
- Multiple regression analysis using age, gender, and number of ACEs as predictor variables and SDQ as the dependent variable revealed a statistically significant prediction, F (3, 56) = 8.08, p < .01 with a large effect of R^2 = .30 and adjusted R^2 = .27.
- Multiple regression analysis using the same predictors and SEARS as the dependent variable revealed a statistically significant prediction, F (3, 52) = 4.42, p < .01 with a meaningful effect of R^2 = .20 and adjusted R^2 = .16.
- Examinations of beta weights in conjunction with structure coefficients revealed that ACEs scores explained almost 100% of the variance in both models (SDQ β = .55, r_s^2 = .99; SEARS β = -.45, r_s^2 = 1.0).
- Results indicate that when age, gender, and number of ACES are used as predictors, children who experience a higher number of ACES are reported by parents to have higher emotional and behavioral problems, as well as lower social emotional competencies.

LONG-TERM EFFECTS OF MULTIPLE ACES

- Physical Effects
- Mental Health Effects
- Drug Use
- Criminal Activity
- Relationships

Felitti et al., 1998; Wade et al., 2016; Monnat & Chandler, 2015; Mersky, Topitzes, & Reynolds, 2013; Haatainen et al., 2003

National Child Traumatic Stress Network Position Statement:
Prerequisite Clinical Competencies for Implementing Effective, Trauma-informed Intervention



http://nctsn.org/sites/default/files/assets/pdfs/nctsn_position_statement_on_clinical_competency.pdf

CALCULATE YOUR ACES SCORE

https://acestoohigh.com/got-your-ace-score/

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **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?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

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?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …

Adverse Childhood Experiences Questionnaire

We are exploring the impact of play therapy with children who have experienced some challenging situations. The following questions about your child's past are sensitive in nature and may be difficult for you to discuss. You are not expected to complete this questionnaire if you are uncomfortable with the nature of the questions. Because children often live with different caretakers, it is not assumed that you are the adult who has been involved in any of the following situations. However, if you disclose that your child has experienced abuse, we are required to report that abuse to the proper agency. Except for information that is legally required to be shared, all information you provide is anonymous and confidential.

1. **Have your child's parents ever separated or divorced?**
   Yes No

2. **Has your child ever been in foster care?**
   Yes No

3. **Was your child adopted?**

CONSENSUS PROPOSED CRITERIA FOR DEVELOPMENTAL TRAUMA DISORDER

A. Exposure.
The child or adolescent has experienced or witnessed multiple or prolonged adverse events over a period of at least one year beginning in childhood or early adolescence, including:
A. 1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence; and
A. 2. Significant disruptions of protective caregiving as the result of repeated changes in primary caregiver; repeated separation from the primary caregiver; or exposure to severe and persistent emotional abuse

B. Affective and Physiological Dysregulation.
The child exhibits impaired normative developmental competencies related to arousal regulation, including at least two of the following:
B. 1. Inability to modulate, tolerate, or recover from extreme affect states (e.g., fear, anger, shame), including prolonged and extreme tantrums, or immobilization
B. 2. Disturbances in regulation in bodily functions (e.g. persistent disturbances in sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions)
B. 3. Diminished awareness/dissociation of sensations, emotions and bodily states
B. 4. Impaired capacity to describe emotions or bodily states

C. Attentional and Behavioral Dysregulation: The child exhibits impaired normative developmental competencies related to sustained attention, learning, or coping with stress, including at least three of the following:

C. 1. Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues

C. 2. Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking

C. 3. Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation)

C. 4. Habitual (intentional or automatic) or reactive self-harm

C. 5. Inability to initiate or sustain goal-directed behavior

D. Self and Relational Dysregulation. The child exhibits impaired normative developmental competencies in their sense of personal identity and involvement in relationships, including at least three of the following:

D. 1. Intense preoccupation with safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation

D. 2. Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness

D. 3. Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults or peers

D. 4. Reactive physical or verbal aggression toward peers, caregivers, or other adults

D. 5. Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance

D. 6. Impaired capacity to regulate empathic arousal as evidenced by lack of empathy for, or intolerance of, expressions of distress of others, or excessive responsiveness to the distress of others

E. Posttraumatic Spectrum Symptoms. The child exhibits at least one symptom in at least two of the three PTSD symptom clusters B, C, & D.

F. Duration of disturbance (symptoms in DTD Criteria B, C, D, and E) at least 6 months.

G. Functional Impairment. The disturbance causes clinically significant distress or impairment in at two of the following areas of functioning:

• Scholastic: under-performance, non-attendance, disciplinary problems, drop-out, failure to complete degree/credential(s), conflict with school personnel, learning disabilities or intellectual impairment that cannot be accounted for by neurological or other factors.

• Familial: conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, non-fulfillment of responsibilities within the family.

• Peer Group: isolation, deviant affiliations, persistent physical or emotional conflict, avoidance/passivity, involvement in violence or unsafe acts, age-inappropriate affiliations or style of interaction.

• Legal: arrests/recidivism, detention, convictions, incarceration, violation of probation or other court orders, increasingly severe offenses, crimes against other persons, disregard or contempt for the law or for conventional moral standards.

• Health: physical illness or problems that cannot be fully accounted for physical injury or degeneration, involving the digestive, neurological (including conversion symptoms and analgesia), sexual, immune, cardiopulmonary, proprioceptive, or sensory systems, or severe headaches (including migraine) or chronic pain or fatigue.

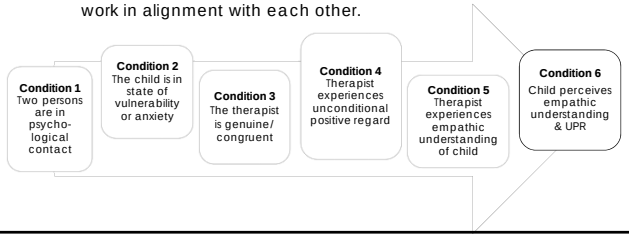
•Vocational (for youth involved in, seeking or referred for employment, volunteer work or job training): disinterest in work/vocation, inability to get or keep jobs, persistent conflict with co-workers or supervisors, under-employment in relation to abilities, failure to achieve expectable advancements.

CHILD-CENTERED PLAY THERAPY AND ACES

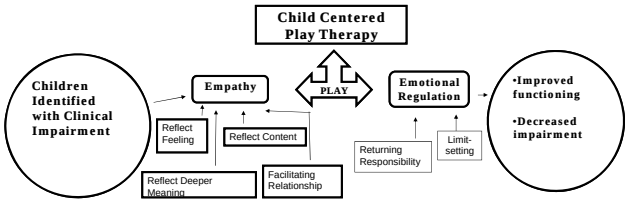
SIX BASIC CONDITIONS FOR PLAY THERAPY

Rogers, 1957

Six necessary and sufficient conditions to work toward constructive personality change. Because the individual is perceived as holistic, feelings, thoughts, & behavior work in alignment with each other.



Theoretical Base for CCPT



EIGHT BASIC PRINCIPLES OF THE THERAPEUTIC RELATIONSHIP
(AXLINE, 1969)

1. The therapist is genuinely interested in the child and develops a warm, caring relationship.
2. The therapist experiences unqualified acceptance of the child and does not wish that the child were different in some way.
3. The therapist creates a feeling of safety and permissiveness in the relationship so the child feels free to explore and express self completely.
4. The therapist is always sensitive to the child's feelings and gently reflects those feelings in such a manner that the child develops self-understanding.

EIGHT BASIC PRINCIPLES OF THE THERAPEUTIC RELATIONSHIP
(AXLINE, 1969)

5. The therapist believes deeply in the child's capacity to act responsibly, respects the child's ability to solve personal problems, and allows the child to do so.
6. The therapist trusts the child's inner direction.
7. The therapist appreciates the gradual nature of the therapeutic process and does not attempt to hurry the process.
8. The therapist establishes only those therapeutic limits which help the child accept personal and appropriate relationship responsibility.

Relationship

Play

Limit-Setting

Encouragement

Consistency

WHAT'S WORKING IN CCPT FOR CHILDREN WITH ACES

FOUR "BE WITH" ATTITUDES

I am here
I hear you
I understand
I care

Landreth & Bratton, 2006

Category	Description	Example
Tracking Behavior	Therapist verbally responds to behavior of the child by stating what is observed.	"You're picking that up."
Reflecting Content	Therapist paraphrases the verbal interaction of the child.	"You went to see the pirate movie and there was a lot of action in it."
Reflecting Feeling	Therapist verbally responds to emotions expressed by child.	"You're angry about being here and want to go home."
Returning Responsibility	Therapist verbalizes statements to help children experience their own capability and take responsibility for it.	"You decided you would be the boss and take charge." "That looks like something you can do."
Facilitating Creativity	Therapist verbalizes statements that help a child experience a sense of freedom and creativity.	"In here, it can be whatever you want it be."
Esteem-Building	Therapist verbalizes statements to help children experience a stronger and capable sense of self.	"You did it. You tried hard and figured it out."
Facilitating Relationship	Therapist reflects statements that build the relationship between therapist and child.	"You wanted to be close to me." "You wanted to do something to help me."
Reflecting Deeper Meaning	Therapist notices and verbalizes patterns in the child's play.	"When you come into the playroom, you want to be the one in charge."
Limit-Setting	Limits are set according to a 3-step procedure of reflecting the child's intention of feeling, setting a definitive limit, and providing an appropriate alternative.	"You are really angry with me but I'm not for throwing sand at. You can throw the sand in the sandbox."

COUNSELING & ACES: SALIENT ISSUES

No Way Around the Need for Relationship

- School Counselor
- Teachers
- Administrators
- Peers
- Parents

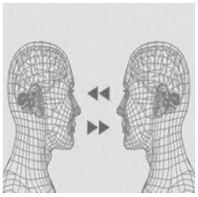
DIAGNOSIS

- Common Inaccurate Diagnoses
  - ADHD
  - Somatic Symptom Disorder
  - Borderline Personality Disorder
  - Autism Spectrum Disorder
  - Oppositional Defiant Disorder
  - Conduct Disorder
  - Disruptive Mood Dysregulation Disorder
  - Mood Disorders
  - Eating Disorders
  - Learning Disorders

Physical Attunement

- Matching child's physical movements
- Matching child's facial expressions
- Leaning toward child
- Making eye contact

RESONANCE CIRCUITRY



- Firing of neurons both when observing and performing a particular action (goal directed behavior)
- How our brains are "linked together"
- Emotional attunement
- Empathy; requires visceral, emotional, and cognitive information

BRAIN DEVELOPMENT

- At birth neurons in the brain are largely disconnected, but we are genetically primed to make synaptic connections through relational experiences
- As we experience ourselves and our environment, neurons form synaptic connections, carry energy and information to other neurons
- All aspects of an experience form into a neural net that encodes a representation of that event
- Memory occurs when a neural net is activated by a current experience
- Neural net is potentially altered by the energy and information of the present moment

Touch

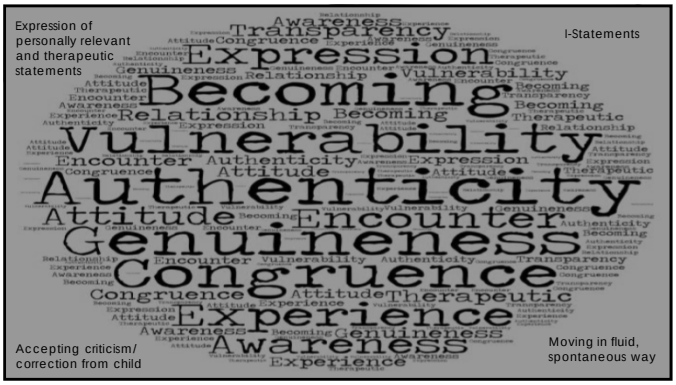
When fully attuned to child, the counselor may reach out to touch a child

Co-Regulation

- Calm breathing by counselor
- Moving closer to child
- Talking in natural tone & rhythm
- Being physically open to child

Expression of personally relevant and therapeutic statements

I-Statements



Accepting criticism/ correction from child

Moving in fluid, spontaneous way

Consistency

Self-Care

Your Childhood Experiences
Unconditional Positive Self-Regard
Belief in Resiliency
Patience
Authenticity

Working with Teachers

Not "What's wrong with this child?" Ask "What happened with this child?"

Trauma-Informed Classroom Practices

Trauma-Informed Classroom and School Practices (Ray, 2018)

Preventative Practices to Keep Problem Behaviors from Escalating

1. Identify possible triggers – sensory, times of day, activities, feelings of incompetence
2. Give opportunity to make choices
3. Provide empathy through reflecting feeling (e.g., You're excited about that, You really liked that activity, You feel bad about what you did)
4. Have a predictable environment with clear expectations
5. Try not to deviate from normal structure of day (If schedule changes, provide as much as notice as possible to student)
6. Teach positive self-talk before a behavioral problem occurs "I am safe" "I can calm myself down" "I'm a good person" "People love me"
7. Use encouraging phrases often "You worked hard on that", "You're really proud of what you did", "You're trying hard", "You did it", "You figured it out"
8. Create an environment of mutual respect
9. Teach how to ask for help
10. Provide tactile coping items (e.g., squeeze ball, clay, drawing materials, etc)
11. Create a safe place – soothing colors, music, pictures
12. Integrate physical movem recess, exercise

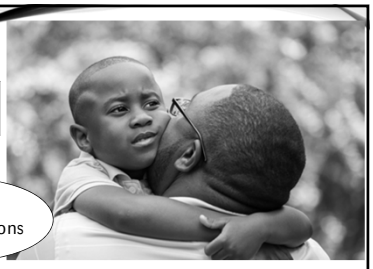
Trauma-Informed Classroom and School Practices (Ray, 2018)

Intervention Practices When Problem Behaviors Occur

NOTE: Children who have experienced complex trauma often become dysregulated in behavioral interactions. When children are dysregulated, soothing techniques are more effective than teaching practices.

1. Breathe – take a second to breathe before engaging with student
2. Talk less – try to use as few words as possible
3. Give short, simple instructions
4. Be aware of voice tone and facial expressions – speak slowly, quietly, and calmly
5. Reflect child's feelings or thoughts
6. Do not move quickly or abruptly
7. Don't lecture or ask too many questions
8. Suggest a replacement behavior (Ex: "You can choose other words", "You can choose to go in your safe place")
9. Create a safe place – soothing colors, music, pictures
10. Avoid trying to teach
11. Try to be alone with child

Working With Parents



- Frequent Consultations
- Lengthier Consultations
- Role-Play Typical Home Scenarios
- Behavioral Plans for Parents

ADJUNCT SERVICES

- Mindfulness Education/Practices
- Social Skills Education
- Social Skills Groups
- Parent Education
- Occupational Therapy
- Others?

RESOURCES

- https://acestoohigh.com/
- https://acestoohigh.com/got-your-ace-score/
- https://www.attachmenttraumanetwork.org/attachment-trauma/developmental-trauma-disorder-2/
- https://www.cdc.gov/violenceprevention/acestudy/
- https://www.cdc.gov/violenceprevention/acestudy
- http://nctsn.org/sites/default/files/assets/pdfs/nctsn_position_statement_on_clinical_competency.pdf
- Infographic: https://www.rwjf.org/en/library/infographics/the-truth-about-aces.html?cid=xsh_rwjf_ec_00046841#/download
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