

# The Role of Trauma in Child Development Diagnostics

## Position Statement

### Child Development Subnetwork

*Document pertains to:* Health Workers, Nurses, Doctors, Allied Health, Allied Health Assistants working within Child Development

*Purpose:* To support the assessment and diagnosis of neurodevelopmental disorders and trauma in child developmental services in Queensland Hospital and Health Services (HHSs) the following position statement for Child Development services has been developed.

## Background

Child Development Services (CDSs) play an important role in supporting and understanding the trauma impacts on a child's neurodevelopment. This is complex work however essential for accurate understanding of children with complex presentations in order to source appropriate treatment and management.

There is overwhelming evidence that traumatic life events, be they single, multiple or multigenerational, can impact on brain development and child development. Trauma can be caused from one adverse event or repetitive experience of adverse events creating 'toxic stress' defined as the prolonged activation of stress response systems in the absence of protective relationships. Stressors contributing to toxic stress can range from physical, emotional or sexual abuse, domestic violence, inter-generational trauma, caregiver divorce, experience of loss, or the substance abuse, chronic health and disability, and mental health of a parent.

When a child experiences 'toxic stress', the part of the brain circuitry responsible for the life-preserving 'fight or flight response' can be disrupted and may result in anatomical changes leading to delays in domains such as executive functioning, self-regulation, social skills, language, sensory impacts and learning. Resultant behaviours are often what is presented to us in clinic and can make diagnosis of neurodevelopmental disorders such as autism, ADHD, learning difficulties and anxiety a complex process. Therefore, understanding the interplay between neurodevelopment and life events has become a critical part of child development service assessment delivery.

## Managing Child Development Diagnostics in a Trauma Informed Way

Diagnostic assessment of a child's neurodevelopment occurs when symptoms are longitudinally evident: where there is evidence of a child's development lagging or being interrupted; and when symptoms are no longer seen to be getting worse or better. Trauma events or environments which are creating 'toxic stress' for a child impact on their presentation as well as their neurodevelopment which will cloud the symptomology observed within the clinic setting. It is important to note that trauma symptomology and neurodevelopmental symptomology have a high correlation, as well as high comorbidity which makes diagnostic differentiation challenging.

Early identification of at-risk environments (with events inducing 'toxic stress') will be essential to supporting the clinical reasoning about whether a child and/or family are 'ready for care' and whether assessment type (standardised vs dynamic) and assessment timing (current or over time) are appropriate. Holding a clear question about the reason for assessment will support this decision making. There may be clinical reasoning that suggests understanding of the current neurodevelopmental baseline in the midst of trauma events will help with understanding the impact of trauma and support advocacy. Where life-long diagnosis is being considered, clinical reasoning may consider that stability of the child's environment is a priority and that diagnostic process should be delayed until symptomology has stabilised.

## Assessment and Diagnosis of Neurodevelopmental Disorders and Trauma

The assessment and diagnosis of neurodevelopmental disorders is complicated by the broad range of neurodevelopmental diversity that exists throughout childhood as well as the myriad of experiences that a child is exposed to throughout their lives, their antenatal period and even throughout their intergenerational family history. Evidence suggests that over 40% of our population have experienced two or more adverse childhood events (ACE's) and that neurodevelopmentally vulnerable children are at higher risk of additional adverse childhood events placing them at higher risk of cumulative harm. Having an awareness of adverse life events and gathering a broad history of risk and intergenerational trauma exposure can no longer be segregated as not 'CDSs' business and is recognised as integral to child development diagnostics.

For child development diagnostics an understanding of trauma will need to occur in two ways;

Firstly, understanding trauma broadly through holistic assessment of the child in context of their intergenerational family and longitudinal life events is required. Use of an intergenerational genogram to map family events and patterns and a life course timeline that can identify patterns of abnormal development aligned with adverse events across the child's neurodevelopmental timeline can be a useful tool to support this.

And secondly, understanding trauma symptomology and its interplay with specific developmental

domains is required. Solid knowledge and understanding of each development domain will be required as a foundation as well as an awareness of how trauma can impact the development of that domain. For example, there is a high correlation between speech and language development and trauma and/or family function; deprivation is correlated with cognitive delay, attachment and emotional safety disruptions correlate with social skill delays. Differentiating the symptomology is not clear if looking at single domains or solely at the child's development out of context from their environment and experiences.

Exploration of trauma broadly and specifically can be done by a single child development clinician if a broad transdisciplinary assessment and formulation framework is applied. Ideally, use of other multidisciplinary team members would participate in this process to support a broad lens being applied and provide multiple lenses of the symptomology being assessed. For areas where a team is not available, an interagency care planning meeting should occur with available service providers such as primary care health practitioners, Department of Education, Mental Health and GP.

Following a child development services assessment process inclusive of family centered assessment principles with a dedicated formulation will support diagnostic differentiation. The high correlation and comorbidity of trauma and neurodevelopmental symptomology means that an integrated formulation process would be required to support diagnostic differentiation and ensure assumptions are not made regarding the sole impact of trauma at the expense of neurodevelopmental understandings.

Careful consideration of the messaging of diagnostic findings to families impacted by trauma is important to ensure that the experience is not re-triggering for the family and that messaging is placed within the family context in a manner that supports understanding of the child and best matches the required management and intervention needed.

### **Managing staff confidence in understanding and manage Trauma in Child Development Services**

Evidence now highlights that most families who access CDSs will have experienced adverse life events and 'toxic' stress. This is an evolution from traditional child development models that took a domain specific focus. There is recognition that the Child Development professional spread does not always have dedicated professions, such as Social work and Psychology, that can manage and assess trauma. Therefore, all professions in child development will need a baseline capability in trauma informed care and assessment to ensure that families are managed and assessed appropriately.

Transdisciplinary training and peer supervision that is inclusive of trauma informed care principles should

be provided to support core capability for all Child Development Staff. Consideration of discipline specific supervision that is inclusive of trauma and neurodevelopmental impacts.

### **Child Development Sub Network Recommendations:**

Recognition that understanding and responding to the impact of trauma is 'everybody's business' and core to CDS delivery

CDSs should offer services across the care continuum that encompass trauma informed care, including:

- Being responsive to client choice, identified risk and the needs of vulnerable populations
- Being integrated with other care and service providers
- Being strength based
- Having a community capacity building approach

CDSs, where possible, follow a development diagnostic framework that:

- Offers diagnostic assessment and formulation that is integrated across multidisciplinary staff and/or other service providers
- Offers diagnostic assessment that includes observation across setting or collateral from other relevant persons/ services
- Understands ACE's and trauma events across the child and family life course and how it impacts each developmental domain
- Applies a biopsychosocial model to understand the interplay of neurodevelopment, biology and social experiences

Queensland Health clinical staff and peer workforce are adequately supported by training and supervision on how best to support, refer and facilitate access to timely trauma informed care responses across the continuum of care and recognise the impact on staff wellbeing in effectively supporting delivery of child and family centered care to families who have experienced trauma

The development of a *Trauma informed Child Development Service Framework* that can provide a guide for best practice management and assessment of neurodevelopment and trauma differentiation in child development services throughout Queensland

## Definitions:

Adverse Childhood Events	The term “ACEs” is an acronym for Adverse Childhood Experiences. It originated in a study conducted in 1995 by the Centers for Disease Control and the Kaiser Permanente health care organization. In that study, “ACEs” referred to three specific kinds of adversity children faced in the home environment—physical and emotional abuse, neglect and household dysfunction. The key findings of dozens of studies using the original ACEs data are that ACEs are quite common, even among a middle-class population. There is a correlation between high ACEs and poor outcomes later in life, including increased risk of heart disease, diabetes, obesity, depression, substance abuse, smoking, poor academic achievement, time out of work, and early death.
Biopsychosocial Model	The biopsychosocial model systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery.
Diagnostic Assessment	Including the measurement of developmental skills; and analysis of social context (esp. family function); a search for an identifiable physical cause (eg neurological/ genetic/ metabolic conditions) or comorbid physical conditions; and consideration of the need for medical investigations. Collateral information (history from other caregivers, questionnaire data) and referral for targeted assessments by other professionals (including multidisciplinary team assessment) are undertaken as required.
Diagnostic Formulation	A multidisciplinary collaborative process that draws information held by several sources into a coherent explanation of the child and family (strengths-based approach) and encompass biological (medical) and psychosocial considerations in addition to clarifying the neurodevelopmental profile. The appropriateness of a formal diagnostic label is considered. The provision of quality feedback to the family and child is core to the role and maybe shared with other team members.
Genogram	Graphic representation of an intergenerational family relationships that identifies detailed data on relationships among individuals. It goes beyond a traditional family tree by analyzing hereditary patterns across generations and psychological factors that highlight relationships
Life course timeline	Graphic representation of a timeline that sequences defining events, ACE’s and developmental milestones that the individual has experienced over time.
Positive Stress	A positive stress response is a normal stress response and is essential for the growth and development of a child. Positive stress responses are infrequent, short-lived, and mild. The child is supported through this stressful event with strong social and emotional buffers such as reassurance and parental protection. The child gains motivation and resilience from every positive stress response, and the biochemical reactions that occur with such a stressful event return to baseline

Protective Factors	Protective factors which may attenuate toxic stress risk include presence of a caring and supportive adult, positive family changes, structured school environment, access to healthcare and social services, involvement with religious community or extracurricular organized activity
Tolerable Stress	Tolerable stress responses are more severe, frequent or sustained. The body responds to a greater degree, and these biochemical responses have the potential to negatively affect brain architecture. Examples include divorce or the death of a loved one. In tolerable stress responses, once the adversity is removed, the brain and organs recover fully given the condition that the child is protected with responsive relationships and strong social and emotional support.
Toxic Stress	Prolonged activation of the stress response in the absence of a caregiver support, reassurance and attachment.
Trauma	Response to a deeply distressing or disturbing event that overwhelms the individual's ability to cope, diminishes sense of self and the ability to feel the full range of emotions and experience.

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### Document history

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Draft Review	18.02.2020	Jordana Rigby	Feedback finalised
1.0	11.03.2020	Jordana Rigby	Final

Previous versions should be recorded and available for audit.

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