Adolescents and Trauma

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What is Trauma?

Definitions of Trauma

- Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

- In short, trauma is the sum of the event, the experience, and the effect. (SAMHSA, 2012).

More Definitions of Trauma

- Overwhelming event or events that render a child helpless, powerless, creating a threat of harm and/or loss.

- Trauma is an event that is extremely upsetting and at least temporarily overwhelms internal resources. (Briere, J. 2006).

Spectrum of Trauma

- Acute Trauma: A single time limited event
- Chronic Trauma: Multiple traumatic exposures and/or events over extended periods of time
- Complex Trauma: Experiences of multiple traumatic events and the impact of exposure to these events (often occurring within the care giving system)
- Toxic Stress: Adverse experiences that lead to strong, frequent, or prolonged activation of the body’s stress response system
- Secondary/Vicarious Trauma: Exposure to the trauma of others by providers, family members, partners or friends in close contact with the traumatized individual

What happens to the Brain?
**Sequence of Brain Development**

- **Brainstem:**
  - Functions necessary for survival
  - Heart rate, breathing, digesting foods, sleeping
- **Limbic system:**
  - Activates the fight or flight response
  - Monitors incoming stimuli
- **Cortex, including frontal lobe or neocortex:**
  - Conscious thinking and reasoning
  - Inhibits emotional and impulsive parts of the brain

**Trauma and the Developing Brain**

- Trauma is a “neuro-developmental insult” and impacts the development of the brain.
- When triggered into a trauma response over and over there are major multi-systemic impacts on the developing brain.
- Brain architecture is “experience dependent” (neuroplasticity).

*Nadine Burke Harris MD, Executive Director, Center for Youth Wellness from presentation at Adolescent Health Working Group, SF May 2013*

**What does trauma do to us?**

- Trauma produces extreme stress that overwhelms the person’s capacity to cope (APA, 2000).
- Chronic trauma interferes with neurobiological development and the capacity to integrate sensory, emotional and cognitive information into a cohesive whole.
- Developmental trauma sets the stage for unfocused responses to subsequent stress.

*Resilient A. van der Kolk, MD*


**Traumatized children have problems with:**

- Unmodulated aggression
- Impulse control
- Attentional and dissociative problems
- And difficulty negotiating relationships with caregivers, peers and, subsequently, intimate partners
- Histories of childhood physical and sexual assaults are associated with:
  - A host of other psychiatric diagnoses in adolescence and adulthood
  - Substance abuse
  - Borderline and antisocial personality
  - Eating disorders
  - Cardiovascular and metabolic disorders

**Trauma Impacted Youth Can have difficulty with:**

- Managing “big” emotions
- Chronic instability/anxiety that interferes with problem solving
- Empathy
- Expressing concerns/needs in words
- Taking into account the wider context of a situation
- Appreciating how one’s behavior impacts other people
- Working in groups/connecting with others

*The Sanctuary Model: Designing and Implementing Trauma-Informed School Based Programs, The Sanctuary Institute*
Persistently AlteredAttributions and Expectancies
- Negative self-attribution
- Distrust protective caretaker
- Loss of expectancy of protection by others
- Loss of trust in social agencies to protect
- Lack of recourse to social justice/retribution
- Inevitability of future victimization

Long-term Impacts of Trauma
- Anxiety, depression, and/or anger
- Cognitive distortions
- Posttraumatic stress
- Dissociation
- Identity disturbance
- Affect dysregulation
- Interpersonal problems
- Substance abuse
- Self-mutilation
- Bingeing and purging (bulimia)
- Unsafe or dysfunctional sexual behavior
- Somatization
- Aggression
- Suicidality
- Personality disorder

(Briere, 1996, 2002 and Briere & Lanktree, 2013)

Symptoms that Overlap with Child Trauma and Mental Illness

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>Overlapping Symptoms</th>
<th>Trauma</th>
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</thead>
<tbody>
<tr>
<td>Attention Deficit/Hyperactivity Disorder</td>
<td>Restless, hyperactive, disorganized, and/or agitated activity, difficulty sleeping, poor concentration, and hypervigilant motor activity</td>
<td>Child Trauma</td>
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<tr>
<td>Oppositional Defiant Disorder</td>
<td>A predominance of angry outbursts and irritability</td>
<td>Child Trauma</td>
</tr>
<tr>
<td>Anxiety Disorder (incl. Social Anxiety, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, or phobia)</td>
<td>Avoidance of feared stimuli, physical and psychological hypervigilance upon exposure to feared stimuli, sleep problems, hypervigilance, and increased startle reaction</td>
<td>Child Trauma</td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>Self-injurious behaviors as avoidant coping with trauma reminders, social withdrawal, affective numbing, and/or sleeping difficulties</td>
<td>Child Trauma</td>
</tr>
</tbody>
</table>

Survival Brain vs. Learning Brain
- We all have normal alarm systems in our brain/body that let us know when we are under threat and mobilize us to fight, flight (flight) or freeze in the face of a threat.
- When youth experience continuous threats/truma, the brain/body is put into a chronic state of fear, activating the “survival brain” (mid/lower areas of the brain).
- This can create an overactive alarm system in the developing brain. A youth’s brain/body that develops within the context of trauma can be more easily triggered into survival brain by “trauma reminders” or “triggers” even when there is no actual threat.

Why is this Important?
- When youth are in a “triggered” state, the “learning brain” (higher functions of the frontal lobe) goes offline.
- A curtain falls on the frontal lobe!
- Verbal warnings or rational arguments that make demands on these higher functions may escalate the situation as youth are physiologically unable to access these functions when they are in a triggered state.
What is the Adverse Childhood Experiences (ACE) Study?

Robert F. Anda, M.D., Vincent J. Felitti, M.D.

ACE Category | Definition | Prevalence
--- | --- | ---
Emotional abuse | Recurrent threats, humiliation | 11%
Physical abuse | Beating, not spanking | 28%
Sexual abuse | Contact abuse only | 22%
Domestic violence | Mother treated violently | 13%
Substance abuse | Alcoholic or drug user in household | 27%
Incarceration | Household member imprisoned | 6%
Mental illness | Household member chronically depressed, suicidal, mentally ill or in psychiatric hospital | 17%
Parental separation | Not raised by both biological parents | 23%
Physical neglect* | Lack of adequate food, shelter, physical support | 10%
Emotional neglect* | Family failed to provide a source of strength, emotional support, and protection | 15%

* Women are 50% more likely than men to have a Score >5.

Adverse Childhood Experiences Score

Number of categories (not events) is summed...

ACE Score | Prevalence
--- | ---
0 | 33%
1 | 25%
2 | 15%
3 | 10%
4 | 6%
5 or more | 11%

- Two out of three experienced at least one category of ACE.
- If any one ACE is present, there is an 87% chance at least one other category of ACE is present.

ACE Score and Intravenous Drug Use

% Injected Drugs

1 | 2 | 3 | 4 or more
--- | --- | --- | ---
ACE Score | 0.5 | 1 | 1.5 | 2 | 2.5 | 3 | 3.5

Where there's smoke........

Basic cause of addiction is experience-dependent, not substance-dependent

Significant implications for medical practice and treatment programs
Prevalence Data

Just how prevalent is trauma?
- National community-based surveys find that between 55 and 90% of us have experienced at least one traumatic event (Fallot and Harris, 2009).
- One in every four women will experience domestic violence in her lifetime (Tjaden & Thoennes, 2000).
- An estimated 1.3 million women and 835,000 men are victims of physical assault by an intimate partner each year (CDC Report, 2003).

In 2011 alone, approximately 681,000 children were victims of maltreatment in the U.S. (National Children's Alliance).
- Almost half the nation’s children have experienced at least one or more types of serious childhood trauma (National Survey of Children’s Health 2011/2012).
- Even more concerning, nearly a third of U.S. youth age 12-17 have experienced two or more types of childhood adversity that are likely to affect their physical and mental health as adults.

Experiences’ and Behavioral Conditions’ Effects on Medical Health

Some medical Costs of Childhood Trauma:
- A conservative estimate of the annual cost of child abuse/neglect in US ($94 billion) includes $2 billion for chronic health conditions (Jennings, 2004).
- In North America, the long-term sequelae of severe child abuse cost more than $100 billion in psychiatric and medical health care per year, although in the majority of cases this connection is unrecognized and misattributed (Jennings, 2004).

Childhood Trauma and Behavioral Health Conditions:
- One estimate puts the prevalence of trauma history among public mental health consumers at 90%, with most carrying the weight of multiple traumatic experiences (Mueser et al., 1998).
- Of these consumers, 34-53% report childhood physical or sexual abuse and 43-81% report some type of victimization (Kessler et al., 1995).
- An estimated 75% of adults in SUD treatment have a history of childhood abuse and neglect (SAMHSA, 2000).

What does the prevalence data tell us?
- The majority of adults and children in psychiatric treatment settings have trauma histories.
- A sizable percentage of people with substance use disorders have traumatic stress symptoms that interfere with achieving or maintaining sobriety.
- A sizable percentage of adults and children in the prison or juvenile justice system have trauma histories.

What does the prevalence data tell us?

- Growing body of research on the relationship between victimization and later offending.
- Many people with trauma histories have overlapping problems with mental health, addictions, physical health, and are victims or perpetrators of crime.
- Victims of trauma are found across all systems of care.


Therefore......

We need to presume the clients we serve have a history of traumatic stress and exercise “universal precautions” by creating systems of care that are trauma-informed (Hodas, 2005).

What is Trauma-Informed Care?

- “Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors to rebuild a sense of control and empowerment.” (Hopper et al, 2010)

- Trauma-informed care is defined as behavioral health treatment that incorporates an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services and/or substance use disorder services (SAMHSA)

Comparing Traditional and Trauma-Informed Paradigms

Trauma-Informed Care vs. Traditional Care

- Trauma Informed Care seeks to change the question from “What’s wrong with you?” to “What has happened to you?”
- In traditional care
  - You are sick
  - You are bad
  - You are sick and bad

- In trauma-informed care
  - You are not sick or bad
  - Something bad happened
  - You are injured
**Trauma-Informed**
- Recognition of high prevalence of trauma
- Recognition of primary and co-occurring trauma diagnoses
- Assess for traumatic histories & symptoms
- Recognition of culture and practices that are re-traumatizing

**Traditional Care**
- Lack of education on trauma prevalence & "universal" precautions
- Over-diagnosis of ADHD, ADD, Conduct D., Bipolar D., & singular addictions
- cursory or no trauma assessment
- "Tradition of Toughness" valued as best care approach

**Trauma-Informed**
- Staff understand function of behavior (rage, repetitiveness, compulsion, self-injury)
- Objective, neutral language.
- Transparent systems open to outside parties

**Traditional Care**
- Behavior seen as intentionally provocative.
- Labeling language: manipulative, needy, "attention-seeking".
- Closed system - advocates discouraged

**A Trauma-Informed Care Approach**
- Trauma is viewed as "a defining and organizing experience that forms the core of an individual's identity" (Harris, M. and Fallot, R.D. (Eds), 2001).
- generalizable across all settings
- creates a shift in organizational culture
- reflects the adoption of core principles

**Comparing Traditional and Trauma-Informed Paradigms**
- Understanding of Trauma
- Understanding of the Person/Survivor
- Understanding of Services
- Understanding of the Service Relationship
A Culture Shift: Core Principles of Trauma-Informed Care

- **Safety:** Ensuring physical and emotional safety
- **Trustworthiness:** Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries
- **Choice:** Prioritizing the individual's choice and control
- **Collaboration:** Maximizing collaboration and sharing of power with the individual we are serving
- **Empowerment:** Prioritizing empowerment and skill-building

A Trauma Informed Approach At School:

- Uses the recognition that certain behaviors are related to traumatic experience to drive a new set of practices at school with young people who exhibit these behaviors.
- Shifts from a model that asks, “What is wrong with you?” to one that asks, “What happened to you?”
- A new question emerges: “How can we shift the school environment and classroom practices to respond more effectively to your needs?”

When an organization (school) is trauma-informed, its environment can be more **collaborative**, its employees (educators) can be more **productive**, and individuals (students) at all levels can feel **valued** and focus on learning.

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