

## Adolescents and Trauma

Lenya Robinson, MA, LPC


## 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

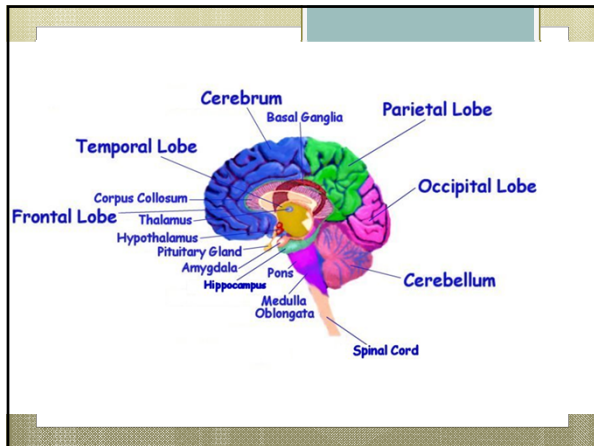
- *Overwhelming* event or events that render a child helpless, powerless, creating a threat of harm and/or loss.
- Trauma is an event that is extremely upsetting and at least temporarily overwhelms internal resources. (Briere, J. 2006).



### 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.

Bessel A. van der Kolk, MD  
[http://www.traumacenter.org/products/pdf\\_files/Preprint\\_Dev\\_Trauma\\_Disorder.pdf](http://www.traumacenter.org/products/pdf_files/Preprint_Dev_Trauma_Disorder.pdf)



- 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 irritability/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 Altered Attributions 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)

### Trauma Triggers

- Activate the “survival brain,” causing youth to react as though a “there and then” experience (previous traumatic event) is happening “here and now” (in current reality)
- Common Triggers include:
  - Unpredictability (e.g. a fire drill)
  - Sensory overload
  - Feeling vulnerable or frustrated
  - Confrontation

Trauma and Resilience: An Adolescent Provider Toolkit: Adolescent Health Working Group 2013

### Symptoms that Overlap with Child Trauma and Mental Illness

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

Trauma, Resilience, and Healing: Solutions Map © Kater 2012

### 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.

### 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, flee (flight) or freeze in the face of a threat.
- When youth experience continuous threats/trauma, 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.*

## 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%

(Felitti et al., 1998)

### Adverse Childhood Experiences Score

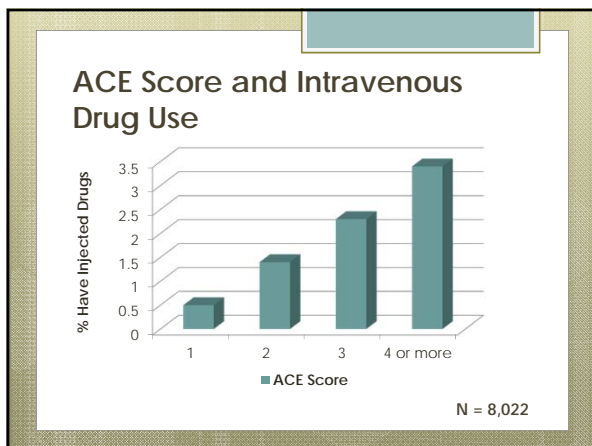
Number of categories (not events) is summed...

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

(Felitti et al., 1998)



- Basic cause of addiction is experience-dependent, not substance-dependent
- Significant implications for medical practice and treatment programs

Where there's smoke.....






## 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 results in more physical dysregulation than adult trauma, and interpersonal trauma results in dysregulation, not only in response to reminders of traumatic stressors, but also in response to intimacy, aggression, and trust in general (Van der Kolk, 1996).
- The younger the child and longer the duration of trauma, the greater the dysregulation (Van der Kolk, 1996).

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 (Muesser 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.

(Hodas, 2004, Cusack et al., Mueser et al., 1998, Lipschitz et al., 1999, NASMHPD, 1998)

### 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.

(Hodas, 2004, Cusack et al., Muesaret al., 1998, Lipschitz et al., 1999, NASMHPD, 1998)

### 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

- "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

<u>Trauma-Informed</u>	<u>Traditional Care</u>
<ul style="list-style-type: none"> <li>Recognition of high prevalence of trauma</li> <li>Recognition of primary and co-occurring trauma diagnoses</li> <li>Assess for traumatic histories &amp; symptoms</li> <li>Recognition of culture and practices that are re-traumatizing</li> </ul>	<ul style="list-style-type: none"> <li>Lack of education on trauma prevalence &amp; "universal" precautions</li> <li>Over-diagnosis of ADHD, ADD, Conduct D., Bipolar D., &amp; singular addictions</li> <li>Cursory or no trauma assessment</li> <li>"Tradition of Toughness" valued as best care approach</li> </ul>

<u>Trauma-Informed</u>	<u>Traditional Care</u>
<ul style="list-style-type: none"> <li>Power/control minimized -constant attention to culture.</li> <li>Caregivers/supporters –<i>collaboration</i>.</li> <li>Address training needs of staff to improve knowledge &amp; sensitivity.</li> </ul>	<ul style="list-style-type: none"> <li>Keys, security uniforms, staff demeanor, tone of voice.</li> <li>Rule enforcers – <i>compliance</i>.</li> <li>"Patient-blaming" as <i>fallback</i> position without training.</li> </ul>

(Fallot & Harris, 2002; Cook et al., 2002; Ford, 2003; Cusack et al.; Jennings, 1998; Prescott, 2000)

<u>Trauma-Informed</u>	<u>Traditional Care</u>
<ul style="list-style-type: none"> <li>Staff understand function of behavior (rage, repetition-compulsion, self-injury).</li> <li>Objective, neutral language.</li> <li>Transparent systems open to outside parties</li> </ul>	<ul style="list-style-type: none"> <li>Behavior seen as intentionally provocative.</li> <li>Labeling language: manipulative, needy, "attention-seeking".</li> <li>Closed system – advocates discouraged</li> </ul>

(Fallot & Harris, 2002; Cook et al., 2002; Ford, 2003; Cusack et al.; Jennings, 1998; Prescott, 2000)

### 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

### Core Principles of Trauma-Informed Care

### A Culture Shift: Core Principles of Trauma-Informed Care

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

### A Trauma Informed Approach At School:

- o 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.
- o Shifts from a model that asks, "What is wrong with you?" to one that asks, "What happened to you?"
- o 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.

### Contact Information

Lenya Robinson, LPC  
 Director  
 Trauma Informed and Integrated Care Programs  
 Office of Behavioral Health  
 303-866-7045  
 Lenya.Robinson@state.co.us

