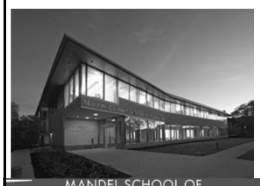
Trauma and Co-Occurring Disorders With Adolescents



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MANDEL SCHOOL OF APPLIED SOCIAL SCIENCES
CASE WESTERN RESERVE UNIVERSITY

Complex and Pervasive Trauma Implications for COD Adolescents

van der Kolk 2005

"Childhood trauma, including abuse and neglect, is probably the single most important public health challenge in the United States, a challenge that has the potential to be largely resolved by appropriate prevention and intervention"

p. 401

Trauma: Basic

From SAMHSA's Trauma and Justice Strategic Initiative

…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

Trauma: Additional

"Stress is commonly defined as a state of real or perceived threat to homeostasis. Maintenance of …requires activation of a complex range of responses involving the endocrine, nervous, and immune systems, collectively known as the stress response."
Smith & Vale 2006

Diagnostic Basics

Trauma-and-Stressor-Related Disorders

"…include disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion." p. 265

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- PTSD
- Acute Stress Disorder
- Adjustment Disorder

Skhizein → Schizo (Greek) To Split

Reactive Attachment

One disorder in the IV – now split into two in the 5: both result from social neglect – an absence of adequate caregiving – limiting a child's opportunity to form selective attachments

- Expressed as internalizing disorder with depressive symptoms: lack of or incompletely formed preferred attachments to caregiving adults – not certain how it is expressed in adolescence

Disinhibited Social Engagement

- Expressed as externalizing disorder and marked by lack of inhibition – can resemble ADHD: Peer relationships are most affected in adolescence, with both indiscriminate behavior and conflicts apparent

PTSD

DSM-5 criteria for posttraumatic stress disorder differ significantly from those in DSM-IV. As described previously for acute stress disorder, the stressor criterion (Criterion A) is more explicit with regard to how an individual experienced "traumatic" events. Also, Criterion A2 (subjective reaction) has been eliminated. Whereas there were three major symptom clusters in DSM-IV—reexperiencing, avoidance/numbing, and arousal—there are now four symptom clusters in DSM-5, because the avoidance/numbing cluster is divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood. This latter category, which retains most of the DSM-IV numbing symptoms, also includes new or reconceptualized symptoms, such as persistent negative emotional states. The final cluster—alterations in arousal and reactivity—retains most of the DSM-IV arousal symptoms. It also includes irritable or aggressive behavior and reckless or self-destructive behavior. Posttraumatic stress disorder is now developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents. Furthermore, separate criteria have been added for children age 6 years or younger with this disorder.

Source: Highlights of Changes…IV to 5 APA

DSM-5 PTSD

A. Exposure to actual or threatened death, serious injury or sexual violence in at least one of 4 ways

This one seems straightforward

B. At least one of five possible 'intrusion symptoms'

Distressing memories, dreams, flashbacks, psychological or physiological distress

This one can be tougher

DSM-5 PTSD

C. One of two possible avoidance symptoms

Avoiding the reminders – the memories themselves or of external reminders

This one seems tough to link to many of our youth too

D. At least two of seven possible symptoms related to emotional numbing

Dissociative amnesia, negative beliefs, decreased interest, detachment, foreshortened future, inability to experience positive emotions…

Sounds like a lot of our youth

DSM-5 PTSD

E. Two of six potential arousal and reactive symptoms

Irritable, self-destructive, hypervigilant, startle, concentration and sleep

Sounds like everyone's youth

Ford and Hawke (Kaminer 2016) note regarding youth:

PTSD symptoms may not occur simultaneously and will vary over time: one set of symptoms may be manifested with high frequency in one period, whereas other symptoms predominate during others

P. 206

Additional Notes: PTSD

Ford and Hawkes: Chapter 9 in Kaminer 2016

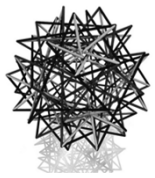
"Compared to adult survivors, adolescents may exhibit more impulsive and aggressive behaviors and engage in more dramatic reenactments (i.e., incorporating aspects of traumatic events into their daily lives)".
p. 210

Overlapping and Multiple Occurring Conditions (Shepler) are quite common with PTSD – and all are increased with poly victimizations.

Differential

With long term, pervasively traumatic exposures and experiences – where do RAD/Disinhibited and PTSD intersect?

Does it matter?



Acute Stress Disorder

Self descriptive: characteristic set of symptoms lasting from 3 days to 1 month after exposure to traumatic event(s)

If this persists beyond one month – it likely moves to PTSD

Adjustment Disorder

The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor

- With depressed mood
- With anxiety
- Mixed anxiety/depress
- Disturbance of conduct
- Mixed: emotions and conduct

*not a specifier – but it can be ongoing with continued exposure

Diagnostic End-All-Be-All?

Seems like something is missing

Complex Trauma: not PTSD

A 1998 study of nearly 400 abused children noted: complex traumatic experiences are not most commonly diagnosed as PTSD.

In order – these children were diagnosed with

1. Separation Anxiety
2. ODD
3. Phobias
4. PTSD
5. ADHD

Ackerman et al. 1998

Considered for the DSM-5

An APA workgroup considered adding Developmental Trauma Disorder (DTD) to Section III, Conditions for Further Study

The DSM-5 workgroup – associated with the National Child Traumatic Stress Network – noted a need for a new diagnosis to better describe and capture the type of pervasive traumatic experiences of many children

From DeAngelis 2007

Developmental Trauma Disorder

"To fill the gap, the group is proposing a diagnosis called "developmental trauma disorder" or DTD, to capture what members see as central realities of life for these children: exposure to multiple, chronic traumas, usually of an interpersonal nature; a unique set of symptoms that differs from those of post-traumatic stress disorder (PTSD) and a variety of other labels often applied to such children (see "Current trauma diagnoses"); and the fact that these traumas affect children differently depending on their stage of development."

DeAngelis 2007

DTD

"While PTSD is a good definition for acute trauma in adults, it doesn't apply well to children, who are often traumatized in the context of relationships," says Boston University Medical Center psychiatrist Bessel van der Kolk, MD, one of the group's co-leaders. "Because children's brains are still developing, *trauma has a much more pervasive and long-range influence on their self-concept, on their sense of the world and on their ability to regulate themselves*."

DeAngelis 2007

Proposed Tx for DTD

1. Teaching the children self-regulation skills and highlighting their resiliencies despite the trauma(s) – and building on these areas of resilience

2. Parent-Child Psychotherapy, developed by Alicia Lieberman. She notes that the parent(s) are often dysregulated themselves – and may be passing 'intergenerational transmission of trauma': skill build with the parents

DeAngelis 2007

DTD DOA D'OH!

Developmental Trauma Disorder was not accepted for inclusion in the DSM-5.

Proposed diagnostic criteria and descriptions can be found on-line:

Developmental trauma disorder: pros and cons of including formal criteria in the psychiatric diagnostic systems

BMC Psychiatry 2013 13:3

Complex/Developmental Trauma

Complex Trauma White Paper of the National Child Traumatic Stress Network (NCTSN) Workgroup on

Complex Trauma

*cited as NCTSN1

"The diagnosis of post-traumatic stress disorder (PTSD) does not capture the developmental effects of complex trauma exposure"

"Complex trauma exposure results in a loss of core capacities for self-regulation and interpersonal relatedness. Children exposed to complex trauma often experience lifelong problems that place them at risk for additional trauma exposure and cumulative impairment (eg, psychiatric and addictive disorders; chronic medical illness; legal, vocational, and family problems)."

Complex Trauma

Children and youth exposed to maltreatment and pervasive traumatic experiences are frequently diagnosed as:

- Depressed
- ADHD
- Anxiety Disorders
- ODD/CD
- Reactive Attachment
- Communication Disorder
- Separation Anxiety
- Eating and sleeping disorders

Reviewing the literature about complex trauma, the NCTSN workgroup identified 7 domains of potential impairment:

1. Attachment
2. Biology
3. Affect regulation
4. Dissociation
5. Behavioral regulation
6. Cognition
7. Self-concept

NCTSN1

Attachment Domain

Think about Erikson's first psychosocial stage – all future development regarding trust, distress tolerance, curiosity, sense of agency and communication stems from this.

"80% of maltreated children develop insecure attachment patterns"

- Problems with boundaries
- Distrust and suspiciousness
- Social isolation
- Interpersonal difficulties
- Difficulty attuning to other people's
- emotional states
- Difficulty with perspective taking

NCTSN1

Biology Domain

Biology regarding neurodevelopment – and risks exist at each stage of development

- Sensorimotor developmental problems
- Analgesia
- Problems with coordination, balance, body tone
- Somatization
- Increased medical problems across a wide span (eg, pelvic pain, asthma, skin problems, autoimmune disorders, pseudoseizures)

NCTSN1

Affect Regulation Domain

Affect regulation begins with the accurate identification of internal emotional experiences, which requires the ability to differentiate among states of arousal, interpret these states, and apply appropriate labels (eg, "happy," "frightened").

- Difficulty with emotional self-regulation
- Difficulty labeling and expressing feelings
- Problems knowing and describing internal states
- Difficulty communicating wishes and needs

NCTSN1

Dissociation Domain

This regards alterations to one's consciousness. Explained as moving to an 'autopilot', 'compartmentalizing the trauma(s)' and detaching from awareness of self and emotions.

How do we see this induced chemically?

- Distinct alterations in states of consciousness
- Amnesia
- Depersonalization and derealization
- Two or more distinct states of consciousness
- Impaired memory for state-based events

NCTSN1

Behavioral Control Domain

Can be described by children and adolescents overcontrolling or undercontrolling behaviors

May be expressed as very rigidly controlled patterns, or as aggressive or oppositionally defiant ones

Can be interconnected with biological and affect regulation domains

NCTSN1

- Poor modulation of impulses
- Self-destructive behavior
- Aggression toward others
- Pathological self-soothing behaviors
- Sleep disturbances
- Eating disorders
- Substance abuse
- Excessive compliance
- Oppositional behavior
- Difficulty understanding and complying with rules
- Reenactment of trauma in behavior or play (eg, sexual, aggressive)

Cognition Domain

Building and snowballing from early age maltreatment, cognitive problems compound and are directly related to language and expressive problems, leading to school problems and over representation of learning disorders, attention and reasoning difficulties…

3X dropout rate as general population

- Difficulties in attention regulation and executive functioning
- Lack of sustained curiosity
- Problems with processing novel information
- Problems focusing on and completing
- tasks
- Problems with object constancy
- Difficulty planning and anticipating
- Problems understanding responsibility
- Learning difficulties
- Problems with language development
- Problems with orientation in time and space

NCTSN1

Self-Concept Domain

Again, consider Erikson…if children receive consistent and warm support – things typically go as scheduled. If not - repetitive
experiences of
harm, rejection, or both by significant others, and the associated failure to develop age-appropriate competencies, are likely to lead to a sense of self as defective, helpless, deficient, and unlovable.

- Lack of a continuous, predictable sense of self
- Poor sense of separateness
- Disturbances of body image
- Low self-esteem
- Shame and guilt

NCTSN1

Some other considerations in this area

<u>Neurobiological Developmental Influence</u>

Early maltreatment can have significant and lifelong impacts on the direction of brain development

Trauma(s) during any developmental stage – especially through Transition Age – can have big impacts. This is likely especially true during the very active brain developmental periods of infancy and adolescence

Neurodevelopmental Impacts

- Early maltreatment and pervasive traumatic exposures can disrupt neurotransmitters and hormones directly related to stress, emotion and memory
- Cortisol
- Norepinephrine
- Dopamine
  - May cause an escalation of the stress response – and lead to lifelong neural patterns

TIP 57

More Neuro

Elevated levels of cortisol and catecholamines can influence 'maturational failures in other brain regions, such as the prefrontal cortex'.

This may influence the later levels of oxytocin – which impact social bonding and trust

2008 study by Heim, Mietzko et al:

Adult women with emotional abuse during childhood had reduced levels of oxytocin: and the more and longer the abuse – the lower the oxytocin

TIP 57

Co-Occurring Youth

What impact could increased stress reactions and lowered oxytocin levels have on our youth?

Or on the parents of youth?

From NCTSN: Looking over our shoulders…

Celia is a 12-year-old girl with a long history of trauma. Child Protective Services first removed her from her mother's home at the age of three for neglect and parental substance abuse. After 10 months, she was reunited with her mother who married her live in boyfriend soon afterwards. Celia remained in their care from ages four through seven and then was removed again when she disclosed that she had been sexually abused by her stepfather and had witnessed domestic violence between her mother and stepfather.

Following this second placement in foster care, Celia was referred for an assessment due to academic problems, severe inattention, hyperactivity, and oppositional behavior, as well as physically violent tantrums. She was diagnosed with oppositional defiant disorder and bipolar disorder. Treatments addressing her behavior, including medication and therapy, have been minimally successful. Following her adoption, at age 9, her unpredictable mood swings, noncompliance, and a more persistent preoccupation with sexual ideas continued to be a concern.

NCTSN: Complex Trauma

Notes: Complex trauma can have such pervasive impact on developmental trajectories that children often end up with problems across many domains of functioning.

This can result in: These children may be diagnosed with a range of disorders, and consequently treated with multiple medications and therapies that are ultimately ineffective because they fail to address the underlying problem and do not reflect a trauma-informed approach to assessment and treatment.

NCTSN: Complex Trauma

Differential diagnostic difficulties – a familiar refrain with COD youth

Unrecognized pervasive – or complex – traumas can 'look like', mask, overlap…in many areas

- Difficulty establishing/maintaining relationships
- Behavioral issues
- Emotional issues
- Dissociation
- Learning disorders
- Chronic health problems
  - What else – based on our experience?

NCTSN: Complex Trauma

"Misunderstood"

"Misdiagnosed"

"Mis-treated"

NCTSN: Responsible Assessment

1. Assess for a wide range of traumatic events. Determine when they occurred so that they can be linked to developmental stages.
2. Assess for a wide range of symptoms (beyond PTSD), risk behaviors, functional impairments, and developmental derailments.
3. Gather information using a variety of techniques (clinical interviews, standardized measures, and behavioral observations.

Assessment: Con't

4. Gather information from a variety of perspectives (child, caregivers, teachers, other providers, etc).
5. Try to make sense of how each traumatic event might have impacted developmental tasks and derailed future development. Note: this may be challenging given the number of pervasive and chronic traumatic events a child may have experienced throughout his or her young life.
6. Try to link traumatic events to trauma reminders that may trigger symptoms or avoidant behavior. Remember that trauma reminders can be remembered both in explicit memory and out of awareness in the child's body and emotions.

Trauma Informed Care: TIC

"…a strengths-based service delivery approach '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, and that creates opportunities for survivors to rebuild a sense of control and empowerment' (Hopper, Bassuk, & Olivet, 2010, p. 82.)"

TIP 57

Furthermore on TIC

"It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma…"

TIC Caution: Retraumatization

"Retraumatization occurs when clients experience something that makes them feel as though they are undergoing another trauma."

TIP 57

What could this look like with our home-based work?

TIP 57
What Can Cause Retraumatization

- Being unaware that the client's trauma Hx significantly affects his/her own life
- Failing to screen for trauma
- Challenging or discounting reports of abuse/trauma
- Using isolation or physical restraints
- Experiential exercises that humiliate
- Endorsing a confrontational approach to counseling
- Allowing the abusive behavior of one client toward continue without intervention
- Labeling behavior/feelings as pathological

TIP 57
Cause Retrauma

- Failing to provide adequate security and safety within the program
- Limiting participation of the client in treatment decisions and planning processes
- Minimizing, discrediting or ignoring client responses
- Disrupting counselor-client relationships by changing counselor's schedules and assignments
- Obtaining urine samples in a nonprivate setting.
- Having clients undress in the presence of others
- Inconsistently enforcing the rules and allowing chaos in the Tx environ

Treatment Ideas

Seeking Safety

Seeking Safety is an evidence-based, present-focused counseling model to help people attain safety from trauma and/or substance abuse. It directly addresses both trauma and addiction, but without requiring clients to delve into the trauma narrative (the detailed account of disturbing trauma memories), thus making it relevant to a very broad range of clients and easy to implement. Any clinician can conduct it even without training as it is an extremely safe model; however, there are also many options for training.

Source: http://www.treatment-innovations.org/ss-description.html

The key principles of Seeking Safety
1) **Safety** as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions).
2) **Integrated** treatment (working on both trauma and substance abuse at the same time)
3) **A focus on ideals** to counteract the loss of ideals in both trauma and substance abuse
4) **Four content areas**: cognitive, behavioral, interpersonal, case management
5) **Attention to clinician processes** (clinicians' emotional responses, self-care, etc/)

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