

Overview of Complex Trauma and Post Traumatic Stress Disorder in the Department of Juvenile Justice Population

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AGENDA

- Demographics of Children and Teens in the United States
- Demographics of Juveniles in the DJJ population
- Impact of Trauma on the population
- Different Presentations
- Implications for Treatment

TRAUMA CHARACTERISTICS OF YOUTH IN THE US

In 2010, 1 in 4 residents in the United States was under age 18
(74,182,000)

1 in 25 children is a victim of abuse or neglect (physical abuse,
sexual abuse, emotional abuse, physical neglect, emotional neglect,
school neglect)

TRAUMA STATISTICS

- ▶ In the US, there are approximately 64,000 referrals for child maltreatment weekly (approximately 1/3 of those are 3 yo or younger; another 25% are between the ages of 4 and 7)- 3,328,000 referrals per year
- ▶ Over 60% of children and teens have been victims of or have witnessed violence
- ▶ 1 in 6 (16.7%) students report having been bullied in school; 1 in 7 (14%) students report cyber-bullying
- ▶ A growing body of research shows that youth involved in both the child welfare and juvenile justice systems present an extraordinary range of challenges compared with youth who are only involved in one system. These challenges generally include earlier onset of delinquent behavior, poor permanency outcomes, substantially higher out-of-home placement rates, more detention stays and frequent placement changes, and overall higher offending rates.
- ▶ 25% of violent crime victims are juveniles

MORE TRAUMA STATISTICS

- ▶ Studies indicate a very high percentage of incarcerated children and teens have a history of being traumatized- lower studies indicate 80% and some studies have found almost 99% of incarcerated teens have a trauma history
- ▶ Usually incarcerated teens have a history of multiple forms of victimization.
- ▶ The average number of traumatic events experienced by an incarcerated child/teen is 5.
- ▶ Longitudinal research shows that childhood traumatic stress is predictive of adolescent delinquency, and is associated with recidivism.
- ▶ If left untreated, it leaves them at long term risk across the lifespan for chronic emotional, behavioral, developmental, and legal problems. It can affect interpersonal relationships, cognitive functioning, mental health disorders (PTSD, substance abuse, anxiety, disordered eating, depression, self injury, and conduct problems).

CONNECTIONS BETWEEN CHILD WELFARE

SERVICES AND DJJ

- 6 in 10 youth referred as first-time offenders had at least some history of child welfare involvement.
- 9 in 10 youth previously referred for an offense had at least some history of child welfare involvement.
- First-time offenders with records of multi-system involvement have much higher recidivism rates than youth without child welfare involvement.
- Youth with an extensive history of child welfare involvement were referred for an offense three times as often as youth with no child welfare involvement.
- Youth with no child welfare history were less likely to be referred for a new offense within 2 years (34%) than youth with extensive child welfare involvement (70%).
- Greater proportions of females and minority youth were found among youth with more extensive histories of child welfare involvement.

COMMON DIAGNOSES ASSOCIATED WITH EXPOSURE TO TRAUMATIC EVENTS

- ▶ PTSD
- ▶ Depressive disorders
- ▶ Other Anxiety disorders
- ▶ Secondary enuresis or encopresis
- ▶ Specific phobias
- ▶ Comorbidity is common
- ▶ ADHD
- ▶ Oppositional Defiant Disorder/Conduct Disorder
- ▶ Substance Use Disorders

CLASSIC PRESENTATION OF POST TRAUMATIC

STRESS DISORDER

- Criterion A- has a traumatic event occurred?
- Criterion B- Is there re-experiencing?
- Criterion C- Is there avoidance?
- Criterion D- Are there changed thoughts and feelings?
- Criterion E- Is there hyperarousal?

WHAT IS COMPLEX TRAUMA AND WHY IS IT

IMPORTANT IN DJJ POPULATION

- ▶ A condition that presents when a child has been exposed to multiple traumatic events, particularly in utero or in early childhood, but it can develop later in a child's life.
- ▶ May include Exposure to Trauma in Utero
- ▶ May include Exposure to Traumatic Context in Early Childhood (0-3 years) — i.e. physical abuse, sexual abuse, domestic violence, neglect (due to parental drug use, mental illness, etc.)
- ▶ May manifest as a result of Difficulty with Attachment to Primary caregiver
- ▶ May manifest as a result of chronic Community Violence

IMPACT OF TRAUMA ON YOUTH- THE STRESS

RESPONSE

➤ Stress Response involves several structures of the brain- particularly the **amygdala**- takes in sights and sounds and perceives danger; if indicated it sends a distress signal to the hippocampus, the **hippocampus**- the command center directs the body to respond- it directs the autonomic nervous system for breathing, BP, circulation by sending out epinephrine. **Epinephrine** is largely responsible for, example, jumping out of the way of an oncoming car. The hippocampus then activates the **HPA** axis which keeps the pedal down on the stress response by Hippocampus sending out the corticotropin releasing hormone (**CRH**) to the **pituitary gland** which sends out the Adrenocorticotropic hormone (**ACTH**) to the **adrenal glands** which lastly releases **cortisol**. The **medial frontal cortex** can then restore the brain to its non stressed state.

IMPACT OF CHRONIC TRAUMA ON EXPOSED

..... YOUTH- BRAIN CHANGES

- Over time several changes may occur with chronic trauma. Due to the frequency and/or intensity of the traumas, brain changes can occur. The hippocampus and the amygdala can be decreased in size. The hippocampus is responsible for storage of long term memory, emotions regulation, and motivation in children.
- Youth may have either a decreased hormonal response to stress or an exacerbated hormonal response.
- Depending on if attachment to caregiver is impaired, there can be even more changes.

IMPACT OF CHRONIC STRESS ON YOUTH-

ATTACHMENT

- Insecure attachment can frequently occur with traumatic events, i.e. physical abuse, sexual abuse, neglect, parent with mental illness or addiction, etc.
- Problems with early infant attachment can manifest in several ways- SECURELY ATTACHED (65%)- Secure healthy attachment with parents who are consistent, attuned; AVOIDANT ATTACHMENT (20%)-distant and disengaged- believes his/her needs will not be met; AMBIVALENT/ANXIOUS (10-15%)-anxious, inconsistent, angry-cannot rely on his/her needs being met; DISORGANIZED ATTACHMENT- depressed, angry, passive, non-responsive with no strategy to have his/her needs met

NEW STRESS RESPONSE RESEARCH

- ▶ Orchid versus dandelion children (W. Thomas Bryce)-15-20% of children have increased sensitivity to stress, however these children also have increased response to nurturing and supportive environments as well
- ▶ Epigenetics Research- we also know that while DNA gives us our basic blueprint for who we are, we now know that there are markers on our DNA that can be developed and passed on through generations due to environmental conditions that can make us more susceptible to certain conditions
- ▶ Bottom line- We can be born with certain stress reactions, and additionally, we also can develop markers on our DNA that can affect our stress response. We also know that, while we cannot protect all children from traumatic events, what we do afterwards can have positive impact

HOW DOES COMPLEX TRAUMA PRESENT?

- ▶ Defining features:
- ▶ Dysregulation of affect- difficulty identifying emotions in self and regulating; increased fear response
- ▶ Dysregulation of behavior- increased fear response often causes spontaneous physical response; decreased ability of problem solve
- ▶ Dysregulation of biology- misperception of cues; difficulty accessing feelings
- ▶ Interpersonal difficulties- difficulty with developing relationships; often mistrusting
- ▶ Self-esteem issues- changed thoughts about themselves
- ▶ Self-injurious behaviors- very complex responses; sometimes self medicating; sometimes self harm to “feel,” sometimes anger related
- ▶ Attention and cognition- often have developmental delays; problems with processing; and difficulty with concentration

CASE STUDY #1- DEVON

- ▶ Devon was a 16 yo biracial male who was adjudicated and placed on house arrest after multiple assault arrests and convictions. He wore an ankle monitor and had been court ordered to attend outpatient psychiatric treatment, specifically trauma treatment. Records indicated that he was born into an inner city family where there was a lot of chaos in the environment. Mom and Dad were drug addicts. It was unclear whether or not Devon was exposed in utero to drugs and alcohol. He lived with mom and dad for the first 3 years of his life, and was removed after he came to his Head Start Program with multiple bruises on his body. Dad was arrested soon afterwards on a drug charge, while Devon was living with a foster family. Mother got herself into treatment, and was able to reunify with him after a year's separation. They lived in a dangerous inner city environment, where Devon was exposed to multiple episodes of community violence, including 1 shooting, 2 stabbings, and multiple muggings.
- ▶ Mother then became involved in a relationship with an abusive boyfriend when Devon was 6 years old, and he witnessed domestic violence for the next 3 years. It culminated in him, at the age of 9, witnessing mother stab her boyfriend, and she was arrested and sent to prison. The aunt again became his legal guardian.

CASE STUDY #1- DEVON (CONT.)

- ▶ He did fairly well for about a year. He had changed schools and was passing. He reported some conflict with peers, but seemed to be adjusting. At the age of 11, however, he was expelled from his school for bringing a knife to school. He then started on a downhill trajectory with multiple arrests for aggression and assaults. The last assault resulted in severe injury to his victim.
- ▶ Upon intake, he presented as shut down and with flat affect. He did not think that treatment was needed, and was just attending so that he could “stay out of jail.” He had no trouble explaining the superficial details of “what happened” when mom stabbed her boyfriend and was arrested. Aunt presented as hopeless, at her wits end, thinking that nothing was going to work.

CASE STUDY #1- DEVON

- ▶ Possible in utero drug exposure/exposure to an unsafe environment
- ▶ Possible neglect
- ▶ Physical abuse
- ▶ Separation from mom/dad
- ▶ Domestic violence
- ▶ Witnessed Mom stab her boyfriend

CASE STUDY #2- ISABELLA

- ▶ Isabella was a 13 yo Hispanic female who had been previously arrested for multiple petty crimes. Her most recent crime was an armed robbery, where a store owner was shot, and she was sentenced to a residential treatment detention facility.
- ▶ Early childhood trauma history revealed that both mom and dad had mental illnesses. Mom had a diagnosis of bipolar disorder, and Dad had a diagnosis of schizophrenia. Isabella was removed from her parents at the age of 5 years old, when she and her 3 year old brother were found left unattended in a crack house. They were emaciated and unkept. Isabella had chlamydia. Both were developmentally delayed. They lived with an aunt and uncle for 3 years during which time they were both physically abused. Thus started their entry into Department of Social Services, where they were placed in numerous homes without success

CASE STUDY #2- ISABELLA (CONT.)

- The brother was eventually adopted, but the family could not manage Isabella, and she was separated from her brother. There was an unsubstantiated report of sexual abuse at one of the foster homes when she was 10 by a 17 yo foster sibling. Lying, stealing, and aggressive behaviors increased, she started using marijuana and cocaine, and by the age of 13, she was sentenced to a detention treatment facility.
- Upon intake, Isabella was guarded and angry. She cursed a lot and refused to engage in treatment. She was getting into trouble for conflicts with peers on the unit, and was oppositional with staff.

CASE STUDY #2- ISABELLA

- Genetic predisposition to mental illness
- Severe Neglect
- Sexual Abuse
- Physical abuse by aunt and uncle
- Separation from brother
- Being in foster care
- Possible sexual abuse by older foster sibling

YOU STILL NEED TO TREAT THE IMPACT OF

TRAUMA ON THE TEEN!

- ▶ Treating symptoms versus underlying causes is often ineffective because the symptoms, if extinguished at all, often return, and you are often fighting a losing battle.
- ▶ So what do we know from research works? Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Integrated Treatment for Complex Trauma (ITCT), Dissociation Focused Therapy, Eye Movement Desensitization and Reprocessing (EMDR). Dialectical Behavior Therapy with Adolescents (DBT with Adolescents).
- ▶ Systems Models- The Sanctuary Model, PCIT, Trauma Systems Therapy (TST)

WHAT ARE THE IMPLICATIONS OF COMPLEX TRAUMA

AROUND TRUST ISSUES?

- ▶ Trust must be established
- ▶ Educate the teen on why trust may be an issue
- ▶ Maintain unconditional positive regard
- ▶ Use empathy and choice whenever possible
- ▶ Creating and maintaining a nurturing environment- include a wide variety of treatment resources for different likes and developmental capacities of the youth
- ▶ Honest clear responses
- ▶ Ongoing challenges due to cognitive distortions and what to do about them- “You can’t depend on anyone.” “You can’t trust anyone.”
- ▶ Check-in regularly to see how the relationship is doing
- ▶ Trust involves adherence to consistency- don’t change the rules- consistent times, stay with the boundaries of the session, try not to cancel appointments
- ▶ Limit set using empathy and choice when possible

WHAT ARE THE IMPLICATIONS FOR COMPLEX TRAUMA

AROUND SAFETY ISSUES?.....

- ▶ Establish the idea that the teen may not feel safe
- ▶ Educate the teen about the possibility that safety may be an issue in several areas of the life- if in RTC- does the environment feel safe? Do they feel safe in your office? If they live in the community, how safe are they and do they feel safe? If they have been with multiple caregivers, how safe do they feel? Safety mapping may be an important first step, and may need to be addressed in every session.
- ▶ Family therapy with teens with complex trauma may, in fact, be triggering due to types of traumas they may have experienced. Explaining and talking to both the foster parents and the client may prevent the teen from “throwing away” a new foster care placement

WHAT DO WE KNOW ABOUT DOING TF-CBT WITH THE COMPLEX TRAUMA YOUTH IN DJJ?

- Maintain fidelity to the model, but with adaptations
- Management of symptoms should be in the context of temporary fixes until treatment of the underlying causes of the impact of trauma are completed.

THANK-YOU!

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