

Understanding the Impact of Trauma on Children's Mental Health

1. Introduction

1.1 Introduction

Welcome back to the National Adoption Competency Mental Health Training for Mental Health Professionals. This lesson is: Understanding the Impact of Trauma on Children's Mental Health.

1.2 Section 1: Overview and Objectives

At the end of this lesson, you will be able to:

- Describe the impact of trauma and early and ongoing adverse experiences on brain development, behavior, and identity formation, and
- Identify relevant diagnoses associated with trauma and the diagnostic limitations

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1.3 Frameworks for Understanding the Impact of Trauma

We will look at frameworks for understanding the impact of trauma on development and mental health, including: trauma symptomatology, Post-Traumatic Stress Disorder (PTSD), Complex Trauma, and Developmental Trauma Disorder (DTD). We will use an actual case study of Billy Campbell to explore these frameworks.

1.4 Case Study: Billy Campbell Reflection

Please review *Handout: Billy Campbell Case Study* and complete the following information on Billy's trauma history by clicking the correct responses for each category.

Types of Trauma Experienced:

- Physical abuse
- Sexual abuse
- Physical neglect
- Emotional abuse
- Witnessing domestic violence
- Child traumatic grief

ACEs:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Mental illness of a household member
- Problematic drinking or alcoholism of a household member
- Illegal street or prescription drug use by a household member
- Separation from a parent
- Domestic violence towards a parent

1.5 Case Study: Billy Campbell Response

Did you come up with these answers? Billy's case is representative of many children with whom you work. As you will see in this case, Billy's exposure to traumatic events, if left untreated, will have significant psychological implications. We will come back to Billy later, but first, let's explore trauma symptomatology.

2. Trauma Exposure Factors

2.1 Trauma Exposure Factors

Different children may experience the same traumatic event in different ways. It is not merely the number and severity of traumatic events experienced, but also the age of the child, the length of exposure, and other factors that contribute to negative developmental and mental health outcomes.

2.2 Impact of Traumatic Events

Research further shows that interpersonal traumas, perpetrated by someone with whom a child shared a close relationship, may differentially influence trauma-related symptomatology.

These experiences alter children's cognitive and emotional orientation to the world and create additional trauma by distorting children's self-concept, world view, and affective capacities.

Protective factors, such as having a supportive relationship with a caregiver or having experienced healthy brain and psychosocial development prior to the trauma, can buffer against the impact of trauma.

2.3 Traumagenic States

In the 1980s, several experts on childhood trauma proposed "traumagenic states" to describe the emotional impact of trauma. These include: self-blame, powerlessness, loss and betrayal, fragmentation of bodily experiences, eroticization, destructiveness, dissociation, and attachment challenges.

Familiarizing yourself with these states, which are summarized in Handout: *Traumagenic States*, will help you to better understand these powerful emotions and thoughts in the children and youth with whom you work.

A therapist needs to examine the specific dynamics of a child's or youth's situation and their thoughts and feelings to evaluate the extent to which these dynamics apply.

2.4 Billy's Traumagenic States Reflection

Now let's look again at Billy Campbell. Based on his case study, what traumagenic states might Billy have experienced?

2.5 Billy's Traumagenic States Response

Did you identify these?

- Self-Blame: Billy didn't know why his father killed himself, but wondered if he was the cause.
- Powerlessness: He felt like a ping pong ball, going back and forth.
- Loss and betrayal: Billy has trouble trusting others; He expressed feeling let down by his mother.
- Fragmentation of bodily experience: Billy had severe nightmares and dreamed of being beaten, locked in a closet, and cut.
- Destructiveness: Billy engaged in risk-taking behaviors and destruction of property.
- Attachment challenges: Billy resisted closeness and affection from his adoptive parents.

2.6 Working with Billy Reflection

How might knowing the traumagenic states help you, as a clinician, in your work with Billy?

2.7 Working with Billy Response

Regardless of his diagnosis, understanding Billy's traumagenic states gives you a window into his responses to trauma, including his beliefs, coping mechanisms, and his self-perception and world view. Knowing this can help you determine and prioritize treatment goals and the most appropriate interventions to use.

3. Post-Traumatic Stress Disorder

3.1 Post-Traumatic Stress Disorder

A second framework for understanding the impact of trauma is Post-Traumatic Stress Disorder, or PTSD.

Please take a few moments to review the link from the National Institute of Mental Health in the Resources tab, which specifies the criteria for this diagnosis.

3.2 PTSD Overview

Post-Traumatic Stress Disorder involves either direct or indirect exposure to actual or threatened death, serious injury, or sexual violation. The event causes clinically significant distress or impairment to the individual's functioning and involves four types of symptoms that last for more than one month.

These types of symptoms include:

- Re-experiencing,
- Avoidance,
- Negative thoughts and mood, and
- Alterations in arousal and reactivity

3.3 Case Study: Shakirah

It is important to note that PTSD manifests differently with children. In particular, while flashbacks are common with adults, children are more likely to experience intrusive thoughts, hyper-alertness, dissociation, and avoidance behavior.

Consider the case of Shakirah, a 14-year-old girl, placed with an aunt in a guardianship arrangement at 8 years of age.

Click the corner of the page to begin, and the corners of the following pages to navigate forward or backward in Shakirah's story.

1. When she lived with her mother, Shakirah often witnessed adult sexual behavior in the home. Her mother had multiple boyfriends who frequently stayed at the house. On occasion, she also saw her mother beaten by some of the men. When she was 7 years old, one of the men came into her room at night and forced her to perform oral sex on him. This was repeated on a number of occasions.
2. Over time, Shakirah became moody, oppositional, and withdrew from her friends. One day, her teacher found her drawing a picture of a man with an erect penis. When questioned, Shakirah started crying and reported what had been happening to her. CPS was called and Shakirah was removed from the home. Eventually, parental rights were terminated, and she was placed with an aunt in a guardianship placement.

3. Although initially Shakirah appeared to adjust well to the placement, her aunt began to notice behavior that worried her. Shakira kept to herself a great deal and had difficulty trusting others. In addition, even mild arguments between the aunt and uncle seemed to frighten her. She would withdraw to her room, cry, and be inconsolable. She kept her distance from the uncle, avoiding any type of physical contact, if possible.
4. At the same time, she seemed preoccupied with her 6-year-old male cousin, Evan, and often volunteered to give him a bath or to help dress him. On one occasion, the aunt came into the bathroom while Shakirah was helping Evan and found her stroking his penis. When questioned, Shakirah was mortified and stated that she didn't know why she had touched her cousin's penis.
5. She did acknowledge, however, that thoughts of her own abuse often came to mind and that she couldn't stop herself from thinking about it. She felt guilty thinking about what had happened, but felt powerless to do anything about it. Teachers also reported that Shakirah often appeared "spacey" in class, staring into the distance, and unaware of her behavior. Classmates occasionally teased her about this behavior, which greatly upset her.

So, as you saw in this case, Shakira's symptomatology clearly aligns with a clinical presentation of PTSD in children.

4. Complex Trauma and Developmental Trauma Disorder

4.1 Complex Trauma and Developmental Trauma Disorder

A third framework for understanding trauma is the concept of Complex Trauma and a proposed diagnostic category, Developmental Trauma Disorder.

4.2 Complex Trauma Study

Complex Trauma describes the cumulative effects of early and prolonged exposure to traumatic experiences, typically occurring in a relationship with a caregiver. It may involve experiencing multiple types of trauma or repeated exposure to the same type of trauma over time.

Exposure to trauma over an extended period in early life is associated with enduring impact that not only incorporates some PTSD symptoms, but also involves impairments in many domains of functioning. The main legacy of chronic traumatic experiences is the way children have tried to organize psychological and behavioral strategies to cope with and defend against ongoing painful events.

Dr. Bessel van der Kolk describes the impact as a "*fundamental reorganization of the way mind and brain manage perceptions*" (2014, p.21). This results in varying dysfunctional beliefs and behaviors.

4.3 Symptoms of Complex Trauma

There are seven primary domains of impairment observed in children experiencing complex trauma. Click on each domain to see the impact and potential responses to complex trauma in each area. For more information, see *The Impact of Complex Trauma* in the Resources tab.

1. Attachment:
 - Distrust and feelings of powerlessness
 - Lack of felt safety
 - Insecure attachment patterns
 - Reactive aggression toward authority figures and peers
 - Difficulty empathizing with other's feelings
 - Boundary problems
2. Biology:
 - Impaired brain development
 - Imbalanced neurochemistry
 - Physical complaints, such as headaches and stomach aches
 - Sensory processing difficulties
3. Affect Regulation:
 - Extreme mood swings
 - Struggles to calm down
 - Difficulty identifying or communicating own emotions
 - Depression or anxiety symptoms
 - Challenges managing anger
 - Strong fears
4. Dissociation:
 - Depersonalization and derealization
 - Shifts in awareness of the environment
 - Diminished awareness of own sensation, emotion, and bodily states
 - Excessive daydreaming or spacing out
 - Distinct alterations or shifts in states of consciousness
5. Behavioral Control:
 - Impulsivity
 - Oppositional or aggressive behaviors
 - High-risk behaviors, such as violence, self-injury, substance abuse, and sexualized behaviors
 - Sleeping or eating difficulties
6. Cognition:
 - Difficulty with:
 - Executive functions
 - Higher level cognitive skills, such as working memory, reasoning, flexibility, focused attention, self-reflection, and problem solving
 - Learning challenges

- Delayed language development
- Sense of shortened future

7. Self-concept:

- Negative self-concept
- Feelings of guilt or shame
- Feeling damaged or defective

4.4 Developmental Trauma Disorder (DTD)

Developmental Trauma Disorder (DTD) was conceptualized by the Complex Trauma Taskforce of the National Child Traumatic Stress Network (NCTSN) and was proposed for, but not included in, the DSM-5. Research is ongoing to underscore the validity of this diagnosis.

According to the National Institutes of Health, DTD emerges from “prolonged and cumulative interpersonal trauma that disrupts the development of secure attachments to caregivers and dramatically alters core assumptions and beliefs about one’s vulnerability to danger in the world.”

While DTD is not yet a diagnosis in the DSM-5, it is important that you integrate the clinical constructs in your treatment when working with children who experienced trauma.

4.5 Understanding Developmental Trauma Video

Watch the following video, *Understanding Developmental Trauma*, with Sebern Fisher to learn more about this work with children.

[Video Transcript]

*ONSCREEN TEXT OVER IMAGE: Sebern Fisher, Author
Neurofeedback in the Treatment of Developmental Trauma: Calming the Fear-Driven Brain*

SEBERN FISHER: Developmental trauma is a term that focuses on the full catastrophe of childhood trauma. It intends to differentiate developmental trauma--trauma that children suffer from abuse and neglect, usually in their own homes, from PTSD or [more?] single event trauma. And still, really now--because this has not been an accepted diagnosis; it's more a description. Children are impacted differently than somebody who has been in a car crash.

So when there is significant neglect or physical or sexual abuse, the alignment that's required between parent and child for optimal brain development--not just character development but optimal brain development--isn't there.

And what we see then is what--we see learning difficulties, behavioral problems, relational problems. These kids and the adults they become can't relate, sometimes become antisocial; as adults can be diagnosed with borderline personality disorder or antisocial personality disorder.

So the consequences of this are huge, and it is also affecting one in four children. So 25 percent of the population in the United States is at risk for the ongoing effects of developmental trauma.

*ONSCREEN SLIDE: "A difficult childhood reduces life expectancy by 20 years among adults who experienced six or more particular types of abuse or household dysfunction as kids."
Source: scientificamerican.com, 2009, reporting on ACE Study*

ONSCREEN SLIDE: "GOOD ENOUGH" ATTACHMENT

What happens when there is "good enough" attachment is that the child's prefrontal cortex develops, and the prefrontal cortex is vital for the inhibition of the amygdala and the limbic brain. If you don't have your prefrontal cortex online, you are going to be driven by these limbic emotions. That leads to a lot of problems in living life.

Well, we find out that that relationship between mother and child, or parent and child. If the mother is impaired in some way the father can step in or grandparents can step in to help this development along. That that allows us to inhibit those emotions and to become regulated, prosocial human beings.

ONSCREEN SLIDE: LEARN MORE AT www.seberfisher.com

[End of Video]

Video obtained from https://www.youtube.com/watch?v=mpjarXMPu_w.

5. Symptoms Often Not Recognized as Post-Traumatic Stress

5.1 Symptoms Often Not Recognized as Post-Traumatic Stress

Many children with trauma symptoms do not have a diagnosis that clearly links to trauma treatment. They are at risk of not receiving effective trauma treatment, particularly if a trauma assessment is not conducted.

5.2 Trauma and Obsessive-Compulsive Spectrum (OCS)

Trauma exposure, for example, is associated with symptoms belonging to the Obsessive-Compulsive Spectrum (OCS), and with greater severity of these symptoms, particularly in females. Adolescence is a period of vulnerability for the onset of these types of psychological symptoms, with a peak around puberty (10-13 years), and another in early adulthood (21-29 years).

One study found that four types of interpersonal trauma are associated with OCS symptom severity, including violence, emotional abuse, sexual abuse, and neglect (Miller & Brock, 2017).

5.3 Symptoms May Be Predominantly Internal

Individuals may have largely internalized, psychological responses to complex trauma and appear to be functional from an external vantage point. This may be particularly true for those whose early years have not been as traumatic.

Some children may repress memories of their trauma, be numb to feelings, or dissociate to psychologically flee from or wall off the traumatic memories. These children may not act out and may not be recognized as suffering from trauma, yet they have reorganized their beliefs and responses to try to minimize their vulnerability.

5.4 Adaptations to Trauma

Dr. Lenore Terr, a child psychiatrist who studied children's adaptation to trauma, recognized that among those who experienced chronic trauma, such as ongoing sexual abuse, some repressed their memories and dissociated. Among those she studied were two sisters from an affluent family who were sexually abused by their father throughout most of their childhoods. An older sister demonstrated externalizing behavior problems and was sent off to boarding school. However, the younger, Marilyn, used repression and dissociation to cope. From the outside, she was the model child, but her internalized problems persisted through her adult life.

Marilyn Van Derbur poignantly described this impact of being sexually abused by her father from ages 5 to 18 and being disbelieved by her mother. She became Miss America and graduated from college with Phi Beta Kappa honors. She later had episodes of paralysis in her legs and finally received psychiatric treatment. To learn more about her story, check out the link in the Resources tab.

5.5 Summary

In summary, you have learned about traumagenic states, PTSD, Complex Trauma, and Developmental Trauma Disorder (DTD). For additional information on understanding the impact of trauma, see the Resources tab.

6. Conclusion

6.1 Wrapping Up

Your understanding of the symptomatology and accurate diagnosis, as well as an understanding of the limitations of current diagnoses for children, will enable you to work effectively with children and families who have experienced trauma.

In the remaining lessons of this module, we will build on this information to discuss significant issues in assessment and treatment of trauma.

6.2 Your Journal

Please click on the journal page to write down your reflections on this lesson.

6.3 Journal Reflection

Reflecting on this lesson, what are your key takeaways and how might you apply these in your practice?

6.4 Journal Response

Click the "Print Results" button to print and save your answers.

6.5 Conclusion

Congratulations! You've completed Understanding the Impact of Trauma on Children's Mental Health. In the next lesson, we will focus on assessing trauma exposure and its impact on children.