*Drawn in part from Responding to childhood trauma: The promise and practice of trauma informed care (Gordon Hodas, M.D., 2006).*

Abstract: Many children and youth served in residential treatment have been traumatized by lifetimes of violence, abuse and chronic neglect. Although their behaviors often appear to be willful defiance or laziness, these are often symptoms of much deeper issues. Agencies and staff must recognize these issues and respond therapeutically to misbehaviors if they hope to provide emotionally and physically safe learning and living environments in which true change can take place.

This brief reading will address the following questions:

1. What is childhood trauma?
2. How prevalent is childhood trauma?
3. How does childhood trauma impact a child's physical, mental and emotional health?
4. How does childhood trauma affect daily behavior in hospital or residential treatment settings?
5. What agency and staff practices help the recovery of children and youth who have experienced traumatic life events?

**1. What is Childhood Trauma?**

The issues of "trauma" and "Post-Traumatic Stress Disorder" (PTSD) are most vividly applied to survivors of violent or catastrophic events, such as returning war veterans or victims of school shootings. Less frequently discussed but far more commonly occurring is lasting childhood trauma resulting from chronic abuse and neglect.

The Centers for Disease Control and Prevention (CDC) defines child maltreatment simply as any act by a parent or caregiver that results in harm, potential for harm, or threat of harm to a child. In particular, child abuse may take the form of neglect, physical abuse, psychological/emotional abuse, or sexual abuse. Severe or repeated incidents of neglect or abuse can lead not only to physical injury, but to psychological trauma as well, defined as "the debilitating result of a traumatic event involving a single experience, or an enduring or repeating event, that completely overwhelms the individual's ability to cope with the ideas and emotions involved."

When psychological trauma occurs with a child, the impact is often much greater and longer lasting. Abuse events, occurring again and again, may come to define a child's outlook on him/herself, others, and life in general. They can easily impact not only emotional and behavioral patterns, but the very chemistry and functioning of the brain itself. The traumatized child may become so conditioned to a survival response that s/he overreacts to all problems as if they were life-threatening.

Consider the following cases. We must ask, How could these children NOT be traumatized by these circumstances?

> Case #1: Alyssa is an 8-month-old infant who is repeatedly left alone for hours, with no one but her 5-year-old sibling for company every afternoon. During these times, her dirty diaper often goes unchanged, her hungry cries unheard, her frightened wailing unsoothed by her absent mother and overwhelmed young brother.

Case #2: Bethany is a 2-year-old toddler confined to a broken down playpen for hours on end, watching television day after day while her drug-addicted mother fades in and out of consciousness. No one speaks to or interacts with her at all. Her cries are ignored except for swift spankings, and her diet consists largely of dry sweetened cereal and a bottle filled with orange soda.

Case #3: Carlos is a 5-year-old kindergartner living in a 1-bedroom apartment, often overwhelmed by responsibility for his infant sister's well-being. He lives in constant fear of his mother's drunken boyfriend, and has witnessed her brutal beatings many times. He keeps a kitchen knife hidden beneath his pillow, and dreams of killing the man who terrorizes the mother he loves.

Case #4: Denny is an 8-year-old boy living with his aunt and her teenage children in a filthy trailer, spending his afterschool hours in the company of an unemployed male neighbor. A recent high fever led to a trip to the emergency room, which revealed that Jamie has contracted gonorrhea, the result of repeated sodomy by the neighbor whose "secret" he has kept for months.

Case #5: Ella is a petite 12-year-old who has spent most of the past 5 years in foster care. At age 6, in the middle of the night, a Child Protective Services worker took from her home while crack-addicted mother was physically restrained by police. Bounced from one family member or foster home to the next for years, she was finally returned to her mother several months ago. She sleeps poorly at night and often "baby-talks" when facing difficult situations.

**2. How Prevalent is Childhood Trauma?**

Research suggests that approximately 18% of all adult men and 26% of all women have had sexually or physically abusive childhood experiences (Hodas, p 17). Studies of adults in correctional or mental health institutions suggest that 50%-60% of inmates and up to 80% of adult patients have experienced repeated childhood abuse or neglect. Other data suggest that up to 40% of all boys and nearly 80% of all girls in juvenile incarceration or residential treatment centers have been sexually fondled, molested, or abused as children, most often by family members or adult friends.

Not all childhood trauma is the result of discrete events such as severe abuse or sexual molestation. More often, it is the result of months or years of physical and emotional neglect. Statistics from the US Department of Labor indicate that 18% of all American children (and 34% of all Black or Hispanic American children) live in households existing at or below the poverty level. While poverty alone does not cause abuse, it often increases the likelihood of abuse or neglect by adding stress on parents or caretakers, by exposing children to physically or emotionally unhealthy conditions, and by reducing protective factors that might otherwise allow a child to succeed in adverse circumstances.

**3. How does childhood trauma impact physical, mental and emotional health?**
Some very resilient children and youth may endure childhood abuse and neglect and emerge relatively unscathed. But for many, trauma becomes a defining experience which forms the very core of their identity. Even years later, virtually everything about the way these children and youth perceive and react to daily interactions and events is colored by their "malignant memories," most of which are buried so deep as to be beyond recollection. Research has shown a significant link between a violent, abusive or negligent upbringing and a number of very serious outcomes.

The first cluster of outcomes is a direct result of the abuse or trauma. In cases of severe child abuse, it is unfortunate but not unusual to discover physical injuries such as multiple bruises, broken bones, malnutrition, and head injury. The abuse may also cause the onset of Acute Stress Disorder ((ASD) or Post-Traumatic Stress Disorder (PTSD). According to the DSM-IV, psychological signs of PTSD in these children include:

a. Dissociation, a disconnection with reality, shown by periods of dazed unresponsiveness, detachment, or feeling completely outside oneself;
b. Hyperarousal, a state of increased psychological and physical tension marked by such effects as reduced pain tolerance, anxiety, exaggeration of startle responses, insomnia, and fatigue.
c. Re-experiencing abusive events, often in frequent nightmares, flashbacks, or overwhelming feelings of distress when reminded of the traumatic incident.

When the trauma is a result of a single isolated event, such as a car accident or a terrifying assault, these symptoms may fade with time and treatment, and the individual may recover fully. When the trauma is the result of long-term abuse and neglect, the symptoms may be far more pervasive and lasting.

The second cluster is as an indirect result of the abuse or trauma, and is not contained within the DSM-IV definitions of PSTD. As a result of chronic exposure to violence, abuse, and/or neglect, children may develop mental, emotional, and behavioral habits which allow them to cope with their situations, but create serious adjustment problems in other settings. Research (cited in Hodas, p 8-9) has indicated the following:

a. Long-term physical changes:
   1. *Disabilities:* 20%-50% of abused children will have a permanent physical disability, and 10%-25% will have a a developmental disability, as a result of their abuse.
   2. *Brain damage*. All forms of abuse, and especially severe, prolonged sexual abuse, can cause permanent damage to a developing brain. In one study, maltreated children had brains 7%-8% smaller than those of normal children their age.
   3. *Hormonal changes:* Long-term abuse can create significant, irreversible changes in hormone levels. In one study, maltreated children showed significantly higher levels of catecholamines, the hormones associated with fight-or-flight emergency responses, than did normal children, even years after their abuse ended.

b. Long-term mental, emotional, and behavioral changes:

*1. General:* In addition to the psychological impacts of PTSD mentioned earlier (dissociation, hyper-arousal, and re-experiencing), children or youth exposed to severe maltreatment tend to feel a sense of overwhelming helplessness, and may later develop clinical levels of depression and anxiety. Children also frequently show some symptoms of both ADHD and Bipolar Disorder; it is not uncommon for adolescents to develop substance abuse problems as well.

2. *Age-related*: Impact of childhood trauma often vary by age.

• Infants (such as the case of 8-month-old Alyssa): Given an absence of not only adequate food and health care, but emotional and mental stimulation as well, infants may fail to thrive, and even die. (Infant deaths account for more than 50% of deaths in all abuse cases.) Those who survive may have stunted mental capacities, as the developing brain is so sensitive to external factors. One classic study found that even non-abused 4-year-olds who were raised with little to no mental stimulation throughout infancy demonstrated IQ's 25 points lower than normal children their age.

• Toddlers and young children (such as the case of 2-year-old Bethany): Before the age of 5, children exposed to repeated abuse and neglect often develop serious attachment and trust issues. Many become deeply anxious, especially if they have directly witnessed violent physical abuse of their mothers or primary caretakers. Especially common is fear of separation from mother; excessive clinging; crying, whimpering, screaming; immobility or aimless motion; and regressive behaviors, such as thumb-sucking, bedwetting, and fear of darkness.

• School-age children (such as the case of 6-year-old Carlos and 8-year-old Denny): Between ages 6-11, severely abused and neglected children often develop a dominant pattern of either internalizing or externalizing their symptoms.

Internalizing symptoms in childhood: Extreme withdrawal; emotional numbing or flatness; irrational fears; depression, anxiety or guilt; inability to pay attention; other regressive behaviors described above.

Externalizing symptoms in childhood: Irritability and impulsivity; outbursts of anger and aggression, such as fighting with peers and damage to property; defiance toward adults or refusal to follow rules.

• Adolescents (such as the case of 12-year-old Ella): Between ages 12-17, adolescents who are being abused, or who were maltreated as young children often show symptoms similar to those of adults.

Internalizing symptoms in adolescence: Emotional numbness; avoidance; flashbacks and nightmares; depression, withdrawal, anxiety or guilt; psychosomatic pains; sleep problems; suicidal thoughts; regression; self-injurious behaviors, especially cutting.

Externalizing symptoms in adolescence: Fighting with peers; frequent verbal and physical aggression with little provocation; direct defiance toward adults or refusal to follow rules; substance abuse; criminal behavior.

*3. Gender-related:* While there are exceptions, girls exposed to childhood trauma more often tend to develop internalizing symptoms (dissociation,

surrender, withdrawal, self-harm). Boys more often exhibit externalizing symptoms (hyperarousal, flight-or-flight, aggression). Victims of sexual abuse often show unusual sexual behavior as well: either complete avoidance of physical contact, especially with adults, or oversexualized (even seductive) behavior toward peers and adults.

**4. How does childhood trauma affect daily behavior in hospital or residential treatment settings?**

Many of the behaviors described above can be seen in any setting in which troubled children or youth are managed, from after school programs to special education classrooms to foster care homes. But in more restrictive settings such as therapeutic group homes, psychiatric hospitals and residential treatment facilities, adults are often much more concerned with safety, control and compliance. As a result, staff provide much closer levels of supervision and interaction, and experience certain problem behaviors more frequently than staff in schools or homes might.

a. Common observations: The following represents a partial list of characteristics noted by adults in these settings (Hodas, p 25-26). The chronically maltreated child is often observed to be:

- Guarded, defensive, angry most of the time (esp. in males).
- Withdrawn, uninvolved, or depressed most of the time (esp. in females).
- Difficult to redirect, and dismissive of support.
- Emotionally overreactive to the smallest situation.
- Extremely explosive in crisis, using offensive sexual comments, racial slurs, personal threats, and actual physical aggression.
- Difficult to soothe or de-escalate during an emotional crisis.
- Unable to calm down after an incident, or let go of grudges afterwards.
- Unwilling to take responsibility for behavior, instead blaming others or minimizing events.
- Lacking in insight and remorse for behavior.
- Constantly attempting to manipulate or split staff.
- Unable to see or respect boundaries with staff or peers.
- Attempting to control people and events around them.
- Unable to learn from past mistakes, repeating the same behaviors despite consequences.
- Overly sensitive to criticism, willing to fight over perceived disrespect.

b. Explanations for behavior. Why do traumatized children and youth behave this way? The answer is complex, but a "trauma informed care" model offers several interlocking explanations.

*1. Pervasive sense of helplessness, powerlessness, and shame.* The first and perhaps most powerful explanation is that their negative behaviors stem from a deep, pervasive sense of helplessness, powerlessness, and shame. Severely abused and neglected children have for months or years been victimized by people or circumstances beyond their control. They have developed what some writers call "an exquisite sensitivity to shaming."

Like all human beings, they crave emotional and physical security, and need their worlds to be predictable. Many traumatized children and youth have come to see the people and events in their worlds as out of their control most of the time. Yet needing some control over what happens to and around them, these youngsters have learned ways to control whatever they can, in any way they can. If they cannot find predictable success, they may settle for predictable failure. If they cannot find consistent affection, they may settle for consistent abuse. If they cannot find dependable and trustworthy adults, they may reject all adults as undependable and untrustworthy.

As a result, many troubled children have developed maladaptive patterns of thinking, feeling, and behaving which give them some sense of control and predictability, but cause them significant problems in the long run. Four patterns are especially common among deeply troubled children and youth (Long & Fecser, 1996):

a. The most direct externalizing way to replace a sense of internal helplessness with a sense of control over people and events is through aggression, behaviors such as threatening, bullying, defiance, and blatant rule breaking. Though the long-term consequences can be severe (restrictions, restraint, even incarceration), the short-term emotional result (a sense of control over one's life) is often worth the price to these youth.

b. A less direct externalizing way to achieve this sense of control is through passive aggression, behaviors such as setting up others, gossiping, undermining authority, and ignoring rules. These manipulative actions allow youth feel some sense of control over what happens around them, but at the cost of vital relationships with others.

c. Internalizing children and youth may find that the emotional-behavioral pattern of depression-withdrawal can create predictable responses in others. The depressed-withdrawn youth attracts helpers who initially try to get involved, especially when the depression is accompanied by threats or attempts to harm oneself. When the youth fails to engage or improve, adults and peers lose interest in helping, which ultimately feeds a self-fulfilling prophesy of predictable abandonment and loneliness.

d. A final internalizing pattern is anxiety-dependency. Like a drowning swimmer latching onto any passerby, the anxious-dependent child forces people to notice and help by demanding assistance and refusing to let adults and peers leave. When helpers finally pull free, their leaving again reinforces the youth's prediction of abandonment and loneliness.

*2. Lack of social-cognitive skills.* A second explanation suggests that these behaviors occur because many troubled children youth have failed to develop critical thinking and social skills needed to get along with others, predict consequences of their behavior, and control their impulses. This deficit might be due to: (a) lack of instruction and role modeling from an early age, (b) traumatic brain injuries as a result of abuse, or (c) the inherent survival nature of life in constant crisis, one in which mainstream social skills may be counterproductive.

This explanation is not in contradiction to the first of course; traumatized youth could easily have both a desperate emotional need to control their worlds, and lack the social-cognitive skills needed to behave more productively and appropriately under stress.

*3. Neurobiological survival responses.* A third explanation suggests that abused and neglected children have developed an underlying neurobiology which may predispose them to "fight, flight, or freeze" survival patterns (Hodas, p 28-29), even in settings which do not require a survival response. Brain research over the past 15 years has provided powerful evidence of the impact of life events on the development of neural pathways within the brain. Repeated incidents of violence, abuse, fear, and uncertainty create not only emotional patterns, but actual neural pathways in the brain.

Ideally, these pre-established pathways improve reaction time and instantly spark the production of catecholamines (such as adrenaline) into the body, allowing the young person a greater chance of survival in threatening conditions. However, these neural pathways and catecholamines may cause traumatized youth to misinterpret and overreact to <u>all</u> stressful situations as if they were life-threatening crises. Many of the behaviors considered externalizing behaviors, such as aggression and passive aggression, function as "fight or flight" survival responses. Many of those considered internalizing, such as withdrawal and dependency, function as "flight or freeze" survival responses. If the neurological and hormonal systems of some traumatized children are "hard-wired" to overreact to the slightest perceived threat, it should not be surprising when youth fight, argue, manipulate, avoid, or demand in response to the slightest provocation.

**5. What agency and staff practices help the recovery of children and youth who have experienced traumatic life events?**

It is certainly the goal of every agency serving troubled children and youth to create an environment in which youngsters can live safely, learning the skills needed to grow toward healthy adult independence.

<u>a. Agency elements.</u> What separates an agency dedicated to trauma-informed care from a more traditional facility serving the same population? The soundness of the physical structure of the facility, and the thoroughness of its educational and therapeutic programs are certainly important parts of the safe learning and living environment that both seek to create.

It is an agency's values and related practices that identifies its alignment. Harris and Fallot (2001) point out four clusters of values which separate the two approaches:

| | **Focus on Power & Control** | **Responsibility for Intervention** | **Treatment Goals** | **Use of Language** |
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| **Trauma-Informed Care**<br><br>Youth centered<br>Strength based | Focus on teaching and allowing youth to make their own decisions and learn from mistakes. | Teaching youth to understand and better cope with their own problems. | To learn self-advocacy skills and achieve healthy independence. | Uses everyday language to speak directly <u>to</u> youth about issues. |
| **Traditional Services**<br><br>Rules centered<br>Deficit based | Focus on quick management and control of problems by staff to minimize problems. | Providing psychiatric interventions for youth by expert medical staff. | To stabilize symptoms of mental illness. | Uses clinical jargon to talk <u>about</u> youth and their problems. |

An agency invested in a trauma-informed care approach recognizes that many problem behaviors stem from deeper issues. It understands that some problems, especially during stressful situations, are a result of a "fight, flight, or freeze" survival reflex, one with neurological hardwiring driving it. It realizes that other behaviors result from a youth's desperate and self-defeating attempts to gain some sense of control and power.

Knowing these things, this agency attempts to avoid reacting to surface misbehavior with rigid rule enforcement, instead studying underlying reasons for misbehavior. It trains staff to avoid power struggles and de-escalate difficult situations, even when this means backing down at times. Instead of doing things <u>to</u> or f<u>or</u> youth, it works <u>with</u> youth, building on strengths to teach them how to better cope with their problems.

Hodas (p 33) suggests that an agency dedicated to the practice of trauma informed care must seek to create conditions in which severely abused and neglected children can:

1. Lessen their physical and emotional reactivity to problems;
2. Learn new social interaction skills;
3. Change self-defeating emotional-behavior patterns;
4. Improve their capacity for building and maintaining relationships;
5. Improve their ability to think clearly and solve problems logically;
6. Change beliefs and values that justify self-destructive ends.

<u>b. Relationship elements</u>. While an agency's policies and procedures are vital to its success, it is the quality of staff relationships with children and youth which is most essential to the sense of emotional and physical safety these youngsters need to make personal progress. James Comer, noted psychologist and educator from Harvard University, once said simply, "No significant learning occurs without a significant relationship."

Which staff are most effective at building relationships and helping traumatized children recover? Three attributes emerge from a wealth of practice and research:

1. Staff who have a deep understanding of the dynamics of trauma, and of the trauma a particular child has endured, tend to respond more sensitively to problems and avoid actions which would exacerbate a child's issues.

2. Staff who operate from a strength-based perspective, who believe that every child has positive traits which can be used to help them address their problems and who seek not to control children but to help them control themselves, tend to build closer relationships and be more effective resources in times of need.

3. Staff who are skilled in crisis de-escalation, behavior management, and safe physical interventions, tend to handle problems in ways which do not dehumanize youth. Specifically, these staff have the ability to:

*a. Prevent stress-related problems* by promoting a calm, physically and emotionally-safe living environment.

*b. Maintain their own self-awareness and self-control* even when angry, by depersonalizing issues and managing their own emotions.

*c. Protect children from retraumatization* by stopping bullying and intimidation, whether by peers or other staff.

*d. Redirect minor misbehaviors* and enforce rules without angry power struggles, shaming, or unnecessary punitive consequences.

*e. De-escalate emotional crises* by helping youth to calm down and talk about emotions.

f. When absolutely needed, *use only minimal physical force* and safe, non-threatening holds to control dangerous behaviors. Never uses angry threats or physical force to "manhandle" children for noncompliance.

*g. Thoroughly and calmly process crises* with youth after stressful situations, especially after restraints.

*h. Recognize when to use other staff* to help with problems beyond their own level of expertise.

**6. Summary**

Many children and youth served in residential treatment have been traumatized by lifetimes of violence, abuse and chronic neglect. Months or years of physical abuse, of inconsistent attention to emotional and physical needs, of being victims of or witness to violence or sexual acts have had a profound effect on them. Maltreated children and youth often recover from their immediate physical injuries, but many maintain deep emotional and mental scars which prevent them from interacting successfully in mainstream society.

The damage can be astounding. Chronic childhood abuse and neglect may cause traumatic brain injury (TBI) or stunted brain development, sometimes leading to developmental disabilities. It can create lasting hormonal imbalances and establish crisis-driven neural pathways in the brain, predisposing children to a state of hyperarousal and hypervigilance, a flight, flight, or freeze survival mode maintained even when they are not threatened.

On a social level, traumatizing conditions seldom allow children to learn interpersonal, self-control, or problem solving skills needed for successful social interactions, family life and workplace relationships. As a result, youth are at much greater risk of

developing secondary problems such as early sexual behavior, pregnancy, sexually transmitted diseases, substance abuse, and criminal activity. Because childhood trauma leaves many children with a deep, pervasive sense of helplessness and shame, many develop self-defeating patterns of thinking, feeling and behaving which give them some small sense of control in their worlds. While emotional-behavioral patterns such as aggression, passive-aggression, depression, and dependency make their worlds more predictable, they often sabotage relationships and long-term success.

Children who develop serious behavioral and social-emotional problems often find their way into increasingly restrictive environments, such as special education classrooms, alternative schools, group homes, treatment centers, and psychiatric hospitals. Lacking social and problem solving skills, and conditioned for survival responses to perceived threats, these children often overreact to difficulties when they feel emotionally or physically unsafe. Exquisitely sensitive to shaming, they may make matters far worse when they feel disrespected or embarrassed by either externalizing (arguing, fighting, destroying property) or internalizing (withdrawing, ignoring requests, harming themselves).

Staff who are not informed of trauma dynamics may misinterpret these behaviors as simple willful defiance or laziness, and respond with punishment to "teach the kid a lesson about who is in charge." However, when misbehavior is a symptom of much deeper issues, this punitive, controlling approach almost always escalates the problem and exacerbates emotional and psychological trauma issues.

To be effective with severely abused and neglected children and youth, to provide emotionally and physically safe learning and living environments in which true change can take place, many agencies are choosing to adopt an approach of "trauma-informed care." This approach is characterized not by a single method or modality, but by its strength-based focus on helping youth learn to understand and cope with their own problems, rather than on strict compliance with rules for their own sake. It is also characterized by staff with the skills to build safe and dependable relationships despite the wariness of the children with whom they work. Among other things, these staff know how to de-escalate emotional problems calmly, to manage misbehavior without shaming, and if absolutely necessary, to physically intervene without retraumatizing youth.

Haim Ginnott, renowned educator and child psychologist, offered these words, shared in closing as inspirational food for thought:

> *"I've come to the frightening conclusion that I am the decisive element in the classroom. It's my daily mood that makes the weather. As a teacher, I possess a tremendous power to make a child's life miserable or joyous. I can be a tool of torture or an instrument of inspiration. I can humiliate or humor, hurt or heal. In all situations, it is my response that decides whether a crisis will be escalated or de-escalated and a child humanized or de-humanized."*

For more information about staff training in this topic, please contact
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