Adolescent PTSD and Dissociative Disorders

Diagnostic Issues

- Diagnosis itself seldom communicates much about the nature of the child and his or her world.

(The ISSD Task Force on Children and Adolescents)

Dissociation

- There is no consensus yet on the exact etiological pathway for the development of dissociative symptomatology, but newer theoretical models stress:

  Impaired parent-child attachment patterns (Barach, 1991; Liotti, 1999; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997)

  Trauma-based disruptions in the development of self-regulation of state transitions (Putnam, 1997;Siegel, 1999).

Dissociation

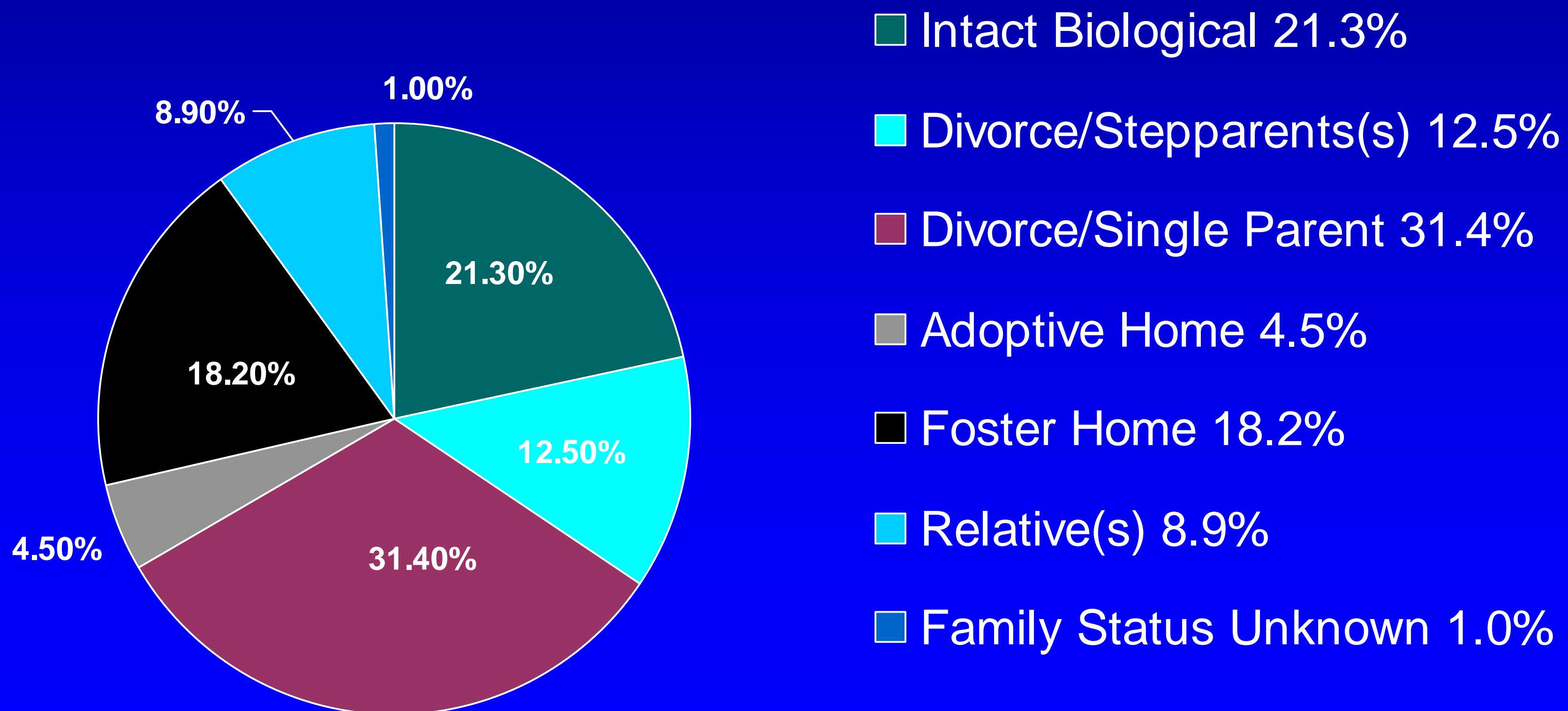
- Newer theorizing ties maladaptive attachment patterns directly to dysfunctional brain development that may inhibit integrative connections in the developing child’s brain (Schore, 2001; Stien & Kendall, 2003).

2003 Survey of 2,200 children across NCTSN.

Gender

- Female 56.9%
- Male 43.1%

Family Status



Child Trauma Exposure: Age of Onset

- Mean Age of Onset: 5.0 (SD = 2.8)
  - Median: 5.0
  - Min, Max: 0, 13.0

Early Exposure: Over 1/3 of the sample is adolescent and yet 98% of clinicians surveyed report average age of onset under 11

Number of Child Trauma Exposure Types

- Mean Number of Exposure Types: 2.9 (SD = 1.8)
  - Median: 3.0
  - Min, Max: 1, 11

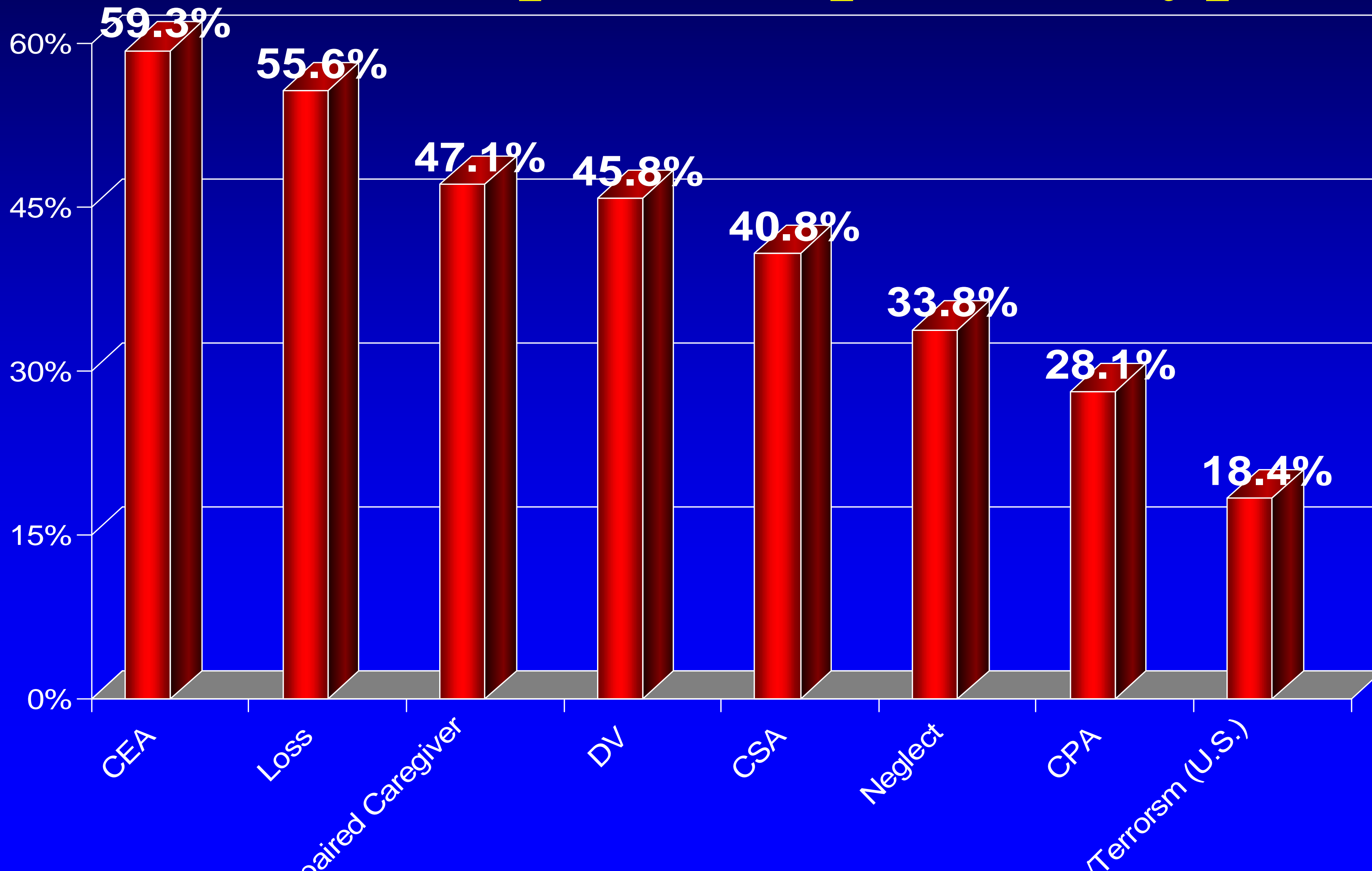
History of Multiple Exposure Types: 94% of clinicians surveyed report average child exposure to more than one type of trauma

Child Trauma Exposure Duration

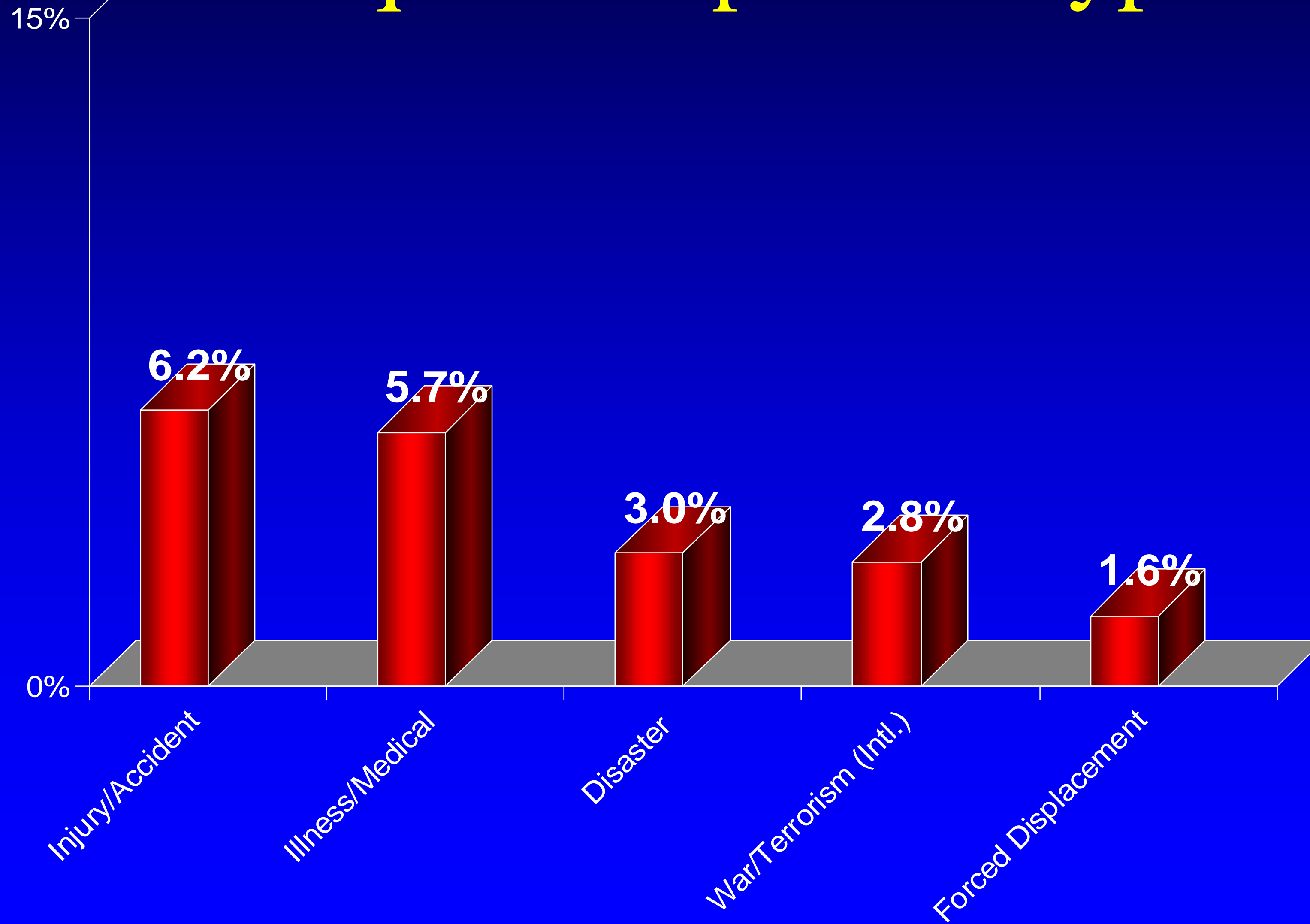
- Duration of Trauma
  - Multiple-event or chronic trauma: **77.6%**
  - Singe Event or Acute Trauma: 19.2%
  - Unknown: 3.2%

CHILD & ADOLESCENT TRAUMA EXPOSURE TYPES

Child Trauma History: Most Frequent Exposure Types

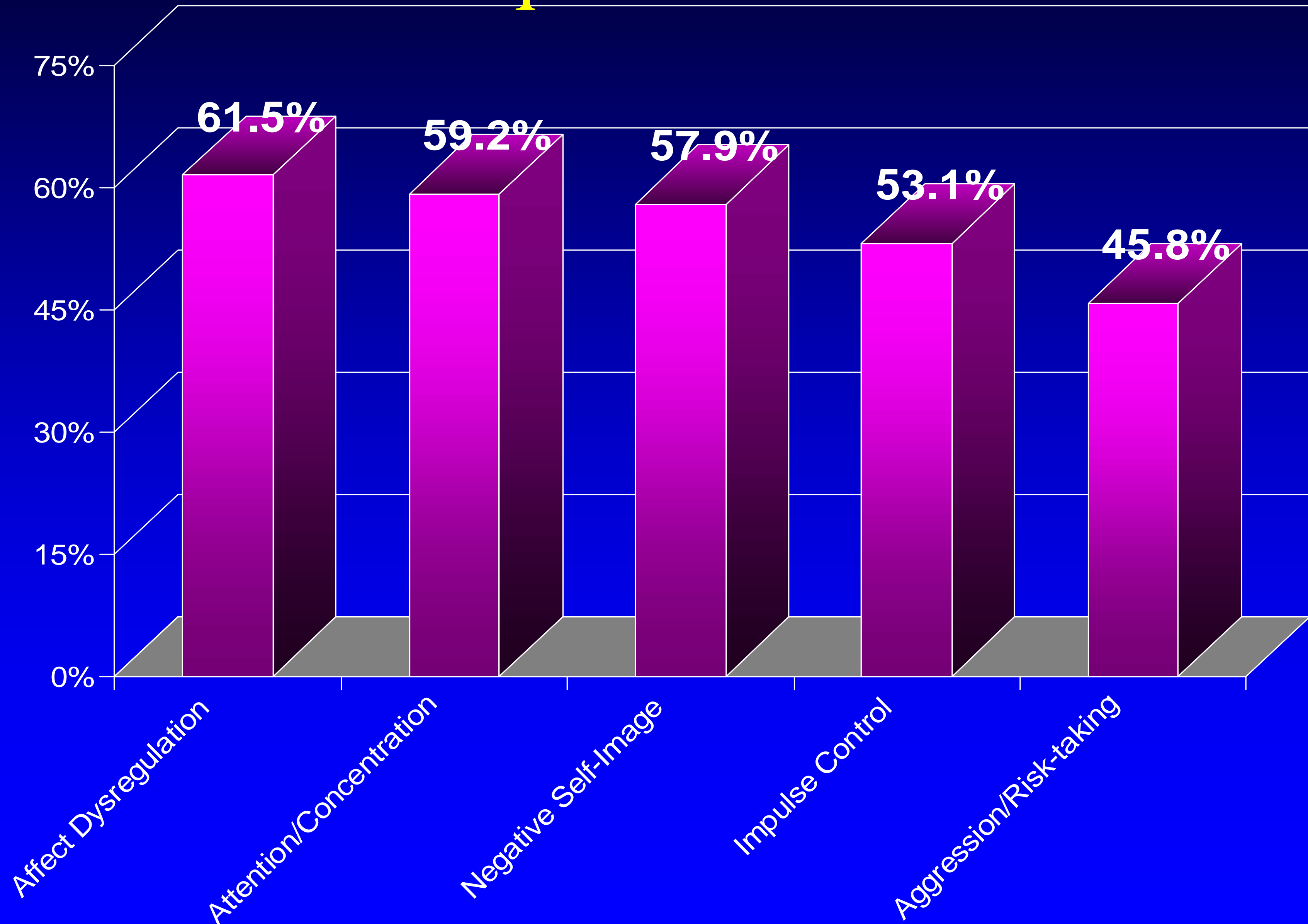


Child Trauma History: Less Frequent Exposure Types

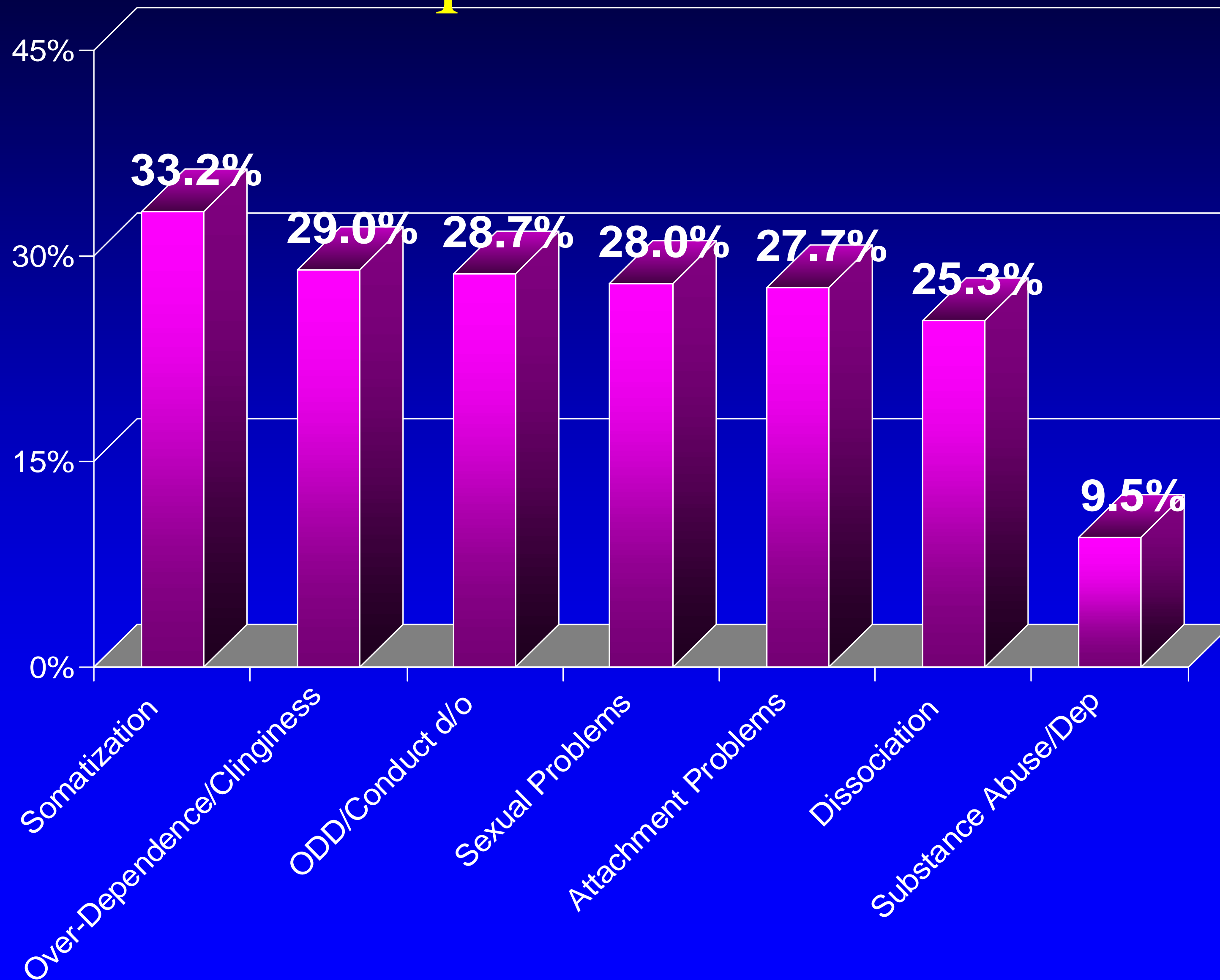


COMPLEX POSTTRAUMATIC SEQUELAE

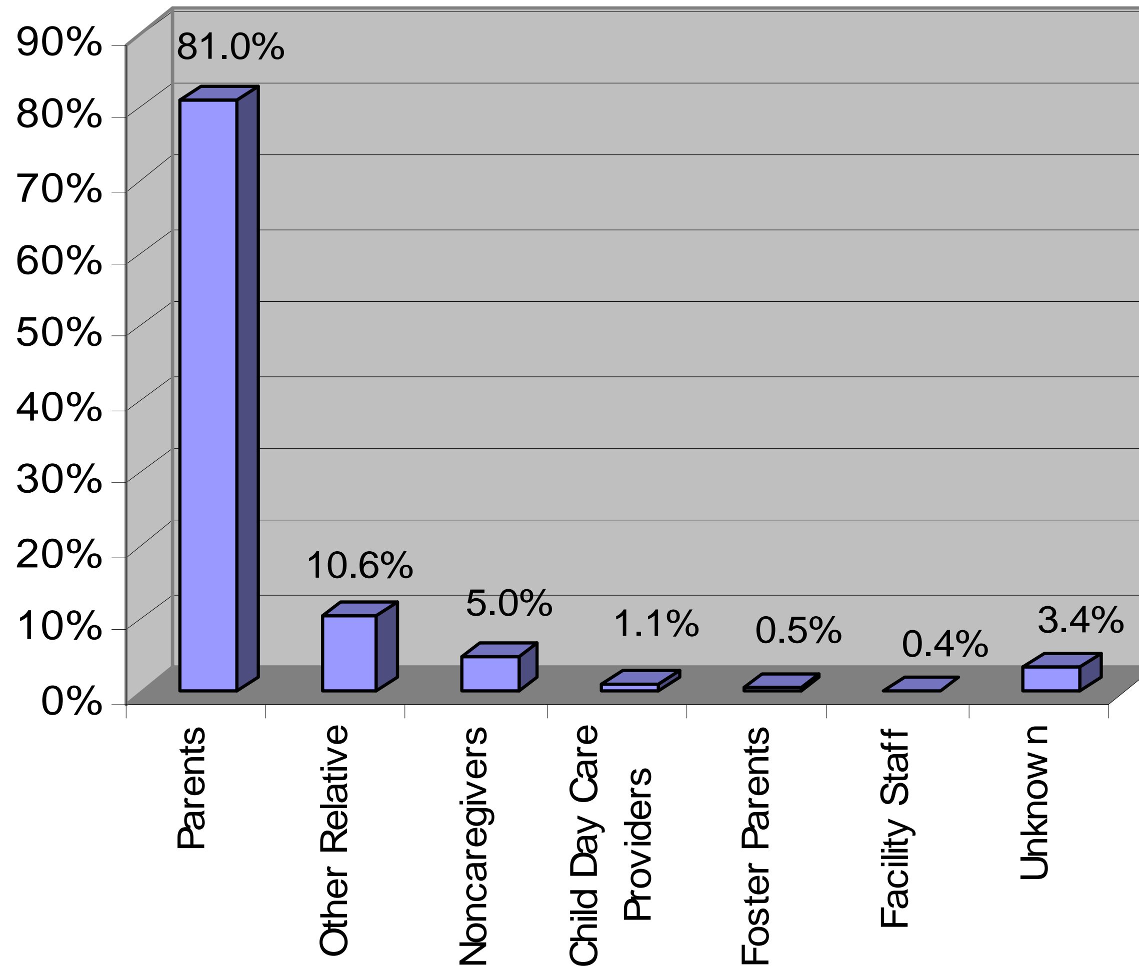
Complex Posttraumatic Sequelae: Most Frequent Difficulties



Complex Posttraumatic Sequelae: Less Frequent Difficulties



Relationship of Victims to Perpetrators in Substantiated Cases



Adverse Childhood Experiences Are Very Common

Percent reporting types of ACEs:

Household exposures:

Alcohol abuse	23.5%
Mental illness	18.8%
Battered mother	12.5%
Drug abuse	4.9%
Criminal behavior	3.4%

Childhood Abuse:

Psychological	11.0%
Physical	30.1%
Sexual	19.9%

CDC
SAFER • HEALTHIER • PEOPLE

Estimates of the Population Attributable Risk* (PAR) of ACEs for Selected Outcomes in Women

Mental Health:	PAR
Current depression	54%
Depressed affect	41%
Suicide attempt	58%
Drug Abuse:	
Alcoholism	65%
Drug abuse	50%
IV drug abuse	78%
Promiscuity	48%
Crime Victim:	
Sexual assault	62%
Domestic violence	52%

CDC
SAFER • HEALTHIER • PEOPLE

Attachment - Human Studies

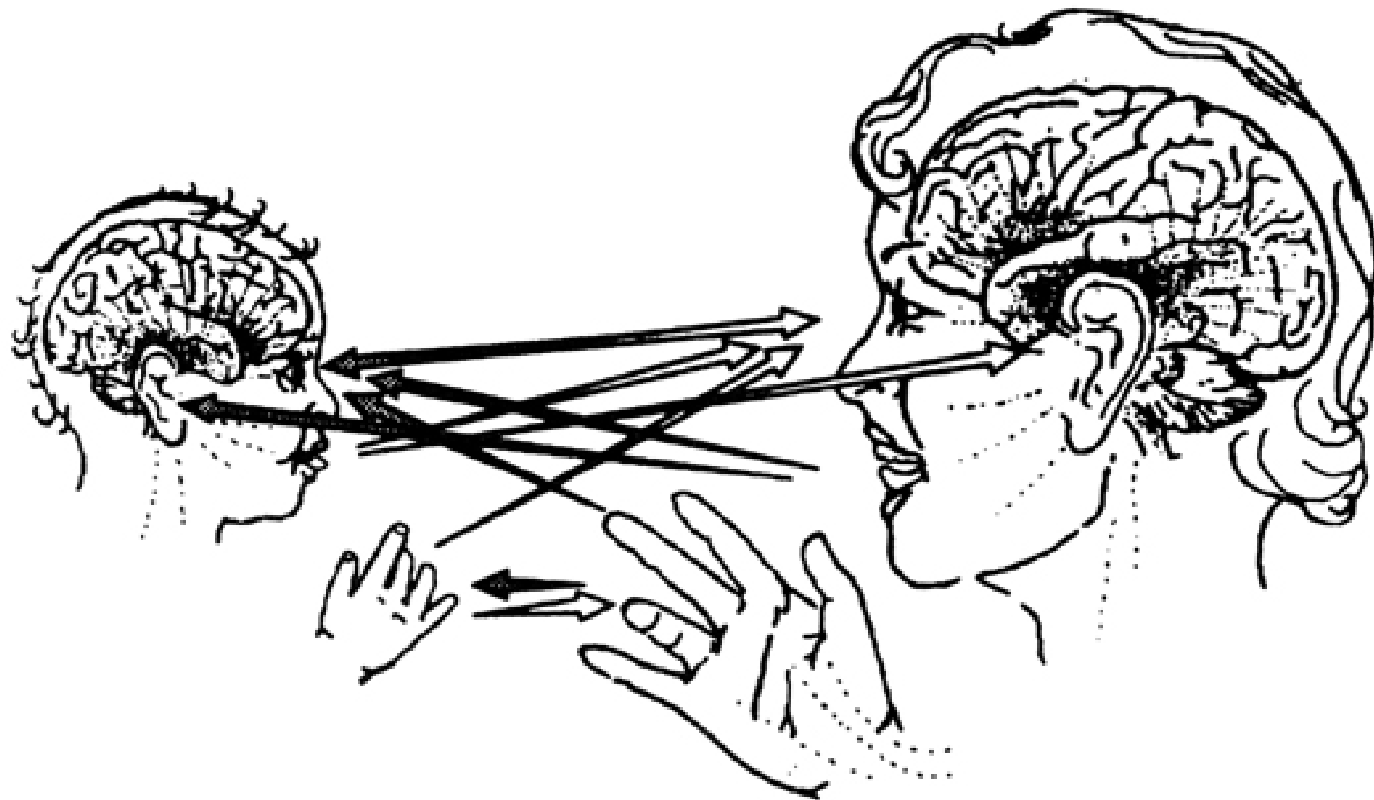
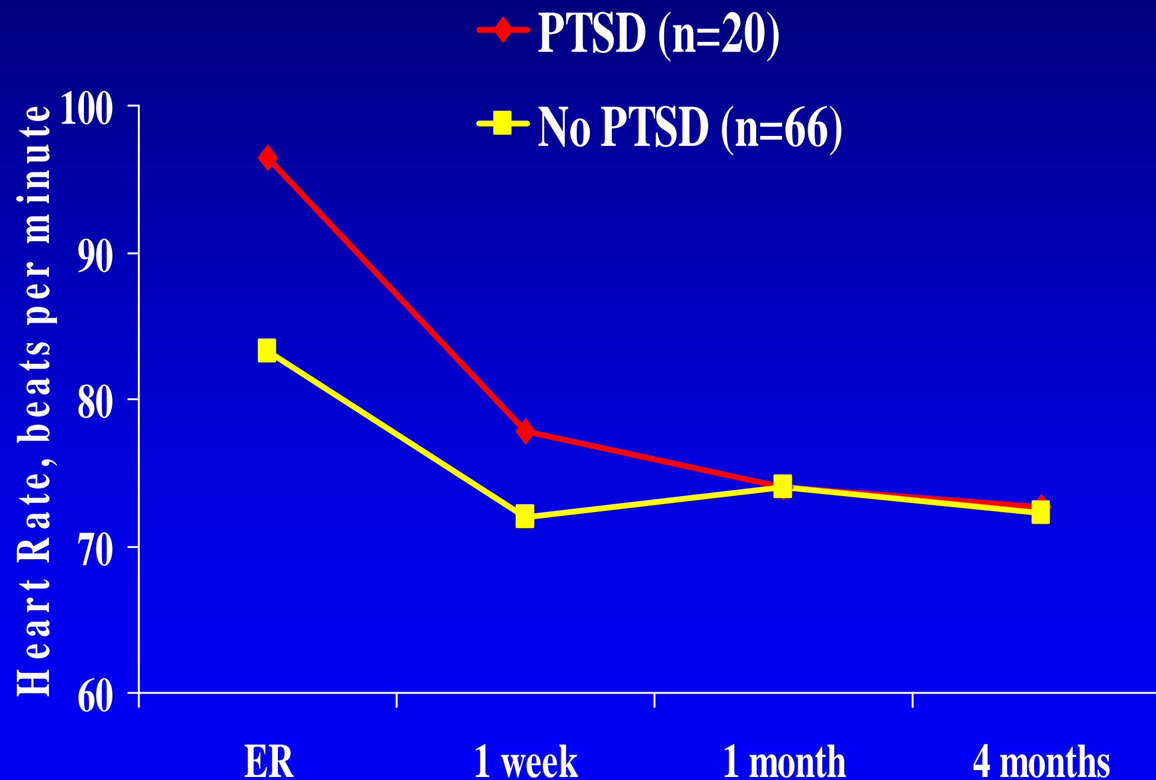


FIGURE 1. Brain–brain interactions during face-to-face communications of proto-conversation, mediated by eye-to-eye orientations, vocalizations, hand gestures, and movements of the arms and head, all acting in coordination to express interpersonal awareness and emotions. Adapted from Aitken & Trevarthen (1993) and used with permission of Cambridge University Press.

Self-regulation is critical issue

Heart Rate following Trauma

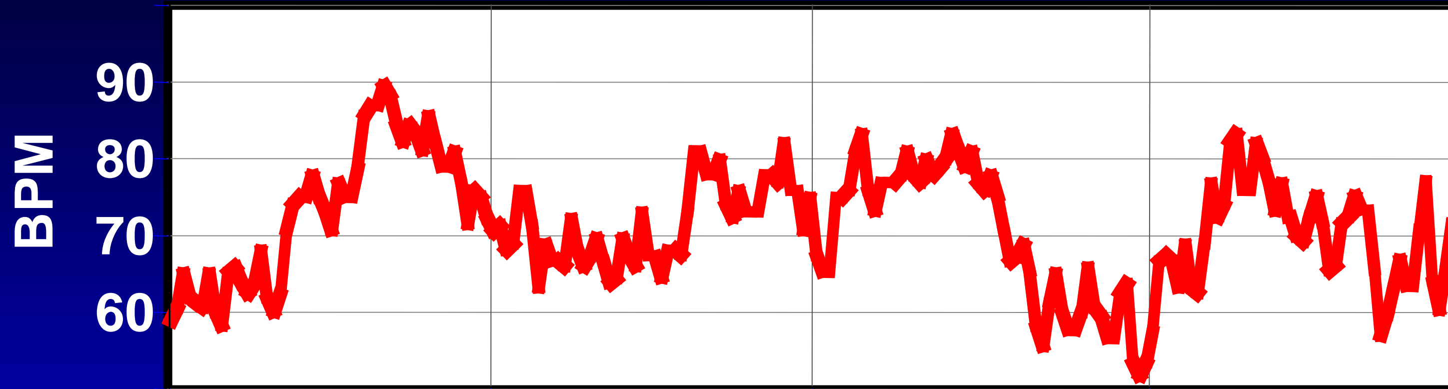


↑ HR in immediate aftermath predicts PTSD

Suggests greater SNS activity or sensitivity predicts PTSD

Shalev et al, Arch Gen Psychiatry, 1998

Low HRV



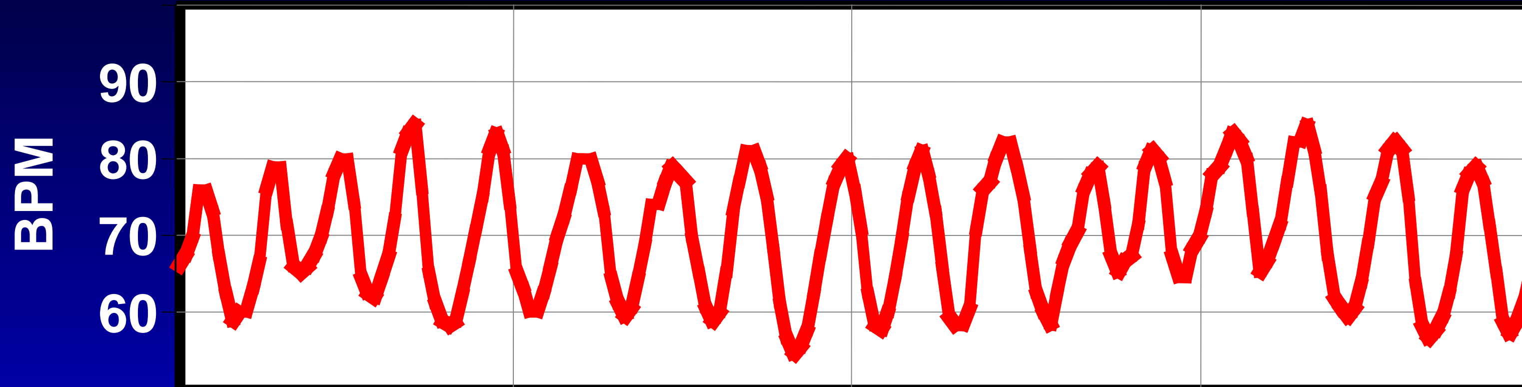
- Chaos
- Anxious and depressed states

  Carney et al., 1988 J Psychosom. Res.
  McCraty et al, 2001 *Bio. Psychol.*
  Rechlin et al. 1994 *J. Affect. Dis.*
  Shibagaki & Furuya, 1997 *Percep. Mot. Skills*

- Predictor of mortality : CVD, cancer, etc.

  Tsuji et al., 1994 *Circulation*; Dekker et al., 1997 *Am. Jal. Epidem.*; La Rovere et al., 1998, *Lancet*

High HRV



- Coherence
- Positive emotions
  McCraty et al., 1995 *Am. Jal Card*
- Predicts resistance to stress
  Porges et al., 1996 *Dev. Psychobiology*
  Katz & Gottman, 1997 *J Clin Child Psychol*

NCTSN DSM V
Developmental Trauma Taskforce

Marylene Cloitre, Julian Ford,

Sandra Kaplan, Alicia Lieberman,

Frank Putnam, Robert Pynoos,

Glenn Saxe, Michael Scheeringa,

Bessel A. van der Kolk.

Developmental Trauma Disorder

- **A. Exposure**
  - **1. Multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma** (abandonment, betrayal, physical sexual assaults, neglect, coercive practices, emotional abuse, witnessing).
  - affects a developmental segment
- **B. Subjective Experience**
  - (rage, betrayal, fear, resignation, shame).

B. Triggered pattern of repeated dysregulation in response to trauma cues

– **1. Dysregulation Type** ***evidence of some type of PTSD?? Interference with core developmental competencies. That have behavioral manifestations***

- **Affective**
- **Somatic** (physiological, motoric, medical)
- **Behavioral** (e.g. re-enactment, self mutilation)
- **Cognitive** (thinking that it is happening again, *confusion,* dissociation, depersonalization*)*.
- **Relational** (attachment clinging, oppositional, distrustful).
- Self-care

B. Triggered pattern of repeated dysregulation in response to trauma cues

2. Regulation Strategy

- **Anticipatory** (e.g avoiding, bullying, ingratiating)
- **Coping** (e.g. cutting, assaulting, dissociating)
- **Restorative** (e.g. compliance, avoidance,)
- **Disorganized**

Developmental Impact on other disorders

- Substance abuse,
- Bipolar
- Depression
- Somatization

C. Generalized expectancies

- Negative self-attribution
- Loss of protective caretaker
- Loss of protection of others
- Loss of trust in social agencies to protect
- Expectation? of future victimization

D. Functional Impairment

- Scholastic
- Familial
- Peer
- Legal
- Vocational

Domains of Impairment

- National Child Traumatic Stress Network Data
- Child and Adolescent Complex Trauma Sample
- Developmentally Focused

Attachment

- Uncertainty about the reliability and predictability of
- the world
- Problems with boundaries
- Distrust and suspiciousness
- Social isolation
- Interpersonal difficulties
- Difficulty attuning to other people's emotional states
- Difficulty with perspective taking
- Difficulty enlisting other people as allies

Biological

- Sensorimotor developmental problems
- Hypersensitivity to physical contact
- Analgesia
- Problems with coordination, balance, body tone
- Difficulties localizing skin contact
- Somatization
- Increased medical problems across a wide span, (e.g., pelvic pain, asthma, skin problems, autoimmune disorders, pseudoseizures)

Affect Regulation

- Difficulty with emotional self-regulation
- Difficulty describing feelings and internal experience
- Problems knowing and describing internal states
- Difficulty communicating wishes and desires

Dissociation

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

Behavioral Control

- Poor modulation of impulses
- Self-destructive behavior
- Aggression against others
- Pathological self-soothing behaviors
- Sleep disturbances
- Eating disorders
- Substance abuse
- Excessive compliance
- Oppositional behavior
- Difficulty understanding and complying with rules
- Communication of traumatic past by reenactment in
- day-to-day behavior or play (sexual,
- aggressive, etc.)

Cognitive

- 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 own contribution to what
- happens to them
- Learning difficulties
- Problems with language development
- Problems with orientation in time and space
- Acoustic and visual perceptual problems
- Impaired comprehension of complex visual-spatial
- patterns

Self-Concept

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

Mental health counseling that has been demonstrated to be effective in helping adolescents deal with traumatic stress reactions typically includes the following elements:

- Education about the impact of trauma
- Helping adolescents and caregivers re-establish a sense of safety
- Techniques for dealing with overwhelming emotional reactions
- An opportunity to talk about and make sense of the traumatic experience in a safe, accepting environment
- Involvement, when possible, of primary caregivers in the healing process

Tri- Phasic Treatment of Trauma

- Stabilization and Safety
- Trauma Processing and Restructuring / Deconditioning
- Reconnection and Resolution

Family Dynamics

Adolescent therapy in cases of unstable families may have more limited goals of crisis intervention and promotion of stability with intermittent services (Wieland, 1997).

Adolescent Treatment

Therapists must forge an empathic connection with the whole child, including disowned experiences and affects that the child may perceive as being contained in voices, imaginary friends or self-states, so that the child feels fully accepted at all levels of experience. This empathic connection is key for the child to begin to accept his/her disowned experience and affect and to take responsibility for moving on.

Adolescent Treatment

- Continuity in the therapist's relating to the child across all changes of state is a key ingredient in the therapy.

Adolescent Treatment

Treatment of children and adolescents with the severity often presented in these cases is often a team effort involving parent, therapist, school, pediatrician, and any significant others involved

Communication within the team should focus foremost on safety and support for the child and development of consistent expectations for the child

Treatment Challenges

- Achievement of physical safety is a primary goal that supersedes any other therapeutic work

Treatment Challenges

- The therapist should recognize his/her role as a potentially powerful reinforcer and shaper of the child's or adolescent's behavior. A stance of gentle, empathic, non-judgmental listening and open inquiry is helpful

Treatment Challenges

- An important goal of therapy is for the child to learn increasingly adaptive and flexible ways to manage affect and to integrate past, current, and new experiences so that development is not compromised.

Therapeutic Challenges

- If the child appears to be regressing in therapy, the therapist should review the course of treatment, evaluate safety in the environment, evaluate possible stressors (e.g., court testimony, visitations, too much focus on traumatic events), and seek other consultations regarding how to modify the treatment approach so that the child is progressing along a developmental trajectory that is as normalizing as possible.

Therapeutic Challenges

- Families may defensively concentrate on the past and avoid discussion of the current stressors that maintain dissociative adaptations. The therapist should help the family find creative solutions to current problems, while exploring feelings from past events that continue to contribute to current difficulties.

Therapeutic Challenges

- Include intervention with the family currently providing care to the child or adolescent

Therapeutic Challenges

- The therapist must help the child and the family understand that any self-states or alternate identities are really part of the child and that the whole child is responsible for his/her behavior

Overarching Therapeutic Goals

- Help achieve a sense of cohesiveness about affects, cognitions, and associated behavior
- Enhance motivation for growth and future success
- Promote self-acceptance of behavior and self-knowledge about feelings viewed as unacceptable

Overarching Therapeutic Goals

- Help the child resolve conflicting feelings, wishes, loyalties, identifications, or contrasting expectations
- Desensitize traumatic memories, and correct learned attitudes towards life resulting from traumatic events
- Promote autonomy and encourage the child to independently regulate and express affects and to self-regulate state changes

Overarching Therapeutic Goals

- Promote healthy attachments and relationships through culturally appropriate means
- Help families and children view the therapist as a stable attachment figure, particularly for children and families from chaotic environments