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CHAPTER TWO
Trauma- and Stressor-Related Disorders

Chapter Objectives

Students should be able to:

1. Distinguish between stress and trauma.
2. Distinguish between the three trauma- and stressor-related disorders and the three dissociative disorders summarized in the text, and describe their primary symptoms.
3. Summarize the concepts of complex trauma, developmental trauma, and relational trauma.
4. Compare and contrast primary psychological explanations (biological, behavioural, cognitive, psychodynamic, and sociocultural) for trauma- and stressor-related disorders.
5. Summarize the NMT model and describe how the brain is affected by trauma.
6. Describe the psychological treatment approaches used in treating trauma- and stressor-related disorders.
7. Describe the impact of trauma in seven domains of functioning.
8. Describe behaviours associated with a trauma response in youth, including the symptoms of complex trauma.
9. Explain trauma-informed care and identify CYC strategies to help young people with memories of trauma and those engaged in self-harm behaviour.

Summary

The lasting undesirable social, emotional, physical, and cognitive effects that result from exposure to stressful or extreme events are referred to as *trauma*.

From a psychological perspective, the DSM-5 considers psychological disturbances associated with exposure to stressful and traumatic events in the general categories of Trauma- and Stressor-Related Disorders and Dissociative Disorders. Psychological explanations for trauma-related symptoms include alterations in brain function and structure, the use of defence mechanisms, classically conditioned fear associations that result in avoidance of stress-related stimuli, and a cognitive fear structure. From a psychological perspective, the most common treatment approaches for trauma-related disorders include exposure therapy and cognitive restructuring.

A CYC perspective views *complex trauma* as the behavioural manifestation of the infliction of deep and lasting emotional wounds. From a CYC approach, the stress associated with relational trauma experienced repeatedly and over time in the interpersonal environment is cumulative. Thus, developmental, relational, or complex trauma is understood to be attachment trauma. CYC therapeutic intervention must create new patterns that reflect new experiences in the brain. The best way to create new patterns in the brain is to expose the child to repeated experiences that break old associations using the NMT (neurosequential model of therapeutics) approach. CYC interventions for children and youth who have been trauma-exposed highlight the tenets of trauma-informed care. Relational practice is emphasized when working with youth exhibiting behaviours related to trauma.

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Teaching Tips/Suggestions

1. *Take a Moment*: Prior to discussion of Chapter 2, ask students to get into groups of 3 or 4 and discuss ways in which trauma can affect a child or adolescent. You can provide general areas of impact (e.g., cognitive, attachment, dissociation, biology, mood regulation, behavioural control, self-concept) and have students identify specific examples of impact in each area. Have students share their examples in a large group discussion. Highlight how trauma can: (1) impact various areas of functioning, (2) be viewed as an adaptive response, and (3) have different expressions depending on individual risks and resiliencies.

2. *Web Quest Activity*: Have students find online assessment tools related to stress and trauma. Some examples include the *Acute Stress Disorder Scale* or ASDS, the *PTSD CheckList – Civilian Version* or PCL-C, and the *Stanford Acute Stress Reaction Questionnaire* or SASRQ. Ask students to examine the various questionnaires and checklists and compare them to the DSM-5 diagnostic criteria for various trauma- and stressor-related disorders. What questions found in these tools might a CYCP find helpful in her or his practice?

3. *Online Video Activity*: Have students view the 28 minute documentary on a young girl named Beth Thomas, entitled *Child of Rage* (available on YouTube). Ask students to address the following after watching the video:
   (a) Is this attachment disorder? Why or why not?
   (b) What other mental health criteria or diagnoses might this young girl meet?
   (c) Have students identify relevant trauma-related behaviours they observe in Beth (e.g., lack of reciprocity, aggression, anxiety, poor eye contact, flat affect, as well as related conduct problems – cruelty to animals and children, destructiveness, assaultive behaviour, self-injurious behaviour, low conscience, compulsive lying, sexual obsession/compulsion, etc.).
   (d) Given what is presented in the video, how might frontline CYCPs encourage attachment in the youth they work with? How might they help young people who try to recreate old relationships with new people? What might they try in their work with someone who has a negative working model? What barriers to attachment and sabotaging of relationships might be encountered?

4. *Research assignment*: Ask students to read the Perry and Szalavitz book titled *"The boy who was raised as a dog and other stories from a child psychiatrist's notebook: What traumatized children teach us about loss, love and healing"* (refer to readings list for detailed reference). Have students respond to the following questions in a written report:
   (a) Dr. Perry describes how the brain is arranged from smallest to largest, from most primal to more complex. Draw an image of the brain and label your diagram with the appropriate brain regions.
   (b) When working on Laura's case, Dr. Perry consulted with a foster mom in the area (Mama P.). Throughout the remainder of the book, he talks about her approach to child care and guidance and how effective it was. What was her approach and what needs did it meet for the children's development?

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(c) In his conclusion, Dr. Perry makes a number of recommendations for overcoming trauma and lasting effects of trauma in the lives of children, families and communities. Name one and explain why it might be helpful**.**
(d) Compare the cases of Leon (the 16 year-old boy who had killed two young girls in his apartment building) and Justin (the 6 year-old boy who had spent years locked in a dog cage). What was different about the neglect that each experienced? Why was Dr. Perry able to have such success in working with Justin yet so little with Leon?
(e) Peter, the boy who was adopted from a Russian orphanage, was having trouble in school and the relationships he had with other kids were no longer nurturing for him. Describe Dr. Perry's intervention and the effects that it had.

5. *Self-reflection*: In working with youth exposed to trauma, it is not unusual for CYCPs to experience vicarious trauma, burnout, or secondary trauma. Access the resource *When Compassion Hurts: Burnout, Vicarious Trauma and Secondary Trauma in Prenatal and Early Childhood Service Providers* (available online). Develop a self-reflection exercise appropriate to your student group that asks students to identify: (1) possible signs and symptoms of vicarious or secondary trauma they would be most likely to identify in themselves, (2) personal risk and protective factors for such trauma, as well as (3) self-care strategies that they are likely to find helpful should they encounter such trauma.

6. *Myths & Stigma:* Have students read the myths about trauma- and stressor-related disorders presented in Box 2.1 (p. 82) in pairs or small groups. What other myths are they aware of? Have students design a brochure that educates others about the myths versus facts for this group of disorders. Students can begin with a brainstorming session that helps them identify other myths about trauma-and stressor-related disorders. Using facts presented in the textbook, students should then find information to counter the myths they identify and present each in the brochure.

Box Exercises

1. *Think About It! Exercise: Experiences of Stress and Trauma (p. 66).* Have students individually journal and reflect on the questions posed in relation to their personal experiences with stressful life events and trauma.

2. *Test your Understanding: Case Examples of Trauma-, Stressor-Related, and Dissociative Disorders (p. 72).* Answers to each case are as follows: (1) David – Acute Stress Disorder; (2) Aliah – Dissociative Identity Disorder; (3) Anna – Dissociative Amnesia; (4) Vera – Depersonalization/Derealization Disorder; (5) Ken – PTSD with Delayed Expression; (6) Carla – Adjustment Disorder.

3. *Jennifer's Case: Revisited (p. 77).* Students can be encouraged to complete this exercise individually at first, followed by comparing their responses in small groups. Given Jennifer's exposure to an extreme event, her emotional outbursts, and quiet 'moodiness' noted by her Kookum, the most likely diagnosis a

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psychologist might apply would be PTSD. From a CYC perspective, Jennifer's behaviour might be considered *pain-based*, a manifestation of the deep emotional wound experienced as a result of seeing her mother stabbed by her stepfather and dying of her injuries. Compared to a psychological approach, the CYC perspective will be more likely to consider her behaviour a trauma reaction rather than indicators of a particular disorder. Other information a CYCP would like to know might include other possible stressors and maltreatment history, other behaviours of concern, coping strategies, and risks and resiliencies.

4. *Where Do You Stand? (p. 89).* Have students write a 5-minute position paper that summarizes their position with respect to the psychological and CYC perspectives on reactions to traumatic events. Student responses will vary, but should include a clear statement of which perspective they prefer and why.

5. *Take Action! Exercise: Alyssa's Case (p. 90).* Although student responses may vary, possible answers for the questions related to the case include:
    i. From a psychological perspective, Alyssa's high risk behaviour may be explained in relation to complex trauma or PTSD.
    ii. From a CYC perspective, Alyssa has unresolved abuse issues and maladaptive coping strategies that include high risk behaviours to numb her pain.
    iii. Due to Alyssa's past sexual abuse experiences she experiences dissociation which helps her cope with her current exploitation.
    iv. Interventions would include developing coping strategies and emotional regulation, exposure therapy, and/or cognitive restructuring.
    v. Benefits associated with a diagnosis of complex trauma or PTSD would include facilitating access to appropriate resources and interventions, as well as potentially having greater insight into her experiences and behaviour.
    vi. As a CYC youth outreach worker, the approach you might take would be relationship building, safety planning, and ensuring access to resources.

6. *Viewpoint Challenge Exercise: Jennifer's and Alyssa's Cases (p. 108).* Extending the insights that emerge from *Jennifer's Case Revisited* and the *Take Action! Exercise: Alyssa's Case*, students can be asked to reread the cases of Jennifer and Alyssa. Psychological explanations for their behaviour would include references to PTSD and/or complex trauma while psychological interventions may include developing coping strategies and emotional regulation, exposure therapy, and/or cognitive restructuring. From a CYC perspective, explanations for their behaviour may include attachment issues, abuse history, and maladaptive coping strategies while interventions would emphasize a relational approach, safety planning, a focus on strengths and resiliencies, alternative healing, and complex-trauma interventions. Students may select any one of the approaches listed but should fully explain why they chose the approaches they did.

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Critical Thinking Questions (text, p. 109-110):

1. *How does ongoing stress contribute to the development of a trauma response in a child or youth?* Ongoing stress sensitizes the nervous system, resulting in chronic hyperarousal, resulting in an increased likelihood that even minor events and/or stressors will be responded to as if they were a significant threat.

2. *What factors do you think contribute to the development of dissociative behaviours in a child or youth?* Student responses may vary but should include the idea that physical and/or sexual abuse is most often associated with dissociative behaviors.

3. *Why do you think some children and youth exposed to trauma develop the symptoms of PTSD and others do not?* Factors that explain variations in trauma may include genetic predisposition, as well as resiliency and protective factors.

4. *Which of the psychological paradigms used to explain trauma and stressor-related disorders do you think best fits with the CYC conceptual model? Why?* Responses may vary but should include some combination of the behavioural and cognitive approaches because of their emphasis on the environmental context and cognitive processes. The sociocultural paradigm may also be referred to because of its emphasis on social and family factors.

5. *Why do the lower parts of the brain develop before the top part? What implications does this have for our work?* Lower parts of the brain are associated with more basic processes (e.g., breathing) that are required for survival and are under less voluntary control. Higher structures of the brain (e.g., the cerebral cortex) are associated with more complex functioning (e.g., decision-making, directing attention) and develop in relation to experiences in the environment. Implications for CYC practice relate to the fact that because different areas of the brain develop at different times, vulnerability to trauma varies with age as does the type of symptoms associated with each brain area and the appropriate intervention (refer to Figure 2.3 for an illustration of this relationship).

6. *Which of the psychological treatment approaches could fit with a CYC-focused intervention approach? Why?* Responses may include any one of the psychological approaches and explanations as to why each could fit with a CYC-focused intervention approach will depend on the approach (e.g., the behavioural and cognitive approaches could fit with a CYC-focused approach because these are evidence-based interventions for children and adolescents exposed to trauma and they emphasize changing thoughts and reducing fear associated with triggers and reminders of the traumatic event(s); the sociocultural approach may be considered a good fit with a CYC-focused approach because it emphasizes the broader cultural and social contexts in which the youth interacts with others.

7. *Why do CYCPs need to practice good self-awareness when working with children and youth with complex trauma needs?* While self-awareness is central to CYC practice, it is particularly relevant when working with traumatized others because

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it will help the CYCP better recognize their own stress, vicarious trauma, and the need for self-care.

8. *Why do you think self-harming behaviours like cutting have become so prevalent among adolescent girls?* Various answers are possible (e.g., it can be used as a way to fit in with peers; as pressure/distress/stress for adolescent females in society increases, so does the use of this coping strategy).

9. *Why do you think it's so important to remain unemotional when responding to a youth who has self-harmed?* Although student responses may vary, remaining unemotional may convey respect and a nonjudgmental attitude toward the youth and their perspective, help ground the youth, create a safe therapeutic environment, and allow the CYCP to respond versus react.

Recommended Readings

Belamy, S., & Hardy, C. (2015). *Post-Traumatic Stress Disorder in Aboriginal people in Canada: Review of risk factors, the current state of knowledge and directions for further research*. Prince George, BC: National Collaborating Centre for Aboriginal Health.
This reading reviews risk and resilience factors, consequences, and treatments for PTSD that are specific to the Aboriginal Canadian population. Available online.

National Child Traumatic Stress Network (2003). *Complex Trauma in Children and Adolescents*.
This White Paper from the National Child Traumatic Stress Network Complex Trauma Task Force presents a comprehensive discussion of complex trauma including its domains of impairment, coping and protective factors, and approaches to treatment. Available online.

Pazderka, H., Desjarlais, B., Makokis, L., MacArthur, C., Steinhauer, S., Hapchyn, C. A., Hanson, T., Van Kuppeveld, N., & Bodor, R. (2014). Nitsiyihkâson: The Brain Science Behind Cree Teachings of Early Childhood Attachment. *First Peoples Child and Family Review, 9*(1), 53-65.
This article presents insights from the Nitsiyihkâson project, designed with an aim to develop a resource to promote attachment and child development consistent with Cree culture. Based on information from talking circles with Saddle Lake Elders from Alberta, Canada, the authors developed the document "awina kiyanaw", which presents Cree teachings and stories for parents to share with their youth children. Those working with Indigenous families may have a better understanding of this culture after reading these teachings.

Perry, B., & Szalavitz, M. (2007). *The boy who was raised as a dog and other stories from a child psychiatrist's notebook: What traumatized children teach us about loss, love and healing.* New York: Basic Books.
Each chapter is its own narrative of a young person's experience with trauma, the psychiatrist's analysis of the impact of trauma on the young person, as well as interventions that were used. Refer to the Research Assignment *under Teaching Tips and Suggestions for recommendations on how to utilize this reading in your course.*

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Ziegler, D. (2002). *Traumatic experience and the brain: A handbook for understanding and treating those traumatized as children.* Phoenix, AZ: Acacia Publishing.
This is an excellent resource for explaining the complicated inner workings of the brain. Chapters include the blueprint of the brain, adaptation, and how trauma affects the brain and consequently perception, self-perception, and one's world view. The last two chapters provide case examples and some responses for working with those traumatized as children.

Online Resources

PTSD Association of Canada:
http://www.ptsdassociation.com/
This link to the homepage of the PTSD Association allows users to review and/or self-administer several different self-assessments including: PCL Test, Screening for PTSD, Adverse Childhood Experiences Test, and Self-Assessment for Veterans. Information about PTSD, coping resources, and personal stories are also available.

Trauma Informed: The Trauma Toolkit, Second Edition:
http://trauma-informed.ca/
This Canadian 152 page toolkit is designed as a resource for frontline service providers. It defines trauma, PTSD and examines various types of trauma including that associated with the legacy of residential schools. The kit provides a section on Trauma-Informed Practices, strategies, and interventions that can be helpful to frontline practitioners.

The National Child Traumatic Stress Network:
http://www.nctsnet.org/
This online resource is a wealth of information with respect to types of trauma, interventions that work, research data bases, and additional resources in the area of youth trauma.

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