Understanding Complex Trauma in Juvenile Justice System Involved Youth

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**Traumatic Event**

- Experiencing, witnessing or being confronted with an event that involves actual or threatened death or serious injury to oneself or others, with the person responding with intense fear, helplessness or horror.
Trauma

Traumatic Events Change:
• Physiological arousal,
• Emotion,
• Cognition and
• Memory

• The fragmentation of memories from trauma serves as a self protection function to the victim.
Common Dynamics and Responses of Abused Children

- Low self esteem
- Mistrust
- Fear of Rejection
- Extreme vigilance
- Withdrawal
- Compulsive lying
- Anger and destruction
- Pretending illnesses

- Sleep related problems
- Low self care skills
- Verbal abuse to others
- Lack of friends
- Attention seeking behavior
- Compulsive stealing
- Irrational fears
Common Dynamics and Responses of Abused Children

- Poor follow through on tasks
- Bizarre or excessive sexual play with peers
- Fire setting
- Destruction of property
- Excessive temper tantrums
- Constant worrying

- Depressed mood
- Daydreaming
- Avoidance of others
- Intentional self harm
- Suicidal attempts
- Perfectionism
- Paranoia
Common Dynamics and Responses of Abused Children

- False beliefs that affect behavior
- Being picked on by other children
- Blaming of others
- Poor attention span
- Severe eating problems

- Rapid/extreme mood changes
- Low work effort
- School refusal
- Impulsivity
- Physical aggression
- Sensory disturbances
- Negative communication
IPV and Trauma

**Sympathetic Nerve System**

- State of Alert...The *Amygdala* role in the process
- Threats invoke intense feelings of fear and panic, change arousal patterns...
- Fight or flight response
- Trauma effects persons ability to remember events...may become hypervigilant, irritable, disconnect symptoms from the actual source
Trauma: Hyperarousal

- After traumatic events, the human system attempts to remain on permanent alert for additional danger.
  - Easily startled
  - Reacts irritably to small provocations
  - Sleeps poorly

They often have difficulty tuning out repetitive stimuli. The trauma “reconditions” the human nervous system.
Effects of IPV and Trauma

- **Basic Trust:** It is the foundation of faith.
  - Traumatic events create a crisis of faith
  - The survivors sense of faith is severely shattered when the traumatic event involves the betrayal of important relationships.
  - Guilt is common when survivor witnessed suffering of others.
Effects of IPV and Trauma

• **Basic Trust:** It is the foundation of faith.
  • Survivors tend to struggle with and intense desire for closeness/ neediness and intense fear and desire to isolate separate
  • (Approach<>avoidance...check BPDO)
  • Intense, unstable relationships
Hyperarousal Manifestations

- Patients may have constant expectation of harm or impending doom
  - Insomnia due to distressing dreams and nightmares
  - Exaggerated startle response
  - Poor concentration on activities not related to potential danger
Chronic Trauma: Factoid

• A great majority of survivors neither abuse nor neglect their children

• Men with histories of childhood abuse are more likely to be aggressive towards others, while women are more likely to be victimized by others or injure themselves
Effects of IPV and Trauma

- **Disconnection**
  - Traumatic events “destroy the victims fundamental assumption about the safety of the world, self and the meaningful order of creation”.
  - Basic trust is the foundation of belief in the continuity of life.
  - A secure sense of connection with caring people is the foundation of personality development.
Traumatic Event:
Symptoms of Re-experience of Trauma

• Examples include but are not limited to:
  • Dreams and nightmares
  • Intrusive memories of the trauma
Traumatic Event: Symptoms of Re-experience of Trauma

- Examples include but are not limited to:
  - Dreams and nightmares
  - Intrusive memories of the trauma
  - Visual, auditory and/or olfactory hallucinations
  - Experiences often remind the victim of inability to escape the trauma: it is usually brief, associated with a physiological response.
Avoidant Behavior

• Victims will avoid certain situations, activities or places which remind them of the traumatic event(s).
• This may also include avoidance of conversations regarding the event(s).
Hyperarousal Manifestations

- They may have constant expectation of harm or impending doom
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Impulsivity, Anger and Irritability

• Impulsive and unpredictable outbursts are common.
• Irritable mood may be related to the feeling others do not understand, care or support.
• Others may feel they have the right to be angry
Guilt and Emotional Responsiveness

- Emotional “numbness” may resemble symptom of depression
- Patients may indicate difficulty feeling happy, with a restricted range of emotion
Guilt and Emotional Responsiveness

• Emotional “numbness” may resemble symptom of depression
• Patients may indicate difficulty feeling happy, with a restricted range of emotion
• Survivor guilt, or guilt for feeling responsible for the harm to self or others
Dissociation is a defense mechanism used against the pain of trauma, thus splitting off or pushing away some aspects of the trauma (Starcevic, 2005).
Memory and Dissociative Problems

- Dissociation is a defense mechanism used against the pain of trauma, thus splitting off or pushing away some aspects of the trauma (Starcevic, 2005).
- Symptoms may include depersonalization or derealization experiences.
Memory and Dissociative Problems

• Memory problems include:
  • Loss of specific aspects of the event(s)
  • Loss of feelings associated with the event(s)
Memory and Dissociative Problems

- Memory problems include:
  - Loss of specific aspects of the event(s)
  - Loss of feelings associated with the event(s)
  - Disturbance of the integration of time and space associated with the trauma
Reenactment?

• Traumatized survivors find themselves reenacting some aspects of the trauma scene in disguised form, placing themselves at risk for additional harm, often unaware of what they are doing...An attempt to MASTER the traumatic event.
Comorbidity

- PTSD and Major Depression co-occur approximately 50% in community samples
  - Similar symptoms
  - Complicates treatment and outcome
  - MDD may precede and/or predispose one to PTSD
Differentials

- **In Acute Settings** (Several weeks or months after the trauma):
  - Acute Stress Disorder
  - Adjustment Disorder
  - MDD
  - Dissociative Disorders
  - Panic Disorder
  - Psychotic reactions
  - Malingering
Differentials

• **In Chronic Settings** (Several months or years after the trauma):
  • Dysthymia
  • MDD
  • Dissociative Disorders
  • Panic Disorder
  • Specific Phobia
  • OCD
  • Personality Disorder
  • Malingering
Primary Goals of Treatment

• Alleviation of symptoms and behavioral disturbances
• Alleviation of comorbid conditions
• Increased understanding of the trauma
• Increased resilience to stress
Primary Goals of Treatment

• Improvement in Functioning
• Minimization of Disability
• Prevention of Complications
Treatment

• Timing is critical; more likely of good outcome if treatment occurs as soon as possible relative to the traumatic event.
• There is no “one-size fits all” treatment approach due to the multiple risk factors, control issues, and individual differences.
Treatment Goals

• Make no assumptions about either the facts or the meaning of the trauma to the survivor...one must not impose ones own feelings onto the survivor.
Treatment Considerations

- Therapist should communicate acceptance and understanding
- Sensitivity and compassion are major emphasis
- Pay close attention to traumatic experience patient expresses guilt, embarrassment, shame, or anger.
Treatment Goals

• Help the survivor construct a new interpretation of the event and share the burden of the emotional trauma associated with the event.
Treatment Goals

• Allow flexibility and ambiguity as the story is reconstructed
• Avoid premature closure; this may minimize the significance of the patients traumatic experience
Treatment Goals

• Role is to be an open minded, compassionate witness and NOT a detective”
Treatment Goals

• The goal is not to get rid of the trauma...it is to integrate, a belief in the restorative power of truth telling...no longer about shame and humiliation, but rather that of dignity and virtue.
The trauma is resolved only when the survivor develops a new mental schema for understanding what has happened.
Models of Treatment: Cognitive Behavioral

• **Cognitive Restructuring:**
  - Identification, challenging and modifying the specific trauma related appraisals

• **Anxiety Management**
  - Muscle relaxation
  - Diaphragmatic breathing
  - Thought stopping
  - Role playing and modeling
Prolonged Exposure (PE) involves:
• Education
• Breathing retraining
• In-vivo exposure to avoided objects or situations
• Repeated prolonged imaginal exposure to the trauma memories.
Eye Movement Desensitization and Reprocessing (EMDR):

- Requires PE and imaginal exposure, free association and in-vivo exposure while also attending to some form of external oscillatory stimulation.
- Conflicting evidence surrounds the efficacy of this treatment, with advocates indicating it activates informational processing areas in the brain responsible for processing traumatic memories (Taylor, 2004).
Flooding Technique

• A detailed written or recorded account of the trauma:
  • Allows client to read or listen to the event(s)
  • Relaxation skills are taught prior to exposure exercises
  • Flooding is NOT effective for chronically traumatized survivors
First Stage of Recovery: Safety

• Recognition of the trauma is central to the process of recovery. The client must feel safe to discuss and recognize that the trauma actually occurred.
• Often it is necessary for the therapist to reframe accepting help as an act of courage.
• Establishment of safety is the first task of recovery
Second Stage: Remembrance and Mourning

- Second stage of recovery is for the survivor to tell the story of the trauma:
  - Make certain client and therapist are clear of the purpose and both are secure in the therapeutic alliance.
  - Careful pacing and timing is important during the uncovering process...balance of safety and confronting the past.
Third Stage: Reconnection

Reconnection begins with:

• Review of life prior to the event
• Recitation of the event, including verbalization of thoughts, feelings, smells, etc...
• Client recites not only what happened, but how they felt
• Client reviews the meaning of the events to self and others.
• Why? Why me? Reconstruct new belief system
Finding a Survivor Mission

• Social action
• Helping other victims
• Bringing offenders to justice
• Raising public awareness
• Public truth telling
Public Truth Telling

• “When others bear witness to the testimony of crime, others share the responsibility for restoring justice…”

• “Truth is what the perpetrator most fears” …the survivor has exposed the crime to others and is no longer silenced by fear.
Resolving the Trauma

• Recovery is never complete...advise clients that PTSD symptoms are likely to recur under stress.

• The best indicator of resolution is the survivors restored capacity to take pleasure in life and engage fully in relationships with others.
Mary Harvey’s 7 Steps of Resolution

1. PTSD symptoms are within manageable limits
2. The person is able to bear the feelings associated with the traumatic memories
3. The person has authority over the memories
4. The memory of the traumatic event is a collective narrative, linked with feelings
5. The persons damaged self esteem is restored
6. The persons important relationships are reestablished
7. The person has reconstructed a coherent system of meaning and belief that encompasses the story of the trauma
Recovery: Final Points

• Survivors cannot assess themselves fairly until they clearly understand that no action on their part absolves the rapist of responsibility for their crime.

• The survivor needs help from others to mourn losses

• The solidarity of a group provides the strongest protection against terror and despair
Open Discussion and Questions
References


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