

## Trauma and Adolescents<sup>1</sup>

---

Ashley Eckes and Heidi Liss Radunovich<sup>2</sup>

The mention of the word trauma can bring about thoughts of war, rape, kidnapping, abuse, or natural disaster. However, trauma can also come from common events, such as sudden injury or an automobile accident (Costello, Erkanli, Fairbank, & Angold, 2002). In the United States, it is estimated that 5 million children are exposed to traumatic events yearly (Ruzek et al., 2007). Seventy to ninety percent of people will be exposed to a traumatic event at some time in their lives. One study found that by the age of 11, 11% of youth have experienced a traumatic event. By the age of 18, 43% of youth have experienced such an event ("Identifying and addressing trauma in adolescents," 2007). This means that during adolescence, there is a dramatic increase in the exposure to trauma.

### What is trauma?

Regardless of the source, emotional or psychological trauma develops from being exposed to an incident in which there is a threat to survival and adaptation (Silove, Steel, & Psychol, 2006). Researchers usually separate traumas into two different types: event trauma and process trauma. An event trauma is a sudden, unexpected stressful event that is limited in its duration and location. A

hurricane or a fire, for instance, is an event trauma. Process trauma is defined as continued exposure to a long-lasting stressor, such as war or physical abuse (Shaw, 2000).

The National Institute of Mental Health describes trauma as a normal reaction to an extreme event (Substance Abuse and Mental Health Services Administration, 2007). It is important to remember that it is not necessarily the event itself that causes trauma, but a person's thoughts, feelings, beliefs, and experience surrounding that event (Boscarino, 1996).

### What happens when someone is exposed to a traumatic event?

It is often easy to know when another person is having a bad day or battling minor emotional distress. During these times, it may be easy to lend a helping hand or a listening ear to try to comfort this individual. When a disaster or traumatizing event takes place, there is nothing normal or routine about it. This type of event may affect many people, normal interactions may be strained, and daily routines are often disrupted (Boscarino, 1996).

- 
1. This document is FCS2280, one of a series of the Department of Family, Youth and Community Sciences, Florida Cooperative Extension Service, Institute of Food and Agricultural Sciences, University of Florida. First published October 2007. Please visit the EDIS Web Site at <http://edis.ifas.ufl.edu>.
  2. Ashley Eckes, graduate student, and Heidi Liss Radunovich, assistant professor, Department of Family, Youth and Community Sciences, University of Florida, Gainesville FL 32611.

The Institute of Food and Agricultural Sciences (IFAS) is an Equal Opportunity Institution authorized to provide research, educational information and other services only to individuals and institutions that function with non-discrimination with respect to race, creed, color, religion, age, disability, sex, sexual orientation, marital status, national origin, political opinions or affiliations. U.S. Department of Agriculture, Cooperative Extension Service, University of Florida, IFAS, Florida A. & M. University Cooperative Extension Program, and Boards of County Commissioners Cooperating. Larry Arrington, Dean

Typical reactions to traumatic experiences include fear and anxiety, sleep disturbances, physical complaints (such as headaches or stomach pain), antisocial behavior, depression and sadness, and fear of separation from loved ones (Boscarino, 1996). In families with children and teens, the impact of the event will depend on the extent to which it disrupts family functioning (Boscarino, 1996). Research has shown that response to traumatic stress is not purely emotional; there are also physiological and neurological components (Saltzman, Holden, & Holahan, 2005). One study on children's reactions to violence in their home showed that children who are exposed to violence had significantly higher heart rates than those who lived in nonviolent homes (Crane & Clements, 2005).

The impact of a traumatic event differs depending on the type of disaster or trauma, its suddenness, and its extent, as well as the person's social surroundings, his or her past experiences, and his or her culture (Silove et al., 2006). Children and teens may experience trauma in different ways depending on their stage of development. There is no way to predict how someone will react to a traumatic event because we are all so different.

## **Adolescents and trauma**

This article focuses on trauma during adolescence. We single out this stage of development because there are many active changes happening during this stage of life. Adolescents are especially vulnerable to the effects of trauma, and trauma can have a significant impact on their development.

First, adolescents are at high risk for experiencing traumatic events (Crane & Clements, 2005). In addition to the traumatic stressors encountered by adults, adolescents are also at risk of trauma related to bullying and embarrassment in school, violence in the home and community, experimentation with drugs, and other risky situations (Shaw, 2000). Adolescents are trying to define who they are. In the course of discovering their identities, some adolescents engage in risky behavior and power struggles with parents and experience wide-ranging emotions (Hales & Yudofsky, 2003). However, because of the behavioral issues that can occur during

adolescence, people may overlook the emotional needs of this population (Crane & Clements, 2005). It is very important for parents, teachers, community leaders, and first responders to be aware of the needs of adolescents in times of crisis, stress, and trauma.

Second, trauma experienced by adolescents is particularly important because significant physical and emotional growth is occurring at this age (Hales & Yudofsky, 2003). The stressors that an adolescent encounters will help to shape his or her growth and perspective, and can have long-lasting impacts (Crane & Clements, 2005). For example, adolescence is a time of increased brain development (Hales & Yudofsky, 2003). There is evidence that the stress associated with traumatic events can change major structural components of the central nervous system and the neuroendocrine system (Shaw, 2000). Severe traumatic stress affects the chemicals in the brain, and can change brain structures, leaving a lasting effect (Spear, 2000).

Furthermore, adolescence is also a time of social and emotional development. Struggling with the effects of a traumatic event during adolescence can lead to social isolation, declining school performance, behavioral problems, and other issues that can impact both current quality of life and future functioning.

It has also been found that those adolescents who have experienced trauma as a child are more likely to develop anxiety-related disorders and fears and are more likely to show a pattern of risky sexual behaviors ("Identifying and addressing trauma in adolescents," 2007). An increase in risk-taking behaviors is sometimes seen in adolescents following trauma (Norwood, Ursano, & Fullerton, 2000).

## **The special case of Post-Traumatic Stress Disorder**

Although not everyone who experiences a traumatic event develops Post-Traumatic Stress Disorder (PTSD), it is important to understand that there is a risk for developing this disorder after exposure to trauma. In order to get a diagnosis of PTSD, a person must be exposed to a traumatic event that involved a threat of serious injury or death and that caused the person to experience great fear and

helplessness (American Psychiatric Association, 2000). In addition to exposure to a traumatic event, the following symptoms must be experienced for more than 30 days and cause significant distress or impairment:

- Re-experiencing of the event.
- Avoidance of related events or scenarios.
- Increased physiological arousal (American Psychiatric Association, 2000).

It is thought that the two strongest predictors of PTSD are exposure to violence and the sudden or unexpected death of a loved one (American Psychiatric Association, 2000). Of these two, unexpected loss of a loved one is most associated with PTSD (American Psychiatric Association, 2000). It has also been found that human-caused traumas (such as terrorism or other violence) are more damaging to mental health than naturally occurring traumas (such as weather-related events or accidents) (Wiesaeth, 1995),

Exposure to trauma and the presence of PTSD affects memory and learning (Yasik, Saigh, Oberfield, & Halamandaris, 2007; Moradi, Doost, Taghavi, Yule, & Dalgleish, 1999). Because the brain continues to grow throughout adolescence and adulthood, it is important to consider the effects of PTSD on this developmental process. Adolescents who have experienced trauma or have PTSD are more likely to have problems in school and with processing information.

It has been found that many health care providers overlook PTSD in adolescents (Crane, & Clements, 2005). This may be due to the fact that some behavior that commonly occurs in adolescence (e.g., rebelliousness, withdrawal) can look very similar to symptoms of PTSD. Also, it may be hard to figure out whether a teen is suffering from PTSD or depression. PTSD is different from depression in that it is marked more by fear and agitation than moodiness and withdrawal ("Identifying and addressing trauma in adolescents," 2007). Even though there are subtle differences between depression and PTSD, an adolescent could suffer from both of these conditions at the same time. If you

are unsure about whether a child is experiencing a significant problem related to trauma, make sure to get assistance from a licensed mental health professional.

### **How to help adolescents cope with trauma**

The way an adolescent adapts to stressors has a lot to do with how well his or her family is functioning (Stern & Zevon, 1990). It has been found that when adolescents lack parental support, they are more likely to have behavioral problems and emotional distress (Garber & Little, 2001).

Boys and girls also experience and respond to trauma differently. Although males are more likely to be exposed to traumatic stressors, females are more likely to experience PTSD (Shaw, 2000; Crane, & Clements, 2005; Stuber, Resnick, & Galea, 2006).

To help adolescents overcome a traumatic event, action should be taken as soon as possible. In the wake of a disaster, teachers, parents, and/or mental health professionals should:

- Explore ways to protect the adolescent from further harm and further exposure. Create a safe place away from onlookers and media.
- Kindly but firmly direct children away from the site of violence or destruction, the severely injured, and any continuing danger.
- Provide support to adolescents who are showing signs of panic and intense grief, such as trembling, agitation, refusing to speak, loud crying, or rage. Stay with them until they are stabilized.
- Help the adolescent feel safe with supportive and compassionate verbal and nonverbal communication. These reassurances are very important.
- Provide information about the traumatic event in language that the adolescent can understand. This will help the adolescent to understand what happened and feel more in control (American Psychological Association, 1998).

It was once thought that providing debriefing right after a traumatic event could be helpful in recovery. One of the most popular types of debriefing, Critical Incident Stress Debriefing (CISD), was widely used after the attacks of September 11th (Villalba & Lewis, 2007). However, recent research suggests that this type of intervention may not only be ineffective, but can cause harm to certain individuals by disturbing the natural coping process (Roth & Fonagy, 2006). Therefore, it is suggested that this method of treatment be avoided.

If you know of an adolescent who has been exposed to a traumatic event, the first step is to identify whether there is a need for intervention. It is important to remember that everyone is different. Some people may be able to deal fairly well with the situation at hand, while others may take years to overcome the emotional pain. Sometimes individuals try to hide or mask the fact that they are hurting emotionally. Reassure adolescents that needing help does not mean that a person is weak, incompetent, or sick (American Psychological Association, 1998). A feeling that it is safe to express emotions can help prevent negative reactions, such as becoming frozen or overwhelmed (American Psychological Association, 1998). At the same time, some people cope best by using distraction and avoidance; forcing these people to talk could negatively impact their ability to heal naturally (Roth & Fonagy, 2006).

Those adolescents who respond to trauma by showing significant anxiety, depression, aggression, school difficulties or extreme withdrawal should receive an evaluation from a licensed mental health professional. Many people who experience trauma and/or PTSD show improvement in their symptoms after receiving individual counseling (Villalba & Lewis, 2007). Cognitive behavioral therapy entails discussion of thoughts and emotions, as well as re-experiencing some of the traumatic event. This form of therapy has been found to be particularly effective in treating adolescents with PTSD or exposure to trauma (Villalba & Lewis, 2007). There is some evidence that Eye Movement Desensitization and Reprocessing (EMDR) also helps in recovery from trauma ((Roth & Fonagy, 2006). Some people may also benefit from the use of medications, such as antidepressant or anti-anxiety medication. Currently

there is research being conducted on the use of propranolol in cases of trauma. Preliminary evidence suggests that this medication may be useful in trauma recovery (Vaiva et al., 2003).

## References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (text revision). Arlington, VA: American Psychiatric Association.
- American Psychological Association. (1998, April). *Just the facts: Managing traumatic stress*. Retrieved July 16, 2007, from <http://www.apa.org/practice/traumaticstress.html>
- Boscarino, J. A. (1996). Posttraumatic stress disorder, exposure to combat, and lower plasma cortisol among Vietnam Veterans: Findings and clinical implications. *Journal of Consulting and Clinical Psychology, 64*, 191-201.
- Costello, E. J., Erkanli, A., Fairbank, J. A., & Angold, A. (2002). The prevalence of potentially traumatic events in childhood and adolescence. *Journal of Traumatic Stress, 15*(2), 99-112.
- Crane, P. A., & Clements, P. T. (2005). Psychological responses to disaster: Focus on adolescents. *Journal of Psychosocial Nursing, 43*(8), 31-38.
- Garber, J., & Little, S. (2001). Emotional autonomy and adolescent adjustment. *Journal of Adolescent Research, 16*, 355-371.
- Hales, R. E., & Yudofsky, S. C. (2003). *The American Psychiatric Publishing textbook of clinical psychiatry* (4th ed.). Arlington, VA: American Psychiatric Publishing, Inc.
- Identifying and addressing trauma in adolescents: A conversation with David A. Wolfe. (2006, April). *The Brown University Child and Adolescent Behavior Letter, 22*(4), pp. 1, 4-6.
- Norwood, A. E., Ursano, R. J., & Fullerton, C. S. (2000). Disaster psychiatry: Principles and practice. *Psychiatric Quarterly, 71*(3), 207-226.

Moradi, A. R., Doost, H. N., Taghavi, M. R., Yule, W., & Dalgleish, T. (1999). Everyday memory deficits in children and adolescents with PTSD: Performance on the Rivermean Behavioural Memory Test. *Journal of the American Academy of Child and Adolescent Psychiatry, 33*, 939-944.

Roth, A., & Fonagy, P. (2006). *What works for whom?, Second edition: A critical review of psychotherapy research*. New York, NY: Guilford Press.

Ruzek, J. I., Brymer, M. J., Jacobs, A. K., Layne, C. M., Vernberg, E. M., & Watson, P. J. (2007). Psychological first aid. *Journal of Mental Health Counseling, 29*(1), 17-49.

Saltzman, K. M., Holden, G. W., & Holahan, C. J. (2005). The psychobiology of children exposed to marital violence. *Journal of Clinical Child and Adolescent Psychology, 34*(1), 129-139.

Shaw, J. (2000). Children, adolescents and trauma. *Psychiatric Quarterly, 71*(3), 227-243.

Silove, D., Steel, Z., & Psychol, M (2006). Understanding community psychological response after disasters: Implications for mental health services. *Journal of Postgraduate Medicine, 52*, 121-125.

Spear, L. (2000). Neurobehavioral changes in adolescence. *Psychological Science, 9*(4), 111-114.

Stern, M., & Zevon, M.A. (1990). Stress, coping, and family environment: The adolescent's response to naturally occurring stressors. *Journal of Adolescent Research, 5*(3), 290-305.

Stuber, J., Resnick, H., & Galea, S. (2006). Gender disparities in posttraumatic stress disorder after mass trauma. *Gender Medicine, 3*(1), 54-67.

Substance Abuse and Mental Health Services Administration. (2007). *Disaster relief and crisis counseling*. Retrieved August 6, 2007, from <http://mentalhealth.samhsa.gov/publications/allpubs/ADM86-1070/chapter2.asp>

Vaiva, G., Ducrocq, F., Jezequel, K., Averland, B., Lestavel, P., Brunet, A., & Marmar, C. (2003).

Immediate treatment with propranolol decreases posttraumatic stress disorder two months after trauma. *Biological Psychiatry, 54*(9), 947-949.

Villalba, J. A., & Lewis, L. D. (2007). Children, adolescents, and isolated traumatic events: Counseling considerations for couples and family counselors. *The Family Journal, 15*, 30-35.

Wiesaeth, L. (1995). Preventative psychosocial interventions after a disaster. In S. E. Hobfoll & M. W. deVries (Eds.), *Extreme stress and communities* (pp. 401-419). Boston: Kluwer Academic Publishers.

Yasik, A. E., Saigh, P. A., Oberfield, R. A., & Halamandaris, P. V. (2007). Posttraumatic stress disorder: Memory and learning performance in children and adolescents. *Journal of Biological Psychiatry, 61*, 382-388.