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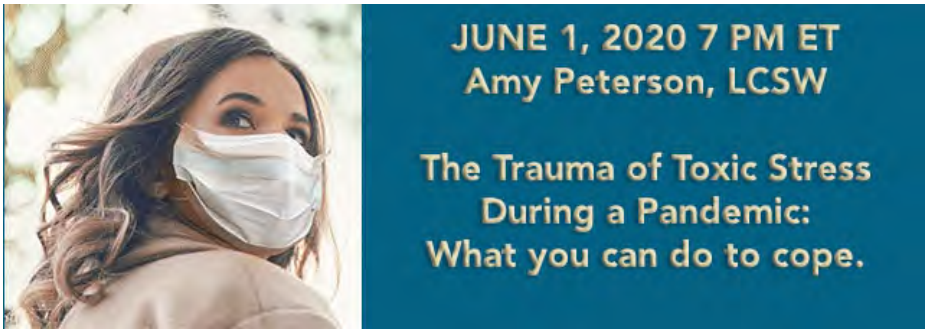


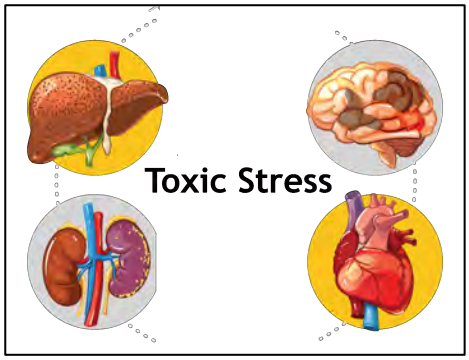
The Trauma of Toxic Stress

Part 1

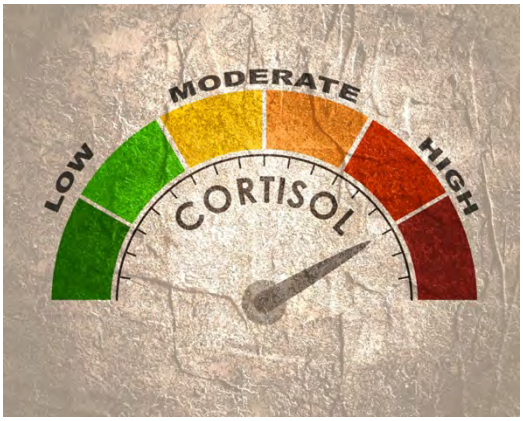
Trauma: A psychological, emotional response (with corresponding behaviors) to an event or experience that is deeply distressing or disturbing

Toxic

Stress: Mental, emotional strain or tension resulting from adverse or very demanding circumstances

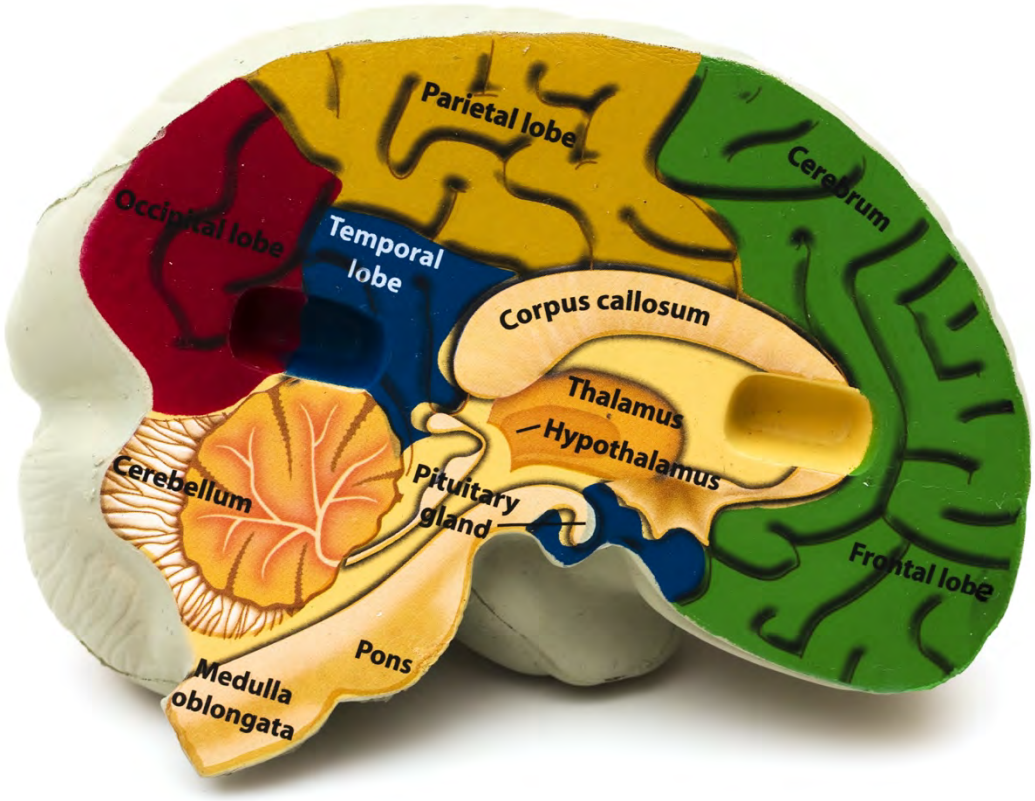


Toxic Stress has damaging effects on learning, behavior, and health (biological systems) across the lifespan.



Cortisol is a stress hormone and when a developing fetus is exposed to elevated amounts (released by the mother), the damaging effects include reduced growth and modified timing of tissue development. Cortisol is associated with an increased risk of miscarriage, preeclampsia, and premature birth. It has also been linked to adult mood disorders.

Part 2 : ACEs, the brain, and hormones

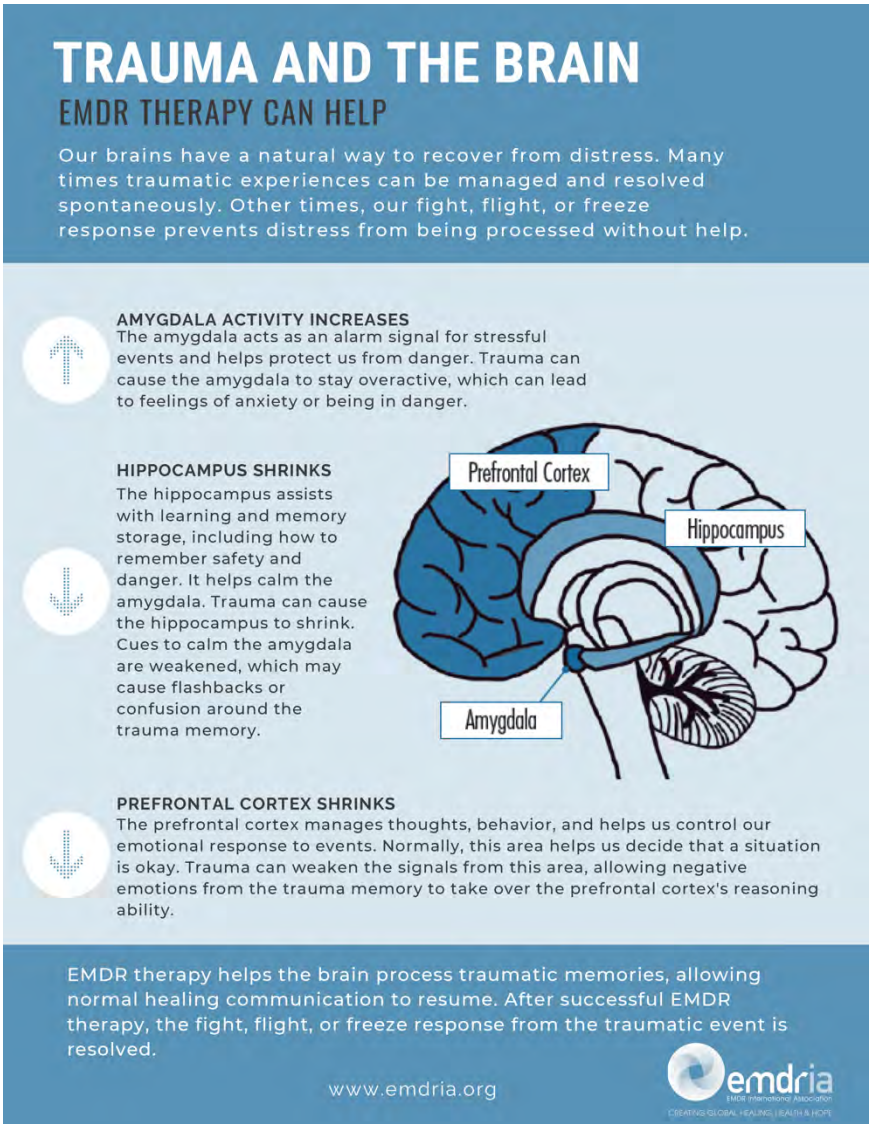


Part 3

What do we do about it?

Decrease stress, increase responsive relationships, and strengthen core life skills (what to teach our children): get and keep a job, provide responsive care for children, manage a household, contribute to the community.

Engage the relaxation response. Many forms or techniques, but these four components should be combined to illicit the relaxation response: a repetitive sound or phrase, a passive attitude of disregard to distraction, relaxed positioning, and a quiet environment.



Therapies (CBT, **EMDR (left)** neurofeedback, hypnotherapy…), guided imagery, yoga, walking, body scans, progressive relaxation, meditation, self-expression, being with others.

Parting Words

"The more healthy relationships a child has, the more likely he will be to recover from trauma and thrive. Relationships are the agents of change and the most powerful therapy is human love."

Recommended:

Bruce D. Perry, The Boy Who Was Raised as a Dog: And Other Stories from a Child Psychiatrist's Notebook (Link)

Article on developmental trauma for educators: **A trauma-informed approach to teaching.**

"Healing takes place within the context of relationships." -- Amy Peterson, LCSW

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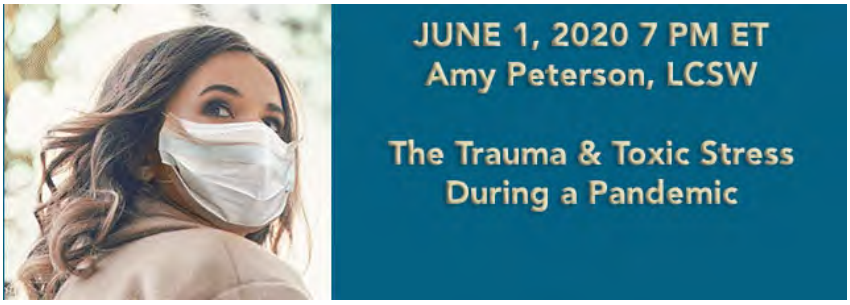

What's Your ACE Score? (and, at the end, What's Your Resilience Score?)

There are 10 types of childhood trauma measured in the ACE Study. Five are personal:

- physical abuse,
- verbal abuse,
- sexual abuse,
- physical neglect, and
- emotional neglect.

Five are related to other family members:

- a parent who's an alcoholic,
- a mother who's a victim of domestic violence,
- a family member in jail,
- a family member diagnosed with a mental illness, and
- the disappearance of a parent through divorce, death or abandonment.

Each type of trauma counts as one. So, a person who's been physically abused, with one alcoholic parent, and a mother who was beaten up has an ACE score of three.

There are, of course, many other types of childhood trauma:

- racism,
- bullying,
- watching a sibling being abused,
- losing a caregiver (grandmother, mother, grandfather, etc.),

- homelessness,
- witnessing a father being abused by a mother,
- surviving and recovering from a severe accident,
- witnessing a grandmother abusing a father,
- involvement with the foster care system,
- involvement with the juvenile justice system, etc.

The ACE Study included only those 10 childhood traumas because those were mentioned as most common by a group of about 300 Kaiser members; those traumas were also well studied individually in the research literature.

The most important thing to remember is that the ACE score is meant as a guideline: If you experienced other types of toxic stress over months or years, then those would likely increase your risk of health consequences.

ACEs Questionnaire

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   No___If Yes, enter 1 __

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   No___If Yes, enter 1 __

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
   No___If Yes, enter 1 __

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

No___If Yes, enter 1 __

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   No___If Yes, enter 1 __

6. Were your parents ever separated or divorced?
   No___If Yes, enter 1 __

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   No___If Yes, enter 1 __
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   No___If Yes, enter 1 __

9. Was a household member depressed or mentally ill, or did a household member attempt suicide? No___If Yes, enter 1 __

10. Did a household member go to prison?
    No___If Yes, enter 1 __

Now add up your "Yes" answers: _ This is your ACE Score

Harvard FAQ on ACEs: Harvard University ACEs information.
ACEs Too High is a good reference as well: https://acestoohigh.com

ACESTooHigh is a news site that reports on research about adverse childhood experiences, including developments in epidemiology, neurobiology, and the biomedical and epigenetic consequences of toxic stress.

They also cover how people, organizations, agencies and communities are implementing practices based on the research. This includes developments in education, juvenile justice, criminal justice, public health, medicine, mental health, social services, and cities, counties and states.

Jane Ellen Stevens is the editor of ACESTooHigh, and founder and publisher of ACEs Connection, which comprises ACEsTooHigh.com and its companion social network, ACEsConnection.com. ACEs Connection receives funding from the Robert Wood Johnson Foundation, The California Endowment, the Lisa & John Pritzker Family Fund, the George Sarlo Foundation, and Genentech. We are very grateful for this support.

Developmental Trauma and a Trauma-informed Approach to Education

by Nancy Hemenway

The concept of developmental trauma as a disorder was birthed by researchers and clinicians from around the world, with the effort led by Bessel van der Kolk and a passionate group of researchers, more than two decades ago. (Kolk, 2007) The effect and influence of the consequences of physical, psychological and societal abuse in reality cannot be separate from the physical aspects of a child's growing and a developing brain. There are long-term consequences over a lifetime. (The Children's Bureau, 2011) The staggering costs, in the hundreds of billons of dollars, make child maltreatment and abuse a major health crisis rivaling other major health crisis. (Centers for Disease Control, 2014) There are a number of studies globally that confirm disabled children are more likely to be victims of abuse than those who are not disabled. (L.Jones, 2012) Motivated teachers should not only understand the long-term toll abuse takes on children and their families but also how to both recognize and manage those who have been victimized to determine how best to educate them. These children sit in front of educators, counselors and other school staff on a daily basis. Educators are on the front lines.

The Characteristics of Developmental Trauma Disorder

According to the American Psychological Association, current diagnoses for children with complex traumas such as abuse, neglect, the death of a loved one, or medical trauma receive a variety of insufficient labels. Some of the labels are: Pervasive Developmental Disorder (PDD), Oppositional Defiant Disorder (ODD), Reactive Attachment Disorder (RAD), Affective Disorders, Anxiety Disorders including Post Traumatic Stress Disorder, and Borderline Personality Disorder. These labels do not adequately provide for their needs. A working group of child experts has recommended Developmental Trauma Disorder (DTD) as a label that would more adequately address the symptoms associated with complex trauma and the problems

of self-regulation dysfunction that come with child trauma. (American Psychological Association, 2007)

Repeated traumatic events experienced by children produce bio-physiological changes observed through exhibited behaviors. The chronic abusive, neglectful maltreatment of children that were found to be so ubiquitous through the ACEs study has a pervasive effect on brain development. Chronic trauma interferes with behaviors and the operation of involuntary neurobiological functions. Although victims of child abuse make up almost the entire criminal justice population in the United States,the routinely traumatized children remain ignored. (Kolk, Developmental Trauma Disorder, 2005)

Children learn to feel secure by having their needs met by their caregivers repeatedly throughout their day and every day. When caregivers are chaotic, abusive, neglectful; when children suffer repeated painful medical interventions; when violence is witnessed at home; a child's developing brain suffers. As a consequence, the brain learns the expectation of a continued lack of stability, abuse or neglect and continued pain. The child becomes helpless in the control of his safety, and he expects the abuse to continue. (Kolk, Developmental Trauma Disorder, 2005) Unfortunately for the educator, that child's expectation of continued abuse is carried into the school environment. Even in the absence of abuse in the school environment, the child's involuntary response to the "perceived" threat is real, and his brain will react involuntarily with a fight/flight/freeze response when triggered. Teachers need to learn to recognize some behaviors as involuntary, in contrast with willful behaviors. They need to figure out the function or cause of behaviors in order make the kind of changes necessary to teach a traumatized child.

Fight/Flight/Freeze.

The fight, flight, freeze response is an alarm reaction to perceived danger. We all need this reaction to keep us out of the pathway of a speeding car or to alert us to danger so we can react quickly, often without thinking, to protect ourselves. Once there is a threat (real or perceived) our bodies are hyperaroused and a series of physiological changes begin. The Central Nervous System begins the process of releasing hormones

such as cortisol and adrenaline. Central and peripheral nervous system activity responsible for processing threat information becomes involved. The reaction is an automatic survival response, directly correlated with the behavior of the child. (The ChildTrauma Academy, 2002)

Hyperaroused children become hyper-vigilant children. Hyper-vigilance becomes the baseline for children who are chronically hyperaroused, so even without active triggers, their hyper-vigilant or hyperaroused starting point involves a constantly heightened state of high arousal. The result is that it takes little to nothing to set them off into freeze/fight/flight.

This state of arousal will cause the child to react quickly (a trigger). It is important to note that the teacher or another observer without a child's history or experience working with traumatized children, may not see anything out of the ordinary. The circumstances may look normal or even calm to the observer. The traumatized child will react to a trigger whether or not observed. As with any child, the importance of understanding the function of any behavior cannot be underestimated. For a child with a trauma history, keen observation to figure out their triggers and function of their behaviors is of paramount importance to ensure successful learning and access to the curriculum. When the child believes there is a danger (a trigger that may be missed completely or even seen as trivial by a teacher and others) he may react with aggression (Fight). The further along he is on the hyperarousal brain continuum, the more aggressive the behavior one might observe. Educators need to examine carefully and understand that behaviors caused by trauma triggers are not willful or voluntary but part of the physiological continuum beginning with the brain's interpretation of the perceived threat. The chronically hyperaroused brain shifts from processing in the pre-frontal cortex where executive functioning takes place to the limbic system or the emotional seat of the brain. The brains of these students cannot filter out the overwhelming bombardment of all kinds of sensory, environmental and extraneous information. The result is the brain's self-preservation response. Cognition, thinking and all of the child's behaving, feeling and reactions will come from the most primitive parts of the brain. Sometimes this primitive brain is referred to as the "reptile brain".

The primitive brain is the part of the brain dedicated the act of survival. (The ChildTrauma Academy, 2002)

Young children are virtually helpless as they are not in control of their environments. Children are small with limited physical strength. Instead of fighting or fleeing, they may freeze when there is a perceived threat. As a result of a lack of safety and control from the child's perspective, they may shut down. The teacher might observe introverted behavior. The introversion could be dissociative behavior. Children who are in a state of dissociation may experience time distortions, detachment, extremes in daydreaming or retreat into an elaborate fantasy world. These children may feel like they are out of their bodies watching their life like a movie. Trauma triggers can induce the child into a dissociative state. This retreat or dissociative behavior may be a coping mechanism or way to self-regulate. A key point to consider and remember is even the same traumatic event for a child can produce a different response depending on his stage of growth and development. The reactions can differ depending on the chronological and the developmental period or stage when the trauma took place. For example, the child may have sustained abuse and neglect in the pre-verbal stage of growth and development which brings with it more complexities. (The ChildTrauma Academy, 2002)

Developmental Trauma Diagnosis.

Surprisingly, posttraumatic stress disorder (PTSD) is not the most common diagnosis for children who have experienced significant trauma. The more common diagnoses are: Separation anxiety, oppositional defiant disorder (ODD), phobic disorders, and attention deficit hyperactivity disorder (ADHD). There are also numerous descriptive references to these children as aggressive, lacking impulse control, attentional and dissociative issues as well as difficulty with relationships. Studies of child trauma suggest global and damaging effects occur during the first ten years of childhood. The diagnosis of PTSD is not developmentally sensitive, and a poor diagnosis for a child because it is not adequate to describe the serious significance of what complex trauma does to a child's neurophysiological development. Teachers should be acutely aware that trauma causes pervasive delays across a wide spectrum of areas including cognition, language and speech delays, and socialization problems. The impact of

trauma is pervasive yet the diagnostic criteria do not reflect this. Instead, there is a plethora of comorbid overlapping conditions ascribed to the child, none of which address the issue or provide for the kind of effective intervention needed in the classroom or elsewhere. (Kolk, Developmental Trauma Disorder, 2005)

A Trauma-informed Approach to Teaching.

Although the educational philosophy of our time is that of non-coercion, practically speaking schools tend toward institutional cultures and practices that are punitive. The current escape routes through dropout rates and the school-to-prison pipeline are byproducts of a historical coercive educational system. Coercion by definition uses punishment or the threat of punishment to get a child to act the way we want. The practice of reward for children who escape punishments is coercion. Those children who need our educational system the most are denied access because of a coercive system. This idea of a coercive educational system is not about responsibility or blame, but instead to put educators on high-alert to be aware that escape (by the child) is the inevitable consequence of coercion. Teachers need to learn the practice of using positive supports and non-coercive techniques. (Sidman, 2000) School personnel and staff need to learn to make learning trauma-sensitive. To teach with trauma-sensitive and trauma-informed techniques means that the entire school and administrative supports have to be of one mind with the shift from coercive toward a flexible framework and action plan.

Some elements of teaching success interwoven into a flexible curricular framework include: strategic planning with all stakeholders, assessment of the needs of the staff, training, confidential reviews of specific cases, training and review of the understanding of trauma, community partnering and liaisons, and progressive and continual evaluation of the process.

Training for teachers should emphasize the importance of their role in the classroom with the traumatized child and the difference of that role as compared with that of a mental health professional. Many teachers will already have the skills necessary to become trauma informed but need to put them into a context of a school-wide supported flexible framework. With continual training and collaboration, teachers can

build their competencies and create a safe space for children within their classrooms. Teachers can help children regulate emotions, so they are free of coercion and able to master social and academic skills. To be trauma informed is to understand that the school will have to develop a peaceful school community. The school trauma-sensitive community is: structured, predictable and safe (from the perspective of the traumatized child). It is most important and key to successful management in the classroom for a child with significant trauma, that the teacher understand the connection between behavior and the child's trauma history. Children often do not understand how to express their feelings. Lacking words to communicate their pain, anxiety and fear may come out as aggression, fighting, fleeing or freezing (think of the introverted or warehoused child in the corner). Teachers should focus on the cause or function of the behavior, not the behavior itself. (Massachusetts Advocates for Children: Trauma and Learning Policy Initiative in collaboration with Harvard Law School, 2005)

For a teacher to become trauma-informed, she must develop a climate of care. The process of educating one's self to provide a trauma-sensitive learning environment is a huge commitment because it means a great shift in school culture. The payoff is tremendous and rewarding. The children will develop social awareness with an emotional and physical support system in place. A trauma-informed approach is developmentally appropriate but also an educationally rich and safe environment for children. All children benefit from this shift, not just traumatized children. The use of positive behavioral supports (PBS) at the worst possible moment when a child has lost all coping skills is critical for a trauma-sensitive approach. PBS are particularly important and useful for the child who experienced pre-verbal trauma – a child who was traumatized significantly before acquiring language. (Craig, 2008)

School staff or other people who come in contact with the traumatized child should be thoroughly trained. An Individualized Education Plan (IEP) is useful if and only if the plan is specific for the child. To write an IEP for a traumatized child is not easy. The present level of performance (PLOP) must include data that are coordinated to drive a trauma-informed IEP. This effort means careful coordination with parents, individual private providers and all involved school staff as well as the local educational agency

representative (usually the principal or a designee) and other community services. The IEP team should include members and other professionals who are experienced and knowledgeable in the research specific to working with children who have trauma histories. If they do not have the experience, the team should request and undergo some training so they might become trauma-informed. Training and other specific elements of need specific to the child receiving trauma informed services must be provided by an trauma informed and experienced team approach. The appropriate is delivered by thoroughly trained and experienced teachers, administrators, parents, and community agencies. Important to note is that trauma-informed training is extensive, takes time and should include ongoing training, case studies and both offsite and onsite supervision by skilled and experienced professionals in the trauma field.

Trauma issues impact lifespan for children and families.

Ask any educator how common stress is among colleagues. As living, breathing human beings, we all experience a certain amount of healthy stress. Stress is necessary and normal to keep ourselves safe from potentially dangerous situations. Stress keeps us "on our toes". However, concentrated and sustained stress can lead to health problems. For young infants and children, it can change the brain development. Stress and the neurobiological changes induced by this kind of intensive stress can lead to drug abuse, alcoholism, depression, eating disorders, heart disease, immune system dysfunction, cancer and other chronic diseases. (National Center for Injury Prevention and Control, 2008)

Positive stress, where adverse reactions from a child are short-lived due to nurturing adults, is short-term. One example of this stress is separation anxiety. A new student brought to school and placed in a foreign environment may be upset or cry. Give him support and the anxiety passes. When this happens, teachers often recognize this for what it is. However, what about the child who has a trauma history? Maybe there is an internationally adopted child in the class; a child who has spent the first couple of years in an abusive orphanage. Maybe the child has only been in the US for a while. The fear she exhibits may look just like separation anxiety but in reality this child may be in fear for her life. Her brain, triggered, is programmed to expect further abuse.

She may shut down completely or may act out with aggression. Shutting down is not positive stress. Instead, it is stress that rises to the level seen in a child with developmental trauma disorder. These two situations may look similar, but **must** be handled differently. Where the first child may need reassurance and then be off to play, the second might need her mother present or have her day shortened. To ignore the elements present in a child with developmental trauma disorder is to fuel the trauma flames eventually escalating detrimental behaviors. This kind of stress is toxic.

Important to remember is internalized toxic stress disrupts behaviors and the normal state of a child's being. This kind of stress leads to a variety of automatic physiological changes that are outside of the control of the child. Children cannot manage this kind of stress without the support and trauma-informed intervention of adults. Over extended periods of time, this leads to damage and permanent changes in the child's brain. (National Center for Injury Prevention and Control, 2008) By nature and for safety reasons, for thousands of years families and multicultural generations of people have lived together in social groups. Our brains have developed key neural networks that are at the core of the way we socialize. Children without the support of social groups and positive interactions do not thrive and develop, in the same way as those who have those supports develop. Socially dysregulated children are not as likely to heal from the effects of trauma without significant attention and change to provide positive relational interactions that will regulate the neurophysiological stress response. For a child who has developmental and complex trauma, one can boil down their situations to be either "safe" or "dangerous" (from the child's perspective). Children raised as dehumanized, degraded, encouraged to believe they are bad, and to internalize shame and to feel guilty, develop these traits as the "familiar" and normal. Childhood for many is violent, unpredictable, chaotic, and development is adversely affected by this experience. (Christine R. Ludy-Dobson, 2010)

The most important first relationship for any child is with that of the mother. Attachment begins pre-conception. Secure attachment brings with it consistent, supportive and responsive relationship between mother and child. Insecure attachment brings the opposite. Healthy attachment with a primary caregiver – even a

caregiver not related – is a predictor of healthy relationships and good self-regulation. This healthy state is only present through the development of object permanence and consistent and repeated appropriate responses from caregivers. An absence of nurturing early on (the first three years of life) can lead to dysfunction of neural systems that facilitate and reconcile social and emotional functions. As children develop, and trauma sensitivity is missed or ignored, it is not surprising they develop maladaptive behaviors and mental health problems. Problems may look different at different stages of development. Students can look compliant and meek during elementary grades but during adolescence fears and behaviors often escalate. Teens can go into a depression (introvert) or become aggressive. These issues are characteristics of developmental trauma occurring in the early years of life. Developmental and complex trauma can lead to a lifespan of neurophysiological problems. The problems start in childhood but transfer into adulthood and to the children of these children. (Christine R. Ludy-Dobson, 2010)

Developmental Trauma Disorder: similarities and differences in other disorders

We all have a different and discerning lens to categorize and compartmentalize. The biggest pitfall to understanding why DTD is misdiagnosed or not recognized, lies in either the inability or refusal to look at the data, for example in the ACEs study. There is agreement among trauma-treating experts that often complex or developmental trauma is missed or overlooked. Another problem concerns the large number of adults who experienced trauma and who remain in denial about its effect on them. Traumatic memories may be triggered in traumatized adults when caring for traumatized children. Caring for abused, neglected or otherwise traumatized allows deep wounds to surface.

The symptoms of Posttraumatic Stress Disorder (PTSD) are similar to DTD. The PTSD diagnosis is not adequate for children with abuse and neglectful histories. In fact, a child grown to adulthood who has an extensive abuse and neglect history and who also has the classic symptoms such as ongoing struggles such as nightmares, hyperarousal, hypo-arousal, and intrusive thoughts, could be clinically excluded from a PTSD diagnosis. Children who have extensive abusive and neglectful histories can overlap into a series of different mental health diagnoses (i.e. depression, anxiety

disorder, panic disorder) but still not have a PTSD diagnosis. There is a huge need for more diagnostic flexibility, particularly for the diagnosis of children. There is also a clear need for correlating histories as well as genetic data when diagnosing any disorder. An accurate diagnosis is critical in developing a treatment plan. A good treatment plan is critical in developing the right educational path.

Chronic, complex trauma (DTD) includes (universally) pervasive body dysregulation. It also includes loss of cognition, explosive or introverted behaviors or a variety of each at different times. Children subjected to chronic trauma often carry no diagnosis, an inaccurate diagnosis or overlapping diagnoses. Teachers need to be aware and understand that some children that sit before them are affected but may not have an accurate diagnosis. There are overlapping similarities to PTSD, depression, ADHD, oppositional defiant disorder (ODD), reactive attachment disorder (RAD), separation anxiety disorder, bipolar disorder, dissociative disorders, and personality disorders. DTD is, however, distinct from other disorders but does coexist with them. (Polzin, 2014)

Abuse is not under-reported, but professionals underestimate a complex or developmental trauma diagnosis in children as a result of that abuse. Teachers should be keenly aware that a child with a trauma history may be shut down and introverted but recognized as a day-dreamer instead of dissociation. A child's aggressive behaviors may look like willful behaviors when in reality they are a response to a trauma trigger.

Sometimes a misunderstood lack of focus or attention, disorganized behavior, and hyperactivity is seen by teachers as an attention diagnosis. The hyperactivity instead may indicate the hyperactivity due to hyperarousal. Use of PBS and discernment of the function of the behaviors in consultation with trauma experts will help educators figure out the best way to help a traumatized child learn.

Summary

Educators need to be keenly aware of their very important role in working with, teaching and helping traumatized children learn. The numbers of children subjected to

abuse, neglect, sudden accident or medical trauma are pervasive. The cost of child abuse and neglect is well over one hundred billion dollars a year. The abuse or neglect report to state and local agencies is close to six referrals every minute. (Centers for Disease Control, 2014) Schools and the community need to shift from coercive and punitive methods in working with children in schools to developing positive support for traumatized children and their families . Many of these children will suffer from complex trauma and DTD.

One key factor to remember is how trauma affects the young developing brain. Children with DTD will not have control of their behaviors. The response to a trauma trigger may be introversion or aggression and is automatic (Fight/Flight/Freeze). DTD is a spectrum disorder. Children on the trauma spectrum need support using trauma sensitivity. Schools need to change to a trauma-informed model. As teachers, these children sit before us daily. Teachers are on the frontline. Educators, administrators and others within the system can make a huge difference in the lives of these children and their families. Statistics can change if professionals work together to become trauma-informed.

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