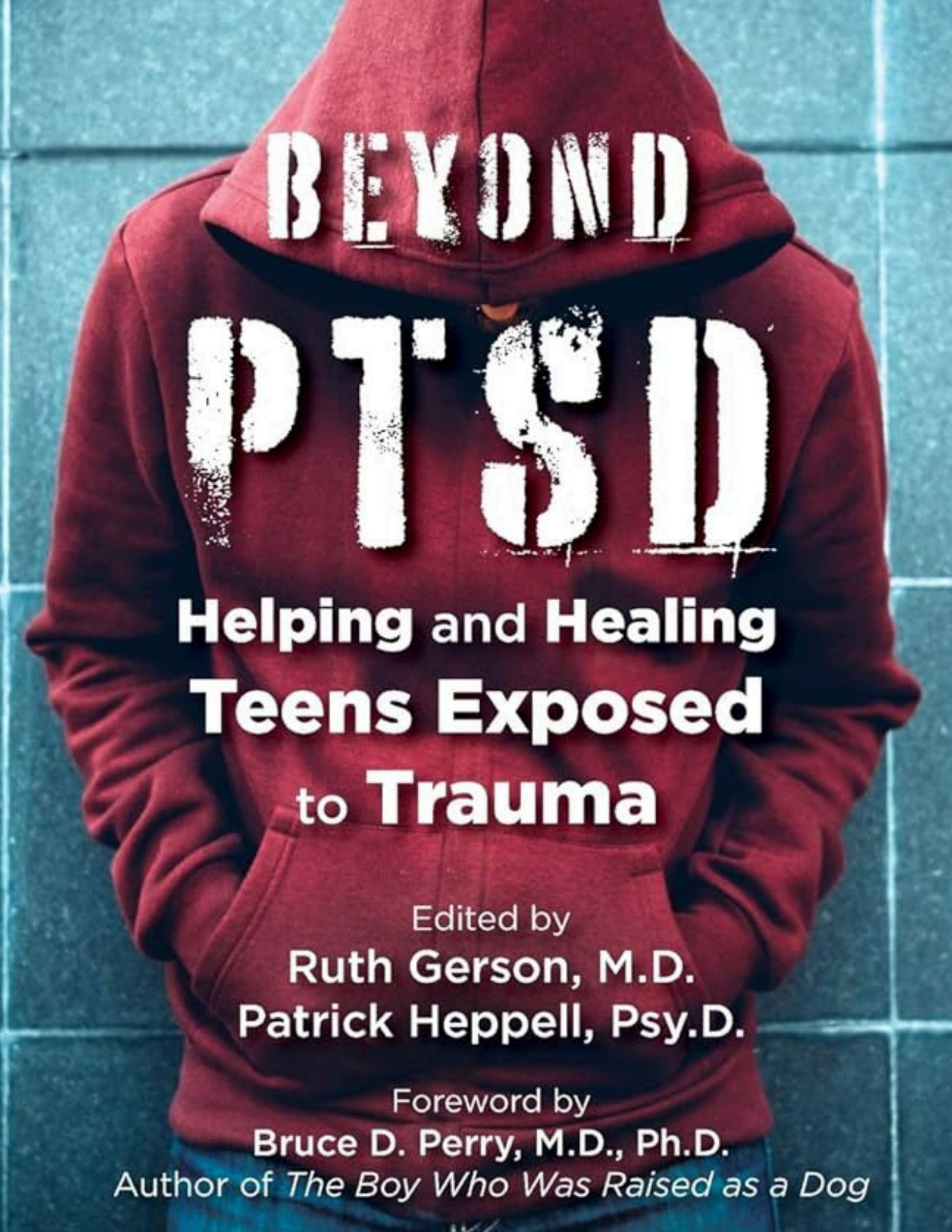
BEYOND
PTSD
Helping and Healing
Teens Exposed
to Trauma
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Contents

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CHAPTER 5

Risky Behavior and Substance Use

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Ana, age 18, and Alex, age 19, arrive at a drop-in center for homeless youth, both looking distressed. Alex, appearing worn out, carries a tattered backpack and reusable grocery bags stuffed with clothes. Ana also looks exhausted with dark circles under her eyes, but seems somewhat more alert and put together than Alex. She carries a large purse with a child's doll and a pack of cigarettes sticking out of it. The communication between them is brief and tense. Ana pushes Alex through a check-in area where personal items are inspected, and both are "wanded" for weapons. Alex is overheard telling Ana, "Nobody better take my shit here." Ana replies, "You need to relax. You're basically out of options and you're lucky I agreed to come here with you."

Alex completes a medical screen, during which the on-site nurse practitioner notices multiple scratch marks on his arms and treats them with disinfectant cream. Alex then meets with Nancy, a case manager, for intake. Alex is short in his responses but admits that he regularly uses drugs and alcohol, frequently has unprotected sex with multiple partners, and has been arrested several times for shoplifting, assault, and selling drugs. Alex tells Nancy that he and Ana have a 2-year-old daughter, Emily, together but that they aren't technically "together" as a couple right now because they "fight too much."

While Alex completes the intake, Ana is overheard on her phone arranging child care for Emily. "I'm trying to help Alex get his shit together. Yes, I know, he doesn't deserve anyone's help, but what am I going to do?" she exclaims to the person on the other end of the call. A staff member notices Ana looking more upset as the call goes on. She comes over to help and no-

tices rows of faint cuts and several bruises on Ana's forearm, and the unmistakable smell of alcohol. Before the staff member can say anything, Ana abruptly hangs up the phone, pulls car keys out of her purse, and announces that she has to get her daughter and can't wait for Alex. The staff member runs after Ana to ask if she is okay and to offer her services, as well. Ana responds, "I'm all good. He's the screwup, not me," and rushes out.

Risk taking is normal in adolescence. Exploration and experimentation are central to adolescents' growth and psychological maturation. These experiences foster teens' identity development and help teens gain a better sense of who they are, what they like, what they're capable of, and how to handle tough decisions. As teens gain independence, taking on new challenges and taking risks helps them understand the world and their own identities. Most risk taking is benign; asking someone on a date, trying a new sport, driving for the first time, and applying for a new job or for college all involve taking risks. But if this developmentally normative risk taking goes too far, it can be dangerous and lead to serious, negative health outcomes, including accidents, illness, and even death,[1] and traumatized teens are particularly at risk. Unfortunately, teens who have experienced trauma or abuse are particularly vulnerable to engaging in more dangerous risky behaviors.

Adolescent experimentation exists on a spectrum of risk. Teens may not realize when their behavior has moved past typical risk taking to something more concerning (Table 5–1). Many factors contribute to whether a teen's risk taking will become dangerous. Trauma is one of those factors, enough so that the DSM-5[2] lists risky and self-destructive behavior as a core symptom of posttraumatic stress disorder (PTSD). Generally, risk behaviors most often seen in adolescence include substance use, unsafe sexual practices, violence among peers or in romantic relationships, dangerous driving and car accidents, self-harm, and running away/homelessness, among others.

Alcohol is the most often used and abused substance among youth in the United States. According to the 2015 National Survey on Drug Use and Health (NSDUH), 20% of youth ages 12–20 years reported drinking alcohol and 13% reported binge drinking in the past 30 days.[1] Binge drinking can have academic (increased truancy, poor grades), social (intimate partner violence, social isolation), and legal (DUI arrest, accidents, physical assault) consequences and can disrupt brain development.

Alcohol use goes hand in hand with unsafe sexual practices. In a 2015 survey of U.S. high school students, 30% reported having had sexual intercourse in the past 3 months, and of these, 43% did not use a condom the last time they had sex, 14% did not use any method to prevent pregnancy, and 21% had sex while drunk or high.[1] The combination of substance use and

TABLE 5–1. Adolescent behaviors: risky or not?

Typical	Not typical/Risky
Increased sexual maturation; heightened focus on body image and self-consciousness	Sexual promiscuity; bingeing, purging, or restricting eating; social withdrawal
Sexual experimentation	Multiple partners; unsafe sexual practices; pregnancy
Increased parent-adolescent conflict	Verbal or physical aggression; running away
Experimentation with drugs, alcohol, and cigarettes	Substance abuse; selling drugs; having heavily substance-using peer group
Increased sensation seeking and risk taking	Multiple accidents; encounters with firearms; excessive risk taking
Stressful transitions to middle and high school	Lack of connection to school or peers; school truancy, failure, or dropout
Increased argumentativeness, idealism, and criticism	Excessive defiance of social rules and conventions; causing trouble with family members, teachers, or other authority figures
Becoming overwhelmed with everyday decisions	Becoming paralyzed with indecision

Source. Adapted from Miller et al. 2007.[3]

risky sexual behavior increases the likelihood of unplanned pregnancies, sexually transmitted infections, sexual assault, and/or teen dating violence.

Intimate partner violence (also called *dating violence* or *domestic violence*) occurs among teens surprisingly often. Defined as psychological, emotional, physical, or sexual violence (including stalking) within a dating relationship, intimate partner violence can occur in person or electronically between current or former dating partners.[4] In the 2013 and 2015 surveys, 10% of high school students reported physical victimization and 10% reported sexual victimization from a dating partner each year.[5,6,7] Teen girls are equally as likely as teen boys to be violent toward a partner.

> Alex tells Nancy, the case manager, that he and Ana met 3 years ago when they were both in high school. They went to the same school, but they were very different. Ana was quiet and studious, whereas Alex was loud and rowdy; he knew everyone and was always talking to girls. He frequently got in trouble for skipping school and talking back to teachers. Despite their differences, Alex

found Ana intriguing. He noticed that Ana looked sad a lot and he wondered why. One day, Ana stopped coming to school. Months later, they ran into each other at a party. Ana looked different. She was dressed provocatively and was smoking a joint, which surprised Alex since she had always seemed so innocent and introverted. He asked for a hit and they talked for a while. They started dating, and a year later Ana discovered she was pregnant.

As mentioned, experiencing trauma is a significant risk factor for a teen's involvement in risky behaviors. The more trauma a teen has experienced, the greater the risk. Experiencing different types of traumatic events also significantly increases the odds of high-risk behaviors.[8] To complicate matters further, risk taking may further put youth into dangerous situations that may expose them to even more trauma.

Working with high-risk youth can be intimidating or scary. Watching teens we care about put themselves at risk is painful. But understanding that trauma is often underlying and driving these behaviors lets us approach teens with more compassion, empathy, patience, and a better understanding of how to help them.

Ana thinks about Alex as she drives to pick up Emily. She regrets drinking so much last night, but she was so upset after her fight with Alex. She loves him and knows he tries his best to be a good dad to Emily, to be a different man than his own dad was to him. But Ana is so tired of how much they fight and how easily he gets "set off." She understands that he has had a rough life and has been through a lot, just like she has. Sometimes this helps them to "get" each other, and other times they trigger each other. She feels stuck: she wants Emily to have a father in her life but doesn't want Emily to see the kind of fighting that she and Alex both saw growing up. She has been thinking of checking out a program for young mothers that her friend Jessica attends. Jessica's baby's father is not in the picture; she broke up with him after he became too violent. When Jessica first suggested Ana come to the program, Ana flipped out. "You have no idea what you're talking about—Alex and I are nothing like you and your baby daddy! I don't need to talk to some therapist." Deep down, however, she knows that they are similar and that she does need help.

Asking Why: How Trauma Can Lead to Risky Behaviors in Teens

Adolescents engage in risky behaviors in part because their prefrontal cortex—the rational-thinking, problem-solving part of the brain responsible for steering teens away from dangerous behaviors—is not yet fully developed. Adding the toxic effects of traumatic stress puts trauma-exposed teens at especially high risk for engaging in risky behaviors.

The Teenage Brain Is Susceptible to Risky Behaviors

Brain development occurs in a hierarchical fashion. The most basic area (i.e., the brain stem, which is responsible for breathing, heart rate) develops in utero. Next to develop in early childhood are the areas responsible for getting physical and emotional needs met, such as the limbic system. The most complex areas develop last, including the prefrontal cortex, which is responsible for executive functions such as decision making, judgment, abstract reasoning, and impulse control. The prefrontal cortex starts to "come online" around age 12 and only reaches full maturity in the mid-20s to early 30s.[9,10,11] The following is very important to remember when working with adolescents: *The prefrontal cortex—the part of the brain responsible for making safe, reasonable decisions; for learning facts about safe sex or the dangers of drunk driving, and then applying this knowledge when deciding whether to use a condom or drink and drive; and for using logic to think through what is "right or wrong"—is not fully developed in adolescence, and won't be for at least a decade.* Meanwhile, the impulsive, emotional parts of the brain developed much earlier, so they are strong and quick to respond. Teens might be able to problem solve or show sophisticated reasoning when things are calm, when the weaker, slower, less-developed prefrontal cortex doesn't have any competition. But when emotions are high and the impulsive brain areas kick in, the rational brain often gets overruled.[9,12]

> Remember that teens can look and even act like "mini adults." This sometimes tricks adults working with teens into thinking that what's going on outside matches what's going on inside. However, although the adolescent body is rapidly changing, teens' emotional awareness and cognitive abilities are still relatively immature. Skills such as foresight and judgment are just starting to develop.
>
> Be mindful of falling into the "you should have known better!" trap when working with teens, even if they sometimes talk or act like they do know better. Remind yourself: teens were children not long ago and are very much still learning.

The toxic effects of traumatic stress make it even harder for the teenage brain to consistently make safe choices. Instead of moving through devel-

opmental milestones as expected, the brains of trauma-exposed youth remain in "survival mode," prioritizing networks and pathways needed for survival rather than those needed to learn language, math, manners, and so forth.[13] Chronic exposure to traumatic experiences puts brains into a constant state of fight, flight, or freeze. Whether teens seem to fight, flee, or freeze more often depends on the nature of the trauma they experienced and when the trauma occurred.[14] Girls, teens who experienced neglect, and teens who experienced trauma during early childhood may be more likely to freeze, whereas boys typically fight or flee.[14] Some teens alternate between the hyperarousal of the fight-or-flight response and the underarousal of the freeze response.

Teens having the freeze response can appear flat, shy, nervous, avoidant, unresponsive, depressed, "checked out," inattentive, or as if in a daydream, although they'll generally tell you they feel fine. They might find themselves often dissociating as a way of avoiding the pain of trauma or memories, or they might use drugs or alcohol in an attempt to "feel something." The freeze response can also make it harder for teens to recognize or escape dangerous situations.

Teens who respond to trauma by developing the hyperarousal associated with the fight-or-flight response can demonstrate agitation, aggression, defiance, extreme alertness or awareness of surroundings, talkativeness, fidgetiness, or the general appearance of being "keyed up." The fight response can lead to physical fights, relationship violence, and impulsive behaviors that can lead to unwanted negative consequences (e.g., getting arrested or in trouble), as well as substance use (as the teen tries to self-medicate to avoid feeling out of control) or homelessness (if the teen is kicked out of the home by adults sick of the fighting or runs away from home to escape violence or trauma triggers).

> Ana and Alex both grew up in families where yelling and fighting was the norm. Even as a baby, Alex was forced to scream to get his parents to notice him, feed him, or change his diaper, so he learned that was what he had to do to get his needs met. If screaming didn't work, aggression always did, especially as he got older. These reactions became so automatic for him that he now often starts yelling without even realizing it himself. Ana's father and stepmother also fought frequently, and her family environment was very chaotic. But in her family, speaking up was met with physical violence or punitive responses. When her stepmother spoke up to her father, he would hit her. When Ana fussed or talked back, her stepmother would take away her next meal. Ana learned to make herself as invisible as possible; the less attention she drew to herself, the safer she'd be.

Alex and Ana both experienced neglect and violence growing up, but their experiences translated into very different patterns of interacting with others and getting their needs met. These patterns are evident in how they engage with each other now. The strategies they use today are those that were reinforced in the trauma-filled environments in which they were raised.

Risky Behaviors Can Be Learned Responses to Trauma

Traumatic experiences involve a profound loss of safety, power, and connection to others. Trauma alters people's ability to trust others, themselves, and the world around them. Children exposed to chronic trauma, and especially interpersonal or developmental trauma, learn from an early age that the world and the people around them are not safe or trustworthy. Many, if not all, reactions to trauma can be thought of in one way or another as efforts to survive (to ensure physical and emotional safety or basic needs). Risky behaviors are no exception. Alex, for example, is quick to throw the first punch because aggression is his way of establishing safety in a world he has learned is dangerous. Similarly, a teen who gets arrested for theft might have developed this behavior by stealing from stores or people as a means of basic survival.

Behaviors considered risky now may have been crucial in helping a teen escape or survive past danger. Alternatively, the risk taking may be useful now by helping traumatized youth cope with ongoing physical and emotional effects of trauma, regain a sense of control over their lives, and create much needed social connections. Asking teens to stop these behaviors without giving them something else to serve these vital functions is like asking people to take off their life vests without first teaching them how to swim.

> Nancy, Alex's case manager, feels unsure about how to work with him. Overwhelmed, she seeks guidance from a senior case manager, who e-mails her a link to a National Child Traumatic Stress Network (NCTSN) Web site called "What Is Complex Trauma? A Resource Guide for Youth and Those Who Care About Them."[15] Reading it, she finds herself thinking in a new way about many of the youth and young adults she has worked with. She learns that teens who have experienced several traumatic events over many years, especially if they were abused or neglected from a very young age, fit the profile of what is called "complex trauma." *Complex trauma* describes both the exposure to and effects of traumatic events, and Nancy realizes that many of the young people she has worked with fit this profile, having difficulties with attachment, emotion regulation, behavior, thinking, and relationships, among others. She is ashamed to recall that she hadn't even

> thought to ask many of them about experiences of trauma. To make sure she doesn't forget, Nancy tapes a quote on the wall above her desk:
>
> Just as an earthquake can cause deep foundation cracks that are the hidden cause of a building's instability even decades later, Complex Trauma can disrupt healthy development and is often the unseen cause of many problems and difficulties youth face years later that are not obviously connected to early childhood experiences.[15, p. 6]

The risky behaviors of high-risk youth can seem like earthquakes, which are threatening and destructive. But in reality, the trauma exposure preceding these behaviors is the earthquake, leading to "foundational cracks" in development that often go unseen. The effects of complex trauma create deep vulnerabilities in a child's developmental foundation. These points of tension and vulnerability can lead to the risky behaviors, which are better thought of as the "aftershocks," smaller earthquakes occurring along stressed fault lines caused by the initial earthquake of trauma. Aftershocks are triggered by changes in stress levels and function to release pressure or tension in the earth created by the original event. Much in the same way, risky behaviors seen in adolescence are direct responses to early traumatic experiences and serve as a means of releasing and managing traumatic stress.

Risky behaviors can be a response to trauma in several ways. As noted above, traumatized teens might be drawn to risky behaviors in an effort to escape painful sensations in their bodies, to dull intense emotions, or to avoid traumatic thoughts or memories. Physiologically, exposure to danger desensitizes the nervous system to be either more or less reactive to internal arousal. Traumatized youth, especially those who experienced traumatic events prior to developing language, feel the effects of trauma deeply in their bodies. Risky behaviors may be a way to regulate what they feel inside, either increasing physiological input in a controlled way ("turning up the volume of experience") through thrill seeking, pain, or sex, or decreasing sensation ("turning down the volume of experience") through isolating or using drugs. For example, Ana has always felt depressed and isolated, and also very confused about how to interact with men. Sex brings affection and helps her feel less alone, but the sex itself either made her dissociate or filled her with shame. Alex uses drugs to numb painful feelings triggered by intrusive thoughts. His parents had always told him he was a "bad kid," so eventually he started to believe it and stopped trying to be "good." Substances helped him get the courage to do even more risky things, which helped him feel alive inside in ways he did not feel when sober. Some teens may turn to substances as a way of accessing and talking about traumatic memories or experiences from which they may otherwise guard themselves. The immediate gratifi-

cation afforded by risk behaviors can serve as a "break" from intense and painful trauma-related symptoms.

> Every behavior has meaning and serves a function for the teen. Before assuming that a teen who is engaging in risky behaviors is irresponsible or rebellious, ask yourself these questions:
>
> - What might the behavior symbolize or communicate given the teen's trauma history?
> - What feelings or experiences is the teen trying to cope with by using the behavior?
> - How are the behaviors helping this teen get his or her needs met at this time?
>
> Even if you don't have the answers yet, when working with traumatized teens it is the safer, compassionate, and more trauma-informed approach to trust that there is a deeper reason for the behavior that you just aren't yet aware of. Stay curious and open.

Adolescents exposed to trauma are more likely to turn to risky behaviors as a way to cope with the painful aftermath of traumatic stress if they lack healthy coping skills and supports. Many traumatized teens, especially those who have experienced early abuse or neglect, never had the positive, safe, consistent caregivers to teach them how to cope with distress in healthy ways. Left to fend for themselves, teens turn to risky behaviors to cope with the physical, emotional, and cognitive effects of complex trauma.

Risky behaviors can also provide a sense of social connection and belonging. Substance use, risky sexual behaviors, and gang affiliation can provide a sense of community, connection, and/or safety that to an isolated or frightened teen makes the potential risks worthwhile.

Some adolescents engage in risky behaviors as a way of reenacting or repeating past traumatic experiences, whether consciously or unconsciously. Repeating these experiences can feel familiar or known and thus safe, or the teen may be trying to "do it differently" and therefore gain a sense of control or mastery over previous traumatic events. Engaging in risky behaviors can also be automatic or reflexive; some teens engage in high-risk behaviors because these are what they were exposed to growing up and therefore are all they know. Repeated risky behaviors may reflect what teens have witnessed, endured, and learned by example from abusive homes, neglectful parents,

or violent neighborhoods. Once these experiences are triggered, traumatized teens instinctively operate from "survival mode" with automatic reactions they learned from early experiences.

It is important to keep in mind that when teens are engaging in risky behaviors, the behaviors may not seem risky or dangerous to them. This is especially true for teens who have experienced trauma, because their perception of safety versus danger can be skewed by their trauma exposure. A teen raised in a neighborhood where shootings occur frequently, among families where violence is common, or within a gang-affiliated community where fighting or other criminal activity is the norm, will perceive these as standard and expected behaviors. Trauma-exposed teens may actually experience calm environments or particularly uneventful periods in their lives as scary, threatening, or uncomfortable.

Even if teens do recognize that their behavior is risky or carries unwanted consequences, it can be difficult to change. Trauma makes people feel powerless, so teens who experienced trauma often lack a sense of self-efficacy and doubt their abilities to change. Or they may worry that giving up gang life, substance use, or stealing may make them more vulnerable to further danger, and sometimes they may be right, especially in the short term. Living in "survival mode" forces teens to live life day to day with little attention to long-term consequences. Complex trauma exposure also inhibits teens' perceptions of the future; they may have negative expectations of what is to come or anticipate no future at all.

That said, teens *can* heal from complex trauma and go on to have rich, productive lives. Caring adults play a key role in this healing, and knowing how to effectively connect and engage high-risk youth is essential.

Positive stimulation helps promote healthy brain development. In particular, positive attachment experiences with caregivers help build trust, strong emotional connections with others, and self-regulation skills. Often, teens exposed to complex trauma lack consistent, reliable, and safe caregivers to help them develop the emotional and interpersonal skills they need to be happy and successful. *But it is never too late.* Because adolescence is a period of tremendous brain growth, it is an opportunity to make changes to the brain in a positive direction. Healthy attachments to positive adults help traumatized teens heal. Just by being a safe, reliable adult in a teen's life, you are helping to rewire his or her brain in healing ways.

Behavior in Context: Understanding and Connecting With Traumatized Youth

When confronted with a teen engaging in risky behaviors, consider the behaviors in the context of the teen's unique trauma history. Looking at the behavior alone can lead to making false assumptions about the adolescent and his or her character. Teens who engage in risky behaviors are often labeled as oppositional, defiant, irresponsible, rebellious, or dangerous. Classmates used to call Ana "crazy" and said that she "just wanted attention" after seeing the cuts on her arms, and neighbors called her a "slut" after finding out she was pregnant. Judging the behavior in isolation this way misses what is actually going on for traumatized teens.

A few weeks later, Ana gets a phone call from Alex. He says he has been trying to "do good": attending the drop-in center regularly, trying to cut back on drinking and drugs, and even considering meeting with a therapist. He asks to speak to Emily and says hi to her on the phone. Before saying goodbye to Ana, Alex tells her that he loves her and is trying to "get on the right path" so they could be a family again. Ana has heard this before, but somehow this time feels different. She decides to check out the program her friend Jessica attends to get help for herself too.

Ana packs Emily's favorite toys and snacks and heads to the clinic. Emily senses Ana's nerves and asks, "What's wrong, Mama?" Ana reassures her daughter but inside feels terrified that the clinic staff will ask about her history. She rarely shares details about her life. Even when she is trying to open up to others, she can't get the words out. How do you tell someone that your own mother abandoned you and never looked back, or that your father molested and raped you for years, and that running away was the only way to escape? How do you admit that you've had to have sex with men just to feel connected or have a place to stay, or that you stayed with several boyfriends who hit you because you had nowhere else to go? How do you share this without making others think you're damaged or crazy? Telling her story has only ever pushed people away.

Over the course of her life, Ana has learned that asking for help was rarely beneficial. Teachers didn't believe her when she told them about what her dad was doing to her, and when police were called to her home to investigate a report of "suspected abuse," officers reprimanded her for "making up stories" before shaking her father's hand and leaving. Even her friends didn't know what to say when she told them small bits of her life. She looks down at Emily's hopeful face and pushes through the doors of the clinic. She wants a better life for Emily, and she knows she won't be able to achieve this without dealing with her own "stuff" first.

While filling out paperwork, Ana pauses at the questions about her period. It was around the time she began puberty that her father began sexually abusing her. He used both physical strength and "charm" to coerce her

to give in to the sexual acts. He would start by telling her how beautiful she was, how he liked her curvy body, and how he was only trying to take care of her. After raping her, he would become angry and yell at her, blaming her and threatening to kill her if she ever told anyone. She started cutting to distract herself from the fear and feel some sense of control, relief, and oddly even a sense of pleasure. She also began binge eating to dissociate from the shame and powerlessness. The binge eating made her gain a lot of weight, which cut down on unwanted male attention, though the sexual abuse by her father continued. Eventually she started bingeing so heavily that she threw up, which was painful but somehow also a relief. Purging was pain she could control. When she was 15, she ran away from her father to live with an older boyfriend. When that boyfriend became abusive too, she lived on the streets or with friends for a while, doing whatever she needed to do to get by. After becoming pregnant with Emily, Ana got a second job at night so she could afford to rent a room from her aunt.

Teen girls exposed to trauma are likely to engage in self-harming or disordered eating behaviors or to have tumultuous romantic relationships, which can put them at risk for sexual exploitation.[8] Self-injurious behavior may provide relief from painful emotions or from emotional numbing; bingeing and purging may have the same effect. Risky sexual behaviors, as discussed above, may provide a sense of connection or may be seen as an effective tool to solve practical issues such as housing, food, or money.

Teens who have experienced trauma are at significantly increased risk of becoming homeless or being runaways. Teens may opt to leave and live on the streets to escape ongoing danger or abuse by their family or in foster homes. Living on the street puts teens at risk for further abuse or exploitation. Homeless youth may turn to "survival sex" or prostitution, selling drugs, gang affiliation, or other risky behaviors in order to earn money, food, or housing. Living on the streets, staying in shelters, or "couch surfing" increases the risk for sexual assault. Homeless teens may turn to drugs and alcohol to momentarily ignore their dire circumstances. Drugs and alcohol may make a teen feel warmer in the cold, less hungry when food is lacking, or less isolated when alone. "Self-medicating" with drugs and alcohol can also numb painful feelings related to PTSD or other symptoms of traumatic stress. Teens who have experienced trauma are three times more likely to use substances than those without histories of trauma.[16]

Although he is generally not open about his personal life or history, Alex often candidly speaks with several staff members and other youth at the drop-in center about his substance use. Alcohol helps him to party with friends, he says, and lets him feel happy and distract himself from problems. Marijuana helps with hangovers, and also lets him "forget things" and fall

asleep when nightmares keep him up. Stimulants such as cocaine and meth help him get "keyed up" to do things that would be hard to do sober. He has tried hallucinogens out of curiosity but had "bad trips." He shares that he was "forced" to get substance use counseling in the past but that "it was a joke" and that he mostly came high to sessions.

> Maintain a neutral, curious, and nonjudgmental approach when learning or asking about high-risk behaviors. Alex was able to share details of his substance use largely because staff and youth at the drop-in center were open and accepting. No one assumed that Alex considered his polysubstance use to be problematic, and no one "lectured" him about the negative health effects of using drugs. Understanding that Alex perceived benefits related to his substance use was essential to his establishing positive and collaborative relationships with specific staff members, as well as the agency as a whole.

Treating More Than Just Behavior: Engaging Teens in Mental Health Services

Finding a Trauma-Informed Frame

Addressing risky behaviors in a trauma-informed way requires first ensuring that teens know we are not judging their behaviors but instead are genuinely trying to understand the behaviors in the context of their unique trauma histories. Intentionally approach each teen keeping in mind the question "What happened to you?" as opposed to "What's wrong with you?" It can be easy to be distracted by and focus on a teen's behaviors, because these are more tangible and visible than the underlying painful emotions driving these behaviors. But remember, these are not the earthquakes!

> Despite our best intentions, sometimes our own "stuff" gets in the way of our being nonjudgmental. We all have our own stories and worldviews. Spend time thinking through your own morals, values, and beliefs and considering how hearing teens' stories about trauma and risky behaviors could trigger you. In the interest of building collaborative and trusting relationships with traumatized teens, take some time to check in with yourself, practice being mindful of your own reactions, and utilize self-care.

There may be times when a teen becomes dysregulated and displays risky behaviors that need to be addressed in the moment—perhaps to maintain a safe environment, or to uphold your program's guidelines or rules, or to model appropriate limit setting for the teen. In such situations, you may feel compelled or even be expected to apply consequences for the behaviors, assert yourself as an adult in a position of authority, and "correct" the behaviors. In situations like this, if you respond to the teen impulsively, emotionally, or punitively, your reaction has the potential to trigger and possibly retraumatize the teen. That said, when implemented with trauma-informed sensitivity and awareness, setting limits and enforcing consequences do not necessarily have to conflict with trauma-informed care. For example, the Hollywood Homeless Youth Partnership (HHYP) encourages the use of trauma-informed consequences (TICs) rather than punishment when responding to problematic behaviors among traumatized youth (Table 5–2). TICs reflect a collaborative, trauma-informed way to effectively and compassionately assist youth in gradually addressing behaviors of concern. More recently, the HHYP shifted to using the term *trauma-informed consciousness* (A. Schneir, personal communication, December 1, 2017) within staff trainings to emphasize the importance of taking the time to understand the core underlying causes of teens' behaviors and choices and to explore ways to generate, facilitate, and support more adaptive approaches. Responding from a place of trauma-informed consciousness has the potential to enhance a teen's sense of overall safety and trust in his or her relationship with you and the agency as a whole.

> Ana feels surprisingly safe talking with Olivia, the social worker with whom she meets for intake. Olivia is warm, but also honest and direct, and doesn't sugarcoat things. Olivia explains the program, services, and policies clearly, and describes each step of the appointment in advance so that Ana knows exactly what to expect. Olivia tells Ana that she can opt out of answering any questions and can take breaks at any time. She gives Ana the choice of telling her story in whatever order she wants, instead of Olivia asking questions. Ana appreciates being able to choose and is more able to open up without fearing that she might be asked to talk about something she isn't ready to share. Nonetheless, Ana feels familiar waves of panic as she touches on the "bad parts" of her story. Her heart beats faster, she feels hot and dizzy, and she struggles to breathe as the words get stuck in her throat. Olivia seems to notice, asking if Ana is okay, offering water, and changing the topic to talk about lighter things like music. Olivia also keeps checking in with Ana about whether she wants to continue the intake or stop for the day. These pauses help Ana focus on the here and now, and with a few deep breaths, her breathing and heart rate return to normal. Olivia talks for a bit, sharing that it's normal for our bodies and brains to need

TABLE 5–2. Trauma-informed consciousness: punishment versus trauma-informed consequences

Punishment	Trauma-informed consequences (TIC)
Punishment is used to enforce obedience to a specific authority and it uses words that escalate conflict.	TICs are intentionally designed to teach, change, or shape behavior, and to offer options within firm limits.
Punishment is usually used to assert power and control and often leaves a young person feeling helpless, powerless, and ashamed.	TICs are logical consequences that are clearly connected to the behavior, given with empathy and in a respectful tone.
Punishment is for the benefit of the punisher and not for the individual whose behavior needs to be corrected.	TICs are reasonable and use words that encourage thinking and preserve connections between people.
Incident: Youth becomes agitated, gets "in your face" and begins calling you "stupid" and "annoying," requesting to speak to your boss because you're "not helping me at all."	
Staff interpretation: Youth is being disrespectful. Youth doesn't appreciate the services we are offering. I need to set a firm example that we don't allow this type of verbal abuse.	*Staff reflection and interpretation:* Did something trigger this youth or bring up uncomfortable feelings or memories? What else could I do to help her feel safe?
Reaction: Staff threatens to ask youth to leave the program if behavior continues.	*Response:* Staff can address youth outside of waiting room to find out what happened. Let the youth know that safety (for her, you, and others in the waiting room) is most important. Validate that the youth seems to feel upset. Ask her if she would like a minute to herself. You can ask her if she wants to talk to someone about any feelings she might be experiencing.

Source. Adapted from Hollywood Homeless Youth Partnership 2009, 2010.[17,18]

a break when talking about emotionally intense situations. When Ana is ready to talk again, she shares about her cutting, and when Olivia doesn't wince or seem disturbed, Ana decides to tell her about being raped. Olivia still doesn't seem to pity or be disgusted by her, so Ana shares more and more. Olivia responds in a calm, quiet, and kind way, reflecting on how awful it must have been and observing aloud how strong Ana has shown herself to be. Ana feels understood and respected, and like maybe she isn't a crazy or terrible person or "too much" for Olivia. Olivia encourages Ana to consider a referral to mental health services. Ana is reluctant, but since she feels like Olivia gets her, she accepts.

> Be curious and stay curious. Traumatized teens may present initially as provocative, uninterested, mistrusting, or "hard." They may push you away, reject your attempts to help, and push to see if you can "handle them." Sometimes this may manifest in the teen telling you all the "bad stuff" (e.g., risky behaviors, details of trauma histories) up front. Other times, they may avoid sharing much personal information with you until they are able to fully trust you and your authentic interest in them. Either way, stay the course and trust in the power of connection.

Psychoeducation can be a powerful and validating intervention. Risky behavior should be framed as an understandable reaction to overwhelming and painful thoughts, feelings, and memories, or as a way to cope with the symptoms of traumatic stress. However, this does not mean that you should encourage risky behavior. What feels useful or inevitable in the short term can have long-term unwanted consequences. Balance validation of the teen's behaviors with gentle guidance toward change. Parents, caregivers, or any other important adults in the adolescent's life should be given the same psychoeducation, and should also be coached on balancing empathy and validation with clear limits and expectations for change.

> Consider giving teens the choice to join while you provide psychoeducation to important adults in their lives. Given that much of trauma is enveloped in secrecy, mistrust, and shame, being open, honest, and transparent are key elements of trauma-informed care.

After her first appointment with Dr. Torres, the therapist that Olivia recommended, Ana feels a strange mix of relief and deep anxiety. On the one

hand, telling her story made her feel lighter, like she had been able to leave pieces of her past behind. On the other hand, she worries about having shared as much as she did with Olivia and Dr. Torres. But Olivia had warned her she might experience these feelings, which she jokingly called "disclosure remorse," so Ana decided to trust her intuitive sense that therapy could be useful to her and continued to see Dr. Torres.

Screening

It is equally important to screen youth with high-risk behaviors for exposure to trauma or abuse, and to screen youth who have experienced trauma for high-risk behaviors. Screening high-risk teens for trauma exposure will help to identify whether they have been exposed to traumatic events and to put their risky behaviors into this important context. Whenever possible, screen repeatedly to assess for exposure to ongoing trauma or maltreatment. If a teen is currently in a dangerous or unstable situation, safety must be addressed before proceeding with anything else. This focus on safety communicates to the teen that he or she is important and worth keeping safe, and that you can be counted on to help. This approach can be considered "therapeutic case management." Assessing safety also includes determining whether a teen's basic needs are being met. For example, when Alex first presented to the drop-in center, his case manager Nancy identified that he needed food, resources for housing, and vocational training, as well as medical and mental health services, parenting classes, and substance use treatment. Helping with these concrete needs builds trust and engagement. If basic needs are not being met, a teen is unlikely to show up for weekly therapy, let alone address issues such as risky sex and substance use.

> You might be in a position where you read documents or hear stories from other people about a high-risk youth before meeting the individual. Take these with a grain of salt. Hold off on making any conclusions until you spend time with the youth, build a trusting relationship, and get a first-hand understanding of the adversities he or she has experienced.

Screening for risky behaviors should assess a teen's type, severity, and frequency of behaviors; immediate needs and safety concerns; the function of the behaviors; and the teen's readiness to change. You might not get this information all at once. The teen may slowly open up over time as his or her trust and relationship with you strengthen. For a more thorough assessment, screening tools can help us. The HEEADSSS psychosocial interview, with questions related to each letter of the acronym (**H**ome environment, **E**ducation and em-

ployment, **E**ating, peer-related **A**ctivities, **D**rugs, **S**exuality, **S**uicide/depression, and **S**afety from injury and violence), is one commonly used screening tool for trauma and risky behaviors.[19,20] There are several versions available, including for typically developing adolescents, runaway and homeless youth, and transgender youth.[21] Don't just ask about negatives; it is equally important to get a good sense of the teens' resilience factors by focusing on strengths, positive qualities, and examples of adversity they have overcome.

Nancy, Alex's case manager, e-mails a psychologist friend for ideas about getting to understand Alex better. The psychologist sends Nancy a copy of HEEADSSS 3.0[22] with a note saying, "This interview focuses on assessing a kid's **H**ome environment, **E**ducation and employment, **E**ating, peer-related **A**ctivities, **D**rugs, **S**exuality, **S**uicide/depression, and **S**afety from injury and violence. It was developed for doctors, but anyone can use it. I typically follow the order of letters in the acronym, and teens seem to like that, but sometimes kids who have been homeless feel uncomfortable starting with the H. In that case start with whatever area you think a teen is most open to." Nancy tries out the HEEADSSS at her next meeting with Alex, asking about Education and employment, Eating, and peer-related Activities. She tries to focus on his strengths in these areas, and encourages Alex's interest in drawing and graffiti. Later, asking about Alex's home and living circumstances, Nancy learns that Alex experienced chronic neglect and physical and emotional abuse growing up, as well as other abusive experiences at school and in foster care. Alex has lived with his biological mother and father, with his maternal aunt, in multiple foster care and group home settings, in the homes of fellow gang members, and most recently on the street. He was briefly in a shelter but was kicked out for threatening another resident. Alex describes multiple sexual partners and boasts about frequent unprotected sex, but Nancy is surprised that he knows little about sexually transmitted infections and has never been tested. Alex said he couldn't remember all of his previous mental health diagnoses but recalled reading records stating that he had been diagnosed with attention-deficit/hyperactivity disorder, bipolar disorder, and antisocial personality disorder. He seems much less comfortable talking about these diagnoses than about his drug and alcohol use, and admits that no one ever explained to him what those "labels" were about.

Use open-ended questions with teens to help avoid assumptions. When inquiring about the home environment, provide prompt by saying "Tell me about your living situation" instead of asking "Did you grow up with your mother and father?" Similarly, use gender-affirming and LGBTQ-inclusive terminology when asking about gender identity, sexual orientation, and sexual practices.

Treatment

Several treatments can help reduce risky behaviors; regardless of treatment type, safety is the first and primary target. Talking about safety concerns up front serves several purposes. Of course, assessing safety is important for practical reasons. Also, as discussed above, it shows teens that you care and aren't just looking to punish or judge them. Genuine, caring adults who overtly prioritize the teen's safety in an understanding way help a teen to begin to chip away at the negative perceptions of others and the world that are the legacy of their early traumatic experiences. Conversations about safety should happen throughout treatment to ensure that there is no new danger and reinforce the importance of safety. For teens who have perhaps experienced little safety in their lives, this focus is tremendously powerful.

> Traumatized teens may initially have a negative reaction to compliments, acts of kindness, or expressions of care and support. Many have never heard positive feedback about themselves. For others, kind gestures or positive comments have been precursors to abuse, or unsafe adults may have used nice words and compliments to engage the teens. Be mindful of teens' reactions to your expressions of concern and adjust as needed. Proceed cautiously, but continue showing kindness so teens can begin associating kindness with safety instead of danger.

If you are trying to link a teen to mental health treatments focused on reducing high-risk behaviors, look for agencies or providers who provide trauma-informed care, and specifically those who offer evidence-based treatments such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)[23]; Dialectical Behavior Therapy (DBT)[24]; Motivational Interviewing (MI)[25]; Attachment, Self-Regulation, and Competency (ARC)[26]; Integrative Treatment of Complex Trauma for Adolescents (ITCT-A)[27]; or Multisystemic Therapy (MST)[28] Keep in mind that even the best treatments take time to work. Expecting that teens will give up all coping behaviors simply because they are being told of the dangers is unrealistic. Instead, remember that it can be really scary for teens to give up risky behaviors that have been very functional over the years for escaping pain and danger. Change will take time, support, and perhaps even forgiveness. Teens' urges to engage in risky behaviors may even increase during treatment, especially during potentially painful parts of treatment, such as the trauma narrative. Knowing this in advance lets you and the adolescent make a plan in advance to cope with these urges and anticipate potential setbacks.

Web sites for the National Child Traumatic Stress Network (NCTSN) and the Substance Abuse and Mental Health Services Administration (SAMHSA) offer resources that may be helpful in obtaining additional information regarding trauma treatments and trauma-informed care. The Hollywood Homeless Youth Partnership Web site is a helpful resource for information focused on youth experiencing homelessness and complex trauma, trauma-informed care, and low-barrier engagement approaches for working with high-risk youth. (See "Resources and Additional Reading" at the end of this chapter.)

> Teens may be more open to a *harm-reduction approach* when discussing the possibility of giving up risky behaviors. This approach focuses on reducing negative consequences of a behavior by supporting any steps toward "safer" choices and suggesting alternative behaviors that are less risky. Examples of this approach include encouraging a teen to practice safe sex rather than to stop having sex altogether or helping a teen to problem solve around how to drink alcohol safely (e.g., sleep at a friend's house instead of driving home). Any steps toward reducing risk are positive and important.

"Emily, music, and not letting my dad 'win.' Those are the things that make my life worth living." Ana has been attending therapy with Dr. Torres for 4 months now, the longest she has ever stayed in therapy. Dr. Torres specializes in trauma therapies and other treatments for improving emotion regulation and improved coping, including DBT. When Dr. Torres first described DBT to Ana, they talked about DBT's goal of "building a life worth living." Ana likes this idea and appreciates that DBT largely focuses on building skills. She hopes these skills will help her deal with the symptoms of PTSD that are making life painful. She also likes that DBT is about understanding how the behaviors we engage in "make sense" in light of our histories. She has always felt so ashamed of herself—her past and the decisions she made after—so this approach is very validating. Ana continues to struggle with flashbacks and panic at times during the treatment, and sometimes still has urges to cut or smoke weed. Dr. Torres is always there to coach her through these moments and reminds her to use her "distress tolerance" skills and to "think effectively, not emotionally."

Meanwhile, Nancy is able to convince Alex to try therapy too. She sets him up with a therapy team that uses the ARC model.

The Attachment, Self-Regulation, and Competency (ARC)[29] model is a way of working with high-risk behaviors in youth who have experienced trauma. It focuses on enhancing and promoting resiliency by targeting three core areas in which traumatized youth often struggle.

Attachment: Focus on promoting positive attachment. Consider these questions:

- What quality of relationship does this youth form with his or her peers?
- How does this youth relate to adults, program staff, and authority figures?

Self-Regulation: Focus on developing and maintaining the ability to notice and control feelings such as frustration, anger, and fear. Consider these questions:

- What does it look like when the teen is experiencing unpleasant feelings?
- What situations trigger unpleasant feelings, and what skill does the teen use to cope?

Developmental Skill Competency: Focus on mastering the developmental tasks of adolescence and developing abilities to plan and organize. Consider these questions:

- Does the teen accurately perceive his or her current life circumstances?
- Is the teen able to think about his or her past, present, and future?
- Is the teen able to problem solve, organize and prioritize time, and plan ahead?
- What specific skills does this youth possess and still need to acquire?

The team works with Alex for more than a year. They provide case management, mental health, medical, occupational/vocational, and other services, including basic needs (food, clothing, mobile health clinic) and help with housing. Alex's treatment team collectively uses the ARC framework to guide his overall care. Dr. Musa, Alex's psychiatrist, uses ARC in his individual therapy and holds regular team meetings to coordinate everyone's work with Alex and support the team's integration across ARC domains. Therapy with Dr. Musa initially focuses on better understanding Alex's attachment/relational history to help Alex connect with others. Dr. Musa and the team prioritize engaging Alex on his own terms, with a collaborative and mutually respectful approach. Over time, Alex becomes acquainted with most of the team, including security, case managers, medical providers, and educational and vocational specialists, as well as other young people receiving services at the drop-in center. At first, Alex's attendance and level of engagement fluctuates, but his team engages him by tapping into his interests in art (graffiti workshops or local events) and exercise ("walk and talk" or throwing a football). They always leave a message when Alex doesn't attend a session, and that simple outreach helps to build trust. The consistency, sincerity, and continuity of treatment in a noninvasive fashion are crucial in helping Alex to build a healthy attachment to this support system.

Slowly, Alex becomes more receptive to learning emotional regulation skills in therapy. He starts to open up about his gang involvement, abuse history, and sexual experiences. One day he tells Dr. Musa that he likes that the staff at the drop-in center "actually care about helping me and making me feel less stressed out." He continues to engage more with services at the center, especially educational services such as the GED program and a training program in set design for film. Staff members help him with his resume and assist him to set up medical care. Although he's hesitant to entirely disengage from the gang and "leave my homies behind," he notices that he has become less motivated to participate in gang activities and instead prefers to spend time with Emily. He starts to have a more hopeful and positive outlook for his future, something he had never thought possible.

Conclusion

Like so many youth, Ana and Alex experienced chronic neglect, abuse, and other horrific traumatic events that no youth should have to experience. Neither had the appropriate emotional support or guidance to prepare them and keep them safe during the trials and tribulations of adolescence. It is no surprise, then, that they struggled to meet the societal and developmental growth expectations for teens and emerging young adults. Understanding their difficulties through the lens of trauma lets us understand how the neurobiological and psychological effects of trauma are at the root of their high-risk behaviors.

When working with high-risk, trauma-exposed teens like Ana and Alex, we must remember that chronic, complex trauma creates "cracks" in teens' psychological foundations and drives them to participate in risky behaviors. It is crucial to remain consistently mindful of the profound and often invisible effects of trauma in order to truly meet teens where they are developmentally. Developing and maintaining a healthy and positive relationship with teens is the first step toward any behavioral change. Remember too that although cracks may give rise to an unstable foundation, cracks are also "how the light gets in," as the late singer-songwriter Leonard Cohen sang. With much adversity comes much opportunity for growth. A teen's life can be changed by digging beneath the surface, nurturing the roots, and fostering a safe and caring environment with strength-based approaches, positive intentions, and resilience-building practices. Remind yourself of the transformative power of positive connections and the important role we can have in teens' healing. Neither Alex nor Ana would have been able to engage effectively in services or begin to make progress had it not been for relationships with caring, safe, and trusted adults. Through safe, consistent, and compassionate relationships, "cracks" can be patched, teens' foundations can be strengthened, and the negative effects of complex trauma can start to be reversed and slowly healed.

Resources and Additional Reading

Online Resources

National Child Traumatic Stress Network: http://www.nctsn.org
Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov/nctic/trauma-interventions
The Hollywood Homeless Youth Partnership: http://hhyp.org

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