THE ADOLESCENT AS A WORK IN PROGRESS: 
BRAIN DEVELOPMENT, IMPACT OF EARLY 
TRAUMA AND IMPLICATIONS FOR TREATMENT

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THEIR BRAIN: 0-3

Attachment is a brain function determined by the neurological makeup and the experiences a child has in the first few years of life.
PRENATAL TRAUMA

• Violence begins in the brain and the brain begins in the womb.
• The roots of violence are often fully developed by age three.
• The effects of prenatal exposure to drugs and alcohol are devastating.
RELATIONSHIPS

• Attachment trauma is the brokenness of a relationship.

• Healing happens in the context of a relationship.

• Positive connections offer the child’s brain an opportunity to develop new capacities.

• They can’t do it without help.
WHAT WORKS

Attachment repair is relationship-based.

– Therapy needs to include the parent (foster, birth or kinship) and the child.

– Lots of individual therapy is typically not useful.

– Group work for teens is good; Didactical Behavioral Therapy...
# Child Development: The Rules

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WHEN ALL THE RULES ARE BROKEN

• The child does not know how to cope with nurture, kindness, intimacy or structure.

• The child can’t make sense of what safety means.
Who am I and who do I want to be?

IDENTITY VS. ROLE CONFUSION
12-18 YEARS

THE TASK:
The child incorporates skills, talents, values, and relationships to create a sense of self. The child mimics or rejects adult role models.
MIDDLE SCHOOL TO EARLY HIGH SCHOOL

Independence
- Struggle with identity and self-esteem
- Peer relationships are very influential

Sexuality
- Concerns regarding physical attractiveness
- Frequently changing relationships
- Worries about “normal”

Values and Self-Direction
- Limited thoughts of the future
- Challenges who is in charge/sets limits
- Development of ideals; selection of role models
- Experimentation with sex and drugs (cigarettes, alcohol, and marijuana)
LATE HIGH SCHOOL AND BEYOND

Independence
• Better sense of identity
• Increased ability for delayed gratification
• More emotional stability
• Increased self-reliance

Sexuality
• Feelings of love and passion
• Increased capacity for tender and sensual love

Values and Self-Direction
• Increased concern for the future
• Can think ideas through
• Interest in moral reasoning
• Capacity to use insight
• Increased emphasis on dignity and self-esteem
• Work habits become more defined
IDENTITY vs. ROLE CONFUSION

• I hate you; I want to be nothing like you.
• You don’t know anything about me.
• We don’t understand each other.
• I am going to be so cool.
• My friends are very cool, unlike YOU.
• I admire you; I want to be like you.
• I want to find a partner, someone like you.
WHAT IS ROLE CONFUSION?

- I don’t fit in anywhere; I am a loner.
- I go “over the top” and break rules to be liked.
- I can’t decide if I am stupid or ugly.
- I am a follower.
- I can be the class clown or the juvenile delinquent.
- I feel lonely and isolated but try hard to hide it.
WHO YOU SEE IN COURT

• The defiant, naughty, entitled child
• The neglected child
• The trauma survivor
• The foster child
• The ‘unadopted’ child
• The FASD child
• The dual diagnosis child
IMPACT OF TRAUMA

• They are socially and emotionally delayed.
• They act before they think.
• They use drugs and alcohol to have fun.
• They are accustomed to feeling out of control.
• They seek chaos; it is familiar.
• They fear success and connection with equal intensity to failure and rejection.
TRAUMA WOUNDS

• Up to 34% of children in the U.S. have experienced at least 1 traumatic event.

• 75-93% of youth in the juvenile justice system are estimated to have experienced some degree of trauma.
EFFECTS OF CHILDHOOD TRAUMA

• **Lifelong psychiatric conditions**
  – Personality and Conduct Disorders; ADHD; PTSD; Depression; Anxiety; Substance Abuse

• **Developmental delays**
  – Decreased cognitive abilities; learning disabilities; lower IQ levels

• **Hindered Success**
  – 3x higher dropout and expulsion rates
INCARCERATION CAN BE TRAUMATIC

• Facilities can exacerbate negative feelings created by previous trauma:
  – Seclusion
  – Staff insensitivity
  – Loss of privacy
  – Verbal and physical aggression

• Trauma-exposed youth sent to disciplinary settings (prisons; group homes) show higher offense rates as adults.
FLIGHT/FIGHT/FREEZE

• Until they resolve their fear-based behaviors with some understanding of alternatives, getting sober or stable will be very hard.

• Trauma work is done over time, in the context of an intimate relationship.

• It is not cognitive/behavioral or group work.
IMPAIRED DEVELOPMENT

• When the child can’t take the next step towards growth and maturity.
• The brain adapts to an unpredictable and dangerous world.
• The child will continue to use their adaptive strategies (symptoms) to compensate.
• Removing coping strategies creates anxiety.
THEY ARE STUCK

• Which task did they not complete?
• At what age did they developmentally ‘fall off the wagon’?
• What service would be most useful to address that developmental task?
• Match the child’s age of impairment with the service that will attend to it.
THEY CAN’T LISTEN WHEN THEY’RE AFRAID

• They won’t remember.
• They will zone out.
• They will act like they understand, even though they don’t.
• They will be distracted.
• They will not discern the meaning of what is being said.
JUST GROW UP

• They won’t heal while they are using.

• They won’t stop using until they have some relief from their pain.

• They won’t mature while they are using.

• Until we help them grow up, they won’t relinquish using.
PREFrontal Cortex

• “CEO” of the brain.

• Major aspect of teenage development; not completed until the early 20s.
A HEALTHY CEO

— Good planning
— Ability to consider consequences of actions
— Self-reflection and introspection
— Impulse control
— Ability to stop, look, listen
WHAT THEIR BRAIN TELLS THEM

Based on their brain development, teens are...

**More likely to:**
- Act on impulse
- Get involved in fights
- Misread social cues/emotions
- Engage in risky behavior

**And less likely to:**
- Think before they act
- Modify inappropriate or dangerous behaviors
- Consider consequences
Adolescent Brains - Acting the Way They Do

Loss of reflection, planning, organization; increase of risk-taking, conflict seeking, distractibility

Amygdala flooded by hormonal activity

Use amygdala to process non-verbal cues

Prefrontal Cortex is under construction until age 20
Anatomy of a Teenager’s Brain

- Sensorimotor area
- Embarrassed by parents section
- Ability to remember the lyrics to offensive hip hop song...
- Have no idea...
- Cars, cars, cars, cars, and... oh, yeah, girls...
- Prefrontal
- Girls are suddenly fascinating section
- Ability to listen to extremely loud bass tracks
- School Work (smallest section of the brain)
CHEMICAL USE/ADDICTION

• This is the age children experiment.
• Children with developmental insults are much more susceptible.
• Addiction often looks like mental health problems.
• Screening and services are critical.
• Follow-up and aftercare with sober supports can be helpful, if they can be found.
40% to 85% of youth in care are affected by a mental health disorder in their lifetime. (Skinner Mendelow)

23% of youth in care have 3 or more diagnoses in their lifetime, compared to 15% of the general population. (Casey Family Programs, 2007)

Screening children upon entry into care doubles detection rate of potential problems. (S. Jee; Univ. of Rochester Med. Center)
9 million American young adults ages 12-25 need help with drug/alcohol problems. (2009 National Study on Drugs and Health)

90% of all adults with drug/alcohol problems started using before the age of 18, and half before age 15. (Dennis 2007)

90% of adolescents who need help with drug/alcohol problems are not getting the help they need. (2008 National Study on Drugs and Health)
VULNERABLE ADOLESCENTS

Teens with increased vulnerability to drug or alcohol problems include those with:

– Histories of abuse, neglect, and/or significant family problems;
– Chemical use at an early age;
– Family history of drug or alcohol problems;
– Existing mental health problems or a psychiatric disorder during childhood (such as ODD, ADHD, or a learning disability).
– Friends who use drugs and alcohol.

NIDA; Tarter as cited in Riggs
TEENS AT RISK

• Teenagers at risk for developing serious alcohol and drug problems include those:
  – with a family history of substance abuse.
  – who are depressed or have a mental illness.
  – who have low self-esteem.
  – who feel like they don’t fit in.
A DOWNWARD SPIRAL

Vulnerable teens often have trouble adjusting to school, leading to:

– Increased risk for school failure
– Demoralization and lack of self-worth
– Escalating behavior problems
– Placement in behavior- and learning-disabled classes, increasing association with similarly vulnerable peers
– Early onset of substance abuse

Riggs
ADOLESCENT STRESSORS

- School frustrations
- Taking on too many activities or having too high expectations
- Low self-esteem
- Peer problems
- Unsafe living environment/neighborhood
- Separation or divorce of parents
- Chronic illness or death in the family
- Moving or changing schools
- Family financial problems
STRESS RESPONSE

A child can do OK in times of low stress.

• When a stress response is triggered, the child goes into default mode.
  – Survival mechanisms take over.
  – We call this regression or decompensation.
  – A child may withdraw, become aggressive, or develop poor coping skills, such as drug/alcohol use.
ACTING OUT

Is actually seeking a response from adults...

– Teens may use hostile, self-destructive and infuriating behaviors.

– These kids can’t regulate strong emotions, but they’re attracted to them, so they activate distress in the adults around them.

– They love drama.

– Defiance is often about anxiety and fear.
PUNISHMENT OR TREATMENT

Punitive consequences...

– May teach nothing of value if there is no opportunity to learn an alternative.

– May reinforce negative messages about adults who have power.

– They often will not motivate a child and, if they do, it will be from a place of fear, not a desire to please.
CAN’T OR WON’T?

• When logical thinking is absent, concrete and time-limited interventions are best.
• Consistent messages help.
• Life-skills services work better than consequences or removal of freedom.
HOW THE CHILD SEES THE SYSTEM

• They don’t give me a voice.

• People don’t care—it’s about money, not me.

• They talk tough but won’t follow through.

• They don’t really know what I need. They just want to run my life.

• I can manipulate and ‘get out of this’.
CO-MORBID BEHAVIORAL THERAPIES

• **Brief Strategic Family Therapy (BSFT)**
  – Targets family interactions thought to maintain adolescent drug abuse

• **Cognitive-Behavioral Therapy (CBT)**
  – Most effective psychotherapy for adolescents with anxiety/mood disorders

• **Motivational Enhancement Therapy (MET)**
  – Techniques to resolve adolescent ambivalence about treatment and strengthen motivation
YOUTH PROGRAMS

Programs focus on giving youth a sense of:
1. Safety and structure;
2. Belonging and membership;
3. Self-worth and social contribution;
4. Independence and control over one’s life;
5. Closeness in interpersonal relationships.
TREATMENT GOALS

• **Enhance skills:**
  – Self-efficacy
  – Coping
  – Problem-Solving
  – Decision-Making
  – Mood regulation
  – Communication

• **In order to:**
  – Anticipate and avoid high-risk situations
  – Identify triggers for drug use
  – Decrease association with drug-using peers
  – Encourage involvement in pro-social activities
EVIDENCE BASED PRACTICE: POSITIVE YOUTH JUSTICE MODEL

Key assets needed by all youth:

1. Learning/Doing
2. Attaching/Belonging

Each asset is developed in 6 life domains:

1. Work
2. Education
3. Relationships
4. Community
5. Health
6. Creativity
WORK

• Work-related efforts:
  – Improve teen attitudes toward their communities
  – Enhance skills and future employment
  – Reduce recidivism

  – Should not be used as punishment or as mere compensation.
EDUCATION

School failure is a main precursor to delinquency.

• **Poor performance is an isolated problem.**
  – But it may have school/family/community aspects.

• **Policies segregate punished students.**
  – But this aggravates the stigma.

• **Teachers view at-risk students as delinquent.**
  – But this may become a self-fulfilling prophecy.
COMMUNITY

• Weak bonds allow delinquency to happen.
• What shapes bonds between teens and society:
  – Attachments (Concern about what others think)
  – Commitments (Investment of time and energy)
  – Involvements (Sufficient time and energy spent)
  – Beliefs (Common value system)
CURRENT PRACTICE

• Strategies focus on isolation of offenders.
  – But delinquency stems from lack of integration.

• Programs assume responsibility for teens’ activities and behaviors.
  – But the goal is to make teens more accountable.

• Probation strategies target only the offender.
  – But delinquency is also found in communities, families, and schools.
INTEGRATED TREATMENTS

*Effective programs are comprised of:*

- Empathic, supportive, motivational techniques
- Behavioral/cognitive-behavioral approaches
- Individual and/or group therapy
- The importance of family involvement
- Relapse prevention/continuing care
BARRIERS TO INTEGRATED TREATMENT

• Shortage of adolescent psychiatrists with training in addictions

• Poor third-party payer coverage for integrated psychiatric services

• Separation of provider networks for psychiatric and substance abuse treatment
FAMILY SYSTEMS INTERVENTIONS

Dysfunctional family dynamics contribute to adolescent drug abuse and related problems.

- Structural Strategic Family Therapy
- Parent Management Training (PMT)
- Multisystemic Therapy (MST)
- Multidimensional Family Therapy (MDFT)
IN VOLVING THE FAMILY

Strategies to improve overall family functioning:

– Restructuring interventions to correct flawed relationship and behavior patterns

– Parental monitoring

– Behavior management skills

– Improve teen’s behavior and reduce drug abuse
CHALLENGES FOR PARENTS

• We assume they are logical.
• We assume they care about the same things we do.
• We assume they can learn from their mistakes.
• We assume they have hopes and dreams for a better future.
• We assume they don’t succeed because they simply don’t care.
ASPECTS OF RESILIENCY:  
THE PARENT

– They have support, or would use services if offered.
– They have attended to mental health issues.
– They are willing to address issues of chemical dependency and violence.
– They can empathize with their child.
– They accept responsibility.
MEDICATION

• If medication is being considered, treatment includes initiation and monitoring.

• Abstinence isn’t necessarily a precursor to medication, as untreated mental illness may have negative affects:
  – Stall treatment engagement
  – Cause early dropout
  – Interfere with achievement of abstinence.
RELAPSE

• Severe substance abuse and chemical dependence in adolescence may be a chronic relapsing disorder.

• Emphasize that relapse is common and does not represent personal failure nor treatment failure.

• Parents should ask what services are available for continued/future treatment.

AACAP; Riggs
RELAPSE PREVENTION

• Prevention strategies
• Continued monitoring of drug use
• Regular follow-ups for psychiatric disorders and addiction.
• Development of specific plans to manage relapse
ASPECTS OF RESILIENCY: THE CHILD

– Prenatal experience
– Genetic makeup
– Attachment relationships
– Cognitive functioning
– Physical features
– Community resources
CULTURAL DIFFERENCES

• Language barriers
• Gender roles and expectations
• Religious and spiritual beliefs
• Parent/child roles and expectations
• Community standards for behavior and social norms
MAKING A CONNECTION

• I believe you can do it better.

• You have the power to do it better.

• We all want to help you do it better.

• I know you want it to be better.

• Do you know what it is you need?

• How can we help you?

• Lots of kids turn it around—you can, too.
RESOURCES


NIDA, www.nida.nih.gov. Data provided from the NIDA funded Monitoring the Future: National Survey Results on Drug Use and the SAMHSA funded 2007 National Survey on Drug Use and Health.)

Perry, Bruce. www.traumaacademy.org.


