

*Article 1*

**Moving Beyond Discipline of Disruptive Behavior:  
Recognizing and Treating the Effects of Trauma  
on Adolescents**

Harriet A. Bachner and James F. Orwig

Educators often call upon professional counselors to provide therapeutic services for students who disrupt class, show aggressive or argumentative behaviors, or have difficulties in their adjustment, particularly during middle and high school. This developmental stage may be the last advantageous opportunity to help these students achieve success before they enter adulthood.

Consider the plight of Alicia, an eighth grader, who daily becomes angry with and hurt by classmates. After school, she and her younger brother frequently aggravate and physically hurt each other. Alicia's teachers note that she "spaces off" and question if she has attention deficit disorder. Her friends call her "bipolar" because of her volatile emotional reactions to her perceptions of threats. She identifies "friends" she wants to fight if they "don't stop spreading lies" about her. She is frequently absent due to headaches or upset stomach.

From the principal's perspective, Alicia needs to get her priorities straight: handing in homework on time, refraining from fighting, attending regularly, and eliminating the tardiness to classes. Her teachers focus on her "spaciness" and think she needs more sleep. They also want her to complete homework and learn to manage her anger. Her family doctor has prescribed Adderal to help her focus.

Her school counselor inquired if she has always had an anger problem. She replied that she noticed getting angry about three years ago. The counselor asked, “Did anything bad happen three years ago?” She replied, “Three years ago a neighbor molested me, but only once.” Her mother acknowledges that she realizes it was not Alicia’s fault. Even so, nothing has alleviated the severity of the daily occurrence of problems. Suspensions, detentions, class reassignments, medication, and anger management have been marginally successful in managing Alicia’s behavior.

Rather than focusing on difficult behaviors, as described in this case, educators and counselors could view these behaviors as clues to trauma symptoms or insecure attachment. This report provides a simple discussion of findings from neuroscience on the impact of early trauma on brain processes and emotional regulation, particularly relating to adolescent brain development. In addition, strategies are explored to help students succeed academically and adjust interpersonally. Recommendations are proposed to assist adolescents in adapting to classroom expectations and forming healthy peer relationships.

Many studies suggest that some pubescent adolescents who are showing behavioral and academic problems are struggling with the reverberations of earlier trauma and continuing upheaval in family life (van der Kolk et al., 2003; Schwarz & Perry, 1994). This research shows a relationship among attachment difficulties and emotionally traumatizing events on learning, behavior, and interpersonal development, particularly as children progress through puberty and adolescence. Findings from The Adverse Childhood Experiences (ACE) Study show that childhood experiences affect many indices of physical and psychological health and behavior, not only during childhood and adolescence, but also into adulthood, even decades later. Such effects are manifested in disorders such as diabetes, hypertension, coronary artery disease, obesity, chronic depression, and in intravenous drug use, smoking, and suicide attempts (Felitti et al., 1998). These findings are daunting and compel mental health professionals to seriously consider the necessity of prevention and intervention strategies with adolescents in their school settings.

Predictable flare-ups of earlier trauma often occur during puberty, adolescent dating, and sexual encounters. These may also manifest during a serious loss or illness, medical procedures, significant dates, or viewing emotionally charged media. Adolescents who have experienced trauma need a sense of safety to help them “decompress” from the chaos happening at home or in their community (Bradley, 2007). Safety and containment are crucial in assisting adolescents to cope in school. Schools can play a pivotal role in providing sanctuary for adolescents grappling with the most costly public health crises in the United States, that being child maltreatment (Schwarz & Perry, 1994). Children with the highest risk find no solace in their chaotic and violent home and may experience pervasive threat in school and community. This unrelenting fear of threat often results in “neurophysiologic adaptations”, manifesting in learning problems and difficulties managing mood and social interactions (Perry, 2001).

### **Symptoms of Trauma and Insecure Attachment**

Bessel van der Kolk (1996) describes trauma as an “assault” on one’s biology and not being able to “reset” oneself. Trauma impacts cognitive processing, emotional regulation, impulse control, and attending behavior; all of which are necessary for learning. Children who have witnessed domestic violence may be more prone to suicidal behavior, substance abuse, and juvenile delinquency (van der Kolk et al, 2003). School personnel identify a wide variety of behaviors problematic in the classroom and overall school milieu, many of which are evident in the previously discussed case of Alicia. Students may be referred to the principal for disruptive behaviors; or to the school counselor for help in dealing with conflicts with friends and difficulty managing emotions in the classroom; or to physicians for evaluation of attention deficit/hyperactivity disorder, depression, bi-polar disorder, and a variety of other disorders.

Students also bring concerns to the counselor for help in dealing with an array of problems, such as: feeling ostracized by peer group, fearing assault, concerns about expressing anger, conflicts

with teachers, worries about grades, drug and alcohol use among their family members, divorce and separation issues, dating and breaking up, sexual orientation, pressures about sexual activity, and perceptions that others have ill intentions toward them. As these adolescents attempt to cope with new challenges of hormonal changes, sexual development, and the accompanying upheavals in peer relationships, their difficulty in regulating emotions and making sense of their perceptions about peer interactions becomes increasingly evident in school and community.

### **Impact of Early Trauma on Brain Development, Processes, and Emotional Regulation**

Academic and social competence in middle and high school is dependent upon higher level cognitive and meta-cognitive processes whose foundation is established early in life, particularly in an attachment relationship (Avieger, Resnick, Sagi, & Gini, 2006). The burgeoning trauma field has labeled the experience of chronic interpersonal trauma during early childhood as “complex trauma” (van der Kolk, 2005). The impact shapes the brain and the way information is stored in implicit memories (as manifested in body memory) and processed in explicit memories. The reciprocal interactions with significant caregivers, the neural pathway development, and the resulting emotional regulation are intertwined in a complex manner (Schore, 1994). Consequently, traumatized youth may show fear, rage, avoidance, or lack of insight in response to what most secure individuals would consider being minor altercations. They have trouble discerning what is important from what is irrelevant in their interactions (van der Kolk, 2005). An understanding of the neurobiology and genesis of these disrupted brain and endocrine processes can help educators and counselors realize that calming strategies assist adolescents in coping and becoming competent.

When children are securely attached and feel safe, they are more likely to trust their emotions and understanding of the world. Thus, they rely on these interpretations as accurate guides in dealing

with stressful situations. Since they feel understood by significant others, they have a healthy self-esteem and confidence in their endeavors (van der Kolk, 2005). On the other hand, unrelenting fear from pervasive threats in the home, community, or school may result in neurophysiologic adaptations. Early traumatic experiences remain unprocessed in the non-verbal, sub-cortical regions of the brain, i.e., amygdala, thalamus, and hippocampus. Therefore, these memories are not accessible to the reasoning pre-frontal cortex. The unfinished and potentially defensive actions or energy become blocked and undischarged throughout the peripheral nervous system. These responses to threat include hyperarousal, the fight or flight response, or hypoarousal, the freeze response. The individual's experiences become frozen in an unfinished state of intense readiness to react to a perceived trauma. The resulting behaviors and emotions manifest as symptoms of trauma. In other words, the amygdala processes emotion before the cortex receives the message and may alarm the system inappropriately to what may in reality be a benign event. There is a perpetual alarm even after a threat of danger has ceased. What is supposed to be a healthy survival response has gone "amok" (Wylie, 2004a, 2004b; van der Kolk, 2005).

The consideration of puberty as being a critical time for intervention has received attention in studying brain reorganization during this stage. Schore (2001) points out that the adolescent brain is progressing through significant changes, particularly in the refinement of neuronal pathways through a process called "synaptic pruning". Thus, adolescent brain development and reorganization is nearly as significant as those processes during infancy. Hormones impact the activation of the amygdala, which is responsive to emotional reactivity, even more so in adolescence whereas, adults typically respond to emotional events with more frontal cortex activation. Early trauma impacts synaptic pruning, resulting in hyperarousal, difficulty with self-soothing, impaired affect regulation, difficulty coping with stress, and diminished potential for positive emotional experiences. Adolescence is an ideal time to effect change in the aforementioned affective processes, by helping teens shift affective processing from being predominantly in the amygdala

to the orbital pre-frontal cortex. This improves their mood regulation, responsibility taking, and social adjustment (Schoore, 2001).

### **Counseling Strategies and Recommendations for Educators**

The issue now for counselors and educators is to find ways to assist young adolescents who have experienced trauma. In order for learning to take place, they need help in developing ways to calm and soothe themselves, particularly when they are facing an unsettling situation. Then, they may begin to learn appropriate ways to respond to academic challenges, social interactions, and perceived conflicts. Educators and parents can refrain from using punitive strategies that may aggravate the way teens react to the plethora of stressful events at school and home. Creating a sense of safety, both in the counseling setting and in the school milieu, helps the student “decompress” from the chaos and trauma (Bradley, 2007). Educators and counselors can manage aggressive behavior by minimizing the possibilities for occurrence, providing supportive interactions with students, and participating in training opportunities to identify and deal with the root causes of the disruptive behavior (Besag, 1989).

This can be accomplished through a coordinated effort involving administrators, teachers, counselors, parents, and family therapists who are working closely with the school. Students detect the subtleties of the “hidden curriculum” on appropriate school conduct and demeanor (Wilezenski et al., 1994). Educators need ongoing support and encouragement in maintaining the safety and containment that are so crucial in helping adolescents cope in the school environment (Shapiro, DuPaul, Bradley, & Bailey, 1996; Steele, 2007). Secure boundaries for adolescents provide protective effects which mitigate the chronic chaos that may be happening at home.

Core counseling beliefs are crucial in working with traumatized youth: compassion, commitment to support the youths’ efforts, trust that counseling and education have an impact, and humility in realizing that the counselor or educator may or may not witness positive change in the adolescents.

The following description is one of the author’s personal

accounts of working with traumatized adolescents who have been referred by school administrators, teachers, or counselors due to disruptive behavior or learning difficulties.

When I first meet clients, I allow them to take initiative in deciding where they want to sit, want me to sit, and how close, and what they want to know about me. I allow them to check me out before I ask them how they ended up being “in trouble”, what they think got them into trouble, and what needs to happen for things to improve. I explore what they like to do and who their friends are. I tentatively inquire about parents and siblings and with their assistance develop a simple genogram that shows a little about their family.

Frequently the issues involve fighting, defiant behavior, or explosive anger. I explore if they can remember a time when it started and what was happening at that time. They often recall some particularly difficult event that they have minimized in their evaluation of its impact on them and their behavior.

Throughout this beginning attempt to establish trust and safety, I am paying close attention to breathing, body tension, eyes tearing up, or foot tapping. I acknowledge that what they are talking about may bring up feelings that they do not like and they can stop the conversation at any time. Usually they don't. When they are experiencing some discomfort concerning their memories, I offer a way of calming themselves. I'm very directive in instructing them about breathing and relaxing the body. We practice this and then discuss the experience of calming down. I tell them that this is something they can do any time or place when they start to feel panicky, angry, or hurt, or at night when they are going to sleep.

I acknowledge their experiences, accept how they are coping with their feelings and begin to explore other ways of responding to what triggers the troublesome behaviors. These are beginning steps in building a trusting counseling relationship. Next, I ask them to locate where in their bodies they experience anger, dread, or threats. Many proceed from threat to reaction without awareness of what is happening in their bodies. Practicing progressive relaxation is one way to help them learn to pay attention to tension and calm and exercise control within their body.

After some success with self soothing or relaxing, then they may be ready to cognitively process questions such as: How do they know someone is a threat? What tone of voice, body language, and facial expressions are triggers? What could they do differently? What would happen if they didn't react so quickly? These are initial steps in helping adolescents develop ways to regulate themselves well enough to function in the classroom and interact appropriately with their peers. There is much to be gained from these counseling strategies and more to accomplish.

The evidence about lingering effects of trauma comes as no surprise to counselors, educators, those who work in the juvenile justice system, and adolescents themselves. Counselors and educators are asking youth to substitute one set of behaviors that "works" for another set of behaviors that may improve their life. Behaviors that society has deemed unacceptable, such as: using a variety of drugs, risk-taking behaviors, defiance, aggression, or isolating behaviors, in some way bring comfort and a sense of personal power to these traumatized youth. How do educators and mental health professionals wean these adolescents from the very things that these youth believe help them survive? What strategies are beneficial to their efforts to change? The challenge for educators and mental health professionals is to shift from using punitive measures to providing a safe environment with clear boundaries, opportunities to learn self-regulation, and supportive interventions. Safety and containment are the crucial elements in helping youth cope in the school setting (Bradley, 2007).

## References

- Avieger, O., Resnick, G., Sagi, A., & Gini, M. (2006). School competence in young adolescence: Links to early attachment relationships beyond concurrent self-perceived competence and representations of relationships. *International Journal of Behavioral Development*, 26(5), 397-409. Retrieved on October 28, 2007, from <http://jbd.sagepub.com>

- Besag, V. (1989). *Bullies and victims in school*. Milton Keynes, England: Open University Press.
- Bradley, M. (2007, August 9). *Counseling victims of sexual trauma: The three stages of healing*. Course workbook and workshop presented for Cross Country Education, Tulsa, OK.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACEs) study. *American Journal of Preventative Medicine*, 14, 245-258.
- Perry, B. D. (2001). *Violence and childhood: How persisting fear can alter the developing child's brain*. A special ChildTrauma AcademyWebSite version of: *The neurodevelopmental impact of violence in childhood*. Retrieved on May 11, 2007 from The ChildTrauma AcademyWeb site: [http://www.childtrauma.org/ctamaterials/vio\\_child.asp](http://www.childtrauma.org/ctamaterials/vio_child.asp)
- Schore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Hillsdale, NJ: Lawrence Erlbaum Assoc.
- Schore, A. N. (2001). The effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal*, 22, 7-66. Retrieved April 3, 2007, from <http://www.trauma-pages.com/a/schore-2001a.php>.
- Schwarz, E., & Perry, B. D. (1994). The post-traumatic response in children and adolescents. *Psychiatric Clinics of North America*, 17(2), 311-326.
- Shapiro, E. S., DuPaul, G. J., Bradley, K. L., & Bailey, L.T. (1996). A school-based consultation program for service delivery to middle school students with attention-deficit/hyperactivity disorder. *Journal of Emotional and Behavioral Disorders*, 4, 73-81.
- Steele, W. (2007). Trauma's impact on learning and behavior: A case for interventions in schools. Reprinted from *Trauma and Loss: Research and Interventions*, 2(2) 2002 (Revised May 2007). Retrieved October 28, 2007, from <http://www.tlcinst.org/impact.html>.

- van der Kolk, B. A. (1996). The body keeps the score: Approaches to the psychobiology of posttraumatic stress disorder. In B.A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: the effects of overwhelming experience on mind, body and society* (pp.214-241). New York: Guilford Press.
- van der Kolk, B. A. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35(5), 401-408.
- van der Kolk, B. A., Spinazzola, J., Ford, J., Blaustein, M., Brymer, M., Gardner, L., et al. (2003). *Complex trauma in the National Child Traumatic Stress Network*. Retrieved October 28, 2007, from <http://www.NCTSNet.org>.
- Wilezenski, F. L., Steegman, R., Braun, M., Freeley, F., Griffin, J., Horowitz, T., et al. (1994). *Promoting "fair play": Interventions for children as victims and victimizers*. Paper presented at the annual meeting of the National Association of School Psychologists, Seattle, WA. (ERIC Document Reproduction Service No. ED380744)
- Wylie, M. S. (2004a). The limits of talk: Bessel van der Kolk wants to transform the treatment of trauma. *Psychotherapy Networker*, 28(1), 30-67.
- Wylie, M. S. (2004b). Mindsight: Dan Siegel offers therapists a new vision of the brain. *Psychotherapy Networker*, 28(4), 29-39.