**////Title: Understanding How Adolescents Respond to Trauma**

**////Standfirst**

Children and youth who experience trauma often develop posttraumatic stress symptoms, and some go on to develop posttraumatic stress disorder or PTSD. Toria Herd from the Pennsylvania State University, US, is exploring the factors that put adolescents at risk of developing PTSD and also those that may protect against this consequence associated with trauma exposure. Her findings have important implications for the trauma-informed care of young people and the reduction of the long-term impact of trauma on individuals and families.

**////Maintext**

Forty-five percent of children and youth in the US have experienced trauma in some form. This can range from parental substance use, significant loss or death, natural disasters, and serious medical events, to interpersonal violence, including child abuse and neglect. These experiences often result in posttraumatic stress symptoms which can be defined as feelings of stress, fear, and helplessness that manifest as re-experiencing the trauma, avoidance of reminders of the trauma, and alterations to one’s stress reactivity.

Although the emergence of posttraumatic stress symptoms following exposure to trauma is common, these symptoms can vary in intensity, and only 16% of youth go on to develop a clinical diagnosis of posttraumatic stress disorder or PTSD. Even for survivors of child maltreatment, including child physical and sexual abuse and child neglect, PTSD estimates only range from 30% to 38%. These estimates suggest that youth respond to trauma in different ways and that PTSD is nota certainty after exposure to trauma. In fact, it may not even be the most typical response.

Nonetheless, even low, subclinical levels of posttraumatic stress symptoms can be distressing to youth and have been linked to depression, anxiety and substance use disorders. Understanding which experiences are most likely to trigger posttraumatic stress symptoms and which youth exposed to these experiences are most at risk of developing chronic posttraumatic stress symptoms is extremely valuable. If we can identify the most vulnerable youth, we can intervene with effective personalised treatment options – and stave off future negative consequences associated with trauma.

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Our first step was to identify the factors that put adolescents at risk for posttraumatic stress symptoms, and also the factors that might facilitate adaptive, healthy responses. We built a comprehensive theoretical model based on different factors in the literature that have been linked to PTSD. These included the type of trauma experienced, as well as individual factors such as age, race, self-esteem and religiousness, and social factors such as parent and peer relationship quality.

We used this model to understand the factors that increase risk for or protect against certain trends in posttraumatic stress symptoms across adolescence in a sample of 498 adolescent girls exposed to trauma. All participants reported having experienced at least one potentially traumatic experience and about half had experienced childhood maltreatment.

We found that 56% of our adolescents experienced recovery from their posttraumatic stress symptoms, demonstrating a trend of an initial elevation of symptoms following trauma exposure that decreased over time and all but disappeared. A further 25% of our adolescents experienced moderate levels of chronic posttraumatic stress symptoms that remained stable over time. Finally, 19% of our adolescents experienced high levels of chronic posttraumatic stress symptoms, that increased slightly over time.

These findings highlight two key points. First, there is notable heterogeneity in adolescents’ trauma responses. Second, high levels of chronic, clinically significant posttraumatic stress symptoms were experienced by only a minority of the adolescents following exposure to trauma. This suggests that the experience of chronically elevated posttraumatic stress symptoms is far from the most common response.

We then used our predictive model to differentiate who demonstrated which trend of posttraumatic stress symptoms based on the array of predictor variables. The most potent risk factor for high, chronic posttraumatic stress symptoms was child sexual abuse.

In explanation of this, there are several mechanisms that may distinguish child sexual abuse from other forms of trauma. For example, traumatic sexualisation, which is unique to sexual abuse, can fundamentally interfere with sexual development, beliefs and norms. Often perpetrated in secret and under the guise of love, sexual abuse violates a personal sense of safety and can elicit feelings of powerlessness and shame which can amplify posttraumatic stress symptoms. Child sexual abuse also tends to occur for long durations and is widely considered to be a highly stressful developmental context which can overwhelm the body’s stress response system and increase the risk for mental health issues.

We also found that racial and ethnic minority youth were much less likely to report chronic posttraumatic stress symptoms than their non-minority counterparts. Although racial and ethnic minority youth experience higher rates of exposure to trauma (especially witnessing and experiencing violence) than white youth, racial and ethnic minority youth seem less likely to meet the criteria for PTSD.

We believe that there are many reasons why racial and ethnic minority youth may demonstrate resilience to trauma. In the field of psychology, strength-based models emphasise that youth chronically exposed to adversity, including racial stress, may adjust to their environments by developing various competencies that allow them to thrive in the face of adversity. Positive identity formation for racial and ethnic minority youth – and Black youth in particular – is likely influenced by a history of systemic racism in the US as well as by persisting discrimination and microaggressions which necessitate the use of race-related stress appraisals and coping strategies. The repeated use of these specific strategies may well translate into skills and competencies that aid in responding to trauma.

Furthermore, ethnic and cultural socialisation central to the cultures of many racial and ethnic minority youth often instils racial pride, teaches skills to deconstruct racism, and promotes a positive racial identity, ultimately building higher self-esteem and safeguarding against psychological distress. Racial and ethnic minority youth are also more likely than white youth to have intergenerational family systems, kinship networks, and faith-based supports that can offer protection against more severe trauma responses.

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Given the legislative interest in both trauma-informed care and racial disparities in health over the past few years, now is an opportune moment for psychology, social work, public health, and related fields to entreat evidence-based policy aimed at better serving youth exposed to trauma. Trauma survivors are often served by multiple systems, highlighting the importance of cross-system collaboration in trauma-informed care. Policy efforts that create incentives and infrastructure to aid in the expansion of trauma-informed approaches across systems of care, access to evidence-based services and programmes, and evaluation of these models should be prioritised. In particular, existing policy levers such as healthcare access may be used to provide comprehensive universal screening for trauma, promote upstream prevention and early intervention, and increase access to treatment for trauma survivors.

Attempts to stabilise youth exposed to trauma as early as possible will not only increase the odds of their optimal development but also hold promise for reducing the long-term consequences of trauma, including its intergenerational transmission as affected children become parents themselves.

This SciPod is a summary of the paper ‘Individual and Social Risk and Protective Factors as Predictors of Trajectories of Post-traumatic Stress Symptoms in Adolescents’, published in *Research on Child and Adolescent Psychopathology*. DOI: https://doi.org/10.1007/s10802-022-00960-y

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