CHAPTER 4

What To Do When Trauma-Impacted Youth Get Triggered

When I first met Joaquin he was in an alternative high school for youth struggling in conventional schools. Many of the youth at this small, community-based school were involved in the probation system or foster care system, or had behavioral issues in conventional high school. Joaquin actually fit none of those criteria. He wasn't on probation, nor involved in the foster care system. He was referred to this school only because his family noticed him struggling with grades.

In the community where he grew up, Joaquin had known many youth involved in gangs, who'd been incarcerated and been victims and perpetrators of violence. He was referred to me because he was suspected of smoking marijuana on campus. He presented with a bravado and a slight resistance to therapy not uncommon to many of the 16-year-old young men I'd worked with in the system.

At the time, I was working at this school twice a week for a few hours each day helping out with youth who got in trouble with the law or had been caught smoking marijuana. I had no office, so I'd always have to find empty classrooms to conduct my therapy sessions.

One afternoon something significant happened while meeting with Joaquin. We were engaged in a conversation about his community and how it was impacting his life, along with his reasons for smoking marijuana. Without any prompting from me, Joaquin started talking about his father.

JOAQUIN: "Yeah, I haven't seen my dad in a long time. I guess maybe that has something to do with me smoking."

I paused at this moment, attuned to what I sensed to be some emotion coming up, and before I could get a word in he continued.

JOAQUIN: "Fuck, man. I fucking witnessed some shit with my dad. They fucking beat him. Fuck. I mean . . ."

At that moment it was clear that he was becoming triggered; a memory was activating his nervous system and he was having trouble finishing his sentences. Again, in the moment I thought to intervene but he beat me to the punch.

JOAQUIN: "They . . . I can't . . . fuck!"

All of a sudden he aggressively got out of the desk chair and before I knew it, SMACK! With no warning he hit the classroom door with a closed fist as hard as he possibly could. He paced back and forth for a few moments; tears were starting to flow down his face; and he looked to me with an expression on his face that suggested he may not have been fully conscious of this outburst.

Later in session, after he'd calmed down, he described a frightening scene when he was 9 years old. He witnessed his father being deported. His father was beaten, stripped naked in the street, thrown in the back of a police car, and deported shortly thereafter. Although Joaquin stayed in touch with this father, they hadn't seen each other in person for approximately 7 years.

Working with youth impacted by trauma is complex. Given the complex resilience factors of a given youth, there are times when they function relatively well in school, at home, and socially. Other times, seemingly out of nowhere, they can become triggered and their central nervous system tells them they're in imminent danger. Even youth who've been multiply traumatized over the course of their lives do not always operate in a triggered state

(i.e., fight, flight, freeze, or feign). Behavioral and psychological defense or protective mechanisms become known as *traumatic adaptations* and manifest in complex defense systems that interact with neurophysiologically triggered states (which we'll review in more detail in Chapter 9).

The Physiology of Trauma

It's critical to understand how threat, imminent danger, and trauma impact the brain. There are a number of intricate structures in the brain, and research continues to evolve. A basic understanding, however, is all that's needed to respond to triggered youth skillfully.

When an as a 9-year-old Joaquin witnesses his father being beaten and deported, the limbic structures of his brain take over and he's not able to think straight. Psychophysiologist Stephen Porges' Polyvagal Theory offers particular insight into what happens in this situation. The vagus nerve, the largest of the 12 cranial nerves that sit atop the human brainstem, works as an unconscious evaluator of danger and safety. Porges calls this process *neuroception*. This is the central nervous system's ability to assess whether you're safe, in danger, or in a life-threatening situation, all unconsciously.

The inner workings of Joaquin's brain, specifically the limbic system and brainstem, took control of his experience. The thalamus (the gatekeeper) that sits atop the brainstem is responsible for processing external stimuli. The images of his father being assaulted quickly get relayed to the amygdala (the alarm system) and interpreted as extremely dangerous and life threatening. Bessel van der Kolk (2014) calls the amygdala the "smoke detector" because this alarm system alerts us (swiftly and unconsciously) of whether an external stimulus is a threat. From there, the hypothalamus quickly sends a message down the brainstem and a person's body shifts into the fight, flight, freeze, or feigned death response.

The fight and flight responses are both *mobilizing defense systems*. When the body mobilizes to take some kind of action, awareness narrows to focus only on whatever is pertinent for survival. The sympathetic nervous system gets activated and the following symptoms are often present:

- The pupils dilate.
- Saliva flow is inhibited.
- Heartbeat accelerates.
- Bronchi dilate.
- Peristalsis and secretion are inhibited.
- Glycogen is converted to glucose.
- Adrenaline and noradrenaline are secreted.
- Bladder contraction is inhibited.

In the flight response, a person is compelled without thought to flee the situation. The sympathetic nervous system subconsciously mobilizes the person away from the dangerous threat. On the other hand, in the fight response, a person is compelled to stand their ground and fight their way through the dangerous and threatening experience.

In Joaquin's case it was the "fight" response. As a 9-year-old watching his father's arrest, he went into a physical frenzy that led his aunts and uncles to restrain him. His prefrontal cortex, the part of the brain that analyzes, controls impulses, and has the ability to plan (which is not fully developed in a 9-year-old, or a 16-year-old, for that matter) was completely offline, rendering him unconscious of his response.

Fast-forward about 7 years, to when I met Joaquin at his high school. When in our counseling session he stumbled upon that memory of his father being physically assaulted, his central nervous system acted as if he was actually going through the experience again. That's why he got up so abruptly and hit the classroom door without thinking about any of the consequences (e.g., a sore hand or broken bones); his prefrontal cortex was essentially offline and his limbic and autonomic systems were in control. This happens when a youth is triggered, even if the youth is not in any current danger.

Getting Triggered Out of Nowhere

A common symptom of trauma is the misinterpretation of neutral or nonthreatening stimuli as threatening or dangerous. Again, this happens on the neuroceptive level; that is, the person is not conscious and not choosing to get triggered, it just happens.

That is why there will be times when youth get what appears to be irrationally triggered. The therapist may perceive them to be in a safe situation, and they may actually not be in any harm's way, but their neuroception is telling them they are in a dangerous or life-threatening situation. In every workshop I offer on this topic I always ask, "Has anyone ever worked with a young person who's become quite triggered for no apparent reason?" only to have over 80% of the room raise their hands to suggest that they too have had that "What the hell happened?" experience.

A common example referenced in trainings is a person encountering a snake in the woods and being startled. In the future, they may be walking around the corner of their home and become just as startled, and perceive just as much threat when seeing a coiled up hose and mistaking it for a snake. (That's the hippocampus working in tandem with the amygdala.)

This shows up in many ways with trauma-impacted youth. One of the most common situations I hear of involves youth who mistakenly perceive another person's facial expression as a threat when it isn't intended that way.

I once worked with a young man whose trauma history included the following:

> He had a secure attachment to a single mother who sheltered him as much as possible from the violence in his neighborhood. Then, when he was 11 years of age, his uncle was killed. He didn't have much support to deal with his grief, and his grief fueled feelings of anger. As a 12-year-old, he started acting out and becoming aggressive at school. He started hanging out with a social group that reinforced those behaviors, and they started breaking the law and stealing money from other kids. Then, at 13 years old, he was walking home from school and got robbed at gunpoint. He didn't want to beat people up and take their lunch money anymore. He wanted to carry a gun, because it would make him feel safe and it would help him rob people better. By the age of 15, he'd been shot and lost countless friends to gun violence. In other words, he experienced trauma upon trauma from age 11 to age 15.

The above trauma history influenced a grave misinterpretation that almost led to him shooting at a family member:

> One day the young man sees someone across the street waving at him. Because he lives in a community with a lot of gun violence and has had multiple traumatic experiences related to gun violence, he assumes this is a threat (i.e., his neuroception is conditioned to jump to this conclusion). When he sees someone staring at him and waving at him, he starts to clutch the gun he's carrying in his waistband. He's ready to defend himself, going into the fight mode. He doesn't think, "I wonder why that person is waving at me"; he's in a hypervigilant mode. Fortunately, there's someone with him who recognizes the person across the street and says, "Hey, isn't that your cousin?" This helps disengage the young man's fight defense and shift back into the window of tolerance as he remembers his cousin is actually in from out of town (and that he hasn't seen him in years so he didn't recognize him at first glance).

Whether the danger or threat is actually happening, or the individual's neuroception has told them that it is happening even if it isn't, they are at risk for shifting out of the window of tolerance and having compromised cognitive functioning.

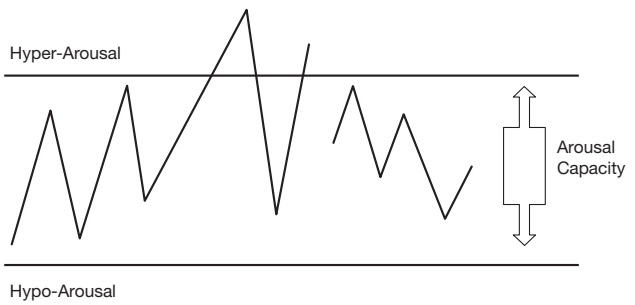
The Window of Tolerance

This window of tolerance is a concept I first mentioned in Chapter 2 (fifth guideline of trauma-informed mindfulness). This concept was developed by Dan Siegel (2012) and is a great way to conceptualize how trauma and dysregulated nervous systems impact youth: In layman's terms, it renders them unable to think straight. If they can't think straight, it will be difficult for them to learn anything new, let alone follow along with an intervention they may not have learned in counseling before.

The window of tolerance can be thought of as a zone of arousal in which a person can experience anything from optimal arousal (i.e., they are in a highly self-regulated state) to tolerable dysregulation (i.e., they may start to

feel uncomfortable or dysregulated but it isn't at a point where their cognitive function and control get entirely compromised). When a person shifts above or below the window, that's when cognitive function and the ability to think, learn, follow directives, and even talk coherently gets compromised. The higher end of the window of tolerance has to do with hyper-arousal and an activated nervous system, while the lower end has to do with hypo-arousal and a deactivated nervous system. Figure 4.1 illustrates this below.

FIGURE 4.1: The Window of Tolerance



Source: Adapted from "Figure 2.1 Window of Tolerance", TRAUMA AND THE BODY: A SENSORIMOTOR APPROACH TO PSYCHOTHERAPY *by Pat Ogden, Kekuni Minton, Clare Pain. Copyright © 2006 by Pat Ogden. Copyright © 2006 by W. W. Norton & Company, Inc. Used by permission of W. W. Norton & Company, Inc.*

Thus far we explained that a youth's neuroception can detect either danger or life threat, whether it's actually there or not (i.e., a symptom of trauma). What then, should the first clinical step be for a person who has shifted toward the edge or out of the window of tolerance? As I'm sure you've probably determined, the goal is to bring youth back into that window first. When their cognitive functioning and social engagement systems come back online, they can be more receptive to other clinical interventions (i.e., relational and cognitive).

Working with Hyper-Aroused Youth

For a youth hyper-aroused like Joaquin, whose traumatic adaptation is to become physically aggressive, a normal assumption would be that we need to calm his hyper-aroused state back into the window of tolerance. We'd use

techniques that depress the central nervous system, such as deep breathing or similar forms of meditation. In theory that's right, but in reality it's much more complex. Remember, his cognitive functioning is compromised and it's difficult for him to speak coherently, let alone take any direction. So our goal is to help him calm down without feeling pushed. Such is the work of the trauma-informed, mindfulness-based therapist.

Helping Joaquin get back into the window of tolerance

Let's return to the moment when Joaquin hit the door. He abruptly gets up out of his chair and runs over to the door and hits it. He then paces back and forth, and it's clear he's shifted above the window of tolerance into a hyper-aroused state. One clear indication of this is that it's difficult for him to speak coherently; he mostly mumbles a half-word or two while pacing back and forth. This is a sign that his brain is down-regulating.

I know that the delivery of the intervention I choose is critical. So I pause as I notice my central nervous system start to activate and I practice an acronym I developed: TAP (as explained in Chapter 3). I *tap in* to my experience to practice mindful awareness by taking a deep breath (or a few), acknowledging both my experience (slightly activated), and that this behavior from Joaquin (hitting the door aggressively) is a form of defensive self-protection that is most likely rooted in his trauma. This helps me contextualize the whole therapeutic experience as a communication from him to me, and then I proceed to implement the intervention I've chosen.

Bruce Perry's (2016) *reason, relate,* and *regulate* reverse pyramid helps me choose an intervention that aligns with Joaquin's neurophysiological state. Perry's pyramid starts with "reason" at the top, corresponding to a neocortex that is essentially functioning and therefore offers me space to choose from a slew of cognitive interventions. The next level down is "relate," and the furthest down is "regulate," corresponding to a down-regulated brain state in which the neocortex is essentially offline (picture a three-level pyramid with the widest level at the top and the point at the bottom).

Because he's out of the window of tolerance, I sense in the moment that Joaquin is mostly functioning from a brainstem-based experience. I know that given his dysregulation, he needs a self-regulation technique to bring

him back into the window of tolerance. But again, I also know I can't just tell him to do a deep breathing exercise. Even if that's what his system needs most, if I push too much, it could trigger him more.

I attune and discern in those moments with Joaquin that the self-regulation needs to happen in relationship with me in order for him to not push back (i.e., co-regulation). This is why the inherently nonclinical relational activity (INCRA) from Chapter 3 becomes critical. I consult my list of INCRAs that may be useful in the current setting (e.g., a classroom or a school).

A quick aside: It is critical to consider ahead of time the types of INCRAs you can use in the setting where you work. This will help you significantly when a youth you're working with gets triggered.

When a youth is shifting out of the window of tolerance, it's the somatic-based INCRAs that will be most helpful to help get them back within the window of tolerance. When Joaquin was triggered talking about his father, I knew I needed to use an INCRA that would bilaterally stimulate his central nervous system. We'd played cards before, and that had helped build rapport and take the edge off doing therapy. However, in this situation I knew that it probably wouldn't be effective, given that it wouldn't channel the energy that was manifesting in his central nervous system.

There was a basketball court right outside the empty classroom we were in and given that Joaquin was pacing, I managed to motion him to follow me outside the classroom to the basketball court and continue walking. (Walking is a low-level form of bilateral stimulation in and of itself, via the movement of the left and right legs.)

I picked up a basketball and handed it to him. He was still escalated so I continued to motion forward as if to guide him to keep walking. He started dribbling the ball as he walked. At this point he was still breathing heavily, and tears were still running down his face. I gently leaned in as I walked next to him and softly said,

SAM: "I'm with you. Don't feel like you need to do anything right now. We're safe and no one else is around so whatever comes up, I'm here and am not going to judge you."

By commenting this way I'm melding what I'd consider two of Perry's levels: regulate and relate. We're moving our bodies via walking, and Joaquin is dribbling the basketball with both hands. When I tell him "I'm with you," I'm activating that relational level explicitly in his consciousness; it's always there, but that type of comment reminds him. This type of relational comment along with the somatic INCRA of dribbling is co-regulation in action.

He then paused and said,

JOAQUIN: "That shit was just so fucked up. It really made me hate this country."

The first thing I noticed is that Joaquin is able to coherently put a sentence together. That tells me that higher functions of the brain are coming back online and that he's most likely shifting back within the window of tolerance. I listened deeply, staying present and attuned, waiting for him to go on and at times softly practicing skillful self-disclosure for the compassion I felt for him. I led our walk back to the classroom and motioned him to keep the basketball when we went in.

Once back in the classroom we sat down in our desk chairs. He said what many therapists hear at some point in their careers.

"I ain't never told that to anyone before," he said as tears continued to fall down his cheeks. We process for another 20 minutes or so; mostly I practice attunement and compassionate listening, making comments about how courageous he was to express himself and my intention to support him.

Our rapport at this point is extremely strong. He's expressed something to me that he hasn't shared with anyone else verbally. Because of the trust that's grown in our relationship, I know he will be receptive if I share practices like mindfulness. I can leverage our trust to help him be more receptive to a practice like mindfulness because I've proven to him that our relationship is primary and techniques are secondary. He gets a real sense that that I care about him and am not just presenting a technique. This builds the sense we are in it together and he in turn trusts me more, lending future leverage for mindfulness practice.

Working with Hypo-Aroused Youth

Recall the story of the young woman from Chapter 2, Jeannette. She presented primarily with depressive and dissociative symptoms and had a tendency to hypo-arouse. Using a somatic-based INCRA to help a young person self-regulate back into the window of tolerance from a hypo-aroused state is equally as critical as when working with hyper-aroused youth. In this situation, we are attempting to stimulate the central nervous system so it doesn't continuously shut down and send a young person into a freeze, feigned death, or dissociative response. These central nervous system responses are the body's *immobilizing defenses*. That is, when they're triggered the body reacts by shutting down rather than activating. These can be the most compromising of bodily defenses because they often get triggered in life-threatening situations (Porges, 2011).

In the *freeze response,* the body is immobile, but it can be tense or limp. In her book *Trauma and the Body* (2006), Pat Ogden defines two types of freeze responses. In Type 1 Freeze, the body tenses up but the person can act. The person is hyper-aroused, hypervigilant, and their sympathetic nervous system is activated, but they freeze out of survival (i.e., movement might draw attention and therefore more danger, e.g., being so scared of a drunk uncle when he comes home that a young girl freezes so as not to be seen in the living room corner he stumbles into). If detected, the young person in this freeze state can still actually flee the situation.

Type 2 Freeze is also a hyper-aroused state, but the difference is that the individual is so afraid that they're incapable of movement (Ogden, 2006). They are essentially frozen and cannot flee if detected. Thus, while immobilizing defense mechanisms appear as hypo-aroused, there are some types of the freeze response in which the person is actually activated but cannot move.

This is opposed to the *feigned death response,* which some researchers and authors include as freeze responses while others distinguish between them. One of the main characteristics of the feigned death response is that the individual goes into complete hypo-arousal. The heart rate drops

dramatically, the blood pressure drops, and the body goes limp. The person experiencing this often dissociates.

From these states, the body needs to be stimulated back into the window of tolerance. This can be done with INCRAs as simple as getting clients to stand up and walk around (Ogden, 2015) but also sometimes takes innovation when working with young people who may have reservations about the therapy process.

Helping Jeannette get back into the window of tolerance

Recall that when Jeannette first learned of her father's death, she was shocked. This later transformed into full-on hypo-arousal and I used a somatic-based INCRA to help her reregulate. Indeed, that wasn't the first of Jeannette's traumas. What seemed to be her whole family was addicted to drugs, and she was estranged from her father and mostly grew up in foster care and in the care of her extended family. When I met her she was interested in getting back in touch with her father and "reconciling," as she put it.

We began by talking about the topic gradually, and I stayed attuned to Jeannette's mixed feelings by asking mainly open-ended questions and then practicing deep listening. After a number of sessions talking about the subject on and off, Jeannette announced, "I'm ready. I want to get in touch." We talked a little more to get her mentally prepared, and then we agreed that in our next session we'd start calling relatives together to try and get her father's number.

Between that and the next session, Jeannette's father died of a drug overdose. I was alerted to this just prior to our session. Jeannette's grandmother and uncle were present and told her the news. She sat for a few minutes in shock. She didn't weep. She wasn't angry. She was merely shocked. The family stayed for a while trying to console her, but it didn't seem she needed consoling. I assured them I'd return to the class with her and be supportive if necessary.

She was so distraught that we ended up going back to my office rather than class. She began to talk: "I just. . . . I can't believe . . . Damn . . ."

As with my experience with Joaquin, this appeared to be another situ-

ation where language functioning was compromised because the brain was down-regulating. Along with that, her face began to look spacey; the muscles in her face appeared to be flat, and she looked to be getting more dissociated. I took a controlled breath and intervened: "Don't worry about this therapy thing right now," I said. "It can be hard to talk about these experiences. Let's just listen to some music for a little while and see where that goes."

She nodded with agreement as much as her nervous system allowed. She was clearly in the process of shifting down below the window of tolerance to a hypo-aroused, dissociated state.

I pulled up YouTube on the computer, gave her the headphones, and asked her the name of the first song she could think of. It was difficult for her to talk, but she managed to mention the name of a song. She listened to that song for about 3 minutes and slowly started to move her head with the rhythm and beat of the music. Then, she clicked on another song in the YouTube sidebar. After about three more songs, and 10–12 minutes of rhythmically moving her head and upper body to the music, she put the headphones down, turned to me, and said: "I just can't believe it. We were talking about getting in touch with him just a week ago. Damn."

As was with Joaquin above, the first thing I noticed was that she could coherently put a sentence together. It appeared she was back in the window of tolerance. The bilateral stimulation of the act of rhythmically moving to the rhythm and the beat of the music most likely helped her self-regulate. Music is a powerful INCRA for that reason and because it evokes emotion.

I respond to her first with compassion: "My heart is full of compassion for you. I'm so sorry this happened."

"Thank you," she says as she looks over to me with a shocked face that seems to start to show more emotion.

JEANNETTE: "I still just can't believe it. Damn. Damn."

Next, I want to check in with her about how she's feeling in her body as a way to assess if she's continuing to come back into the window of tolerance. After a pause of silence:

SAM: "How do you feel right now in your body?"

JEANNETTE: "I feel . . . It's hard to feel right now."

SAM: "Can you feel yourself breathing?"

JEANNETTE: "Yes."

SAM: "Let's just take a moment and stay with that if that's okay with you and see what happens."

JEANNETTE: "Okay."

After a couple of moments (probably around 20 seconds), we start to talk again. We process her feelings of shock and disbelief. She even expresses sadness, and a couple of tears flow down her face. This is important to note because those who dissociate and get hypo-aroused generally do not cry and show emotion. This tells me she's back in the window of tolerance, where more interventions are available for use.

At this point Jeannette and I had been working with each other almost 7 months. She asked if we could do a combination of prayer and a body scan meditation. I obliged.

The Role of the INCRA and TAP in Co-Regulation

Thus far I've described two examples of working with triggered youth whose nervous systems were dysregulating out of the window of tolerance. Our own self-regulatory capacities in those moments are critical. I described in the instance with Joaquin the practice of TAP (*T*ake a breath, *A*cknowledge, *P*roceed) because it helped me stay in the moment and recognize any negative, disrespectful, or triggering behavior as potentially coming from a trauma response.

It doesn't matter whether you use TAP, or STOP (*S*top, *T*ake a breath, *O*bserve, *P*roceed), or any other of the many mindfulness-based acronyms, or simply pause and become present in your own way to attune to yourself and the youth and transcend your own defense structures in the moment. The key component is the ability to do this so that whatever happens next (i.e., your intervention) comes from a place of presence.

For youth who are hyper-aroused, your ability to calm yourself can potentially have a calming effect on them, just as your ability to stay present and slightly energized can help a youth who's dissociated and becoming hypo-aroused shift up into their window of tolerance. This is mindfulness as applied to you as the therapist (the most critical component).

Another critical takeaway from the above examples is how I did or did not use mindfulness as an intervention. It was clear to me that, given Jeannette and Joaquin's neurophysiological responses, mindfulness as an explicit exercise was not going to be skillful.

It was important that in those moments I was not under the illusion that mindfulness was some silver bullet technique that would work at all times. On the contrary, it was clear that in both of those situations above, attempting to teach mindfulness meditation or even an informal mindfulness technique could have easily triggered both those youth further out of the window of tolerance. That's why somatic-based INCRAs that support bilateral stimulation are so critical.

The activities are inherently nonclinical, so they are not as triggering as a technique. They are also something that's done in the relationship and thus supports the co-regulation between you and the youth and in turn within the youth themselves (i.e., self-regulation).

Trauma manifests in many ways in the classroom, therapy room, and other youth work settings. What's most important is that professionals have an understanding of how trauma affects the brain and how sometimes youths' behaviors really are a result of triggered trauma and not simply a decision to be disruptive. With deeper understanding of present-moment practices such as TAP, along with an understanding of how bilateral stimulation works and the nonevangelizing of mindfulness (as powerful as it is), therapists and other youth workers can be compassionate and respond skillfully. This in turn can enhance therapist understanding and act as a mechanism to build relationships, safety, and trust.