THE TRAUMA INFORMED HELPER

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Case Study: Andrew

Andrew is a 16-year-old, biracial male who identifies as "queer-ish."

Andrew never knew his father. Then, at age four he witnessed the death of his mother from an overdose. They were living in a car at the time. With no family members willing to take him in, Andrew entered foster care. Between the ages of four and fifteen, he had nearly a dozen placements. With each move, his behavior became more problematic – including angry outbursts, lying, hoarding food, and stealing.

At nine, Andrew started drinking alcohol. By eleven, he was using alcohol and marijuana regularly. At fourteen, he discovered meth and eventually went to an inpatient treatment program. He ran after three days, reporting, "Inpatient was stupid. I had to go to my room at, like, 9:00pm and couldn't have any books or music, at least not anything I wanted. Just stupid crap like rainforest sounds. So, I'd just lay there, not sleeping, because nobody goes to sleep that early, and think about stuff. If I didn't leave, I would've gone nuts."

Following inpatient, Andrew's substance-related problems and behavioral issues continued to increase. By sixteen when I met him, he was on probation and had moved into a transitional living program after several months on the streets. He reported his drug of choice was meth and he used "something" every day. "Meth if I can get it, but other things, too... Ritalin, coke, crack. Or just drinking or smoking weed. I'm not that picky, just as long as it gets me altered."

At intake, Andrew met the diagnostic criteria for alcohol use moderate, amphetamine use-severe, cannabis use-severe, cocaine use-moderate, and opioid use-moderate. He also had a long list of pre-existing mental health diagnoses that included PTSD, ADHD, conduct disorder, generalized anxiety disorder, and major depressive disorder.

Andrew reported a desire to stop using amphetamines, cocaine, alcohol, and heroin. "Those things are messing up my life!" However, despite possible legal consequences, he reported no desire to stop using marijuana. "It's my life. People should just leave me alone. Besides, weed is pretty much the only thing I've got... My friends have ditched me. My family wants nothing to do with me. Why would I stop?"

Andrew repeatedly stated that he didn't think treatment was necessary, but at the end of the intake session agreed to enter services. "I gotta do it or I'm going to juvie and I don't want that. Besides living on the street isn't really that great, I guess."

Read the case study above.
Then in small groups, discuss the questions
on the other side.

What are some ways trauma has led to more trauma for Andrew? Within your scope of competence, what are ways to meet Andrew where he's at and disrupt this cycle?

Andrew's ongoing substance use is an obvious example of Surviving Mode behavior. What are some others?

What are some ways that safety, trust, collaboration, and connection have been missing in Andrew's past treatment experiences? What would you do differently?

What would be challenging for you about working with Andrew while staying within your scope of competence, agency/system expectations, and his level of willingness?

RECOMMENDED READING

- **Beautiful Boy**, by David Sheff
- **The Boy Who Was Raised as a Dog**, by Bruce Perry and Maia Szalavitz
- **The Body Keeps Score**, by Bessel van der Kolk, MD
- **The Deepest Well**, by Nadine Burke Harris
- **Ghosts from the Nursery**, by Robin Karr-Morse and Meredith Wiley
- **In the Realm of Hungry Ghosts**, by Gabor Mate
- **The Myth of Normal**, by Gabor Mate
- **No Bad Parts**, by Richard Schwartz
- **Trauma and Recovery**, by Judith Herman
- **Trauma and the Avoidant Client**, by Robert Muller
- **Trauma Stewardship**, by Laura van Dernoot Lipsky
- **Treating Addiction**, by Alyssa Forcehimes, William Miller, and Allen Zweben
- **Treating Trauma in Adolescents**, by Martha Straus
- **Tweak**, by Nic Sheff

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