Child Trauma Measurement & Evaluation

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CTTN
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Overview of Child Traumatic Stress, PTSD, & DTD
Acknowledgments

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• The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of CMHS, SAMHSA, or USDHHS.

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Acknowledgments

The following includes slides from...

Think Trauma: A Training for Staff in Juvenile Justice Residential Settings

Developed by:

Dr. Monique Marrow, Dr. Joseph Benamati, and the NCTSN Juvenile Justice Treatment Subcommittee
Self-Care Alert!

• Step out and take a break.
• Talk to someone you trust.
• Do something relaxing.
The National Child Traumatic Stress Network

The National Child Traumatic Stress Network is supported through funding from the Donald J. Cohen National Child Traumatic Stress Initiative, administered by the Department of Health and Human Services (DHHS), Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA).
The mission of the National Child Traumatic Stress Network (NCTSN) is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States.
What is traumatic stress?

- Exposure to serious injury, actual or threatened death, or violence
- Common causes: physical/sexual abuse, DV, war, community violence, natural disasters, displacement
- Can occur via direct experience or witnessing event, hearing about an event of a caregiver, close family member, or friend, or experiencing repeated or extreme exposure to aversive details
- Reactions vary with age, but even very young children experience intense reactions
Range of Traumatic Events

- Child abuse and maltreatment
- Domestic violence
- Community violence and criminal victimization
- Neglect
- Sexual assault
- Medical trauma
- Traumatic loss
- Accidents/fires
- Natural disasters
- War/Terrorism/Political Violence
- Forced Displacement
<table>
<thead>
<tr>
<th>Children: Signs &amp; Symptoms of Trauma Exposure</th>
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<tbody>
<tr>
<td>✓ Sleep disturbances</td>
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<td>✓ Separation anxiety</td>
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<td>✓ Hyper-vigilance</td>
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<td>✓ Dissociation</td>
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<td>✓ Regressive behaviors</td>
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<td>✓ Withdrawal</td>
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<td>✓ Blunted emotions</td>
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<td>✓ Distractibility</td>
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<td>✓ Changes in play</td>
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<td>✓ Changes in social functioning</td>
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<td>✓ Impulsivity</td>
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<tr>
<td>✓ Aggression</td>
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<tr>
<td>✓ Sadness/negative mood</td>
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</table>
We Learn by Experience
We Learn by Experience
The Fear Response in the Brain
The Fear Response in the Brain

Fight or Flee
Fight, Flee, or Freeze (to protect)

- Hypothalamus
- Hippocampus
- Heart rate and blood pressure increase
- Breathing rate increases
- Release of adrenaline and cortisol
Which children & adolescents develop acute and posttraumatic symptoms?

• Not all children develop symptoms following exposure to a traumatic event

• Studies show that approximately 20% of children who are exposed to trauma develop PTSD symptoms

• Development of symptoms seems to be mediated by a variety of factors
Continuum

Resilience → Severe Distress

Varies by:

• Type of trauma
• Severity
• Chronicity
• Cultural beliefs
• Other experiences
• Timing
• Cumulative risk
Multiple Traumas and Losses

- Most youth by adolescence have experienced a traumatic event, many have experienced multiple traumas --often beginning in early childhood, and recurring over a long period of time.

- Many experienced trauma at the hands of those who were supposed to protect them.

- This chronic trauma can derail physical, emotional, and social development. Chronic trauma influences the way youth think, feel, behave, and interact with others. It influences the way they see the world.
Adverse Childhood Experiences Study (ACES)*

Felitti et al. 1998;
Negative Coping Mechanisms

- Smoking
- Severe obesity
- Suicide attempts
- Alcoholism
- Drug abuse
- 50+ sex partners
- Repetition of original trauma
- Self Injury
- Eating disorders

ACE Score

Risk for these
Symptoms of PTSD

- Re-experiencing (intrusion)
- Avoidance
- Negative alterations in mood & cognition
- Alterations in arousal and reactivity

DSM 5- Four Clusters

- B. Intrusion symptoms (1)
- C. Avoidance symptoms (1)
- D. Negative alterations in mood and cognition (2)
- E. Alterations in arousal and reactivity (2)
**DSM-IV**

A. Exposed to traumatic event. Both are present:

1. Experienced, witnessed, or was confronted with event that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or other.

2. Person’s response involved fear, helplessness, or horror.

**DSM-5**

PTSD in children older than 6 years

A. Exposed to actual or threatened death, serious injury, or sexual violence in 1 or more of these ways:

1. Directly experienced.

2. Witnessed, in person, as it occurred to others. **Note:** witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.

3. Learning that the event occurred to a parent or caregiving figure.

Acute response deleted.
**DSM-IV**

B. 1 or more re-experiencing items:

1. Recurrent and intrusive, distressing recollections of the event.

2. Distressing dreams of the event. In children, there may be unrecognizable content.

3. Acting or feeling as if event were recurring (includes sense of reliving, illusions, hallucinations, and dissociative flashbacks).

4. Psychological distress to reminders.

5. Physiological distress to reminders.

**DSM-5**

PTSD in children older than 6 years

B. 1 or more intrusion items:

1. Recurrent, involuntary, and intrusive, distressing recollections of the event. **Note:** Repetitive play with themes of the event.

2. Distressing dreams of the even where content and affect are related to the trauma.

3. Dissociative reactions (e.g., flashbacks, reenactment thru play) which feel like recurring. (Reactions may occur on a continuum with the most extreme being complete lack of awareness of present surroundings).

4. Psychological distress to cues/reminders.

5. Physiological reactions to reminders.
### DSM-IV

C. 3 or more avoidance or numbing items:
1. Avoid thoughts, feelings, or conversations.
2. Avoid activities, places, or people.
3. Inability to recall an important aspect of the trauma.
4. Diminished interest in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of a foreshortened future.

### DSM-5

PTSD in children older than 6 years

D. 2 or more negative alterations in mood and cognitions

1. Inability to remember important aspects of the trauma
2. Persistent negative beliefs about self, others, or world (I am Bad)
3. Persistent distorted cognitions about cause or consequences (blame)
4. Persistent negative emotional state (fear)
5. Diminished interest in significant activities, including play.
6. Feelings of detachment
7. Persistent reduction in expression of positive emotions (happiness)
**DSM-IV**

D. 2 or more increased arousal items:

1. Difficulty with sleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilance.
5. Exaggerated startle response.

**DSM-5**

PTSD in children older than 6 years

E. 2 or more marked alterations in reactivity

1. Irritable behavior/ outbursts
2. Recklessness or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response.
5. Difficulty concentrating
6. Sleep disturbance
C. 3 or more avoidance or numbing items:
1. Avoid thoughts, feelings, or conversations.
2. Avoid activities, places, or people.
3. Inability to recall an important aspect of the trauma.
4. Diminished interest in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect.
7. Sense of a foreshortened future.

**DSM-5**

PTSD in children older than 6 years

C. 1 or more avoidance items:
1. Avoid memories, thoughts, or feelings activities, places, or physical reminders.
2. Avoid people, conversations, or interpersonal situations that are reminders.
Specify whether with dissociative symptoms, as shown by either:

1. Depersonalization: feeling detached from, and as if one were an outside observer of, one’s mental processes or body (e.g., feeling in a dream; sense of unreality of self or time moving slowly).

2. Derealization: unreality of surroundings (e.g., the world around the person is experienced as unreal, dreamlike, distant, or distorted).

Specify: delayed expression
DSM-IV

Duration 1 month

DSM-5

PTSD in children older than 6 years

F. Duration 1 month
G. Impairment in social, occupational or other important areas
H. Not attributable to substance use
How Youth Can Respond to Trauma: Reexperiencing/Reenacting

Re-experiencing/Reenacting: Images, sensations, or memories of the traumatic event recur uncontrollably.

This includes
- nightmares
- disturbing thoughts
- flashbacks
How Youth Can Respond to Trauma: Avoidance

- Avoidance of friends and activities, even those he/she used to enjoy.
- Sometimes youth withdraw to avoid any reminders (thoughts, feeling, memories, things) of the traumatic event.
How Youth Can Respond to Trauma: Negative Alterations in Mood & Cognition

Negative Alterations in Mood & Cognition: persistent negative thoughts about yourself, the world, and others. Failure to remember important parts of the trauma – dissociation

This includes:

• Self blame (It’s my fault)
• Shame
• Cognitive Distortions (I am bad)
• Fear
How Youth Can Respond to Trauma: Dissociation

• One form of withdrawal and avoidance

• Mentally separating the self from the experience

• May experience the self as detached from the body, on the ceiling, somewhere else in the room

• May feel as if in a dream or unreal state

• May lose blocks of time

• May lose touch with parts of the self
How Youth Can Respond to Trauma: Hyperarousal/Reactivity

• Hyperarousal/Reactivity: jumpiness, nervousness, or quick to startle. For some youth this feeling never fully goes away.

• Hyperarousal can lead to hypervigilance: a need to constantly scan the environment and other people for danger.
Behaviors You Often See: What Trauma Can Look Like

- Anger
- Hostility and coldness
- Inability to trust other people
- Perceiving danger everywhere
- Problems with change and transitions
- Acting guarded and anxious

(Kaplow, Dodge, Amaya-Jackson & Saxe, 2005; Shields & Cicchetti, 2001)
Behaviors You Often See: What Trauma Can Look Like

- Difficulty being redirected
- Physical and emotional reactivity
- Difficulty calming down after outbursts
- Difficulty letting go, holding onto grievances
- Regressive behaviors (behaving much younger than his/her age)
- Rejecting support from peers and adults

(Kaplow, Dodge, Amaya-Jackson & Saxe, 2005; Shields & Cicchetti, 2001)
Comorbidity

PTSD

- Anxiety Disorders
- Sleep Disorders
- Thought Disorders
- Disruptive Behavior Disorders
- Substance Abuse
- Eating Disorders
- Dissociative Disorders
- Somatoform Disorders
Limitations of PTSD Diagnosis for Children

- Conceptualized from an adult perspective
- Identified as diagnosis via Vietnam vets and adult rape victims
- Focuses on single event traumas
- Is not developmentally sensitive and does not reflect the impact of trauma on brain development
- Many traumatized children do not meet full diagnostic criteria
- Does not direct clinical attention to attachment history and attachment-related injuries
Beyond Posttraumatic Stress Disorder

Developmental Trauma Disorder (van der Kolk, 2005) proposes that following exposure to multiple, chronic adverse interpersonal stressors, including neglect, emotional abuse, violence, children develop symptoms of dysregulation across multiple areas:

- Affective (emotional)
- Somatic (physiological, motoric, medical)
- Behavioral (re-enactment, cutting)
- Cognitive (dissociation, confusion)
- Relational (clinging, oppositional, distrustful)
- Self-attribution (self blame, hate)
Cluster B: Affective and Physiological Dysregulation

Ostrowski et al., 2009

![Bar chart showing comparison between DTD+ and non-DTD groups for Depression, Somatization, Sleep disorder, and Dissociation with p-values (**p<.001) for each category.](chart.png)
Cluster C. Attentional and Behavioral Dysregulation.

Ostrowski et al., 2009

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The graph shows the percentage of individuals with and without DTD (Disruptive Trauma Disorder) with regard to substance abuse, behavior problems at home, and behavior problems at school. The data indicates significant differences in these behaviors between the two groups, with a p-value of less than .001 for behavior problems at home and at school.
Cluster D. Self and Relational Dysregulation

Ostrowski et al., 2009
Complex PTSD

Problems with

- Regulation of Affect & Impulses
- Cognitive Functioning/Dissociation
- Somatization
- Sense of Self
- Relationships
- Systems of Meaning
Update on DTD Field Trial
Resilience is the ability to recover from trauma. What supports resilience?

- Family Support
- Peer Support
- Competence
- Self-efficacy
- Self-esteem
- School Connectedness
- Spiritual Belief
Screening and Assessment: Clinical Activity
Benefits of Assessment

• Screening for trauma is opportunity to validate, begin exposure, identify maladaptive cognitions
• Targeted assessments improve the quality of clinical practice and outcomes
• Good evaluation tool when tied to other implementation and outcome measures
• Results from assessments can be used to promote program development and sustainability
• Can enhance organizational support for EBP
What is Your Assessment /Intake Workflow?
Elements of Engagement (Mckay)

• Clarify the process (assessment, treatment)
  – Clarify expectations

• Set the foundation for a collaborative process
  – Roles and responsibilities → shared goals

• Focus on immediate, practical concerns
  – Demonstrates commitment and capacity to help

• Identify and problem solve around barriers to help seeking
  – Time, transportation, cultural issues, previous experiences, fear of systems, system navigation/negotiation barriers, etc.
Ways to Complete the Assessment

• Put assessment on agenda & connect it to treatment
• Using the waiting room: self-administered format
  – Caregiver completion of CBCL
• During the session: interview format
  – With youth...allows for collection of additional ‘data’ (affect & physiological signs)
    * For youth, ask follow-up questions after you’ve completed the measure
  – Parents with reading problems

• Can complete over 1-3 sessions (balance with engagement)
Making Assessments Child-involved & Helping Motivate Kids to Complete Them

• Use developmentally appropriate strategies...
• For school-age youth & young adolescents
  – Dry erase board/chalk board for marking answers
  – Small rewards for each ‘set’ of questions completed.
  – Praise for ‘hard work’ on completing questions
• For all youth (& parents)
  – Attention span & age determines whether this is 5 questions or an entire questionnaire)
• Complete 1 or 2 measures each session so session can include therapeutic activities
Multiple Reporters

• Can get seemingly conflicting information; but it is all useful for case formulation

• Adults: better reporters of *Externalizing* “acting out” problems
  – Behavior at home
  – Behavior at school

• Youth: better reporters of *Internalizing* “feelings or emotional” problems
• **Young children are strongly affected by parental reactions**

**Young Children**

• Be aware of developmental differences in manifestation of symptoms
• Often present with generalized anxiety symptoms
• Fears of separation, stranger anxiety
• Re-enactment in play or drawings
• Loss of recently acquired developmental skills
  – Regress in areas like feeding, toileting
• Uncharacteristic aggression, irritability
Reactions to Trauma - Summary

• Nature & severity of symptoms can vary from child to child
  – Asymptomatic
  – Delayed onset of symptoms
  – Moderate distress
  – Major mental health disorders (severe distress)

• Absence of problems may be the result of:
  – Active symptom suppression
  – Avoidant coping strategies
  – Resilience
Special Considerations

- Assess safety
  - Identify environmental and contextual risks & understand the level of risk of harm
- Safety Planning
- Parent’s Perception of Abuse
  - Mandated to tx. by the court or DSS
  - Dispute allegations
  - Minimize the impact
  - Low engagement (barriers, readiness to change)
Assessment

- Accurate
- Comprehensive
- Followed by reasonable tx. planning
- Ongoing
- Risk assessment
  - Suicidal/homicidal ideation
Assessment of Children – Cont.

- Developmentally informed
- Abuse-specific outcomes
- Abuse-informed cognitions & symptoms
- Other behavioral and emotional problems that may not be the result of the abuse experience
- Functional impairments in multiple domains
  - Home, school, community
Assessment of Parent-Child Relationship

- Nature of the relationship
  - Offender- victim
  - Parent-child relationship
- Quality
  - Affection
  - Conflict
  - Discipline
  - Trust
  - Attachment
  - Parental response to child’s symptoms/misbehavior
Clinical Case Activity

Lisa
Case Based Learning Rationale

- It is important to sharpen the skill of staffing and conceptualizing cases
- Each of you may use this in your practice in preparing for working with children and families
- It will help you accelerate your learning on consultation calls
Lisa - 12 year old Female

Lisa is a 12 year old Nepali female who immigrated here at 12. While in Nepal, she witnessed domestic violence between her mother and father, to include her father hitting her mother, pulling her down a flight of stairs, and threatening her with a knife. Her mother left Nepal when Lisa was 9, leaving Lisa in the care of different relatives. While living with these relatives, Lisa experienced two sexual assaults by strangers as well as seeing dead bodies from political unrest in Nepal. Lisa reports irritability, nightmares, and trouble falling asleep, not wanting to think or talk about her sexual assaults, feeling unconnected to others, and being anxious a lot. Lisa blames herself for being sexually assaulted, saying that she would frequently go out alone at night and that is when the rapes occurred. Lisa’s mother eventually brought Lisa over to this country. Mother has since remarried. Lisa is also somewhat of a behavior problem for her mother, often yelling at mother or getting in fights over chores.
• What do you see as Lisa’s primary clinical difficulties/presenting problems?

• What do you see as some possible clinical treatments that might be a good match for Lisa?
Discussion

• What do you see as Lisa’s primary clinical difficulties/presenting problems?

• What do you see as some possible clinical treatments that might be a good match for Lisa?
Concerns About Assessments

- **Time** to administer
- **Time** to score/interpret
- **Time** involved to get scores back
- Providing Feedback
- Engagement/ Cultural Relevance
- ‘Fit’ with Clinical interview
- All those questions!!!!
- Access to measures, interpreters, other resources
Using a Run Chart

• What are the 2 or 3 problems that, if addressed, would help this family be in a much better place?
  – The problems should be relevant to your job as a therapist
  – May select symptoms from UCLA or other measures

• Measure these things every week through parent and/or child report
## Example of Weekly Measurement

<table>
<thead>
<tr>
<th>Parent</th>
<th>Circle Your Rating</th>
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<tbody>
<tr>
<td>How stressed are you about parenting your child?</td>
<td>None</td>
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<tr>
<td>How much are you feeling you wish you could escape what has happened to your child/family?</td>
<td>None</td>
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<tr>
<td>How many times has Jasmine been suspended in the last week?</td>
<td>None</td>
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</table>

<table>
<thead>
<tr>
<th>Child:</th>
<th>Circle Your Rating</th>
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<tbody>
<tr>
<td>How much are the scary things that have happened to you popping into your mind when you don’t want them to?</td>
<td>None</td>
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<td>How much are you watching out for danger or things you’re afraid of?</td>
<td>None</td>
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<td>How much have you felt angry, grouchy, or mad?</td>
<td>None</td>
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</tbody>
</table>
Sample Weekly Run Chart for Kira

Symptom Tracking - Parent Report

Kira

Target Symptom A (session started: 1)
Road: Feeling upset when reminded of sexual abuse

Target Symptom B (session started: 1)
Road: Not wanting to think about sexual abuse

Target Symptom C (session started: 1)
Road: Feeling Irritable / Angry

Target Symptom D (session started: 1)

Target Symptom E (session started: 1)
### Trauma History Timeline: Male Age 12

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Standardized Measures (Child)

Trauma Exposure & Symptoms
- Exposure to Violence (Amaya-Jackson, 1995 adapted from Richters & Martinez)*
- Child PTSD Checklist (Amaya-Jackson & March, 1995)*
- Trauma Symptom Checklist for Children (Briere, 1996)*
- UCLA PTSD Reaction Index (Child & Adolescent, Steinberg, Pynoos, et al)

Depression
- Children’s Depression Inventory (Kovacs, 1992)*

Broad-band
- Youth Self Report Form (Achenbach, 1991)*
- Strengths and Difficulties Questionnaire (Goodman et al., 1997)
Assessments – TSCC-A

• Trauma Symptom Checklist for Children – Alternate (TSCC-A)
  – 44 items (does NOT include items on sexual behaviors/problems)
  – Subscales = Anxiety, Depression, Anger, PTS, Dissociation
  – Critical items
  – Scores reported as T-scores (standardized)
    • T-Score of 65 or higher indicates serious problem(s) in that domain
    • T-Score of 60-64 suggests difficulty/sub-clinical
  – Also includes validity scales
    • Underresponse (Und)
      – >70 = invalid
    • Hyperresponse (Hyp)
      – >90 = invalid

Available at PAR http://www4.parinc.com/Products/Product.aspx?ProductID=TSCC
Assessments – UCLA PTSD-Index for DSM-IV

UCLA PTSD – Index for DSM-IV

• Assesses for DSM-IV PTSD symptoms (5 point-likert)
• Indicates whether the child meets each of three criteria (B -Re-experiencing, C - Avoidance, D - Hyperarousal) required for a diagnosis
• Can also be used as a continuous measure (cut-point of 38 associated with increased likelihood of having PTSD)
• Measure also assesses exposure to more than 20 different traumatic events (CDS uses general trauma and detail forms to assess exposure)


Available at: UCLA Trauma Psychiatry Service
Email: HFinley@mednet.ucla.edu
Assessing Lifetime Trauma History with the UCLA PTSD-RI (Items 1-14)

UCLA PTSD INDEX FOR DSM IV (Child Version, Revision 1)

Below is a list of VERY SCARY, DANGEROUS OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some people have had these experiences, some people have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen to you.

**FOR EACH QUESTION:** Check "Yes" if this scary thing HAPPENED TO YOU
Check "No" if it DID NOT HAPPEN TO YOU

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<tbody>
<tr>
<td>1</td>
<td>Being in a big earthquake that badly damaged the building you were in.</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>2</td>
<td>Being in another kind of disaster, like a fire, tornado, flood or hurricane.</td>
<td>Yes</td>
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<td>3</td>
<td>Being in a bad accident, like a very serious car accident.</td>
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<td>Being in place where a war was going on around you.</td>
<td>Yes</td>
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<td>5</td>
<td>Being hit, punched, or kicked very hard at home. (DO NOT INCLUDE ordinary fights between brothers &amp; sisters).</td>
<td>Yes</td>
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<td>6</td>
<td>Seeing a family member being hit, punched or kicked very hard at home. (DO NOT INCLUDE ordinary fights between brothers &amp; sisters).</td>
<td>Yes</td>
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<td>7</td>
<td>Being beaten up, shot at or threatened to be hurt badly in your town.</td>
<td>Yes</td>
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<td>Seeing someone in your town being beaten up, shot at or killed.</td>
<td>Yes</td>
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<td>Seeing a dead body in your town (do not include funerals).</td>
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<td>Having an adult or someone much older touch your private sexual body parts when you did not want them to.</td>
<td>Yes</td>
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<td>11</td>
<td>Hearing about the violent death or serious injury of a loved one.</td>
<td>Yes</td>
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<td>12</td>
<td>Having painful and scary medical treatment in a hospital when you were very sick or badly injured.</td>
<td>Yes</td>
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Trauma History Profile
## Chronic/Repeated Trauma

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<td>Robbery</td>
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<td>Assault</td>
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<td>Homicide</td>
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<td>Suicide</td>
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<tr>
<td>Suicide Attempt</td>
<td>□</td>
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<tr>
<td>Bullying/Discrimination</td>
<td>□</td>
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</tbody>
</table>

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The National Child Traumatic Stress Network (NCTSN)
## Loss/Separations

<table>
<thead>
<tr>
<th>Loss/Separations</th>
<th>AGE(S) EXPERIENCED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1  2  3  4  5  6  7  8  9  10  11  12  13  14  15  16  17  18  19  20</td>
</tr>
<tr>
<td><strong>Traumatic Bereavement</strong></td>
<td>□ Parent □ Sibling □ Friend □ Primary Caregiver □ Other Relative</td>
</tr>
<tr>
<td><strong>Divorce</strong></td>
<td>□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □</td>
</tr>
<tr>
<td><strong>Extended Separation and Displacement</strong></td>
<td>□ Foster Care □ Refugee □ Parent in Prison □ Parent Hospitalized</td>
</tr>
</tbody>
</table>

---

**NCTSN**
The National Child Traumatic Stress Network
Assessments – CBCL

Child Behavior Checklist (CBCL)
- Completed by parent/caregiver
- Can be self-administered (or read to parent)
- Caregiver uses their own judgment on scoring each item
- Competence scales plus list of problem behaviors

Scoring based on extensive research in clinical and non-clinical populations
- Clinical = “in the clinical range” – definitely a problem
- Borderline = “in the borderline range” – subclinical, but potential problem
- Not Applicable = not a problem for this child/not developmentally Appropriate

Available at ASEBA  http://www.aseba.org/
Standardized Measures (Parent)

Parental Distress
- Brief Symptom Inventory-18 (Derogatis)
- Symptom Checklist-90-Revised (Derogatis, 1983)*
- Beck Depression Inventory (Beck, 1996)*
- Trauma Symptom Inventory (Briere, 1995)

Parental Stress
- Parenting Stress Index/Short Form (Albidin)

Parental Reports of Child Functioning
- Child Behavior Checklist (Achenbach, 1991)*
- Child Sexual Abuse Inventory (Friedrich, 1998)*
- Trauma Symptom Checklist for Young Children (Briere, 2004)
Assessment of Parents

- Parental Distress/Stress
- Parent Trauma History
- Level of belief & support about the abuse/trauma
- Attitudes towards violence
- Behavior management skills/deficits
- Degree of responsibility taken for abuse/trauma
- Empathy
- Cultural beliefs & values
Summary

- Screening and assessing for trauma is beneficial to clients, clinicians and administrators
- Targeted assessments improve the quality of clinical practice and outcomes
- Assessment can be a potent evaluation tool when tied to other implementation and outcome measures
- Results from assessments can be used to promote program development and sustainability
- Requires organizational readiness and support to sustain this clinical practice
How does intervention help children?

- Provides safety and stability
- Counselors can assist the family in getting legal help, advocacy, or access to other services
- Counseling provides an opportunity for children to talk about their worries and fears
- Counseling can also provide parents with information about how to talk to the child about the violence.
Barriers to Services & Treatment

• Cultural and linguistic barriers
  – Norms and mores: violence, relationships, children, health
  – Use of an interpreter
  – Definitions of disease/illness; stigma
  – Expectations about health & wellness (cure vs. treatment)

• Gender related barriers
  – Exploitation/mutilation/rape

• Financial constraints

• Poor awareness of available services (consumers)/poor awareness of complex health needs (providers)

• Social and geographic isolation

• Distrust (government, social service providers)

• Fear of deportation
Implementation & Dissemination
NCCTS Learning Collaborative on Adoption & Implementation of EBT®

- Toolkit
- Fidelity Guidelines

12 Month intensive collaborative with faculty & practitioner teams

Emphasis on:

• Clinical competence
• Fidelity to the EBT model being used
• Implementation capability for providers
• Use of Improvement methods to achieve necessary change
• Sustainability strategies

Used in 50+ Learning Collaboratives across the country
Components of an NCCTS Learning Collaborative

Figure adapted from the Institute for Healthcare Improvement (IHI), Breakthrough Series Model, 2003.
Fixen, Naoom, Blase, Friedman & Wallace (2005)
http://nirn.fmhi.usf.edu
Fixen, Naoom, Blase, Friedman & Wallace (2005)
## Evidence-Based Practices Matrix

<table>
<thead>
<tr>
<th>EBP</th>
<th>Incredible Years (IY)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>The Incredible Years: Parents, Teachers, and Children Training Series is a comprehensive set of curricula designed to promote social competence and prevent, reduce, and treat aggression and related conduct problems in babies, toddlers, young children, and school-aged children. The interventions that make up this series—parent training, teacher training, and child training programs are guided by developmental theory concerning the role of multiple interacting risk and protective factors (child, family, and school) in the development of conduct problem.</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>Two long range goals: The first goal is to provide cost-effective, early prevention programs that all families and teachers of young children can use to promote social, emotional, and academic competence and to prevent children from developing conduct problems. The second goal is to provide comprehensive interventions for teachers and parents that are targeted at treating and reducing the early onset of conduct problems in young children (ages two to eight years).</td>
</tr>
<tr>
<td><strong>Target Population</strong></td>
<td>Ages 2-8yrs old; Targets youth who may have behavioral problems (e.g., oppositional, defiant, conduct problems or other disruptive behaviors); Targets parents with harsh or ineffective parenting practices.</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>This intervention has been offered in community mental health centers, housing units, churches, schools, and child care centers.</td>
</tr>
<tr>
<td><strong>Cultural Factors/Adaptations</strong></td>
<td>The Incredible Years (IY) Parenting program has shown promising effects in many random control group studies with diverse cultures in the as well as in other countries</td>
</tr>
<tr>
<td><strong>Cost Implementation</strong></td>
<td>On-Site Training: $1500-$2000 per day for trainer x 3-4 days (this will be cost effective if you have more than 8-10; Agency or school may purchase one set of tapes to be shared by multiple group leaders (approximately $1000-$1300 per series); Leader manuals (leaders will want their own manuals) Cost $150 x # of leaders plus shipping charge. Suggested Budget $1500 per program</td>
</tr>
</tbody>
</table>

**NCTSN**

The National Child Traumatic Stress Network
## Evidence-Based Practices Matrix

<table>
<thead>
<tr>
<th>EBP</th>
<th>Incredible Years (IY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk/Benefit</td>
<td>Applicable to kids 2-8 with behavioral problems</td>
</tr>
<tr>
<td></td>
<td>Can be used by new providers, paraprofessionals, teachers</td>
</tr>
<tr>
<td></td>
<td>Relatively short curriculum</td>
</tr>
<tr>
<td>Qualifications of Providers</td>
<td>Group leaders come from many disciplines, including counseling,</td>
</tr>
<tr>
<td></td>
<td>social work, psychology, psychiatry, nursing, and education.</td>
</tr>
<tr>
<td></td>
<td>Potential Group Leaders should have training in child development, behavior management and group process</td>
</tr>
<tr>
<td>Materials</td>
<td>Tapes, manuals, handouts, etc.</td>
</tr>
<tr>
<td>Assessment Measures</td>
<td>Achenbach Child Behavior Checklist, Eyberg Child Behavior Inventory, Parent Practices Interview</td>
</tr>
<tr>
<td>Sustainability Factors</td>
<td>Cost of training &amp; materials</td>
</tr>
<tr>
<td></td>
<td>Easily implemented within the community</td>
</tr>
<tr>
<td></td>
<td>Training certification program available at additional costs</td>
</tr>
</tbody>
</table>
http://learn.nctsn.org
http://kb.nctsn.org

NCTSN Knowledge Bank

The National Child Traumatic Stress Network Knowledge Bank provides access and referral to the resources, programs, projects and people that are part of the Network. Most resources cataloged here are just a click away! The Knowledge Bank also features resources from organizations outside the Network.

* Use Search Resources for quick access.
* Browse Resources by categories.
* Use Advanced Search for power searching.

Click About in the box at the right for detailed information on searching.

New Additions

**Economic Crisis Resources**
A series of resources developed by NASP and school psychologists to “support students, families, and school staff affected by the economic crisis.”

http://www.nasponline.org/educators/economic....

**Resilience Guide for Parents & Teachers**
Helps parents and teachers assist children of different ages to build resilience through practical steps that help them manage stress and reduce feelings of anxiety and uncertainty. Also available in ...


**Teen Dating Violence: Fact Sheet 2012**
The fact sheet defines dating violence, also known as date rape or acquaintance rape, explains whose at risk and describes the long term consequences of dating violence. The publication also provides ...

http://www.cdc.gov/ViolencePrevention/pdf/Tee...
An Introduction to the New Data Collection Efforts in the NCTSN: Using Technology to Improve Care

Ernestine Briggs-King, John Fairbank, Lisa Richardson, Carrie Purbeck, & Meghan Gurlitz
Measurement-based Care in the National Child Traumatic Stress Network (NCTSN)

• Patient-centered approach that promotes data driven individualized care

• Assessment forms an individualized collaborative treatment planning process.
Measurement-based Care in the NCTSN

- Evidence that EBPs & MBC improve the outcomes of adults treated for depression in primary care.

- EBPs & MBC reduce relapse rates in adults treated SUDs/AUDs.
Measurement-based Care in the NCTSN

Based on NCTSN experience and consensus recommendations for constructs, variable domains and specific measures to be used for measurement-based care of children and adolescents exposed to traumatic stress.
CIMI
Clinical Improvement through Measurement Initiative

Working together to raise the standard of care and improve outcomes for children exposed to trauma.
Content & Enhancements

• Reduce burden on families and clinicians
• Expand trauma history (Commercial Sexual Exploitation/Trafficking, Bullying, Bereavement vs. Spearation)
• Capture Lifetime Service Involvement
• Expand indicators of health and developmental disability
• Assess strengths and resiliency
• Expand domains covered by standardized assessments
• Enhance our assessment of special populations (Military, Refugees, 0-6)
Incorporating Regular Measurement

1. Baseline
   - New Client
   - Initial Intake

2. Trauma History
   - Trauma Event 1
   - Trauma Event 2
   - Trauma Event 3

3. Follow-up
   - Client Visit
   - Update Information

NCTSN - The National Child Traumatic Stress Network
Features

Measurement & Assessment
NCTSN supported FREE access to multiple measures and assessments with real-time scoring.

Reporting & Dashboards
Customizable dashboards and reports. Track client progress and visualize your positive impact.

User Levels
Site Administrator can enter data for multiple clinicians. Clinicians can manage cases with their own account.

Mobility
Off-line administration capabilities. Compatible with mobile technology.
Benefits of participation

**Children and Families**
Participate in shared decision-making. Collaborate in the development of treatment goals. Actively monitor progress.

**Clinicians**

**Supervisors**
Monitor client trends, demographic characteristics, and outcomes. Highlight areas of strength and identify gaps in services. Make program and organizational recommendations.

**Centers and Agencies**
Ensure continuity of care across providers and over time. Systematically track patients and groups. Monitor quality improvement efforts. Utilize findings to engage key stakeholders. Make data-driven decisions.

**Network**
Identify and share effective strategies for quality improvement. Develop standards for trauma-focused assessment and measurement. Monitor outcomes and make data-driven decisions and system improvements. Inform national policy and key stakeholders.
Anna is a 14 year old Hispanic girl who was referred for therapeutic services by a family court judge following an arrest for engaging in prostitution. Anna shared with her therapist that she currently sleeps only 3-4 hours per night, always feels nervous and has a lot of nightmares. Anna is proud of her excellent writing ability and academic achievement, but shares that she has not been submitting assignments at school and was recently suspended for skipping class.

During her intake evaluation session the clinician was able to get Anna’s full trauma history which includes sexual abuse by her babysitter from ages 5-8, physical abuse by her stepfather at age 7, domestic violence between her mom and step dad at ages 7-11 which eventually resulted in his incarceration. At age 12 Anna was placed in a residential facility for three months for aggressive behavior, truancy, and repeated alcohol and drug use. She also reports community violence from 11-14. Anna continues to use substances to deal with the persistent thoughts about her abuse and has started to exchange sex for drugs and money.
Technology Demonstration
Traumatic Childhood Experiences: Preliminary Findings from the Core Data Set

Ernestine C. Briggs-King, PhD
UCLA- Duke University National Center for Child Traumatic Stress
Duke University, School of Medicine
Acknowledgments

• The work described in this study is funded through the Center for Mental Health Services (CMHS), Substance Abuse & Mental Health Services Administration (SAMHSA), U.S. Department of Health & Human Services (USDHHS) through cooperative agreement SM 3530249 with the UCLA-Duke University National Center for Child Traumatic Stress.

• The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of CMHS, SAMHSA, or USDHHS.

• We are grateful to the leadership, staff, children, youth, and families participating in the NCTSN centers throughout the U.S. who have made this collaborative work possible. Special thanks to the members of the Data and Evaluation Program. We also thank our colleagues and partners at CMHS/SAMHSA for their leadership and guidance.
Scope

• Traumatic events are a pervasive part of children’s lives
  – Estimates vary by type, definition & sample
  – More than 2/3 of youth report exposure to at least one significant trauma by 16
  – More than 1/3 report exposure to multiple traumatic events by 16
Background

• Early and repeated trauma is associated with heightened risk for a myriad of maladaptive coping, outcomes, and psychosocial sequelae (Cook et al., 2005; van der Kolk, 2003; Richardson, Henry, Black-Pond, & Sloane, 2008).

• Adverse childhood experiences have been linked to increased risk for morbidity and/or mortality.

• Expanding our understanding of adverse and traumatic experiences is crucial to accurate diagnosis, treatment selection, and development of national policies.
Background

• Few *prospective* studies of the consequences of ACEs during childhood and adolescence
  – Many ACE studies involve *retrospective* reports concerning adverse events that occurred several decades prior
• Many ACE studies assess a *limited range of only 10 adverse life events*
  – *Abuse* - emotional abuse, sexual abuse, physical abuse
  – *Neglect* - emotional neglect, and physical neglect
  – *Household dysfunction* - domestic violence, parental separation or divorce, mental illness in household, household substance abuse, & criminal household member
Study Questions

Aim: Build on the ACE framework by exploring additional types of trauma exposure

1. Describe the patterns of trauma exposure, risk profiles, and outcomes for subsamples of children and adolescents in the NCTSN Core Data Set.

2. Identify behavioral and functional impairments associated with specific patterns of trauma exposure.
Continuum

Resilience ← Continent ← Severe Distress

Varies by:

- Type of trauma
- Severity
- Chronicity
- Cultural beliefs
- Other experiences
- Timing
- Cumulative risk
Adverse Childhood Experiences and Maladaptive Coping Strategies

The Adverse Childhood Experiences Study

Dr. Felitti – Kaiser Permanente

Dr. Anda – Center for Disease Control and Prevention
Adverse Childhood Experiences (ACE) Study

• Examines the health and social effects of ACEs throughout the lifespan among 17,421 members of the Kaiser Health Plan in San Diego County
  – Household dysfunction
  – Abuse
  – Neglect
Adverse Childhood Experiences Study (ACES)*

*Felitti et al. 1998;
Negative Coping Mechanisms

- Smoking
- Severe obesity
- Suicide attempts
- Alcoholism
- Drug abuse
- 50+ sex partners
- Repetition of original trauma
- Self Injury
- Eating disorders

ACE Score → Risk for these
What Impact Do ACEs Have?

As the number of ACEs increases, so does the risk for negative health outcomes.

- 0 ACEs
- 1 ACE
- 2 ACEs
- 3 ACEs
- 4+ ACEs
Possible Risk Outcomes:

**Behavior**
- Lack of physical activity
- Smoking
- Alcoholism
- Drug use
- Missed work

**Physical & Mental Health**
- Severe obesity
- Diabetes
- Depression
- Suicide attempts
- STDs
- Heart disease
- Cancer
- Stroke
- COPD
- Broken bones
NCTSN Core Data Set

- **Data on >14,000 children**
- Demographic and living situation information
- Trauma history and detail
- Indicators of severity/impairments
- Clinical evaluation
- Treatment services

Standardized Assessment Measures

**PTS Symptoms**
- UCLA PTSD Reaction Index
- Trauma Symptom Checklist for Children-Alternate (also taps associated difficulties: depressive symptoms, anxiety)

**Behavioral and Emotional Difficulties**
- Child Behavior Checklist

CDS measures: administered at treatment entry, end of treatment (if short term) or every 3 months
# CDS: Demographics Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N=14,088</th>
</tr>
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<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>M=10.5 yrs</td>
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<tr>
<td>SD=4.3 yrs</td>
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<tr>
<td>Range=0-21 yrs</td>
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<tr>
<td>0 to 5</td>
<td>17.2%</td>
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<tr>
<td>6 to 12</td>
<td>48.7%</td>
</tr>
<tr>
<td>13 to 18</td>
<td>33.8%</td>
</tr>
<tr>
<td>19 to 21</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>48.5%</td>
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<tr>
<td>Female</td>
<td>51.5%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
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<tr>
<td>Black/African American</td>
<td>29.3%</td>
</tr>
<tr>
<td>White</td>
<td>51.0%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
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<tr>
<td>Hispanic/ Latino</td>
<td>28.3%</td>
</tr>
<tr>
<td><strong>Living Arrangements</strong></td>
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<tr>
<td>Home with Parents</td>
<td>49.5%</td>
</tr>
<tr>
<td>With Relatives</td>
<td>12.1%</td>
</tr>
<tr>
<td>Foster Care</td>
<td>8.5%</td>
</tr>
<tr>
<td><strong>SES</strong></td>
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</tr>
<tr>
<td>Eligible for Public Insurance</td>
<td>56.0%</td>
</tr>
</tbody>
</table>
Most Commonly Reported Trauma Types

- Loss/Separation: 47.9%
- DV: 47.2%
- Impaired caregiver: 43.6%
- Emotional abuse: 37.7%
- Physical abuse: 29.9%
- Neglect: 29.0%
- Sexual abuse: 23.9%

- Not mutually exclusive
- There are 20 trauma types

Percentage of Children & Adolescents

NCTSN
The National Child Traumatic Stress Network
### Most Commonly Reported Functional Impairments

<table>
<thead>
<tr>
<th>Problems in the Home/Community</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior Problems at Home</td>
<td>59.1%</td>
</tr>
<tr>
<td>Attachment Problems</td>
<td>44.1%</td>
</tr>
<tr>
<td>Criminal Activity</td>
<td>7.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social and School Functioning</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Problems</td>
<td>52.0%</td>
</tr>
<tr>
<td>Behavior Problems in School</td>
<td>47.0%</td>
</tr>
<tr>
<td>Problems Skipping School</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Taking Behaviors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self injury</td>
<td>12.7%</td>
</tr>
<tr>
<td>Suicidality</td>
<td>13.9%</td>
</tr>
<tr>
<td>Inappropriate sexual behaviors</td>
<td>15.8%</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>7.2%</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>5.7%</td>
</tr>
<tr>
<td>Running away</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

- Impairments in multiple domains
### Most Commonly Reported Clinical Problems

<table>
<thead>
<tr>
<th>Clinical Problems</th>
<th>% Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>54.8%</td>
</tr>
<tr>
<td>General Behavior Problems</td>
<td>52.0%</td>
</tr>
<tr>
<td>Depression</td>
<td>51.1%</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>38.8%</td>
</tr>
<tr>
<td>Attachment Problems</td>
<td>34.3%</td>
</tr>
<tr>
<td>Traumatic Grief</td>
<td>32.7%</td>
</tr>
<tr>
<td>ADHD</td>
<td>29.9%</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>23.5%</td>
</tr>
</tbody>
</table>
## Service Utilization Prior to Treatment Entry

<table>
<thead>
<tr>
<th>Service Sector</th>
<th>Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Educational Sector</strong></td>
<td></td>
</tr>
<tr>
<td>School Counselor/Psych/SW</td>
<td>26.4%</td>
</tr>
<tr>
<td>Special Class/School</td>
<td>18.1%</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient Therapy</td>
<td>28.4%</td>
</tr>
<tr>
<td>Case Management</td>
<td>27.1%</td>
</tr>
<tr>
<td>In-home Counseling</td>
<td>9.6%</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>12.2%</td>
</tr>
<tr>
<td>Residential Treatment Center</td>
<td>5.4%</td>
</tr>
<tr>
<td><strong>General Medical</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care MD/Pediatrician</td>
<td>18.1%</td>
</tr>
<tr>
<td><strong>Child Welfare</strong></td>
<td></td>
</tr>
<tr>
<td>Social Services</td>
<td>37.1%</td>
</tr>
<tr>
<td>Foster Care</td>
<td>21.2%</td>
</tr>
<tr>
<td>Treatment Foster Care</td>
<td>5.6%</td>
</tr>
<tr>
<td>Group Home</td>
<td>2.4%</td>
</tr>
<tr>
<td><strong>Juvenile Justice</strong></td>
<td></td>
</tr>
<tr>
<td>Detention Center, Jail or Prison</td>
<td>3.0%</td>
</tr>
<tr>
<td>Probation Officer or Court Counselor</td>
<td>6.9%</td>
</tr>
</tbody>
</table>

- 64.3% used any type of service
- 35.0% were involved with multiple service systems
As the number of ACEs increases, so does the risk for negative health outcomes.

- 0 ACEs
- 1 ACE
- 2 ACEs
- 3 ACEs
- 4+ ACEs
Percentage of Children Experiencing Cumulative Traumas

Range 1-15 trauma types
Relationship Between Number of Trauma Types & Functional Impairments

“Cumulative Risk of Trauma”

- Behavior Problems at Home
- Attachment Problems
- Behavior Problems in School
- Academic Problems

Percentage of Children & Adolescents

# of Trauma Types

- 1: 29.8 (29.8), 40.7 (40.7), 50.0 (50.0), 53.4 (53.4)
- 2: 33.9 (53.4), 49.3 (40.9), 53.4 (50.0), 56.9 (53.1)
- 3: 36.1 (49.3), 49.6 (44.2), 57.7 (53.4), 67.0 (56.9)
- 4+: 53.1 (44.2), 56.9 (49.6), 59.4 (57.7), 67.0 (56.9)
Relationship Between Number of Trauma Types & Health Risk Behaviors

- Suicidality
- Self-injury
- Substance Use
- Alcohol Use

NCTSN - The National Child Traumatic Stress Network
Dose-Response: Externalizing Problems in Clinical Range

- Aggressive Behaviors
- Attention Problems
- Rule Breaking
- Social Problems

Percent in Clinical Range

Number of Trauma Types

1 2 3 4 5 6 7 8 9 10

The National Child Traumatic Stress Network (NCTSN)
Method: Trauma Type and Context Study

- Participants
  - Age 13-18, with \( \geq 1 \) confirmed trauma exposure
  - \( n = 3,785 \)

- Measures (@ Baseline)
  - Demographics
  - Trauma History Profiles
  - Indicators of Severity/Functional Impairments
  - UCLA PTSD-REACTION Index

- Trauma Groups
  - Family Violence/Maltreatment Group
    - CPA, CSA, Psych. Maltx., Neglect
  - Community Violence Group
    - Community violence, School violence, Extreme Interpersonal Violence
  - Both Family and Community Violence Group
Is There a Dose-Response Relationship?

- Behavior problems in school or daycare
- Problems skipping school or daycare
- Behavior problems at home or community
- Alcohol use
- Substance abuse
- Criminal activity

Number of Trauma Types:

1: N=625
2: N=624
3: N=532
4: N=511
5: N=425
6: N=363
7: N=248
8: N=173
9: N=124
10+: N=160

NCTSN: The National Child Traumatic Stress Network
Method: Young Children & Relational Trauma

• Participants
  - Age 0-5 yrs
  - At least 1 trauma exposure
  - ~ 50% female
  - White (42%), AA (23%)
    Hispanic (26%), Other (9%)
  - n = 1,417

• Measures (@baseline)
  - Demographics
  - Trauma History
    • (1) Traumatic Loss/Separation/Bereavement; (2) Domestic Violence; (3) Impaired Caregiver; (4) Emotional Abuse; (5) Neglect; (6) Physical Abuse; (7) Sexual Abuse
  - Child Behavior Checklist 1½-5
Dose Response: Number of Traumas by Behavior Problems

<table>
<thead>
<tr>
<th>Number of Trauma Types</th>
<th>N</th>
<th>Internalizing Behavior</th>
<th>Externalizing Behavior</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>373</td>
<td>21% 23%</td>
<td>21% 26%</td>
<td>32% 33%</td>
</tr>
<tr>
<td>2</td>
<td>187</td>
<td>26% 28%</td>
<td>21%</td>
<td>38% 38%</td>
</tr>
<tr>
<td>3</td>
<td>125</td>
<td>32% 33%</td>
<td>38%</td>
<td>41%</td>
</tr>
<tr>
<td>4</td>
<td>96</td>
<td>38% 34%</td>
<td>38% 41%</td>
<td>45%</td>
</tr>
<tr>
<td>5</td>
<td>64</td>
<td>45% 45%</td>
<td>27% 45%</td>
<td>36%</td>
</tr>
<tr>
<td>6-7</td>
<td>53</td>
<td>45% 47%</td>
<td>27% 47%</td>
<td>45%</td>
</tr>
</tbody>
</table>

CBCL Score

NCTSN The National Child Traumatic Stress Network

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Changing the course of children’s lives by changing their care
Children & Adolescents in the Clinical Range: Baseline & Last Follow up

<table>
<thead>
<tr>
<th>Condition</th>
<th>Baseline</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Problems*</td>
<td>41.9</td>
<td>13.2</td>
</tr>
<tr>
<td>PTSD*(n=2665)</td>
<td>27.1</td>
<td>10.5</td>
</tr>
<tr>
<td>Traumatic Stress*</td>
<td>9.0</td>
<td>1.5</td>
</tr>
</tbody>
</table>

n.b., Last follow-up may include children still in treatment

*p ≤ .0001
Limitations & Future Directions

Limitations:

• Clinic referred sample, generalizability

Future Directions

• Examine differential patterns or profiles based on trauma histories & other factors (timing of trauma, duration, severity, etc)
• Extend the analysis to include other developmental considerations.
• Explore clinical implications of these findings.
Latent Class Analysis – Developmental Epochs

Probability of PTE Endorsement
Contact Information

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National Center for Child Traumatic Stress
Data & Evaluation Program, Director
919-613-9855
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www.nctsn.org
Unseen Wounds: The Contribution of Psychological Maltreatment to Child and Adolescent Mental Health and Risk Outcomes

Joseph Spinazzola, Hilary Hodgdon, Li-Jung Liang, Julian D. Ford, Christopher M. Layne, Robert Pynoos, Ernestine C. Briggs, Bradley Stolbach, and Cassandra Kisiel
Main questions

- Do Psychologically Maltreated children and adolescents have comparable baseline levels of symptom severity, risk behaviors and functional impairment to Physically and/or Sexually Maltreated youth?
- How does co-occurrence of Psychological Maltreatment (PM) effect clinical profiles of Physically (PA) or Sexually Abused (SA) youth?

Motivation for addressing this topic

- Despite proliferation of EBPs for childhood trauma over past decade, attention to PM remains limited; no EBPs focus on the effects of PM, few include specific considerations, guidelines or recommendations for use with this population; rarely identified as a focus of treatment.
- Adult retrospective research, child clinical observation, and emerging child literature suggest potentially substantive effects of this historically overlooked form of maltreatment, both in conjunction with other forms of maltreatment and as a standalone trauma
“Population” of youth (N = 5,616; 40%) contained in the NCTSN CDS (40% of total database) with positive exposure to one or more of the following three trauma exposure categories in the NCTSN Core Data Set:

- Psychological Maltreatment (PM)
- Sexual Maltreatment (SA)
- Physical Maltreatment (PA)
• PTSD Reaction Index Total Score
• CBCL Internalizing Behavior Scale
• CBCL Externalizing Behavior Scale
• Frequencies of Indicators of Severity (12)
• Frequencies of Clinical Evaluation (Diagnostic Indicators (17))
Results: Clinical Symptoms

• CBCL:
  - PM > problems with Internalizing Behavior on the CBCL than those with either SA or PA
  - PM > problems with Externalizing Behavior than youth with CSA (equal to those with CPA)
  - PM > than combined SA+PA group on Internalizing; marginally lower on Externalizing

PTSD Reaction Index:
- No group differences observed
- PM = combined SA+PA group on PTSD-RI
• PM > frequency on the vast majority (78%; 21 of 27 indicators assessed) of Diagnostic and Severity Indicators.
  - PM > frequency than either SA or PA on 17 (63%) of the severity and diagnostic indicators
  - PM < frequency than either SA or PA on only 6 (22%) indicators
  - In no instance did the PM group exhibit < frequency than both maltreatment comparison groups on any indicator
  - PM > than PA group on five indicators: behavior problems at home, attachment problems, ASD, and GAD; marginally higher odds than PA on skipping school or day care, and self-injurious behaviors.
  - PM > SA group on 17 of 27 (63%) of indicators
  - PM < PA on CD, general behavior problems, and ADH
  - PM < SA on sexualized behaviors, PTSD and, marginally, suicidality.
PM Versus Combined PA + SA

- PM > frequency of nearly all severity and diagnostic indicators than PA+SA (93%; 25 of 27 indicators)
  - PM > SA+PA on 5 indicators (19%)
    - Substance abuse, ASD, GAD, Separation Anxiety, Depression
  - PM < frequency than SA+PA on 2 indicators (7%)
    - PTSD Diagnosis
    - Sexualized Behaviors
PM Potentiates SA & PA

- **CBCL & PTSD Reaction Index:**
  - PM+SA > PTSD, Internalizing and Externalizing
  - PM+PA > PTSD and Internalizing Behaviors

- **Clinical Evaluation and Severity Indicators:**
  - PM+SA > frequency of 63% (17 of 27) of clinical evaluation and diagnostic indicators
  - PM+PA > frequency on 60% (16 of 27) of study indices.
Severity Indicators: Odds Ratios
Summary and Conclusions

• In this study, PM independently contributed to risk for negative youth outcomes to an extent comparable to that associated with exposure to PA or SA: Findings suggest the potency of PM as a risk factor appears to be at least on par with PA or SA across a broad range of adverse outcomes.

• Co-occurrence of PM not only potentiated most clinical outcomes associated PA or SA, but appears to wield disproportionately traumagenic effects on children and adolescents as compared to these other more extensively studied forms of maltreatment; these findings require reconsideration of prevailing cumulative / polyvictimization models of trauma impact.

• PM emerged as the strongest and most consistent predictor of internalizing problems (e.g., depression, GAD, SAD, and attachment problems), as well as substance abuse, an associated coping mechanism and secondary outcome.
Clinical Implications of Study

• PM was the most prevalent form of maltreatment in the NCTSN CDS (38% of all cases reporting trauma exposure information; PM identified in majority (62%) of the 5,000+ maltreatment cases examined in the CDS; nearly 1 in 4 (24%) maltreatment cases comprised exclusively of PM.

• Efforts to increase recognition of PM as a formidable type of maltreatment in its own right should be at the forefront of MH and social service training, including incorporation of education on PM into graduate training curricula and in-service training of child service professionals.

• Psychometric instruments are needed to help providers identify PM, categorize and appreciate various forms of emotional abuse and emotional neglect, and examine the function of PM characteristics (e.g., duration, perpetrator, age of onset) on clinical outcomes.

• Effective, theoretically grounded interventions for PM are needed: it remains empirically untested whether existing child trauma-focused EBPs sufficiently address the broad array of problems and needs of PM-exposed youth, or whether adaptation of existing models or development of PM-focused models would be beneficial or is necessary.
Examining Child Sexual Abuse in relation to Complex Patterns of Trauma Exposure within the National Child Traumatic Stress Network:

Key Findings and Implications

Cassandra Kisiel, Ph.D., Tracy Fehrenbach, Ph.D., Li-Jung Liang, Ph.D., Brad Stolbach, Ph.D., Gene Griffin, J.D., Gary McClelland, Ph.D., Nicole Maj, B.S., Alan Steinberg, Ph.D., Rebecca Vivrette, M.A., Joseph Spinazzola, Ph.D.
1. Youth with multiple, caregiver-related traumas will have unique trauma characteristics including earlier age of onset and longer duration compared to other youth with multiply traumatized youth without caregiver-related trauma.

2. Youth with caregiver-related traumas will have distinct clinical characteristics (e.g., risk behaviors, emotional difficulties) compared to youth with other constellations of traumas.

3. Youth with sexual abuse and other caregiver-related traumas will have a greater range and severity of symptoms and functional difficulties
Preliminary Results: Initial Exploratory Factor Analyses

<table>
<thead>
<tr>
<th>Factor</th>
<th>Trauma Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physical Abuse, Emotional Abuse, Neglect, Domestic Violence, Impaired Caregiver</td>
</tr>
<tr>
<td>2</td>
<td>Physical Assault, Community Violence, School Violence</td>
</tr>
<tr>
<td>3</td>
<td>Illness/Medical Trauma, Serious Injury, Natural Disaster</td>
</tr>
<tr>
<td>4</td>
<td>Sexual Abuse, Sexual Assault</td>
</tr>
</tbody>
</table>
Empirically Informed Study & Comparison Groups

Study Group 1:
Children with 3 or more caregiver related traumas including physical abuse, emotional abuse, neglect, domestic violence, and impaired caregiver including sexual abuse

Study Group 2:
Children with 3 or more caregiver related traumas including physical abuse, emotional abuse, neglect, domestic violence, and impaired caregiver excluding sexual abuse

Comparison Group
Children with 3 or more non-caregiver related traumas including illness/medical trauma, serious injury, natural disaster, community violence, school violence, physical assault, and sexual assault
Trauma History Profiles: Age of Onset

SG 1: CG Trauma w/ CSA  SG 2: CG Trauma w/o CSA
Trauma History Profiles - Duration

Duration/Years

- Physical abuse
- Emotional abuse
- Neglect
- Domestic violence
- Impaired caregiver
- Sexual abuse

SG 1: CG Trauma w/ CSA   SG 2: CG Trauma w/o CSA
Complex Trauma Exposure and Clinical Profiles: Preliminary Results from Standardized Assessments
Trauma Symptom Checklist for Children

Mean Scores

- Anger
- Anxiety*
- Depression**
- PTSD**
- Dissociation*
- Fantasy
- Overt dissociation

SG 1  SG 2  Reference

* P < .05, ** P < .01
Complex Trauma and Clinical Profiles: Areas of Significant Differences between Groups

Clinical Evaluation

- Post Traumatic Stress Disorder*** OR = 2.3
- Depression* OR = 2.9
- Attachment Problems** OR = 2.5
- Sexual Behavioral Problem** OR = 2.7
- Suicidality* OR = 3.8
- Substance abuse*

* P < .05, ** P < .001

NCTSN
The National Child Traumatic Stress Network
Complex Trauma and Clinical Profiles: Areas of Significant Differences between Groups

Indicators of Severity

<table>
<thead>
<tr>
<th>Indicator</th>
<th>SG 1</th>
<th>SG 2</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidality*</td>
<td>10</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>* OR = 1.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexualized Behaviors**</td>
<td>20</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>* OR = 4.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Abuse*</td>
<td>30</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>* P &lt; .05, ** P &lt; .001</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse*</td>
<td>20</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Academic*</td>
<td>15</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>* P &lt; .05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attachment Problems**</td>
<td>30</td>
<td>50</td>
<td>40</td>
</tr>
<tr>
<td>* OR = 2.7</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* P < .05, ** P < .001

NCTSN The National Child Traumatic Stress Network
Summary and Conclusions

• Caregiver–related, ‘complex’ traumas were characterized by earlier age of onset and much longer duration (in years) compared to non-caregiver related traumas.

• Youth exposed to chronic, interpersonal trauma by caregivers may be at greater risk for a range and severity of clinical problems and functional difficulties in comparison to other multiply traumatized youth.

• Exposure to sexual abuse, in the context of other co-occurring CR traumas, was a significant risk factor for several negative outcomes and functional difficulties.

• Youth with CSA as part of their trauma history profile had more significant risk for PTSD symptoms, suicidality, and sexualized behaviors, in comparison to both of the groups without CSA.

• Youth with any constellations of CR trauma were also at greater risk for difficulties in some key areas, including attachment and depression; this is consistent with a complex trauma framework.
Clinical Implications of Study

- This study suggests some important considerations in terms of the staging of treatment. With sexual abuse present, there may be some key areas of concern that will likely need to be a primary focus at the outset of treatment.

- In the context of other CR traumas, the next stage of treatment may need to focus on resolving potentially more persistent, internalizing effects of these traumas and pervasive attachment-related issues once specific CSA issues are resolved.

- This also suggests the importance for using a broad, complex trauma framework and a developmental lens when conducting an assessment and targeting treatment goals for multiply traumatized youth.

- It is also beneficial to determine how clinical interventions might take on a more comprehensive focus and staged or integrated to meet the range of needs associated with different constellations of traumas.