What are Child Traumatic Stressors?
Events that threaten the life of a child or a child’s caregiver, including but not limited to:

- Child Abuse
- Domestic Violence
- Natural Disasters
- Community and School Violence
- Medical Trauma
- Traumatic Loss
- Terrorism
- War-Related Trauma
- Hate Crimes

General Population Studies of Traumatic Stress

The Great Smoky Mountains Study (Copeland et al., 2007)
- A majority of children (67.8%) were exposed to one or more traumatic events by age 16.
- Children exposed to trauma had almost double the rates of psychiatric disorders of those not exposed.

New York City, NY Department of Education Study (Hoven et al., 2005)
- At 6 months post World Trade Center attack, the prevalence of PTSD at 10.6%.
- Over 60% experienced at least one major traumatic event prior to the attacks.
At-Risk Groups: Maltreated Children and Incarcerated Children

The National Incidence Studies (NIS), mandated by the U.S. Congress to establish the incidence of child maltreatment:

- The most recent National Incidence Study (NIS-4) findings indicated that 1 in every 25 children had experienced maltreatment.

National Child Abuse and Neglect Data System (NCANDS, 2007), a federally sponsored analysis of annual data on child abuse and neglect submitted by the states:

- In 2009, 702,000 children were confirmed victims of child abuse and neglect.

Northwestern Juvenile Study (Abram et al., 2004, 2007)

- Of youths 10-18 years of age held in a detention center:
  - 84% reported multiple exposures to trauma with a majority exposed to six or more.
  - PTSD was prevalent and highly co-morbid with other disorders.

At-Risk Groups: Service Members and Their Families

DoD Study of Active and Reserve Component Soldiers (Veilleux et al., 2007)

- Longitudinal study of 88,235 U.S. soldiers returning from Iraq
- Clinicians identified 20.3% of active and 42.4% of reserve component soldiers as requiring mental health treatment.

Study of Reserve Component Soldiers (Veilleux et al., 2007)

- Longitudinal study of 468 U.S. Army National Guard soldiers returning from Iraq who were parents.
- 28% soldiers reported receiving VA psychosocial care
- Soldiers reporting worse PTSD symptoms also reported greater impairments in parenting and couple adjustment during reintegration.

Study of children in deployed military families (Veilleux et al., 2008)

- Study of 1507 parents and their 11-17 year old children.
- Length of parental deployment and non-deployed caregiver mental health were associated with greater child mental health problems both during deployment and reintegration.

Conclusions from the Epidemiological Evidence

- Exposure to traumatic events is associated with immediate and – if untreated - lifelong problems including depression, posttraumatic stress disorder (PTSD), substance abuse, low educational and occupational attainment, and poor medical health.

- Important to understand differences often found in prevalence of exposure to traumatic events and its adverse outcomes, e.g. developmental, age, gender, racial-ethnic, cultural, and contextual.
Impact of traumatic stress

- Traumatic stress manifests as symptoms
  - With or without full disorder
  - Acute stress disorder (<= 1 months post event)
  - Posttraumatic stress disorder (> 1m post event)
- Problem of diagnostic classification system for children
  - No developmental context provided
    - This may be addressed in DSM 5 if proposed inclusion of developmental trauma disorder is accepted
  - So, need to consider symptoms within a developmental context

Traumatic stress symptoms

- Re-experiencing
  - “It keeps replaying in my head”
  - “feels as if it’s happening again”
  - “I keep dreaming about it”
  - “I can’t bear it when something reminds me of it”
- Avoidance
  - “I try not to think about it”
  - “I don’t go near places or people or things that remind me of (the event)”

Symptoms

- Hyperarousal
  - “I find it hard to sleep”
  - “can’t focus on anything”
  - “the smallest thing bugs me”
  - “I jump at the slightest thing”
  - “I’m always scared that something bad will happen”
- Dissociation
  - “I can’t even remember big chunks of it”
  - “It was like I was in a dream – unreal”
Childhood Traumatic Stress Short-term effects: Acute Disruptions in Self Regulation

- Eating
- Sleeping
- Toileting
- Attention & Concentration
- Withdrawal
- Avoidance
- Fearfulness
- Re-experiencing /flashbacks
- Aggression; Turning passive into active
- Relationships
- Partial memory loss

Long Term Effects: Chronic Developmental Adaptations

- Depression
- Anxiety
- PTSD
- Personality
- Substance abuse

Risk factors for posttraumatic stress disorder

- Prior psychopathology (incl. PTSD)
  - Severe early reaction to event
- Trauma history
  - History of exposure to other traumatic events
- Nature of child’s exposure to the event(s)
  - E.g. gruesome sights and sounds
- Intense fear during the event
- Separation from parents during and following injury, exposure, or treatment
- Degree of pain experienced during injury or treatment
Protective factors/processes for posttraumatic stress

• Social support
  — Family, peers, community

• Effective parenting
  — Parenting practices
  — Parents may be more likely than children to experience posttraumatic stress symptoms

• Child’s coping skills
  — Including emotion regulation

Responding to child traumatic stress

• Identification and assessment
• Intervening (at multiple levels)
  — Practice
  — Organization/systems
  — Local and national
    • NCTSN

The National Child Traumatic Stress Network (NCTSN)

Established by the U.S. Congress in 2000 through the Donald J. Cohen National Child Traumatic Stress Initiative, the SAMHSA-funded NCTSN is, in 2011, a collaborative Network of over 130 university, hospital, and diverse community-based organizations, located in 40 states and the District of Columbia, with thousands of national and local partners

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.
Screening and assessment

- Assessment – more detailed, diagnostically oriented evaluation process.
  - May include structured clinical interviews, self-reports, observational and other multi-informant, multi-method data
  - Completed by mental health professional
  - Product is a case formulation, diagnosis, and treatment plan

Notes on the reporting of trauma exposure and symptoms

By children
  - Underreporting consistent with posttraumatic symptoms (i.e. denial)
  - Fear of disclosure; shame; stigma
By their caregivers – underreporting well documented
  - Guilt
  - Denial
  - Concern about child protection involvement
Discrepancy between parent and child report of both history and symptoms
The assessment process

- Assessing trauma in context of ‘regular’ assessment?
  - Becoming ‘trauma-informed’ in organization
- Who does the assessing?
  - E.g., triage unit, therapy clinicians, front line providers
- Types of assessment tools
  - Trauma history assessment
  - Assessing trauma symptoms
  - Other symptoms/issues

Assessing exposure to trauma and violence

- Two key variables to assess:
  - Exposure history
    - Violence exposure scale (Fox)
    - Things I have seen and heard (Richters & Martinez)
  - Symptoms related to the trauma event(s)
    - PTSD reaction index (PTSD-RI; Pynoos et al.)
    - Trauma symptom checklist for children (Briere)
    - Levonn (Richters & Martinez)

Assessing PTSD

- Standardized instruments vs. clinical interview in assessing PTSD diagnostic criteria.
- You should directly ask children (ages 7 and older) about PTSD symptoms relating to a traumatic event. If they are not asked, they are less likely to talk about them!
Interventions for childhood trauma

Children’s exposure to violence: interventions

• Psychotherapy interventions
• Preventive interventions
• Multi-system initiatives

Trauma treatment

• Trauma-focused cognitive behavior therapy
  – See http://tfcbt.musc.edu
  – Validated for 3-18 year olds
  – Essential components:
    • Establishing and maintaining therapeutic relationship with child and parent
    • Psycho-education about childhood trauma and PTSD
    • Emotional regulation skills
    • Individualized stress management skills
Comparison of subsample of children served by Ambit Network vs. NCTSN nationwide data

<table>
<thead>
<tr>
<th></th>
<th>Minnesota (N=836)</th>
<th>Network (N=12,462)</th>
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<tbody>
<tr>
<td>Age at Baseline (Tx Entry) Mean = 12.2; Range = 4-18</td>
<td>Mean=10.47; Range=4-3</td>
<td></td>
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<tr>
<td>Race</td>
<td>Caucasian 62.2%</td>
<td>52.3%</td>
</tr>
<tr>
<td></td>
<td>African American 21.1%</td>
<td>30.4%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Hispanic/Latino 8.5%</td>
<td>26.6%</td>
</tr>
<tr>
<td>Sex</td>
<td>Female 53.1%</td>
<td>52%</td>
</tr>
<tr>
<td></td>
<td>Male 46.9%</td>
<td>47.9%</td>
</tr>
<tr>
<td>Living Situation</td>
<td>Parent(s) 53.5%</td>
<td>53.5%</td>
</tr>
<tr>
<td></td>
<td>Other Relatives 8.1%</td>
<td>12.9%</td>
</tr>
<tr>
<td></td>
<td>Foster care 7.3%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Insurance Coverage</td>
<td>Any insurance 70%</td>
<td>70.4%</td>
</tr>
<tr>
<td></td>
<td>Public 50.7%</td>
<td>60.8%</td>
</tr>
<tr>
<td></td>
<td>Private 20.3%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Most commonly reported traumas: MN vs NCTSN children

Single VS. Multiple Traumas (MN)

\[ M = 4.6 \text{ Range 1-20} \]
Clinical Evaluation (MN; N=836)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>% of children with a probable or definite diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalized Anxiety</td>
<td>35.3%</td>
</tr>
<tr>
<td>Depression</td>
<td>45.7%</td>
</tr>
<tr>
<td>ADHD</td>
<td>25.8%</td>
</tr>
<tr>
<td>ODD</td>
<td>24.9%</td>
</tr>
<tr>
<td>Gen. Behavioral Problems</td>
<td>38.8%</td>
</tr>
<tr>
<td>PTSD</td>
<td>52.2%</td>
</tr>
<tr>
<td>Attachment problems</td>
<td>33.4%</td>
</tr>
<tr>
<td>Traumatic grief</td>
<td>25.3%</td>
</tr>
<tr>
<td>Acute stress disorder</td>
<td>14.8%</td>
</tr>
</tbody>
</table>

Functional Impairments (MN)

<table>
<thead>
<tr>
<th>Category</th>
<th>Somewhat and very much a problem</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problems in the Home/Community</strong></td>
<td></td>
</tr>
<tr>
<td>Behavior problems at home/comm.</td>
<td>50.3%</td>
</tr>
<tr>
<td>Attachment problems</td>
<td>49.2%</td>
</tr>
<tr>
<td>Criminal activity</td>
<td>5.9%</td>
</tr>
<tr>
<td><strong>Social and School Functioning</strong></td>
<td></td>
</tr>
<tr>
<td>Academic problems</td>
<td>47.8%</td>
</tr>
<tr>
<td>Behavior problems in school</td>
<td>41.9%</td>
</tr>
<tr>
<td>Problems skipping school</td>
<td>11.4%</td>
</tr>
<tr>
<td><strong>Risk Taking Behaviors</strong></td>
<td></td>
</tr>
<tr>
<td>Self injury</td>
<td>13.8%</td>
</tr>
<tr>
<td>Suicidality</td>
<td>18.1%</td>
</tr>
<tr>
<td>Inappropriate sexual behaviors</td>
<td>15.9%</td>
</tr>
</tbody>
</table>

Multiple Traumas & Problems in Other Domains of Functioning (MN)
Clinical Outcomes at End of Tx Follow Up on the UCLA PTSD-RI (MN)

Pre and post-treatment changes for MN children on the Child Behavior Checklist

Infant, toddler or child-parent psychotherapy

- Attachment-based model
- Based on the work of Selma Fraiberg
  - “Ghosts in the nursery”
- Lieberman & colleagues at USCF
  - Child trauma research project
  - One year manualized treatment with child-parent dyads
  - Replicated by Toth, Cicchetti and colleagues
Parent-child interaction therapy (PCIT)

- Developed by Sheila Eyberg
- 16-20 session intervention based on parent training targeting 2-7 yr olds with acting-out behavior
- Adapting for use with physically abusive parents
- Aims to change child behavior by improving parenting

Prevention programs for families affected by traumatic stress

- Goal: to prevent or ameliorate symptoms associated with exposure to traumatic events
- Empirically supported programs have clear research evidence for programs' effectiveness in reducing or eliminating the target problem behavior or risk factor
- Databases screen and list promising or model interventions

Prevention best practices: parent training (Oregon model)

- Rationale for parent training in trauma
  - Complexity of post traumatic responses in kids
  - Many traumatized children are not referred for mental health services
  - Key: Child behavior is predicted by parenting, and parenting is compromised under stressful conditions
  - Parents are critical available sources in traumatic contexts!
What is the Oregon Model of Parent Management Training: PMTO?
Tailored to prevent and address problems for youth from preschool through adolescence

- Overt antisocial behavior (noncompliance, aggression, defiance, hyperactivity, fighting)
- Covert antisocial behavior (lying, stealing, truancy, fire setting)
- Internalizing problems (depressed mood, peer problems)
- Substance abuse
- School Failure

PMTO for families affected by traumatic stress

- ADAPT: After Deployment Adaptive Parenting Tools
  - Goal: promote children’s resilience and parents’ wellbeing in families dealing with deployment
  - Group format
  - Includes addition of mindfulness training to address emotion regulation issues, and emotion coaching to help parents support children’s emotion socialization

www.umn.edu
or www.cehd.umn.edu/fsos/adapt