Assessment and Trauma Focused Treatment for Children

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Child and Family Focused Torture Treatment Services Institute
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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.
An Overview of Child Traumatic Stress and PTSD
Range of Traumatic Events

- Trauma embedded in the fabric of daily life
  - Child abuse and maltreatment
  - Domestic violence
  - Community violence and criminal victimization
  - Sexual assault
  - Medical trauma
  - Traumatic loss
  - Accidents/fires
  - Natural disasters
  - War/Terrorism/Political Violence
  - Forced Displacement
What We Know.....

- Violence exposure through families, schools, neighborhoods, communities, and media are at epidemic levels
- Young children are particularly at risk
- Maltreatment of children and violence against women often go hand in hand
- Children suffer severe emotional and developmental consequences from exposure to violence
- The effects of trauma are further complicated by poverty and adversity
What is traumatic stress?

- Exposure to events that involve threats of injury, death, or danger where intense terror, anxiety, and helplessness is experienced.
- Common causes: physical/sexual abuse, DV, war, community violence, natural disasters, displacement.
- Can occur via direct experience or witnessing event, or hearing about an event.
- Reactions vary with age, but even very young children experience intense reactions.
Children: Signs & Symptoms of Trauma Exposure

- Sleep disturbances
- Fear/Worry
- Separation anxiety
- Hyper-vigilance
- Physical complaints
- Irritability
- Emotional upset
- Learning/School difficulties

- Regressive behaviors
- Withdrawal
- Blunted emotions
- Distractibility
- Changes in play
- Changes in social functioning
- Impulsivity
- Aggression
Symptoms of PTSD

- Re-experiencing
- Avoidance/Numbing
- Hyperarousal

**DSM-IV Posttraumatic Stress Disorder**

(American Psychiatric Association, 1994)

- **A) A traumatic event**
  - experienced, witnessed or confronted an event, involving actual or threatened death, serious injury
  - Trauma response involved fear, hopelessness, horror
- **B) Reexperiencing**: intrusive recollections, dreams, flashbacks, (traumatic play), distress w/ exposure to cues, physiological reactivity to trauma cues
- **C) Avoidance**: thoughts, feelings, activities, amnesia
  - Numbing: restricted affect, foreshortened sense of future
- **D) Hyperarousal**: insomnia, irritability, anger outbursts, trouble concentrating, hypervigilance, increased startle, *somatization
  - Duration > 1 month
  - Related impairment
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

**Young children are strongly affected by parental reactions**
Comorbidity

PTSD

- Sleep Disorders
- Affective Disorders
- Anxiety Disorders
- Somatoform Disorders
- Thought Disorders
- Dissociative Disorders / SIB
- Disruptive Behavior Disorders
- Substance Abuse
- Eating disorders

-March & Amaya-Jackson '98
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
Reactions: Refugee Children & Families

- Physical and psychological problems
- Idioms of distress
- Often multiple and complex trauma histories
- May appear asymptomatic
- Many problems are treatable & some problems are preventable
Assessment of Children

- Developmentally informed
- Culturally sensitive/relevant
- Include multiple informants
- Abuse/Trauma-specific outcomes
- Abuse/Trauma-informed cognitions & symptoms
- Other behavioral and emotional problems that may not be the result of the abuse/traumatic experience
- Functional impairments in multiple domains
  - Home, school, community
The Importance of Early Identification

- Difficulties resulting from exposure to trauma can persist (beyond a normal reaction to an abnormal event) and result in PTSD & other impairments.
- PTSD affects children in every area of development (e.g., peer relationships, learning).
- PTSD can lead to increased risk of substance abuse & delinquent behavior.
- Chronic trauma affects brain development and therefore may be particularly harmful for young children.
Screening and Assessment
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
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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)

Pynoos, R., Rodriguez, N., Steinberg, A., Stuber, M., & Frederick, C. (1998). UCLA PTSD Index for DSM-IV. 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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1) Being in a big earthquake that badly damaged the building you were in</td>
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<tr>
<td>2) Being in another kind of disaster, like a fire, tornado, flood or hurricane</td>
<td>Yes</td>
<td>No</td>
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<td>3) Being in a bad accident, like a very serious car accident.</td>
<td>Yes</td>
<td>No</td>
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<td>4) Being in place where a war was going or around you.</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>5) Being hit, punched, or kicked very hard at home. (DO NOT INCLUDE ordinary fights between brothers &amp; sisters).</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>6) 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>
<td>No</td>
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<td>7) Being beaten up, shot at or threatened to be hurt badly in your town.</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>8) Seeing someone in your town being beaten up, shot at or killed.</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>9) Seeing a dead body in your town (do not include funerals).</td>
<td>Yes</td>
<td>No</td>
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<td>10) Having an adult or someone much older touch your private sexual body parts when you did not want them to.</td>
<td>Yes</td>
<td>No</td>
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<td>11) Hearing about the violent death or serious injury of a loved one.</td>
<td>Yes</td>
<td>No</td>
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<td>12) Having painful and scary medical treatment in a hospital when you were very sick or badly injured.</td>
<td>Yes</td>
<td>No</td>
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NCTSN  The National Child Traumatic Stress Network
Trauma History Profile
# Chronic/Repeated Trauma

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<tr>
<th>TRAUMA TYPE</th>
<th>Trauma Features</th>
<th>Primary Features</th>
<th>AGE(S) EXPERIENCED</th>
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<td>□ Victim □ Witness</td>
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<td>Sexual Abuse</td>
<td>□ Penetration □ Non-Family □ Intra-familial □ CPS Report</td>
<td>□ Victim □ Witness</td>
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<tr>
<td>Physical Abuse</td>
<td>□ Serious Injury □ Weapon Used □ CPS Report</td>
<td>□ Victim □ Witness</td>
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<tr>
<td>Emotional Abuse</td>
<td>□ Caregiver Substance Abuse</td>
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<td>Domestic Violence</td>
<td>□ Weapon Used □ Reported □ Serious Injury □ Report Filed</td>
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<tr>
<td>Community Violence</td>
<td>□ Gang-Related □ High Crime □ Drug Traffic</td>
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<td>War/Political Violence</td>
<td>□ ________________</td>
<td>□ Victim □ Witness</td>
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<td>Medical Illness</td>
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## Circumscribed Trauma

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<td>Hospitalized</td>
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<td>Dog Bite</td>
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<td><strong>School Violence</strong></td>
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The National Child Traumatic Stress Network (NCTSN) is a leading organization dedicated to advancing care and understanding for children and youth who have experienced trauma.
# Loss/Separations

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**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/](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
Quality Improvement Initiative: Core Data Set
What is in the CDS?

- Demographic and living situation information
- Trauma history and detail
- Indicators of severity
- Clinical evaluation
- Treatment
- N=14,088

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

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## Demographics

<table>
<thead>
<tr>
<th></th>
<th>Refugee (N=62)</th>
<th>NCTSN (N=12,567)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age at Baseline (in yrs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 to 5</td>
<td>4.8%</td>
<td>17.8%</td>
</tr>
<tr>
<td>6 to 12</td>
<td>35.5%</td>
<td>48.1%</td>
</tr>
<tr>
<td>13 to 18</td>
<td>59.7%</td>
<td>33.8%</td>
</tr>
<tr>
<td>19 to 21</td>
<td>0.0%</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>50.0%</td>
<td>51.0%</td>
</tr>
<tr>
<td>African American</td>
<td>30.6%</td>
<td>29.3%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>35.5%</td>
<td>25.0%</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>46.8%</td>
<td>51.8%</td>
</tr>
<tr>
<td>Male</td>
<td>53.2%</td>
<td>48.2%</td>
</tr>
<tr>
<td><strong>Living Situation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent(s)</td>
<td>72.6%</td>
<td>51.7%</td>
</tr>
<tr>
<td>Other Relatives</td>
<td>9.7%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Foster Care</td>
<td>4.8%</td>
<td>12.0%</td>
</tr>
<tr>
<td><strong>Insurance Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>37.1%</td>
<td>60.6%</td>
</tr>
<tr>
<td>Private</td>
<td>61.9%</td>
<td>8.6%</td>
</tr>
</tbody>
</table>
## Baseline Use of Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Refugee (N=62)</th>
<th>NCTSN (N=12,567)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Educational Sector</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Class/School*</td>
<td>41.8%</td>
<td>18.2%</td>
</tr>
<tr>
<td>School Counselor/Psych/SW</td>
<td>30.6%</td>
<td>26.2%</td>
</tr>
<tr>
<td><strong>Mental Health/Other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detention Center</td>
<td>1.8%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Case Management*</td>
<td>44.6%</td>
<td>27.7%</td>
</tr>
<tr>
<td>Outpatient Therapy</td>
<td>30.9%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>9.1%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Residential Treatment Center</td>
<td>5.4%</td>
<td>5.5%</td>
</tr>
<tr>
<td><strong>General Medical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care MD/Pediatrician</td>
<td>22.2%</td>
<td>17.8%</td>
</tr>
<tr>
<td><strong>Child Welfare</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Services*</td>
<td>17.3%</td>
<td>38.2%</td>
</tr>
<tr>
<td>Foster Care*</td>
<td>7.1%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Treatment Foster Care</td>
<td>1.8%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

*p <.05 for all comparisons

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Trauma Exposure Comparisons: Refugees vs. NCTSN

- Impaired Caregiver: 37.5% (NCTSN) vs. 43.7% (Refugees)
- Emotional abuse/Psych malt: 37.7% (NCTSN) vs. 39.0% (Refugees)
- Physical maltreatment/abuse*: 29.9% (NCTSN) vs. 43.1% (Refugees)
- Domestic Violence: 47.2% (NCTSN) vs. 45.3% (Refugees)
- Community Violence*: 15.6% (NCTSN) vs. 50.0% (Refugees)
- Forced Displacement*: 1.4% (NCTSN) vs. 55.7% (Refugees)
- Traumatic Loss or Bereavement*: 47.9% (NCTSN) vs. 65.0% (Refugees)

*p < .05 for all comparisons
# Most Common Clinical Problems

<table>
<thead>
<tr>
<th></th>
<th>Refugee (N=62)</th>
<th>NCTSN (N=12,567)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Traumatic Stress Disorder</td>
<td>65.5%</td>
<td>54.7%</td>
</tr>
<tr>
<td>Generalized Anxiety*</td>
<td>60.3%</td>
<td>38.5%</td>
</tr>
<tr>
<td>Dissociation*</td>
<td>50.0%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Depression</td>
<td>50.0%</td>
<td>50.4%</td>
</tr>
<tr>
<td>Traumatic Complicated Grief*</td>
<td>48.3%</td>
<td>32.3%</td>
</tr>
<tr>
<td>Attachment Problems</td>
<td>43.1%</td>
<td>34.4%</td>
</tr>
<tr>
<td>Somatization*</td>
<td>41.4%</td>
<td>15.6%</td>
</tr>
<tr>
<td>General Behavioral Problems</td>
<td>39.7%</td>
<td>51.9%</td>
</tr>
</tbody>
</table>

*\(p < .05\) for comparisons

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## Functional Impairments

<table>
<thead>
<tr>
<th>Problem Type</th>
<th>Refugee (N=62)</th>
<th>NCTSN (N=12,567)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problems in the Home/Community</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior problems at home*</td>
<td>44.8%</td>
<td>59.2%</td>
</tr>
<tr>
<td>Attachment problems</td>
<td>41.1%</td>
<td>44.2%</td>
</tr>
<tr>
<td>Criminal activity</td>
<td>3.5%</td>
<td>7.3%</td>
</tr>
<tr>
<td><strong>Social and School Functioning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic problems</td>
<td>55.2%</td>
<td>51.5%</td>
</tr>
<tr>
<td>Behavior problems in school</td>
<td>49.1%</td>
<td>46.9%</td>
</tr>
<tr>
<td>Problems skipping school</td>
<td>16.1%</td>
<td>11.9%</td>
</tr>
<tr>
<td><strong>Risk Taking Behaviors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self injury</td>
<td>7.0%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Suicidality</td>
<td>12.1%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Inappropriate sexual behaviors</td>
<td>14.0%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>5.3%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>3.5%</td>
<td>5.8%</td>
</tr>
</tbody>
</table>

*p < .05

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Adverse Childhood Experiences Study (ACES)*

Felitti et al. 1998;
Multiple Traumas & Functional Impairments

- Academic problems
- Problems skipping school or daycare
- Behavior problems at home or community
- Substance abuse
- Attachment problems

Percent vs. # of Trauma Types

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Refugee Children in the Clinical Range: Baseline and Last Follow up

Percentage of Children & Youth

Measure (T-scores)

Behavior*  | Baseline: 9.8  | Follow-Up: 0
PTSD*      | Baseline: 29.03 | Follow-Up: 6.45
Traumatic Stress* | Baseline: 7.84 | Follow-Up: 1.96

*p ≤ .05

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The National Child Traumatic Stress Network
The Role of Intervention
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
Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical & Sexual Abuse

(www.musc.edu/ncvc)

National Crime Victims Research & Treatment Center
Medical University of South Carolina
Ben Saunders, PhD

Center for Sexual Assault & Traumatic Stress
Harborview Medical Center
Lucy Berliner, MSW

Office of Victims of Crime
U.S. Dept. of Justice
Treatment Guidelines: Children and Adolescents with PTSD


- [www.aacap.org](http://www.aacap.org)
- [www.istss.org](http://www.istss.org)
Trauma Specific Evidence-Based Practices

Available at NCTSNet.org

Summary Table

Treatment Classification Criteria Used by the Office for Victims of Crime’s (OVC’s) Guidelines for the Psychosocial Treatment of Intrafamilial Child Physical and Sexual Abuse


Treatment Classification System
1. Well-supported: efficacious treatment
2. Supported and probably efficacious treatment
3. Supported and acceptable treatment
4. Promising and acceptable treatment
5. Novel and experimental treatment
6. Concerning treatment

Intervention Fact Sheets

Level-of-Evidence Criteria
Treatment Best Practice (Kaufman Report)

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for child sexual abuse
- Abuse-Focused Cognitive Behavioral Therapy/Alternatives for Families Cognitive Behavioral Therapy (AF-CBT) for child physical abuse

--Wilson et al, 2005

- Parent Child Interaction Therapy (PCIT)
TF-CBT Web is an Internet-based, distance education training course for learning Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT).

TF-CBTWeb is offered free of charge.
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Esther Deblinger, Ph.D.
Center for Children’s Support University of Medicine and Dentistry of New Jersey

Judith Cohen, M.D., and Anthony Mannarino, Ph.D.
Center for Traumatic Stress in Children and Adolescents Alleghany General Hospital
Recommended Treatment Manuals


TF-CBT: Just the Facts

- For traumatized children 3-18
- Research initially conducted on sexual trauma, now looking at traumatic grief, and other forms of trauma
- 12-20 one hour sessions
- Homework
- Parent and child seen separately and together
- Research base on clinic setting but has been done in home and schools
- Applied within child developmental framework
Trauma-Focused Cognitive Behavioral Therapy

- Psycho-education and Parent Treatment
- Relaxation
- Affect Modulation
- Cognitive Processing
- Trauma Narrative
- In Vivo Exposure when appropriate
- Conjoint Family Sessions
- Enhancing Future Normal Developmental Trajectory

(Deblinger, Cohen, and Mannarino)
Implementation & Dissemination
NCCTS Learning Collaborative Model

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

NCCTS Training & Implementation Program, 2008
J Markiewicz, L Ebert, L Amaya-Jackson, N Tise
Fixen, Naoom, Blase, Friedman & Wallace (2005)
http://nirn.fmhi.usf.edu
Core Implementation Components

Selection

Integrated & Compensatory

Preservice Training

Consultation & Coaching

Staff Evaluation

Program Evaluation

Facilitative Administrative Supports

Systems Interventions

Fixen, Naoom, Blase, Friedman & Wallace (2005)
Implementation - “Selection and Coordinated Training”

- Selection of practitioners is a neglected area of implementation and needs to really include who will be a good fit with the practice to be implemented
  - Champions and early adopters

- “Train-and-hope” approaches (Stokes & Baer, 1977) do not work!

- Training should include presenting information (knowledge), demonstrations (live or taped) of the important aspects of the practice or program, and opportunities to practice key skills in the training setting (behavior rehearsal; Joyce & Showers, 2002)

  Fixen, Naoom, Blase, Friedman & Wallace (2005)
Key Objectives for Implementation and Sustainability

3 Domains:
* Organizational Support and Capacity
* Family and Child Engagement
* Clinical Competence
NCTSN Products: Some Highlights

[Images of "Children of War" and "The Courage to Remember"]
An Assortment of NCTSN Products

Available on www.NCTSN.org
An Assortment of NCTSN Products

Available on www.NCTSN.org
http://kb.nctsn.org
Contact Information

Ernestine Briggs-King, PhD
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(919) 613-9855

THANK YOU!!!!!
For more information about the NCTSN please visit our website: www.nctsn.org
Questions?