TRAUMA WORLD: THREE DECADES OF INTERVENTION

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DSM-5 (APA, 2013)

Criterion A: Exposure to actual or threated death, serious injury, or sexual violence in one or more of the following ways:

1. Directly experience
2. Witness in person
3. Learning of traumatic event occurring to close family member
4. Experiencing repeated or extreme exposure to aversive details

EXPOSURE IN CLEVELAND AND DETROIT

- Masters Practicum Student (Cleveland)
  - Residential Care
  - Inpatient Dual Diagnosis
- Home Health Care (Cleveland)
- Psychiatric Day Treatment (Detroit)

EXPOSURE IN NORTH CAROLINA AND KENTUCKY

- Children's Mental Health Project
- National Child and Adolescent Well-being Study
- Israeli Presentation and Testing of a Model of Coping and Resiliency
- Refugee Research
- Center on Trauma and Children

CRAIG & SPRANG, 2007

Craig, C. D., & Sprang, G. (2007). Trauma exposure and child abuse potential: Investigating the cycle of violence. *American Journal of Orthopsychiatry*, *77*(2), 296-305.

THEORIES OF VIOLENCE

- **Intergenerational transmission of violence theory –**Males observe violence by adult male figure and the modeling results in adulthood transmission of violence.

- **Mimetic theory**- violence is generated through scapegoating and mimetic desire. People imitate the actions of those they admire and have an inherent need for power. Victims become perpetrators in order to regain power.

- **Developmental Accumulative hypothesis**- as trauma exposure frequency increases so will violent tendencies in adulthood.

TRAUMA EXPOSURE AND ABUSE POTENTIAL

- 1680 caregivers with open, substantiated cases of abuse or neglect who were evaluated at a university-based outpatient assessment and treatment center at the request of public child welfare

- The participants completed the Child Abuse Potential Inventory (CAPI) and a trauma history screen

SAMPLE

- The sample was 50.1 % female, 65.8% Caucasian, and ranged in age from 14 to 72 (M = 33.74, SD = 10.28). The average income was $8938.33 with a range from 0 to $90,000 and the sample averaged 11.20 years of education with a range of 0 to 20 years.

- 725 (43.2%) caregivers of 1680 reported experiencing traumatic events with a mean of 4.84 traumas per individual for the sample of those reporting trauma and ranging from experiencing 1 trauma to 32

RESULTS OF HIERARCHICAL REGRESSION ANALYSIS

- Hierarchical Regression Analysis was employed to determine

- If addition of information regarding eight types of traumatic events improved prediction of child abuse potential in adult caregivers beyond that afforded by differences in age, race, and gender.

HIERARCHICAL LINEAR REGRESSION FOR SQUARE ROOT OF CHILD ABUSE POTENTIAL BY TYPE OF TRAUMA EVENTS

Model	R	R^2	ADJ R^2	SDEE	ΔR^2	ΔF	Sig.
1 *F*(3, 1055) = 24.21*	.254	.064	.062	3.85	..	..	
2 *F*(4, 1054) = 23.89*	.288	.083	.080	3.82	.019	21.52	*.0005
3 *F*(5, 1053) = 25.74 *	.330	.109	.105	3.76	**.026**	30.47	*.0005
4 *F*(6, 1052) = 24.96*	.353	.125	.120	3.73	.016	18.85	*.0005
5 *F*(7, 1051) = 26.03*	.384	.148	.142	3.68	**.023**	28.54	*.0005

Note. SDEE = Standard Error of Estimation, ADJ R2 = Adjusted R2
P < .0005

1 Age + Gender + Race
2 Age + Gender + Race + Child Physical Abuse
3 Age + Gender + Race + Child Physical Abuse + **Child Sexual Abuse**
4 Age + Gender + Race + Child Physical Abuse + Child Sexual Abuse + Adult Physical Assault
5 Age + Gender + Race + Child Physical Abuse + Child Sexual Abuse + Adult Physical Assault + **Adult Sexual Assault**

HIERARCHICAL LINEAR REGRESSION FOR SQUARE ROOT OF CHILD ABUSE POTENTIAL BY TYPE OF TRAUMA EVENTS (CONTINUED)

Model	R	R^2	$ADJR^2$	SDEE	ΔR^2	ΔF	Sig.
6 *F*(8, 1050) = 25.10*	.401	.161	.154	3.66	.013	16.01	.0005
7 *F*(9, 1049) = 22.68*	.404	.163	.156	3.66	.002	2.97	**.085**
8 *F*(10, 1048) = 20.84*	.407	.166	.158	3.65	.003	3.72	**.054**
9 *F*(11, 1047) = 19.05*	.408	.167	.158	3.65	.001	0.93	**.336**

Note. SDEE = Standard Error of Estimation, ADJ R2 = Adjusted R2

P < .0005

6 Age + Gender + Race + Child Physical Abuse + Child Sexual Abuse + Adult Physical Assault + Adult Sexual Assault + Domestic Violence

7 Age + Gender + Race + Child Physical Abuse + Child Sexual Abuse + Adult Physical Assault + Adult Sexual Assault + Domestic Violence + Disaster

8 Age + Gender + Race + Child Physical Abuse + Child Sexual Abuse + Adult Physical Assault + Adult Sexual Assault + Domestic Violence + Disaster + Motor Vehicle Accident

9 Age + Gender + Race + Child Physical Abuse + Child Sexual Abuse + Adult Physical Assault + Adult Sexual Assault + Domestic Violence + Disaster + Motor Vehicle Accident + Death of Loved One

RESULTS OF SEQUENTIAL LOGISTIC REGRESSION

- Sequential logistic regression analysis was performed
- One of two categories of outcome (clinical CAPI as indicated by a cutoff score ≥ 215 on the CAPI | non-clinical CAPI as indicated by a score of ≤ 214)
- First on the age variable (32 or below, above 32) then with the addition of gender, followed by the addition of race (Caucasian or other race), and then the addition of a trauma grouping variable (no trauma, child trauma, child-adult trauma, adult trauma).

TRAUMA EXPOSURE STUDY

Study on Cycle of Violence and Child Abuse Potential

- N = 699
- Logistic Regression using cut-off Scores on CAPI (Milner, 1990)

- The odds of being in the clinical child abuse potential group were 2.1 times higher (*p = .007) for women than for men.*

- Child only trauma 2.26 times more likely (*p = .029) to be in the clinical CAPI group than those who did not* experience trauma.

- The adult-only trauma group was 3.03 times more likely to be in the clinical CAPI group (*p < .001) than those* in the no-trauma-exposure group.

- The child–adult trauma group, when controlling for all demographic variables, was 4.23 times more likely to be in the clinical CAPI group than was the no-trauma-exposure group.

DISCUSSION SUMMARY OF FINDINGS

- Findings of this study partially support the intertransmission theory of violence in that those with trauma exposure had significantly higher child abuse potential scores than those with no exposure.

- Logistic regression analysis suggests that those with trauma exposure in childhood and as adults had higher odds of sharing intrapersonal and interpersonal characteristics similar to known physical child abusers.

- Less support for the accumulative developmental hypothesis in terms of direct effects, which suggests the frequency of trauma exposure would be a strong predictor of child abuse potential score elevations.

DISCUSSION SUMMARY OF FINDINGS (CONTINUED)

- Instead, the type of traumatic event was found to be the strongest predictor of elevated child abuse potential with child sexual abuse and adult sexual abuse being the largest significant contributors when controlling for age, gender, and race.

- The important finding here is that it did not matter when in the development of the caregiver that trauma exposure occurred.

- Females had higher child abuse potential scores than males.

LIMITATIONS

- Sample was not representative of the general population
- Reliance on retrospective accounts and recollections
- Misinterpretation or avoidance
- Cross sectional nature of the study
- Other intervening variables

CONCLUSION

- The findings lend support to Bloom and Reichert's (1998) assertion that "we live in a society that is organized around unresolved traumatic experience . . . and that violence is the primary cause of unhealed trauma"

- Highlights the importance of routine trauma exposure screening in health and mental health facilities and calls into importance the early identification of sexual abuse, especially in females

CRAIG & SPRANG, 2014

Craig, C. D., & Sprang, G. (2014). Gender differences in trauma treatment: Do boys and girls respond to evidence-based interventions in the same way? *Violence and Victims, 29*(6), 927-940.

METHOD

- Sample consisted of 218 children ranging in age from 6 to 18 (*M* = 11.7)
- Over half of the sample was female (56%) and the majority of the sample was of Caucasian race (82.9%).
- All children had at least one traumatic event that met the DSM-IV-TR A1 and A2 criteria with a mean of 4.1 different types of traumatic events experienced by each child (this does not include intensity).
- The rates of children meeting the clinical cut off of 38 or above on the UCLA PTSD at baseline was 27.5% with another 42.7% being in the subclinical range of 17 to 37 on the UCLA PTSD measure (*M* = 22.1, *SD* = 15.3).

GENDER DIFFERENCES

- Investigated gender differences in children ages 7-18 presenting at a trauma treatment clinic who received evidence based treatments for post-trauma exposure distress.
- MANCOVA and trend analysis using ANCOVA were conducted on baseline and end of treatment UCLA PTSD-RI total scores.
- Results suggest that female children start at higher reported total PTSD rates than males but both groups experience significant symptom reduction during the course of treatment.
- At post-treatment, girls are still reporting higher symptom levels on the UCLA PTSD-RI than boys, suggesting that their clinical presentation at discharge may differ despite significant treatment gains.
- There were no differences in these response patterns when type of treatment was considered.
- Identification of these gender-specific response patterns are an important consideration in treatment and discharge planning for children who have been trauma-exposed and are presenting for treatment with post trauma exposure disturbances.

SPRANG, CRAIG, CLARK, VERGON, COHEN, STANTON-TINDALL, & GURWITCH, (2013)

Sprang, G., **Craig, C. D**., Clark, J. J., Vergon, K., Cohen, J., Staton-Tindall , M., & Gurwitch, R. (2013). Factors impacting the completion of trauma-focused treatments: What can make a difference? *Traumatology, 19*(1), 28-40.

NATIONAL CHILD TRAUMATIC STRESS NETWORK DROPOUT STUDY

- Used sample of 2,579 de-identified data generated by the National Child Traumatic Stress Network (NCTSN) Core Data Set (CDS) collected between spring 2004 and fall 2010
- Majority of sample were female 55.9% and white 53%, mean age 11.45.
- The NCTSN is a collection of 60 academic and community-based service centers that provide trauma informed, evidence-based intervention to children with traumatic stress symptoms across the country.
- These centers are funded by the Substance Abuse and Mental Health Services Administration through a competitive process that supports the delivery of services and collection and entry of clinical data into the CDS.
- The CDS collected information on (a) demographics, (b) domestic environment and family characteristics, (c) health insurance, (d) trauma exposures and experiences, (e) service use, and (f) behavioral problems, distress reactions, and functioning.

DROP OUT OF TRAUMA INFORMED EVIDENCE BASED/ EMPIRICALLY SUPPORTED TREATMENTS

- To ascertain if the treatment outcome groups differed on the basis of predictor characteristics, a multinomial regression analysis was conducted using the three outcome data categories (0 = *treatment completion*, 1 = *drop out*, 2 = *lost missing data*) with six demographic variables.
- Two variables proved to be significant ($p < .01$) individual predictors of dropout when compared with the lost missing category data cases. Hispanics and children in state custody were 3.79 and 1.20 times more likely, respectively, to be in the dropout versus lost category.
- There were no significant differences in age, gender, race, and insurance type by treatment completion category.

AND NOW . . . NEVADA!

- Continuing Refugee research
- Continuing Measurement Research
- Responded to October 1, 2017 shooting
- Major new direction past few years is emotional abuse

PSYCHOLOGICAL/EMOTIONAL ABUSE

Psychological/emotional maltreatment means a repeated pattern of care-giver behavior or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs. It includes: (1) spurning; (2) terrorizing; (3) isolating, (4) exploiting/corrupting; (5) denying emotional responsiveness; and (6) mental health, medical, and educational neglect (American Professional Society on Abuse of Children, 1995).

DEFINITIONS OF PSYCHOLOGICAL/EMOTIONAL ABUSE

- *Spurning* – may involve verbal and nonverbal behaviors, such as belittling children, shaming or ridiculing them, and general degrading or rejecting or abandoning them.
- *Terrorizing* - refers to acts of placing children in danger, threatening them, someone, or something they care for, or generally creating a climate of fear.
- *Isolating* – imposing severe restrictions on a child, preventing developmentally appropriate social interaction, and separating a child from the rest of the family.
- *Exploiting/corrupting* - encouraging children to develop inappropriate and/or antisocial behaviors or values, such as stealing, abusing others verbally, breaking into houses, and hurting older people or younger children.
- *Denying emotional responsiveness* – being emotional unavailable, ignoring the child, failing to express affection, becoming distant physically and emotionally, and being dismissive of children's needs for warmth and affection
- *Mental health, medical, and educational neglect* – failing to provide and attend to the psychological, medical, and cognitive and developmental needs of the child

(Moran, Bifulco, Ball, Jacobs, & Benaim, 2002)

- *Humiliation/degrading* – actions or comments that degrade and humiliate the child and have the potential for invoking shame

- *Terrorizing* - attempts to invoke extreme fear or dread in the child in a calculated way, excluding physical attacks

- *Cognitive disorientation*- techniques aimed at confusing and disorienting the child in terms of 1) his or her belief in the evidence of his or her senses, 2) memory, or (3) sense of identity

- *Deprivation of basic needs* – depriving the child of basic needs such as light, sleep, food, or the company of others.

- *Deprivation of valued objects* – depriving the child of a specific object that he or she values or treasures.

- *Extreme rejection* – involves rejection that indicates abandonment or wishing the child was dead.

(Moran, Bifulco, Ball, Jacobs, & Benaim, 2002)

- *Inflicting marked distress or discomfort* – involves the use of tactics to induce distress and discomfort (e.g., force feeding either at meal time or with noxious substances such as shoe polish or feces).

- *Emotional blackmail* – use of serious threats to close others to ensure control and compliance.

- *Corruption/exploitation* – forcing the child to take part in (usually) illicit activities such as stealing or drug taking.

- *Complex psychological abuse* – co-occurs with physical and/or sexual abuse

EMOTIONAL ABUSE AND PTSD

- Currently emotional abuse does not meet the DSM-5 criterion A for PTSD
- Conducted a Systematic Literature Review on 40 articles
- Inclusion if article cover child emotional /psychological/ verbal abuse and PTSD and or domestic violence
- Searched over 7 major data bases
- Results are convincing that emotional abuse has a major relationship in PTSD
- Statistical controls for physical and sexual abuse found a significant relationship above and beyond for emotional abuse
- The majority of the articles found a significant contribution of emotional abuse to PTSD

IMPLICATIONS

- Better measures of emotional abuse are needed the expands the domain
- More research and clinical attentions needed on emotional abuse
- What is the relationship of emotional abuse to PTSD and other trauma-related symptoms and disorders?
- Is there a direct effect or is it mediational in nature
- Does chronic emotional abuse have a major impact on brain?
- Is emotional abuse a mere risk factor for more severe forms of abuse?