NCTSN The National Child Traumatic Stress Network

Complex Trauma in the National Child Traumatic Stress Network

Joseph Spinazzola, Ph.D., Julian Ford, Ph.D., Bessel van der Kolk, M.D., Margaret Blaustein, Ph.D., Melissa Brymer, Psy.D., Laura Gardner, BsPH, Susan Silva, Ph.D., Stephanie Smith, Ph.D.

NATIONAL CHILD TRAUMATIC STRESS NETWORK

- 38 Sites in 2002 across 19 States & D.C.
- Level I: National Center (Duke & UCLA)
- Level II: Intervention Development & Evaluation Centers (10)
- Level III: Community Treatment & Services Centers (26)
- (Network Expansion as of October 2003 to 54 Sites across 31 States & D.C.)

Complex Trauma Taskforce: MISSION

The mission of the Complex Trauma Taskforce is to assist and advise the NCTSN, increase public awareness and influence social policy on:

(a) the characterization and diagnostic classification of children and adolescents exposed to multiple or prolonged traumatic events, and

(b) the development and dissemination of effective, accessible and sustainable prevention and intervention services for these children and their caregivers that address the full complexity of associated functional impairment and psychiatric sequelae encountered in real-life clinical settings

COMPLEX TRAUMA NETWORK SURVEY

- Designed to Assess the Following Factors:
  - Trauma Exposure History
  - Posttraumatic Sequelae
  - Intervention Utilization & Perceived Effectiveness
- Survey based on Network Activity in 2002
- Survey composition based on Taskforce review of literature and collective clinical & research experience; multi-level survey design, review and approval process through NCCTS

SURVEY LIMITATIONS

- Sampling: Representative vs. Random
- Unit of Analysis: Clinician vs. Child
  - Aggregate data on child trauma caseloads
  - Does not enable study of interrelations among demographic, trauma exposure & symptom variables
- Survey Construction
  - Content Validity via Expert Consensus group
  - Psychometrics not evaluated
- Etc.

SURVEY DISSEMINATION PROCESS

- Regional liaisons solicited names of up to 5 direct child service clinicians per site from 36 Level II & III Network Directors
- No information about survey content provided prior to clinician selection
- Clinician selection to address range of service settings and types offered at site
- Clinicians with caseloads $\geq$ 10 requested

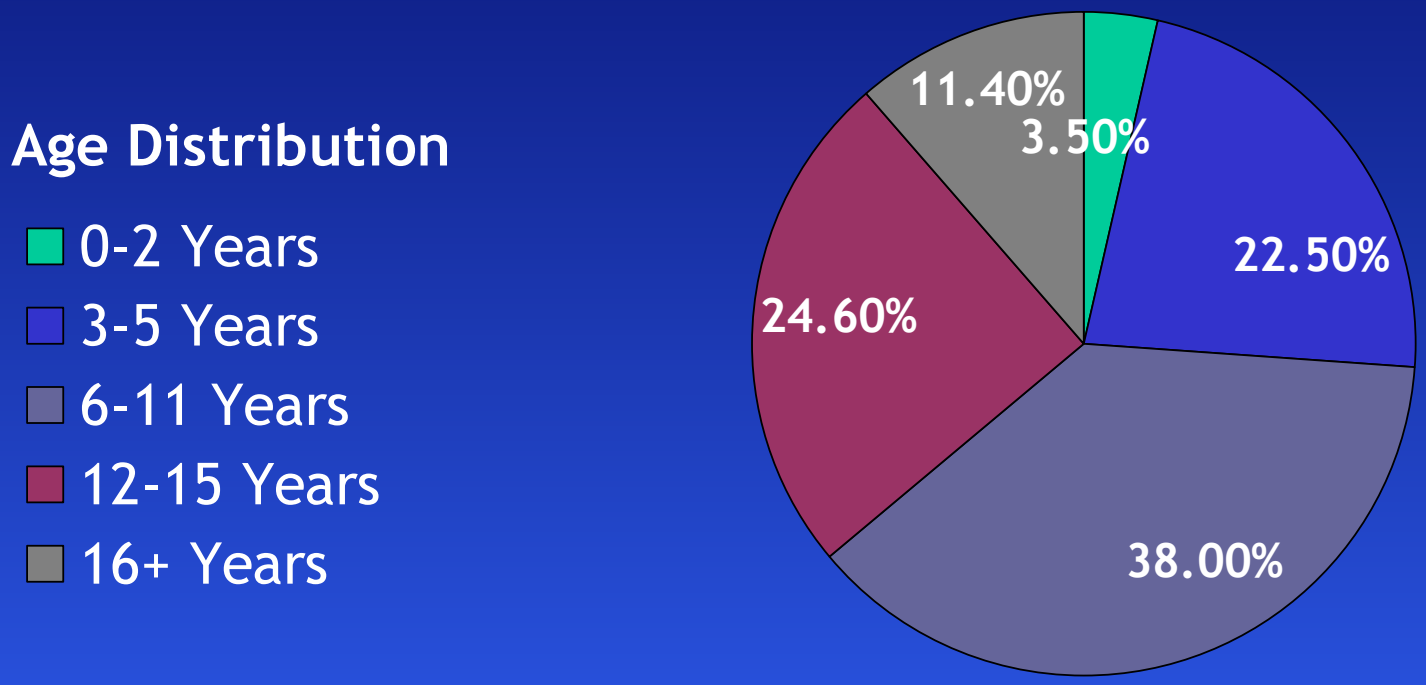
NCTSN SITE RESPONSE TO COMPLEX TRAUMA SURVEY

- Completed Surveys received from 62 Clinicians across 25 sites (1,699 children represented)
- 8/10 Level II Sites provided Survey Data
  - 1 site ineligible (no active clinicians in 2002)
  - 1 site declined participation
- 17/26 Level III Sites provided Data
  - 1 site ineligible (no active clinicians in 2002)
  - 1 site unable to respond in time 2º IRB
  - 3 sites clinicians failed to complete survey
  - 4 sites did declined participation/did not respond

Child Trauma Caseload

- Caseload Size based on direct provision of treatment and/or comprehensive assessment services to traumatized children between Jan 1 & Dec 31, 2002
- Mean Caseload: 27.4 (SD = 23.3)
  - Median: 23.5
  - Min, Max: 4 , 150
- 79% of Children seen in Outpatient Mental Health Settings

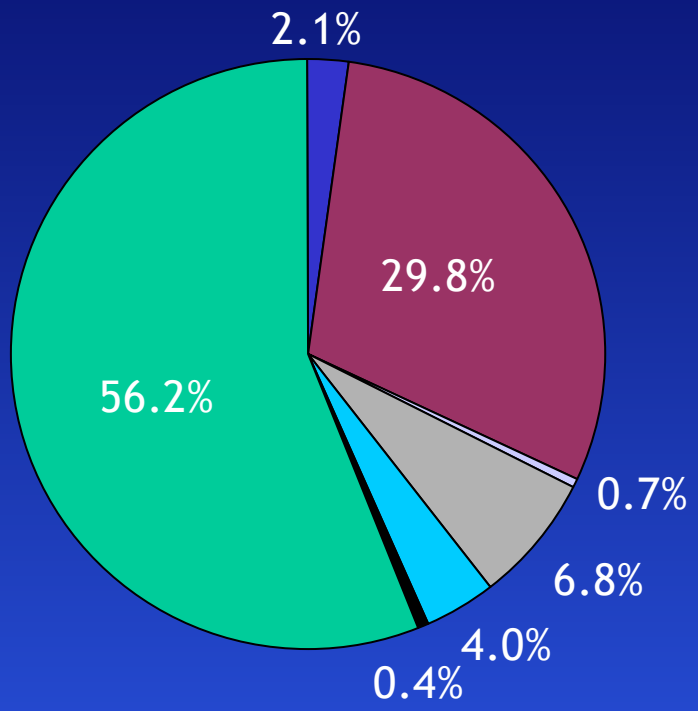
Age Distribution of Children Represented in Survey



Racial & Ethnic Distribution

Race Distribution

- Asian 2.1%
- Black 29.8%
- American Indian/Alaskan Native .7%
- Mixed 6.8%
- Unknown 4.0%
- Hawaiian/Pacific Islander .4%
- White 56.2%



Ethnicity

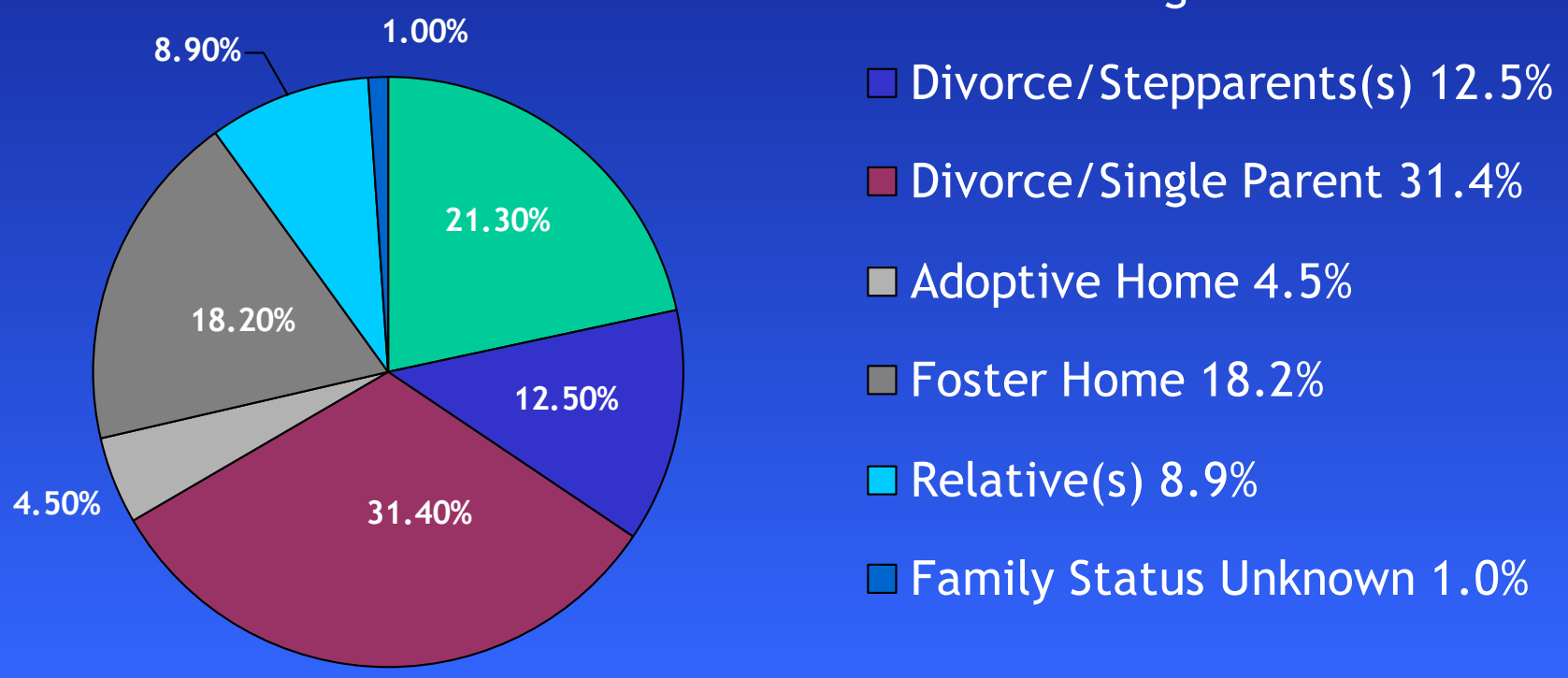
- Hispanic 21.7%
- Non-Hispanic 76.2%
- Unknown 2.1%

Gender & Family Status

Gender

- Female 56.9%
- Male 43.1%

Family Status



Child Trauma Exposure: Age of Onset

- Mean Age of Onset: 5.0 (SD = 2.8)
  - Median: 5.0
  - Min, Max: 0, 13.0

Early Exposure: Over 1/3 of the sample is adolescent and yet 98% of clinicians surveyed report average age of onset under 11

Number of Child Trauma Exposure Types

- Mean Number of Exposure Types: 2.9 (SD = 1.8)
  - Median: 3.0
  - Min, Max: 1, 11

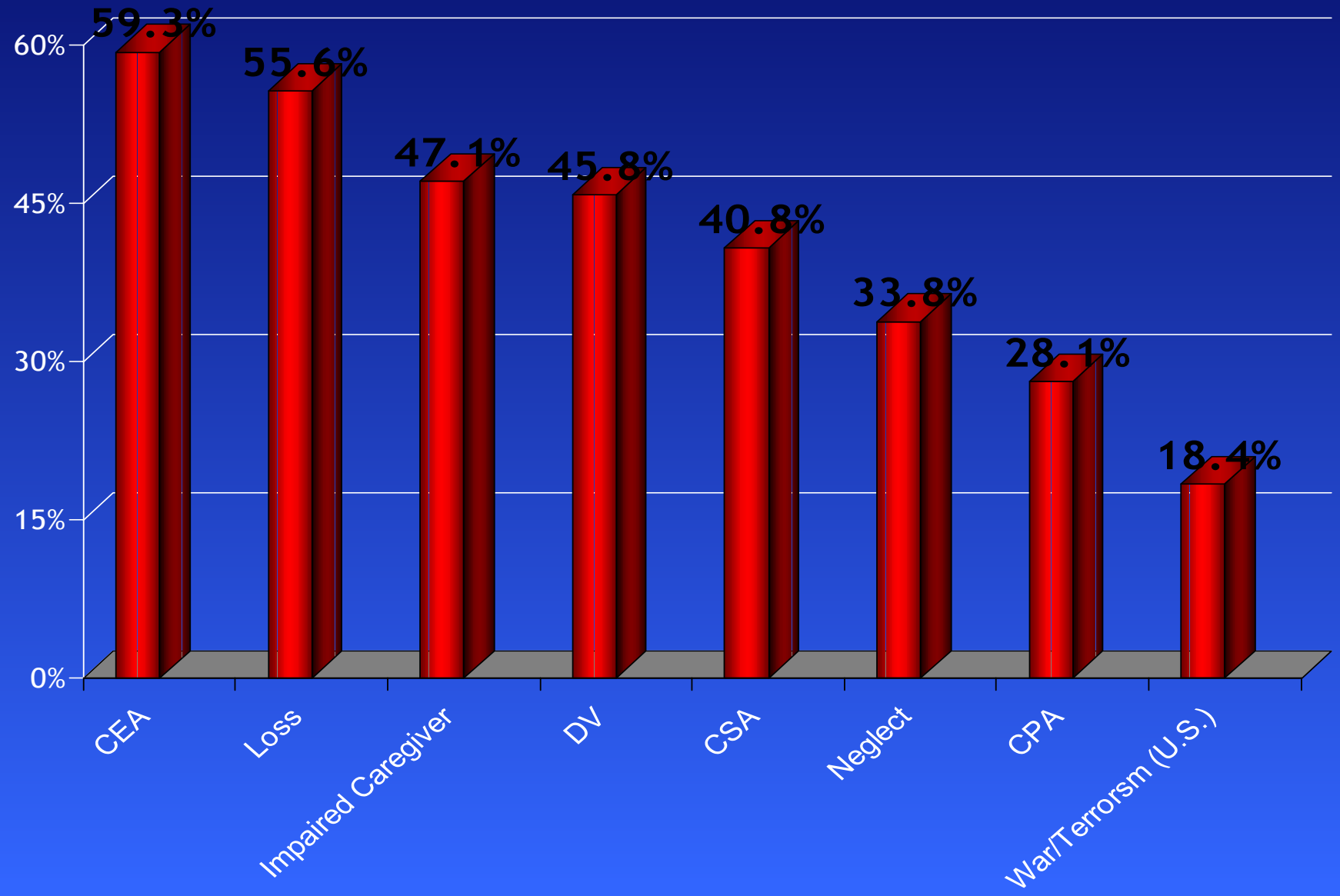
History of Multiple Exposure Types: 94% of clinicians surveyed report average child exposure to more than one type of trauma

Child Trauma Exposure Duration

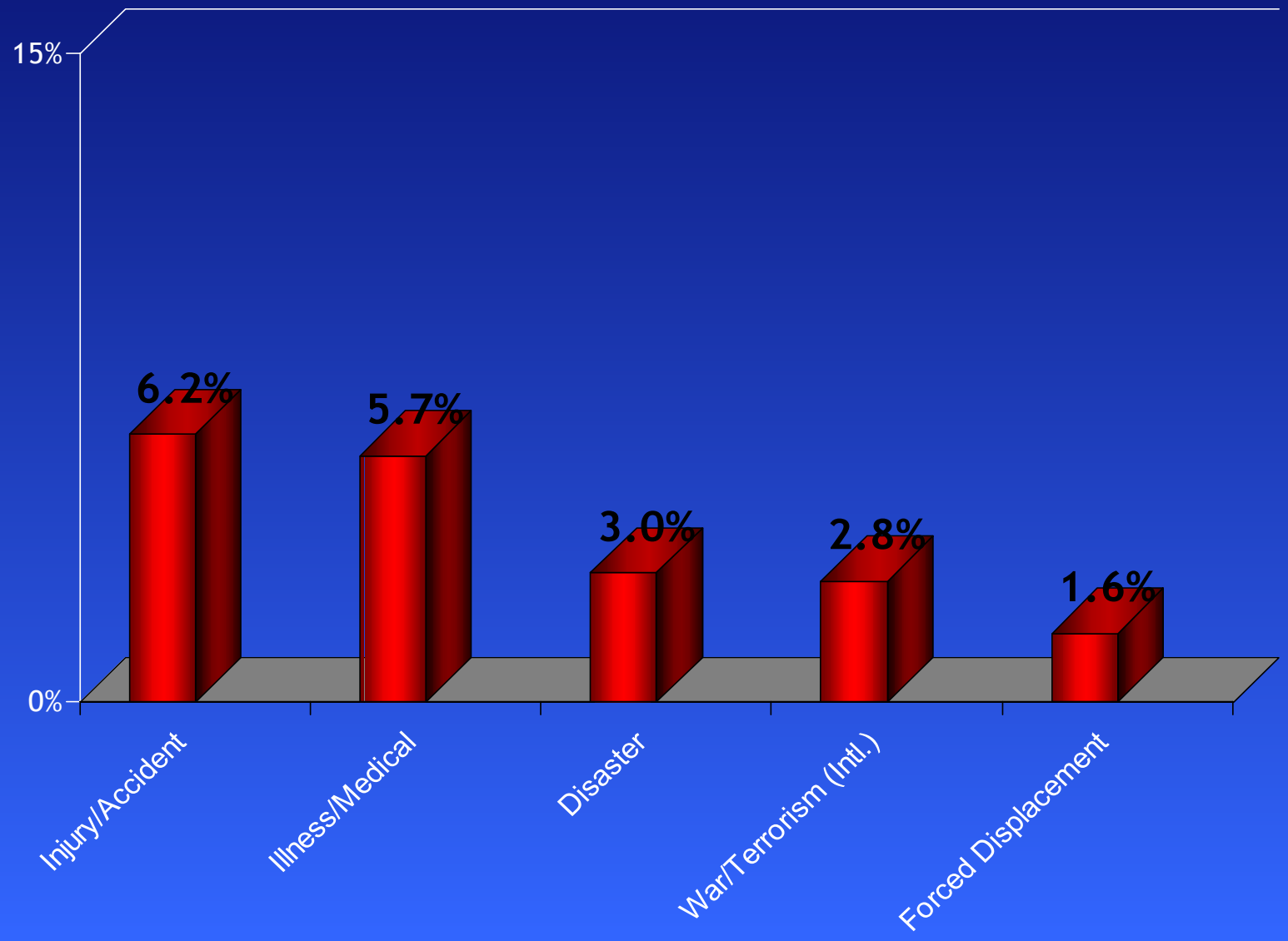
- Duration of Trauma
  - Multiple-event or chronic trauma: **77.6%**
  - Singe Event or Acute Trauma: 19.2%
  - Unknown: 3.2%

CHILD & ADOLESCENT TRAUMA EXPOSURE TYPES

Child Trauma History: Most Frequent Exposure Types

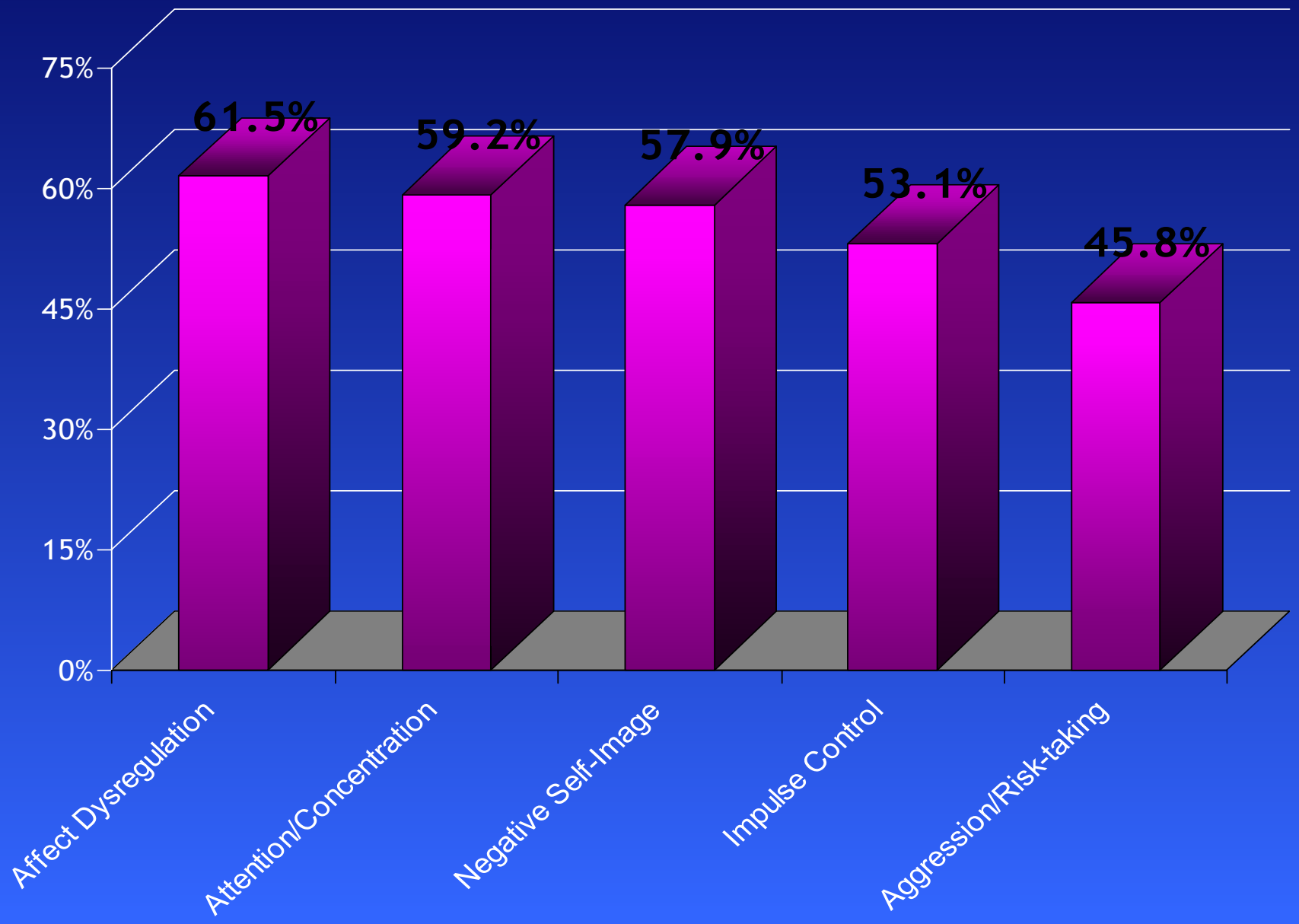


Child Trauma History: Less Frequent Exposure Types

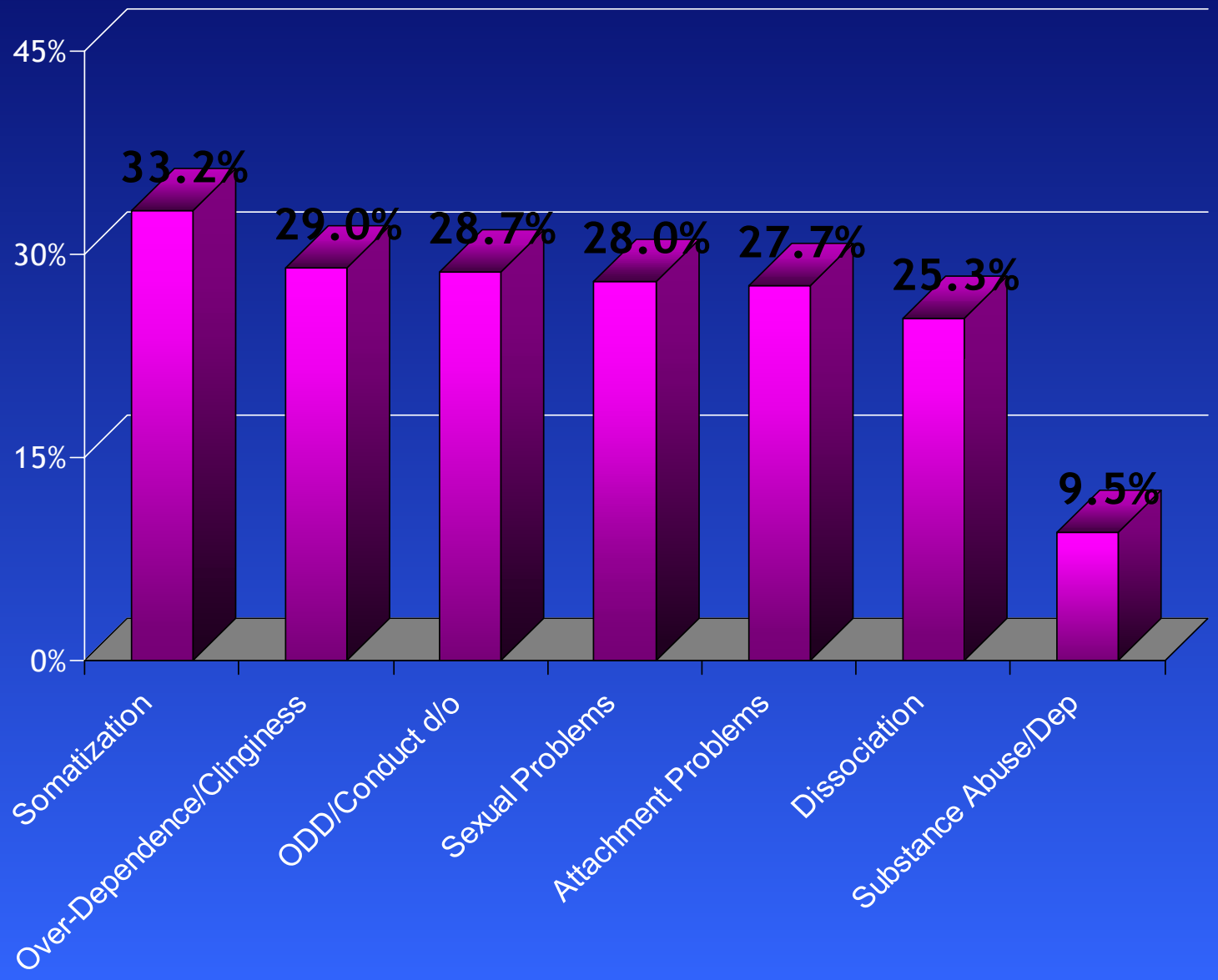


COMPLEX POSTTRAUMATIC SEQUELAE

Complex Posttraumatic Sequelae: Most Frequent Difficulties

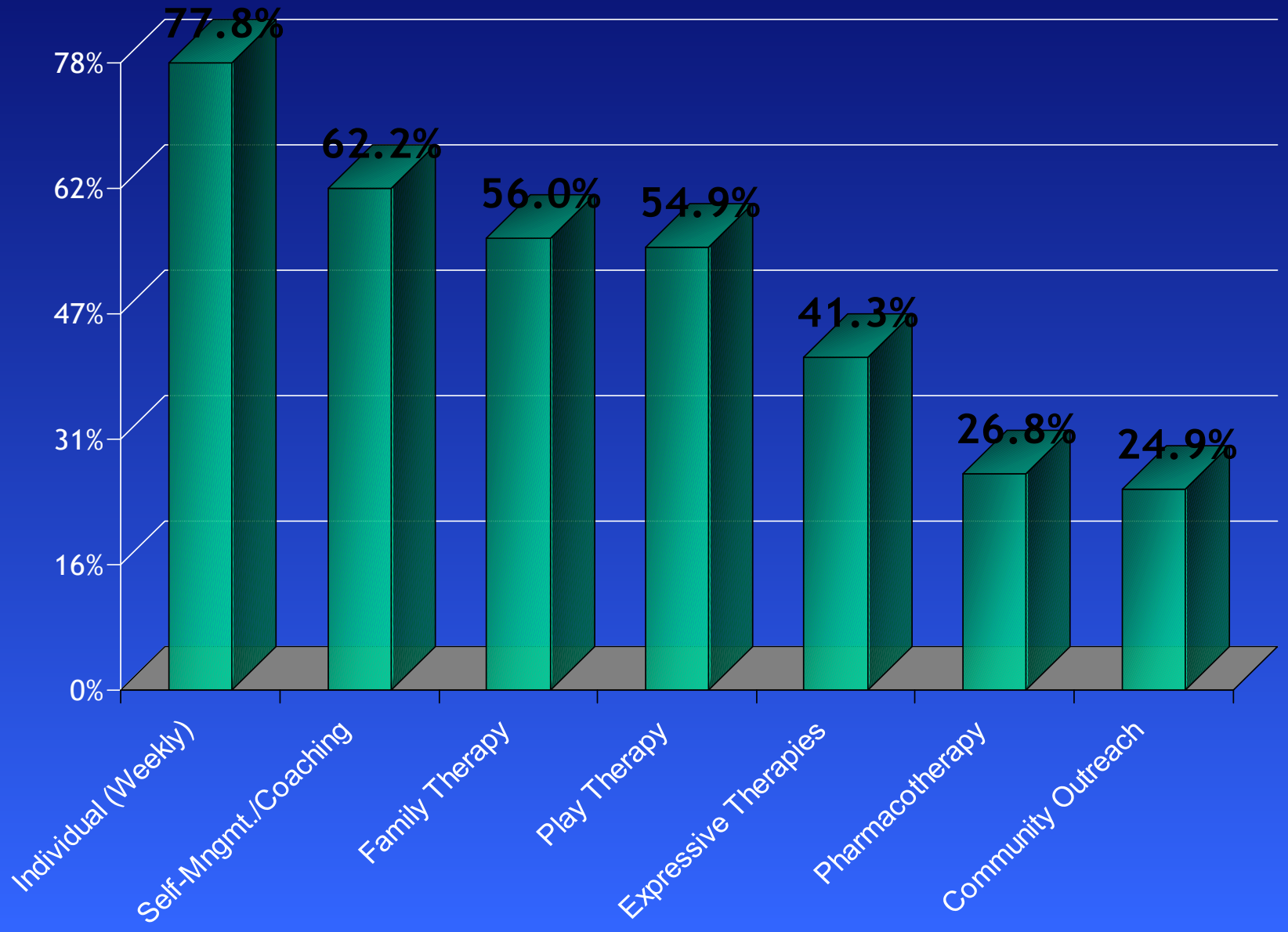


Complex Posttraumatic Sequelae: Less Frequent Difficulties

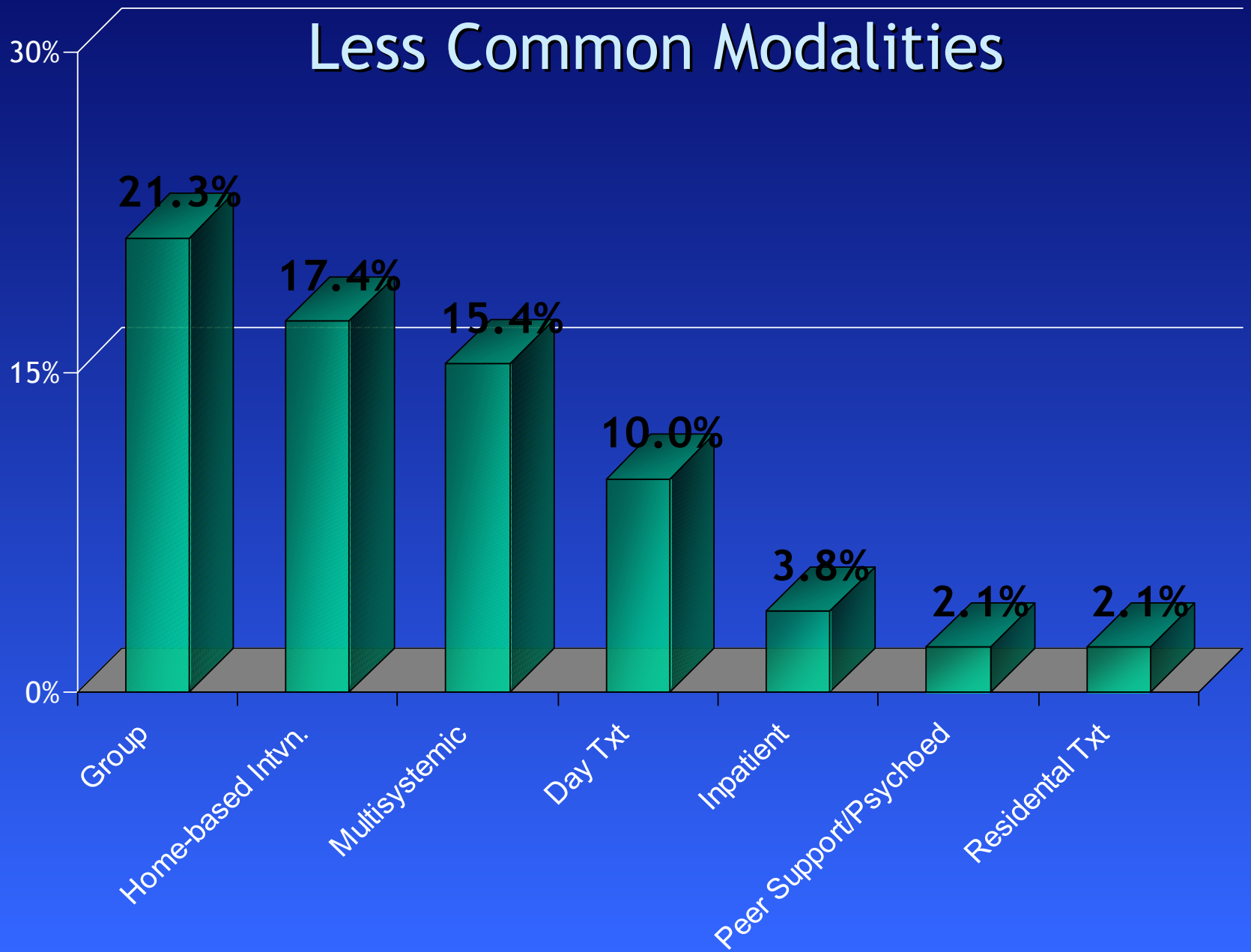


COMPLEX TRAUMA INTERVENTIONS

Child Trauma Intervention: Most Common Modalities



Child Trauma Intervention: Less Common Modalities



Perceived Effectiveness of Available Services for use in Treatment of Complex Child Trauma

- Clinicians ranked Top Three Most & Least Effective modalities for treatment of complex trauma in children
  - Selection based on subset of modalities in practice at clinicians' treatment setting
  - Rankings based on direct clinical observation and/or empirical demonstration of efficacy at their site
- Reported findings based on overall endorsement & weighted ranking of modalities

MOST Effective Modalities

Modality	% Endorsed Top 3 (Weighted Rank)	# of Clinicians
1. Individual Therapy	77.4% (107)	48
2. Family Therapy	56.5% (76)	35
3. Play Therapy	33.9% (43)	21
4. Self-Management/Coaching	30.6% (41)	19
5. Group Therapy	21.0% (17)	13
6. Expressive Therapies	16.1% (17)	10
7. Multisystemic Therapy	12.9% (17)	8

LEAST Effective Modalities

Modality	% Endorsed Top 3 (Weighted Rank)	# of Clinicians
1. Home-based Therapy	24.2% (31)	15
2. Play Therapy	22.6% (34)	14
3. Pharmacotherapy	21.0% (31)	13
4. Group Therapy	21.0% (25)	13
5. Expressive Therapies	19.4% (23)	12
6. Self-Management/Coaching	17.7% (18)	11
7. Multisystemic Therapy	12.9% (19)	7

Comparison of Perceived Intervention Effectiveness

MOST EFFECTIVE	LEAST EFFECTIVE
1. Individual Therapy	1. Home-based Therapy
2. Family Therapy	2. Play Therapy
3. Play Therapy	3. Pharmacotherapy
4. Self-Management/Coaching	4. Group Therapy
5. Group	5. Expressive Therapies
6. Expressive Therapies	6. Self-Management/Coaching
7. Multisystemic Therapy	7. Multisystemic Therapy

Comparison of Perceived Intervention Effectiveness

MOST EFFECTIVE	LEAST EFFECTIVE
1. Individual Therapy	1. Home-based Therapy
2. Family Therapy	2. Play Therapy
3. Play Therapy	3. Pharmacotherapy
4. Self-Management/Coaching	4. Group Therapy
5. Group	5. Expressive Therapies
6. Expressive Therapies	6. Self-Management/Coaching
7. Multisystemic Therapy	7. Multisystemic Therapy

Comparison of Perceived Intervention Effectiveness

MOST EFFECTIVE	LEAST EFFECTIVE
1. Individual Therapy	1. Home-based Therapy
2. Family Therapy	2. Play Therapy
3. Play Therapy	3. Pharmacotherapy
4. Self-Management/Coaching	4. Group Therapy
5. Group	5. Expressive Therapies
6. Expressive Therapies	6. Self-Management/Coaching
7. Multisystemic Therapy	7. Multisystemic Therapy

Comparison of Perceived Intervention Effectiveness

MOST EFFECTIVE	LEAST EFFECTIVE
1. Individual Therapy	1. Home-based Therapy
2. Family Therapy	2. Play Therapy
3. Play Therapy	3. Pharmacotherapy
4. Self-Management/Coaching	4. Group Therapy
5. Group	5. Expressive Therapies
6. Expressive Therapies	6. Self-Management/Coaching
7. Multisystemic Therapy	7. Multisystemic Therapy

Comparison of Perceived Intervention Effectiveness

MOST EFFECTIVE	LEAST EFFECTIVE
1. Individual Therapy	1. Home-based Therapy
2. Family Therapy	2. Play Therapy
3. Play Therapy	3. Pharmacotherapy
4. Self-Management/Coaching	4. Group Therapy
5. Group	5. Expressive Therapies
6. Expressive Therapies	6. Self-Management/Coaching
7. Multisystemic Therapy	7. Multisystemic Therapy

Effective Interventions

- 16/40 mention parents/caregivers
  - 1 of these is a parent support group
  - 2 of these is psychoeducation
  - 1 is therapy for caregiver
  - 5 of these are parent-child (infant) work
- 8/40 mention "family"
  - 2 specifically refer to siblings
  - 1 is family advocacy
- 11/40 mention combined approaches
  - Play txt, expressive txt, skills training
  - Individual, play, support group
  - In home family & individual talk & expressive txt
  - CBT, dir & non-dir play, psychodynamic, trauma
  - Trauma-focused, non-directive play, family txt
  - Coping skills & exposure
  - CBT w/ conjoint parent-child txt
  - Individual txt leading towards group then family txt
  - Trauma-focused, narrative, therapeutic summer camp
- 4/40 mention using multiple systems/case mgmt/community services

Ineffective Interventions

- 4/24 all work, depends on client
- 3/24 multiple systems/ case mgmt
  - Cite lack of trauma training in those systems
  - Cite staff turnover
- 2/24 community services (due to lack of training or lack of available services)
- 1/24 short inpatient services
- 1/24 residential
- 1/24 ed & coaching for change (works as 1st step only)
- Specific interventions
  - Conventional Western talk-based therapy models
  - Follow-up recommendations
  - Play therapy
  - Non-directive
  - behavioral

Mediating Factors

- Caregiver involvement in own treatment
- Family commitment to process
- Age
  - "Effectiveness depends on age of client"
  - Groups ineffective, due to age of clients *(mostly 3-5 yrs)*
- Timing
  - Need groups prior to stabilization
  - Seeing children/families as close to event as possible
- Combination Approaches
  - Psychiatric w/out support therapy is ineffective
  - Fragmented services contribute to ineffectiveness (multidisciplinary services needs to target consistent symptoms & domains)

CONCLUSIONS

- The Network primarily serves children exposed to multiple-exposure, chronic and early-onset trauma
- Predominant traumas are interpersonal in nature (child maltreatment, family violence, U.S. community/political violence (war/terrorism)
- These exposure lead to prevalent problems with affect regulation, attention, self-image, impulse control, aggressive behaviors, risk-taking, somatization & attachment
- No clinical consensus on effective treatments for this majority subpopulation of child trauma victims

IMPLICATIONS

Three Critical Questions:

- What are the implications of these survey results for characterization & diagnosis of children exposed to complex trauma?
- How should these findings inform policy initiatives for traumatized children?
- What are the implications of these findings for child complex trauma treatment development and clinician training initiatives?