Childhood Trauma and Eating Disorders: Clinical and Scientific Impact and Practical Interventions

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Objectives for Today

1. Participants will gain an understanding of the trauma-psychopathology association for eating disorders
2. Participants will understand the psychobiological impact of trauma
3. Participants will gain a practical understanding of screening and assessment of child trauma.
4. Participants will become familiar with evidence-based and trauma-specific treatments that help children and families recover from traumatic events.
Part 1: Eating Disorders
Eating Disorders: The Big Issue (Schmidt et al; Lancet)

• Peak age of onset: 15-25 years.
• Average duration of disorder: 6 years.
• AN and BN more common in young women, but men/boys affected; BED equally split between genders.
• EDs diagnosed in people at increasingly younger ages.
• AN is one of the most common chronic illnesses of adolescence- similar to incidence rates of Type I Diabetes in rates.
Eating Disorders: The Big Issue
(Schmidt et al; Lancet)

- Mortality rates for EDs are 2x general population and AN is 6x greater.
- 1 of 3 people with BN or BED will become obese.
- 1 in 4 ED patients is unemployed.
- Women with EDs are more likely to stay childless and need fertility treatment to conceive.
- Women with ED have significant problems feeding and interacting with their children.
Eating Disorders: The Big Issue (Schmidt et al; Lancet)

- Caregivers of ED patients spend nearly twice as much time care-giving (24 h/week vs. 14 h/week) than caregivers of patients with other disorders (e.g. cancer, psychosis, dementia).
- Recent estimates: 20 million people in Europe have an ED with a cost of 1 trillion Euros per year (financial cost-249 billion and burden of disease cost-763 billion)
DSM-5 Criteria for Anorexia Nervosa

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.
DSM-5 Criteria for Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
   2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, and other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.
DSM-5 Criteria for Binge Eating Disorder

A. Recurrent episodes of binge eating.

B. The binge-eating episodes are associated with three (or more) of the following:
   1. eating much more rapidly than normal
   2. eating until feeling uncomfortably full
   3. eating large amounts of food when not feeling physically hungry
   4. eating alone because of being embarrassed by how much one is eating
   5. feeling disgusted with oneself, depressed, or very guilty after overeating

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.
Other Feeding and Eating Disorders

1. Rumination disorder

2. PICA

3. Avoidant restrictive food intake disorder (ARFID)
Closer Look at Eating Disorders

https://www.youtube.com/watch?v=50rvA5SorPg
Part 2: Child Maltreatment
Types of Abuse
Physical Abuse
Physical Abuse

**Signs of neglect**
- Physically and emotionally neglected child may exhibit dull "vacant" stare and signs of poor hygiene; pallor suggests anemia
- Wasted buttocks caused by malnutrition
- Wasting of subcutaneous tissue and untreated skin lesions in physically neglected child
- Abdominal distention caused by malnutrition
- Malnourished child with emaciated appearance and distended abdomen; height and weight are often well below percentiles normal for age

**Staging of injuries-bruises**
- Acute bruise with marked swelling (1–3 days)
- Purple (1–5 days)
- Green (5–7 days)
- Yellow (7–10 days)
- Brown (>10 days)

**Staging of injuries-subdural hematomas**
- Acute hemorrhage
- Fresh subdural hematoma (acute)
- Organized clot mistaken for atrophic brain tissue on CT scan
- Organized subdural hematoma (months)
Sexual Abuse

- Fargo Forum, 1/16/17
Emotional Abuse

https://www.youtube.com/watch?v=1G7nohXbolc
**Children and Abuse**

- 10 – 13% of America’s children have been kicked, burned, bit, punched, hit with an object, beaten or threatened with weapon by a parent

- 25% of school children experience a trauma

- 20% of traumatized children have a mental health diagnosis and only 10% of those receive treatment

- 21 – 32% of U.S. women were sexually abused before age 18

Kilpatrick, 1996
Vogeltanz et al., 1999
NCTSN School committee, 2008
ACE STUDY

Adverse Childhood Experiences

1. Child physical abuse.
2. Child sexual abuse.
4. Emotional neglect.
5. Physical neglect.
6. Mentally ill, depressed or suicidal person in the home.
7. Drug addicted or alcoholic family member.
8. Witnessing domestic violence against the mother.
9. Loss of a parent to death or abandonment, including abandonment by parental divorce.
10. Incarceration of any family member for a crime.

(Anda & Felitti, 2009)
<table>
<thead>
<tr>
<th>Disease</th>
<th>4 or More Adversities (Odds Ratio)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>2.2</td>
</tr>
<tr>
<td>Obesity</td>
<td>1.6</td>
</tr>
<tr>
<td>Depression</td>
<td>4.6</td>
</tr>
<tr>
<td>Suicide Gesture</td>
<td>12.2</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>7.4</td>
</tr>
<tr>
<td>Illicit Drugs</td>
<td>4.7</td>
</tr>
<tr>
<td>Injectable Drugs</td>
<td>10.3</td>
</tr>
<tr>
<td>Sexual Promiscuity</td>
<td>3.2</td>
</tr>
<tr>
<td>STD</td>
<td>2.5</td>
</tr>
</tbody>
</table>
The ACE Study  
(Felitti et al., 1998)

<table>
<thead>
<tr>
<th>Disease</th>
<th>4 or More Adversities (Odds Ratio)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>2.2</td>
</tr>
<tr>
<td>Cancer</td>
<td>1.9</td>
</tr>
<tr>
<td>Stroke</td>
<td>2.4</td>
</tr>
<tr>
<td>Bronchitis/Emphysema</td>
<td>3.9</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1.6</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>2.4</td>
</tr>
<tr>
<td>Fair/Poor Health</td>
<td>2.2</td>
</tr>
</tbody>
</table>
Ace Study

% Attempting Suicide

0% 1% 2% 3% 4%

ACE Score

0 1 2 3 4+

% Attempting Suicide vs ACE Score
The ACE Study
(Felitti et al., 1998)
Part 3: Trauma and Psychopathology: A Closer Look at Eating Disorders
THE AMERICAN JOURNAL OF PSYCHIATRY

Editorial

“Sexual Abuse,” Pathogenesis, and Enlightened Skepticism
FIG. 3. Cumulative curves on the delivery of food pellets to isolates and normals during the course of 24 hr. Each curve represents the mean of three animals over ten testing sessions with ad lib access to food upon a bar-press.

(Miller et al., 1971)
Is there a relationship between trauma and disordered eating in traumatized samples?
Childhood maltreatment and eating disorder pathology: a systematic review and dose-response meta-analysis

M. L. Molendijk\textsuperscript{1,2*}, H. W. Hoek\textsuperscript{3,4,5}, T. D. Brewerton\textsuperscript{6} and B. M. Elzinga\textsuperscript{1,2}
Method

- 3938 studies examined some aspect of CM and psychopathology related to ED-82 included in review
- 13059 individuals with ED
- 15092 individuals considered healthy controls (HC)
- 7736 individuals considered psychiatric controls (PC)
Results

1. CM in ED higher than in HC (odds ratios >2)
2. CM in ED higher than in PC (odds ratio = 1.31)
3. CM in ED associated with greater psychiatric comorbidity, suicidal behavior, and self harm
Conclusion

1. CM linked to ED - particularly binge eating

2. Dose response relationship of CM and psychopathology
Impact of Psychological Trauma on ED Treatment
The impact of childhood sexual abuse in anorexia nervosa *

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b Department of Psychiatry, University of Toronto, Toronto, Ont., Canada
c Department of Psychology, York University, Toronto, Ont., Canada

Received 29 May 2005; received in revised form 31 August 2005; accepted 24 September 2005
Method

- 77 hospitalized AN patients
- 37 (48%) reported CSA before AN
- CSA more depression, anxiety, interpersonal problems and OCD
Did CSA Influence Dropout?

![Graph showing proportion of patients still in treatment or completed successfully over weeks after starting treatment.](image)
So, how may early trauma operate to increase risk?
Possible Mediators/Mechanisms

Trauma → • Shame
         • Dissociation
         • Impulse Control
         • Anxiety
         • Substance Use
         • Cognitions
         • Mood Instability

ED

(Andrews, 1997; Kent et al., 1999; Hart & Waller, 2002; Murray & Waller, 2002; Wonderlich et al., 2001)
Psychobiological Mediation (Animal Studies)

EARLY STRESS → Altered Biological Stress Response → Behavioral Response

Suomi, 1991; Kraemer, 1992; McEwen, 1998; Meaney et al., 1988; Sapolsky et al., 1986
Suppressed HPA Axis and Trauma
(Carpenter et al., 2007)
Suppressed HPA Axis and Trauma (Carpenter et al., 2007)
Does Child Maltreatment Damage the Brain?

In a child’s brain elevated catecholamines and cortisol may lead to:

- Loss of neurons
- Delays in myelination
- Deviant pruning processes
- Inhibiting of neurogenesis

(Lauder, 1988; Sapolsky, 1990; DeBellis et al., 2002; Dunlop et al., 1997; Tanapat et al., 1998; Bremner, 1999)
Does Child Maltreatment Damage the Brain?

This PET scan of the brain of a normal child shows regions of high (red) and low (blue and black) activity. At birth, only primitive structures such as the brain stem (center) are fully functional; in regions like the temporal lobes (top), early childhood experiences wire these circuits.

This PET scan of the brain of a Romanian Orphan, who was institutionalized shortly after birth, shows the effect of extreme deprivation in infancy. The temporal lobes (top), which regulate emotions and receive input from the senses, are nearly quiescent. Such children suffer emotional and cognitive problems.
Biological Correlates of Trauma in Children with PTSD

MRI Based Volume

↓ Total Brain (Early Onset, Duration)
↓ Corpus Callosum
↓ Prefrontal Cortex
↑ Superior Temporal Gyrus
↑ Hippocampal Volume
↓ Cerebellum
Ø Pituitary

Summary

• Trauma elicits psychobiological changes that may result in increased impulsive dysregulated behavior (i.e., binge, purge, self-harm).

• Trauma may reduce effectiveness of psychiatric and psychological treatment
PTSD (untouched) elicits psychiatric disorders which perpetuate the PTSD (“vicious cycle”)

A Vicious Cycle

<table>
<thead>
<tr>
<th>UNIDENTIFIED &amp; UNTREATED PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSYCHIATRIC DISORDERS</td>
</tr>
<tr>
<td>- DEPRESSION</td>
</tr>
<tr>
<td>- ANXIETY DISORDERS</td>
</tr>
<tr>
<td>- SUBSTANCE USE DISORDERS</td>
</tr>
<tr>
<td>- EATING DISORDERS</td>
</tr>
<tr>
<td>- CONDUCT DISORDERS</td>
</tr>
</tbody>
</table>
Process Without Early Identification and Intervention

Child Trauma → Psychobiological Change

Behavior Change

Family Change

Social Change

Diagnosis (often multiple at this stage) → Lengthy Passage of Time

Treatment (often not trauma specific)
Child Trauma

Psychobiological Change

Trauma Screen

Refer

Trauma Assessment

Refer

Trauma-Specific, Evidence-Based Treatment

BRIEF Passage of Time
Defining Trauma

Any witnessed or experienced event that threatens the life or physical integrity of the child or someone critically important to the child

**ACUTE**
An isolated traumatic event
e.g., car accident, dog bite, date rape

**CHRONIC**
Multiple traumatic events, often over a long period of time
e.g., repeated physical abuse

**COMPLEX**
Multiple traumatic events that begin at a very young age and are caused by the adults who should have been caring for and protecting the child
Types of Childhood Trauma

- Sexual Abuse
- Physical Abuse
- Emotional Abuse
- Neglect
- Sexual Exploitation
- Witness Domestic Violence
- Community/School Violence
- Bullying
- Death of Loved One
- Suicide
- Motor Vehicle/Travel Accidents
- Weather-Related Events
- Natural Disasters
- Fires
- Medical Trauma
- War
PTSD

A. Exposure to a traumatic event

A. Intrusion symptoms [1]
B. Persistent avoidance of stimuli associated with the trauma [1]
C. Negative alterations in cognitions and mood that are associated with the traumatic event [2]
D. Alterations in arousal and reactivity [2]

A. Persistence of symptoms for more than one month
F. Significant symptom-related distress or functional impairment
G. Not due to medication, substance or illness
PTSD Young Children (≤6)

A. Exposure to a traumatic event

A. Intrusion symptoms [1]
B. Avoidance of stimuli associated with the trauma OR Negative alterations in cognitions and mood [2]
C. Alterations in arousal and reactivity [2]

F. Persistence of symptoms for more than one month
G. Significant symptom-related distress or functional impairment
H. Not due to medication, substance or illness
PTSD in Children

RE-EXPERIENCING
- Intrusive Memories
- Nightmares
- Flashbacks
- Psych distress at triggers
- Physical reactivity at triggers

AVOIDANCE
- Avoiding people, places, activities
- Avoiding thoughts, feelings, memories
- Avoiding talking about it
- Denial

NEGATIVE EMOTIONS/COGNITIONS
- Recall difficulties
- Negative emotional state
- Socially detached
- Loss of interest
- Negative thoughts/beliefs self, others, world
- Distorted cognitions lead to self-blame

PHYSICALLY ACTIVATED
- Sleep problems
- Irritable, angry
- Self-destructive behavior
- Hypervigilance
- Concentration problems
- Exaggerated startle response
- Clingy and whining behavior
Complex PTSD

1. Emotion Regulation
2. Behavioral Control
3. Attention/Consciousness
4. Self-Esteem
Complex PTSD

5. Relationships
6. Biology/Physical complaints
7. Cognitive problems
8. Damage to World View
Common Diagnoses

- Depressive disorders
- Anxiety disorders
- ADHD
- Oppositional Defiant Disorder
- Substance Use Disorder
- Bipolar Disorder
- Reactive Attachment Disorder
- Psychotic Disorder
  - Up to 20% of traumatized children have psychotic symptoms
- PTSD???
## Differences between Screening and Assessment

<table>
<thead>
<tr>
<th>Screening</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Evaluating for the possible presence of a problem (identification)</td>
<td>• Comprehensive process intended to help diagnose, define, or develop treatment</td>
</tr>
<tr>
<td>• Outcome is typically a yes or no</td>
<td>• Tends to be longer and more resource intensive</td>
</tr>
<tr>
<td>• Brief</td>
<td>• Used selectively with based on individual need</td>
</tr>
<tr>
<td>• Can be used universally or with targeted groups</td>
<td>• Often require extensive training</td>
</tr>
<tr>
<td>• Frontline workers</td>
<td></td>
</tr>
</tbody>
</table>

(NCTSN, 2012; SAMSHA, 2014)
Screening and Assessment of Youth PTSD Symptoms

<table>
<thead>
<tr>
<th>SCREENING</th>
<th>Age Range</th>
<th>ASSESSMENT</th>
<th>Age Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>MN TSSCA</td>
<td>Child 5-18</td>
<td>CATS</td>
<td>Parent 3-18</td>
</tr>
<tr>
<td>(Trauma – Internalizing)</td>
<td></td>
<td></td>
<td>Child 7-18</td>
</tr>
<tr>
<td>PSC-17</td>
<td>Parent 3-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Trauma – Externalizing)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
University of Minnesota’s Traumatic Stress Screen for Children and Adolescents (TSSCA)

Name of Child/Adolescent: ________________________  DOB: ____________  Gender: ☐ M  ☐ F
Interviewer Name/ID: ________________________  Assessment Date: ____________

Below is a list of problems that people sometimes have after experiencing a bad or upsetting event. Bad or upsetting events might include being threatened or hurt, seeing someone else threatened or hurt, or feeling like your life was in danger.

Have you ever experienced a bad or upsetting event? ☐ Yes  ☐ No

If yes, what was the bad or upsetting event? Feel free to list more than one.

When thinking about your bad or upsetting event(s), how often have the following problems happened to you during the past month?

<table>
<thead>
<tr>
<th>DURING THE PAST MONTH, HOW OFTEN HAVE YOU...</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.  Had upsetting thoughts, images, or memories of the event come into your mind when you didn’t want them to?</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
</tr>
<tr>
<td>2.  Felt afraid, scared, or sad when something reminded you about the event?</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
</tr>
<tr>
<td>3.  Tried to stay away from people, places, or activities that reminded you of the event?</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
</tr>
<tr>
<td>4.  Had trouble feeling happiness, enjoyment, or love?</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
</tr>
<tr>
<td>5.  Been on the lookout for danger or other things that you are afraid of (for example, looking over your shoulder when nothing is there)?</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
</tr>
</tbody>
</table>

TOTAL
Comparison of the PSC-17 and Alternative Mental Health Screens in an At-Risk Primary Care Sample

WILLIAM GARDNER, PH.D., AMANDA LUCAS, M.B.A., DAVID J. KOLKO, PH.D., AND JOHN V. CAMPO, M.D.

ABSTRACT
Objective: To validate the 17-item version of the Pediatric Symptom Checklist (PSC-17) as a screen for common pediatric mental disorders in primary care. Method: Patients were 269 children and adolescents (8-15 years old) whose parents completed the PSC-17 in primary care waiting rooms. Children were later assessed using the Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime version (K-SADS-PL). The PSC-17's subscales were compared with K-SADS-PL diagnoses and measures of anxiety, depression, general psychopathology, functioning, and impairment. Results: In receiver operating characteristics analyses, the PSC-17 subscales performed as well as competing screens (Child Depression Inventory, the parent and child Screens for Child Anxiety-Related Disorders) and Child Behavior Checklist subscales (Aggressive, Anxious-Depressed, Attention, Externalizing, Internalizing, and Total) in predicting diagnoses of attention-deficit/hyperactivity disorder, externalizing disorders, and depression (area under the curve ≥0.80). The instrument was less successful with anxiety (area under the curve = 0.68). None of the screens were highly sensitive, many were insensitive, and all would have low positive predictive value in low-risk primary care populations. Conclusions: The PSC-17 and its subscales are briefer than alternative questionnaires, but performed as well as those instruments in detecting common mental disorders in primary care. Continued research is needed to develop brief yet sensitive assessment instruments appropriate for primary care. J. Am. Acad. Child Adolesc. Psychiatry, 2007;46(5):611–618. Key Words: screening, primary care, mental health assessment.
Child and Adolescent Trauma Screen (CATS)

Mark 0, 1, 2 or 3 for how often the following things have bothered the child in the last two weeks:

0 Never / 1 Once in a while / 2 Half the time / 3 Almost always

1. Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.
   0 1 2 3

2. Bad dreams related to a stressful event.
   0 1 2 3

3. Acting, playing or feeling as if a stressful event is happening right now.
   0 1 2 3

4. Feeling very emotionally upset when reminded of a stressful event.
   0 1 2 3

5. Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).
   0 1 2 3

6. Trying not to remember, talk about or have feelings about a stressful event.
   0 1 2 3

7. Avoiding activities, people, places or things that are reminders of a stressful event.
   0 1 2 3

8. (Ages 7+ only): Not being able to remember an important part of a stressful event.
   0 1 2 3

9. (Ages 7+ only): Negative changes in how s/he thinks about self, others or the world after a stressful event.
   0 1 2 3

10. (Ages 7+ only): Thinking a stressful event happened because s/he or someone else did something wrong or did not do enough to stop it.
    0 1 2 3

11. Having very negative emotional states (afraid, angry, guilty, ashamed).
    0 1 2 3

12. Losing interest in activities s/he enjoyed before a stressful event. Including not playing as much.
    0 1 2 3

13. Feeling distant or cut off from people around her/him.
    0 1 2 3

14. Not showing or reduced positive feelings (being happy, having loving feelings).
    0 1 2 3

15. Being irritable. Or having angry outbursts without a good reason and taking it out on other people or things.
    0 1 2 3

16. (Ages 7+ only): Risky behavior or behavior that could harmful.
    0 1 2 3

17. Being overly alert or on guard.
    0 1 2 3

18. Being jumpy or easily startled.
    0 1 2 3

19. Problems with concentration.
    0 1 2 3

20. Trouble falling or staying asleep.
    0 1 2 3

Please mark “YES” or “NO” if the problems you marked interfered with:

1. Getting along with others □ Yes □ No
2. Hobbies/Fun □ Yes □ No
3. School or daycare □ Yes □ No
4. Family relationships □ Yes □ No
5. General happiness □ Yes □ No

CATS – Caregiver Report for ages 3-17 Years
Determining Treatment

- Co-occurring Eating Disorder
  - NICE Guidelines for ED treatment
    - www.NICE.org.uk
  - Important to address ED and PTSD concurrently
    - Trottier, Monson, Wonderlich, MacDonald, & Olmsted, (2017)
  - New studies examining outcomes of integrated trauma and eating disorder treatment in adults
    - Trottier, et al. In Preparation
What Helps Youth with PTSD?
Evidence Based Treatments

https://www.youtube.com/watch?v=7dzkS0ioqqw&list=PL8BF506DEC670ADF&index=5
PTSD Treatment Efficacy

Effect Size (Hedge's $g$)

-1 -0.5 0 0.5 1 1.5 2

Primarily Cognitive
Mixed Exposure
Primarily Exposure
Skills-based/SIT
EMDR
Psychodynamic
Hypnotherapy
Self-help
Group
Biofeedback
Acupuncture
Venlafaxine
Alpha blockers
SSRIs
TCAs
MAO-Is
Other Antidepressants
Atypical
Benzodiazepines
Mood Stabilizers

Watts et al., 2013; cited by Monson, 2017
Cognitive Therapy

The Cognitive Triangle

Feelings

Thoughts

Behavior
Exposure

The Situation

Thought
THAT DOG IS GOING TO BITE ME!

Feeling Scared

Still Worrying

I'M SAFE BECAUSE I'M STAYING AWAY FROM A DOG

Avoidance

Reinforcement
Trauma Specific Evidence-based

TRAUMA FOCUSED COGNITIVE BEHAVIOR THERAPY (TFCBT)

- INDIVIDUAL OR FAMILY
  AGES 3-18
- Psychoeducation on trauma and PTSD, parenting skills, coping strategies, trauma narrative, safety planning.
- ANY TRAUMA
Empirical Support for TF-CBT

• 21 randomized controlled trials (RCT) using comparison treatments with children exposed to a variety of trauma types (e.g., sexual abuse, domestic violence, natural disasters, domestic violence)

• Efficacy data exists for preschool, school-aged, and adolescent populations (3-18 years old)
Evidence that TF-CBT Works

- Replicated findings across countries
  - TF-CBT in Community Clinics in Norway (Jensen et al, 2013)

- Randomized trial comparing TF-CBT to TAA in Germany (Goldbeck et al, 2016)

- TF-CBT in Democratic Republic of the Congo (McMullen et al, 2013; O'Callaghan et al, 2013)
  - 52 war affected boys and sexually exploited girls treated in groups
Empirical Support for TF-CBT

- TFCBT has greater impact compared to other treatments
  - PTSD symptoms
  - Depression, anxiety
  - Internalizing, externalizing
  - Sexualized behavior problems
  - Behavior problems
  - Abuse-related cognitions
  - Parent distress

- For reviews see: de Arellano, et al., 2014; Dorsey, Briggs & Woods, 2011; Silverman, et al., 2008
TF-CBT Proportionality

- **Psychoeducation**: Relaxation, Affect Modulation, Cognitive Coping
- **Trauma Narrative and Processing**: Parenting Skills, Gradual Exposure
- **In vivo Conjoint sessions**: Enhancing safety

**Stabilization Phase**: 1/3

**Trauma Narrative Phase**: 1/3

**Integration/Consolidation Phase**: 1/3

Time: 8-16 sessions
Trauma specific and evidence-based treatment works!
TCTY Outcomes:
Trauma Symptom Checklist for Young Children (TSCYC): Pre and Post Treatment
Clinical Centers with Clinicians already trained by TCTY in TF-CBT
https://www.tcty-nd.org

➢ Resources
➢ Clinician Roster
Thank You!