



Assessment, Treatment, and Youth Response to a Trauma-Informed Program

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Trauma-Informed Care & Residential Programs

Youth in residential programs have high rates of traumatic experiences that include abuse and neglect (Briggs et al., 2012, Pane et al., 2015)

Posttraumatic Stress Disorder (PTSD; APA, 2013) is diagnosed in more than 1/3 of youth in residential programs (Boyer, Hallion, Hammell, & Button, 2009; Mueser & Taub, 2008)

Traumatic stress is related to other psychiatric conditions and self-injurious behavior (Harr et al., 2013)

Trauma-informed care is a requirement for Qualified Residential Treatment Programs (QRTP; Bipartisan Budget Act, 2018)

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Trauma-Informed Care at Boys Town

- Staff training:
  - identify and understand the types and effects of trauma.
  - promote nurturing & safe environments.
- Use trauma screening to identify trauma exposure and symptoms.
- Program strategies help youth and families:
  - use praise and encouragement to promote self-efficacy and empowerment.
  - teach and reinforce prosocial skills.

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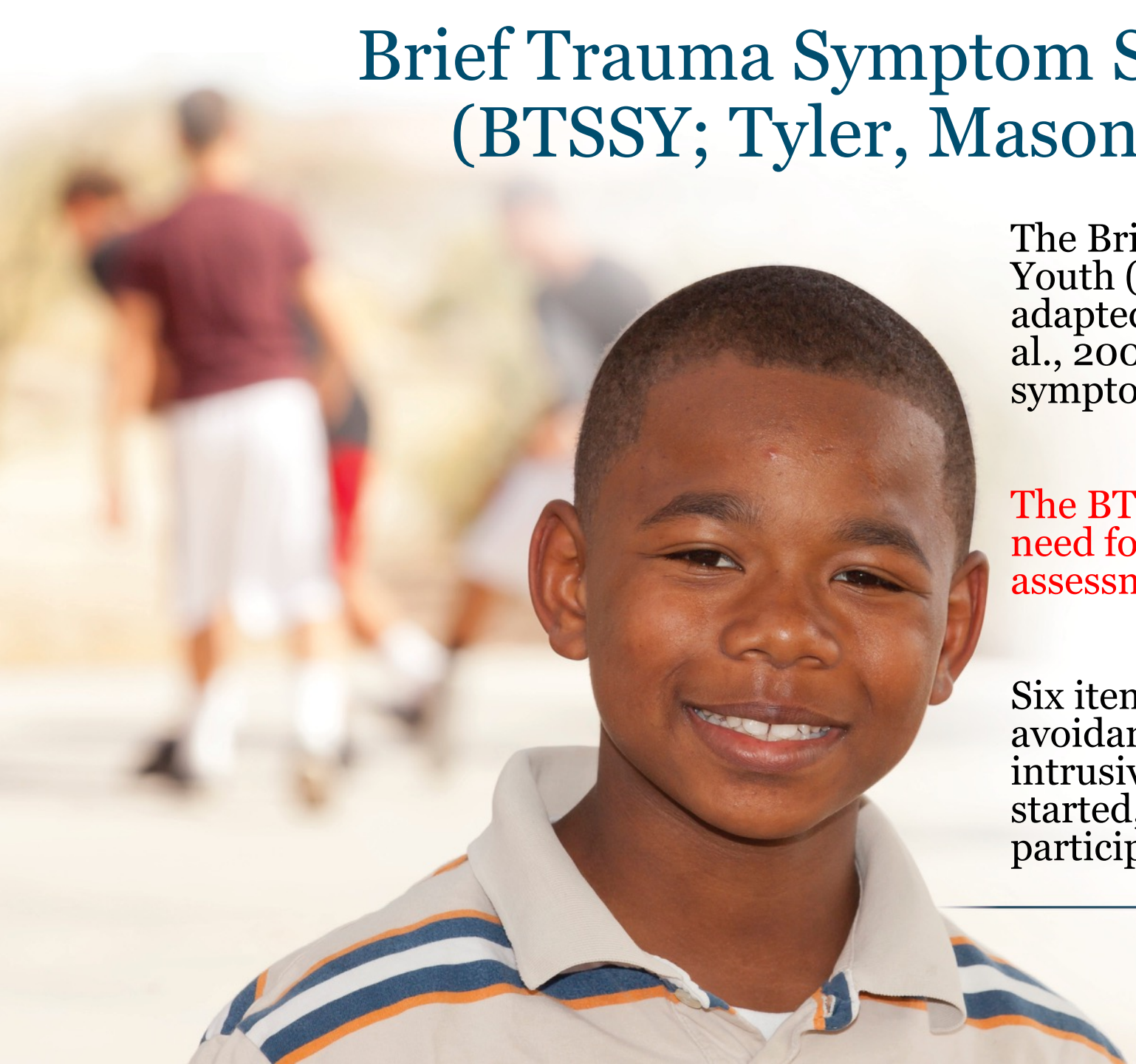
Trauma Exposure (adapted from Felitti et al., 1998)

	Total	Girls	Boys	*p*
• Poor Parental Anger	61%	66%	59%	*
• Physical Abuse	28%	35%	25%	**
• Sexual Abuse	18%	38%	8%	***
• Neglect	58%	64%	55%	***
• Parent Partner Violence	24%	27%	22%	>.05
• Parental Marital Discord	58%	60%	57%	>.05
• Mental Illness in Family	35%	45%	31%	***
• Substance Abuse in Family	59%	62%	57%	>.05
• Criminal Parent	39%	46%	36%	**

* $p<.05$, ** $p<.01$, *** $p<.001$

Brief Trauma Symptom Screen for Youth (BTSSY; Tyler, Mason, et al., 2019)



The Brief Trauma Symptom Screen for Youth (BTSSY) is a self-report screening tool adapted from the PC-PTSD Screen (Prins et al., 2003) and DSM-5 (APA, 2013) to detect symptoms of PTSD.

The BTSSY is used to quickly determine the need for further assessment. It is not an assessment to diagnose PTSD.

Six items: Recurrent distressing dreams, avoidance of internal/external reminders, intrusive memories, hypervigilance & easily started, detachment and decreased participation, and physiological reactions.

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BTSSY

Each item is rated on a 3-point scale as demonstrated.*

		Not True	Somewhat True	Certainly True
1.	I have recently had nightmares about really bad things that happened to me in the past.	0	1	2
2.	I try hard not to think about really bad things that happened to me in the past or try to avoid situations that remind me of them.	0	1	2

- BTSSY Scores are calculated from item-level responses and total scores can range from 0-12.

*A truncated excerpt

BTSSY Psychometric Results (N = 572)

Composite Reliability = .80; Convergent Validity – r = .64 with UCLA-PTSD-RI (Pynoos et al., 1998)

Trauma symptoms scores:

- ranged from 0 - 12
- higher for girls (M = 2.9) than boys (M = 1.7)
- stronger association with emotional versus conduct problems on Strength & Difficulties Questionnaire (SDQ; Goodman, 2001).
- stronger association with abuse (i.e., emotional, sexual, physical) compared to neglect on Childhood Trauma Questionnaire (CTQ; Bernstein, & Fink, 1998

Trauma symptom means differed significantly between groups based on clinical needs.

- Typically Developing = 1.2
- Clinical Concerns without PTSD = 2.2
- PTSD = 5.4

A score of 3+ had 75% accuracy in detecting youth with/without a diagnosis of PTSD made by a psychiatrist (3+ indicates need for further assessment for PTSD).

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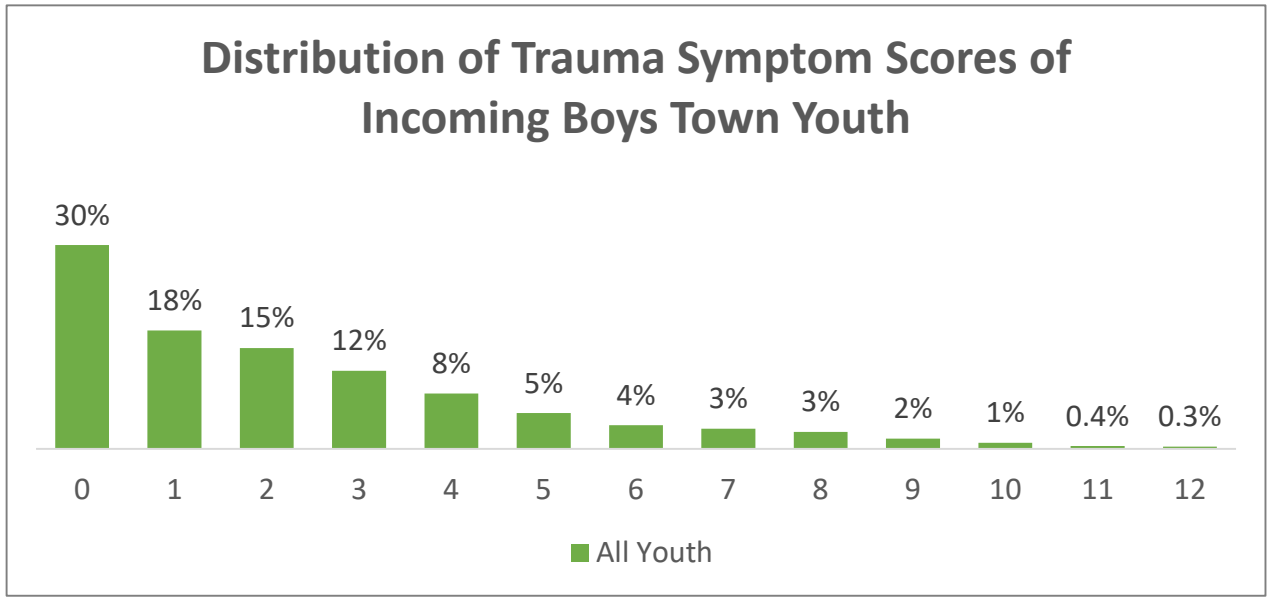
Family Home Program (Nebraska)
BTSSY Scores of Incoming Boys Town Youth



- 1,623 BTSSY were completed by youth (March 1, 2013 - December 31, 2018).
- 70% of incoming Boys Town youth exhibited at least one Trauma Symptom.
- The mean BTSSY Score for all incoming youth was 2.34.
- Incoming female youth (M = 3.25, SD = 2.86) had higher BTSSY scores than male youth (M = 1.85, SD = 2.17).
- 37% met the trauma symptom cut-off of 3+ on the BTSSY

Youth Treatment Response to Family Home Program (N = 1096) (Tyler, Patwardan, Ringle, Chmelka, & Mason, 2019)

Psychopathology (SDQ) & Significant Incidents (Daily Incident Report).

Overall youth in high and low trauma groups both showed decreases in disruptive and self-injurious behaviors and parent reported conduct problems.

- Girls had significantly higher emotional problems, trauma symptoms and self-injurious behaviors than boys.
- Boys had significantly higher conduct problems.

Trauma exposure and Service Plan Assessment Tool (SPAT) ratings were more strongly related than with Trauma Symptoms.

- Consultants may rely more on exposure than symptoms to determine service plan rating.

Trauma symptoms (BTSSY) was the best predictor of emotional problems and self-injurious behaviors (i.e., self-destructive, suicidal ideation).

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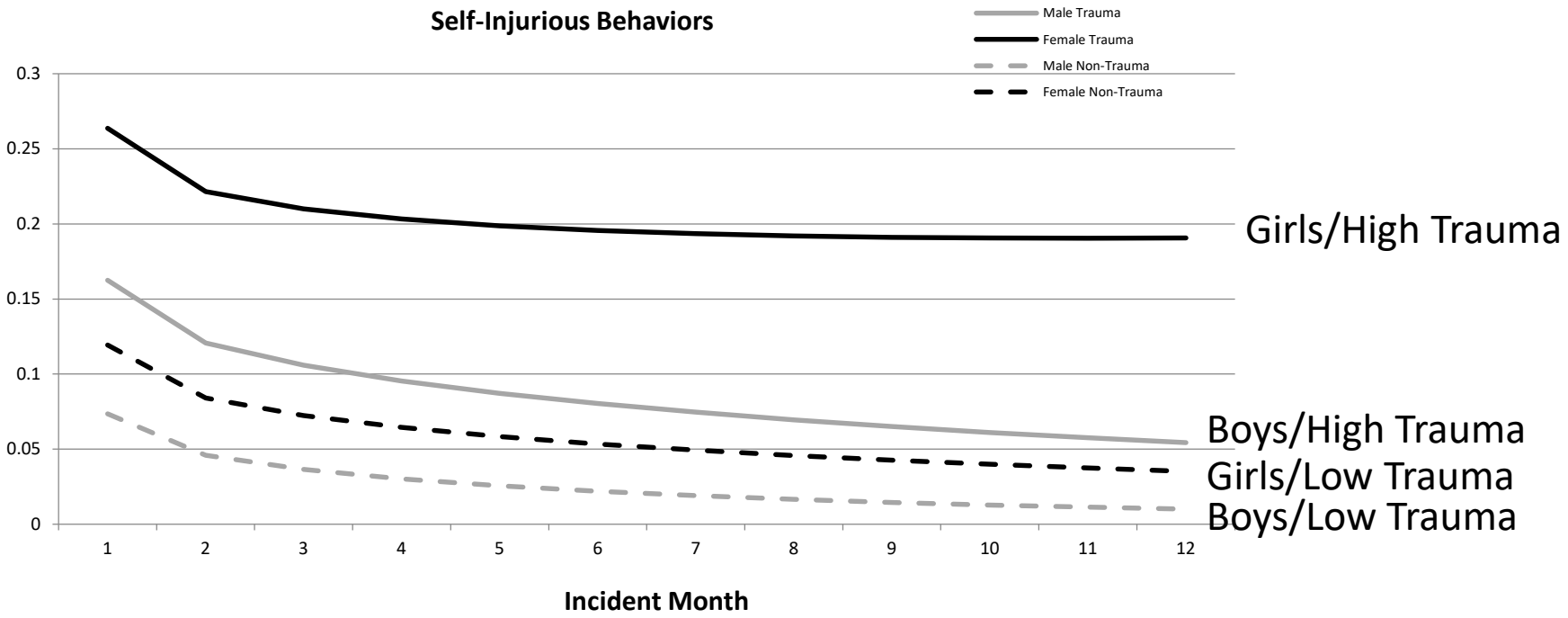
Self-Injurious Behavioral Incidents

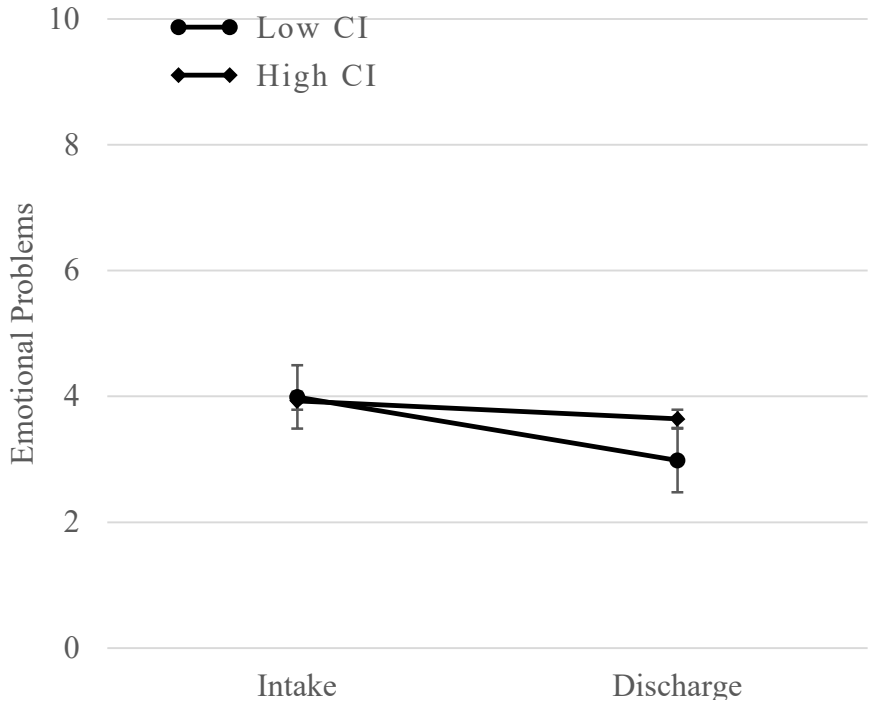
Youth with high trauma symptoms (and especially girls) started higher and finished higher, but made the same rate of change over time as the other groups.



Tyler, Patwarden, et al., 2019

Clinical Impression (SPAT) & Emotional Problems

Youth whom staff deemed to have lower levels of trauma (clinical impression for trauma on the Service Plan Assessment Tool) showed a more significant decrease in emotional problems.



Tyler, Patwarden et al., 2019

Evaluating Life Skills Training for Youth with Trauma Symptoms (*N* = 677) (Tyler, Aitken, Ringle, Stephenson, & Mason, in press)

Is specific life skills training related to improvements in psychopathology and behavioral incidents in youth with high trauma symptoms?

Life Skills (found in other evidence-based treatment models)

- 56% had a self-advocacy skill (12 skills: e.g., express feelings, ask for help)
- 63% had an emotional regulation skill (14 skills: e.g., calming down, dealing with frustration)
- 33% had a problem solving skill (12 skills: e.g., SODAS problem-solving, planning ahead)

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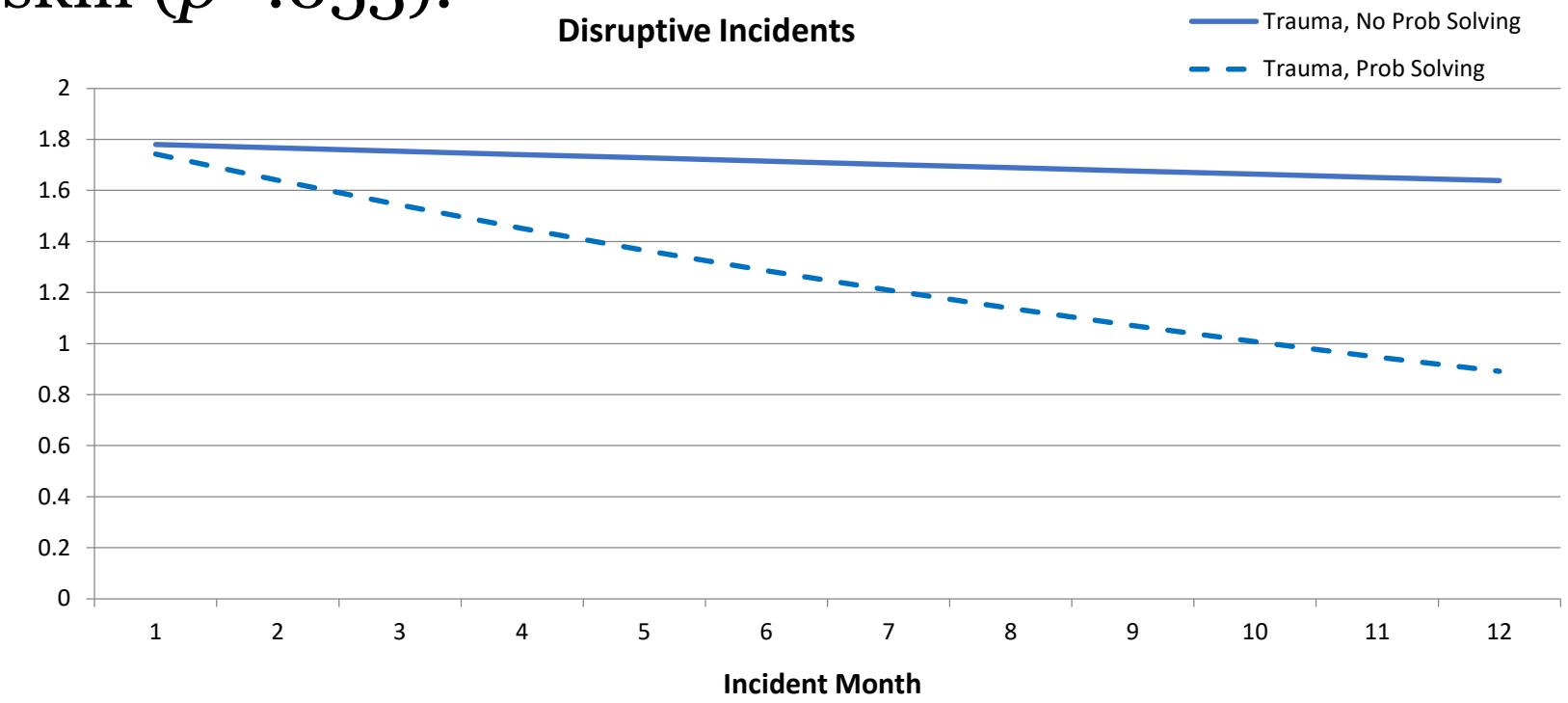
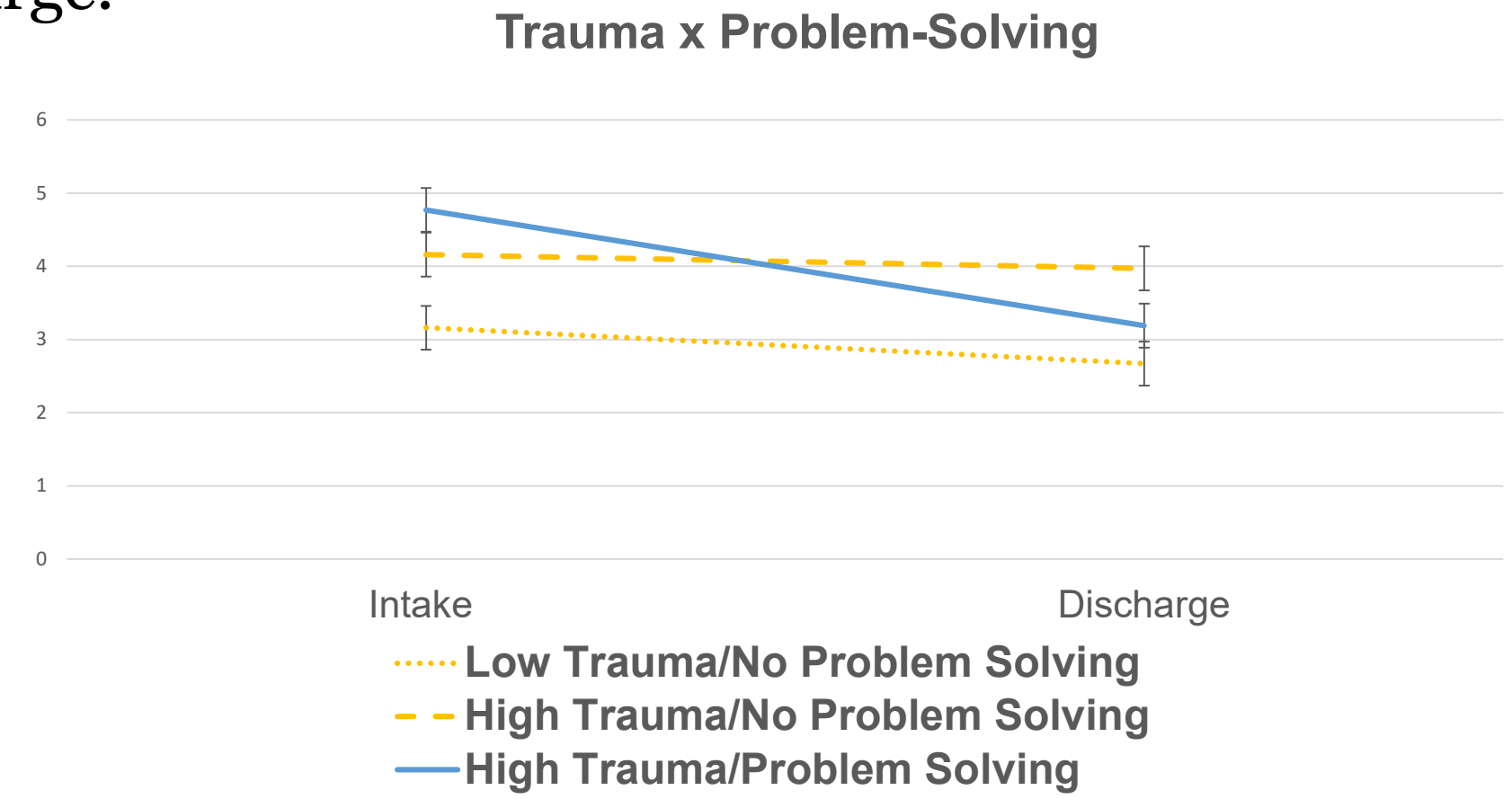
Disruptive Behaviors (Tyler et al., in press)

For youth with high trauma symptoms, disruptive behaviors decreased at a higher rate over time for those who had a problem-solving skill (p=.053).



Emotional Problems (Tyler et al., in press)

Youth with high trauma symptoms who had a problem-solving skill showed a significant decrease in emotional problems from intake to discharge.



Convergence with Other Literature

Problem-solving is a component in many evidence-based treatments such as TF-CBT (Cohen et al., 2012) and Dialectical Behavior Therapy Skills Training for Emotional Problem Solving for Adolescents (Mazza et al., 2016).

Problem-solving contributes to resiliency (Williams et al., 2001) and is a protective factor for youth during civil unrest, war & terrorist attacks (Braun-Lewensohn et al., 2009; Dawson et al., 2018; Fayyed et al., 2017).

Collaborative problem-solving between staff and youth was related to decreased seclusion and restraints (Greene et al., 2006; Martin et al., 2008).

Problem-solving training can be provided through psychoeducation to improve support to youth in under-resourced areas (Dawson et al., 2018; Patel et al., 2011).

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Summary & Recommendations

Trauma symptoms and exposure information should both be used in Service Planning. Increased use of trauma symptom screening could improve earlier identification of youth who are in need of further assessment for PTSD.

Youth with low and high levels of trauma showed a favorable response to the trauma-informed Family Home Program.

Life skills training in problem-solving is a promising strategy for youth with high levels of trauma symptoms. More testing with randomization is needed to see if this finding replicates.

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Questions to Consider

1) What are some of the trauma-informed components of your programs/agency?

2) What are strengths/weaknesses of the trauma-informed components of your programs/agency?

3) What have you found to be effective strategies for youth with trauma receiving services in residential programs?

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