



TREATMENT OF CHILDREN AND ADOLESCENTS EXPOSED TO COMMUNITY VIOLENCE

JACQUELINE A. RAIA, PH.D.



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Many American children and adolescents are exposed to multiple acts of community violence before reaching adulthood. The purposes of this article are: a) to alert the clinician to the phenomenon of community violence exposure in youth; b) to present the symptom response picture for children and adolescents who have been exposed; and c) to highlight critical components of treatment for victimized youth, paying particular attention to developmental concerns of this patient population.

approximately 5000 teenagers are victims of violent crimes. Of particular concern is the finding that firearm homicides are the second leading cause of death for adolescents (15-19 years old), with rates four to six times higher in the inner-city regions (3). These rates refer to fatalities; however, Rosenberg and Mercy (4) estimate the ratio of nonfatal to fatal victimization to be 100 to 1.

Official crime statistics are informative; however, they significantly underestimate the actual rates of victimization. Surveys conducted by the government demonstrate that over half of violent crimes are not reported to the police (5). Moreover, adolescent victimization is least likely to be reported to the police and detailed

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Scope of the Problem

The study of community violence exposure in children and adolescents is a relatively recent venture. Some of what we know was guided by evidence from research in combat veterans, abuse survivors, and children exposed to political violence. Thus, some of the skills and strategies used in the treatment of these groups may serve as a helpful foundation for expansion to treatment of youth exposed to community violence.

Community violence refers to crime or violence that occur against humans by humans through intentional and volitional acts. Examples of community violence include murder, sexual assault, physical assault, arson, suicide, and threatening behavior. Over the past decade community violence rates continued to increase steadily, reaching such intense levels as to qualify as a major national public health concern. Recently the overall crime rate appears to be dropping; however, the rate of adolescent crime remains disturbingly high. The American Psychological Association predicts that juvenile crime rate will continue to rise. Their report contends that even if the arrest rate remains constant, violent arrests for adolescents could still increase by about 22% until 2010 because the children of the baby boomers will reach adolescence (1). A report by the Children's Defense Fund (2) estimated that each day

statistics are not usually available for children under 12. In addition, whereas crime statistics report only the main target of the crime, there may be other victims of the crime, including those who witnessed the incident or who suffer a direct loss as a result of the violence.

Therefore, we must assume that vicarious (hearing about the crime) or witnessing violence is even higher than statistics demonstrate. For these reasons, clinicians and medical staff would be wise to routinely screen for community violence exposure and concomitant stress reactions as part of a routine intake assessment (6).

Rates of exposure to community violence vary according to race, socioeconomic strata (SES), sex, and geographic location. Exposure is higher for those who are nonwhite; for example, African American adolescents are six times more likely to be murdered than White adolescents. Similarly, victimization is substantially higher for those who are poor and live in large urban communities (7). Males have higher overall rates of direct victimization but findings are mixed with respect to indirect victimization (i.e., witnessing and hearing about another's victimization).

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FROM THE EDITOR...

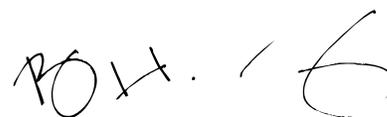
Violence in our communities continues to shock but no longer surprise us. Crime rates are dropping, but violent crimes, especially those involving adolescents, remain at historically high levels. While rapid response critical incident debriefing interventions may be useful, it is clear that comprehensive treatment models caring for children and adolescents exposed to violence are needed, and that intervention be broadly defined to include the need for more detailed assessment of affected individuals and their families. Instruments validated for this purpose are being developed (see p. 59), as well as methods of interviewing children (e.g., 1-3).

Innovative program planners are beginning to integrate the services of police, medical and mental health professionals, and the support of parents, family members, peers, teachers, and religious leaders. As programs develop for children of different age groups and specific settings (e.g., school, clinic, and home), they must take into account the issues related to the cultural diversity of our communities and to treatment matching considerations. A "one size fits all" approach will fail to maximize treatment outcomes.

This issue of the *Clinical Quarterly* highlights current thinking related to prevention, assessment, and treatment for children exposed to community violence. Though each of the articles is brief, collectively, Jacqueline Raia, Lisa Jaycox, Bradley Stein, and Greg Leskin provide an informative digest of the effects of violence, the factors associated with stress reactions to violence, selected validated inventories, and brief secondary intervention programs. In addition, Jenifer Wood and Winifred Reed describe the recent federal efforts to create partnerships among common interest groups. From a mental health perspective, such partnerships can help restore children's sense of place in the community, mitigate feelings of shame and isolation, and promote a renewed sense of faith in others. Recently, the Departments of Education and Justice began working together to develop a guide to help school personnel, parents, community members and others identify early indicators of troubling and potentially dangerous student behavior. Similarly, David Foy has been developing a conceptual model for identifying adolescents at risk for perpetrating violence. In his article, he describes the advantages of analyzing the risk factors associated with community violence from a multi-factorial perspective. By taking into account multiple determinants, more case-sensitive profiles can be developed to sharpen the focus of prevention with individuals who present a high-risk for violent behavior. Together, the articles in this issue underscore the fact that violence is complex, and that its prevention, as well as the treatment of its effects, require that all interested community members, professional and nonprofessional, work together.

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Bruce H. Young, Editor

NATIONAL CENTER FOR PTSD

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Age appears to be related to the number of incidents of violence one experiences rather than the overall number of types of incidents to which the youth are exposed. There are, however, a few findings regarding types of violent events. Young children are more likely to be exposed to violence within the family, such as the murder of a parent (8, 9), whereas older adolescents are more likely to be victims of violence in the community (10).

Surveys of community violence better estimate the complete range of victimization. A survey of elementary school children in New Orleans indicated that 90% of children had witnessed severe violence with 70% having seen a weapon used (11). Similarly, Shakoor and Chalmers (12) surveyed 1000 Chicago-area students aged 10-19. An astonishing 75% of students reported witnessing either a shooting or a stabbing, and 23% had witnessed a homicide. Studies of inner-city youth indicate that as many as 90 percent of urban children witness violence, such as murders, shootings, and stabbings, whereas nearly one of two inner-city adolescents has directly experienced (i.e., as a victim) a violent crime.

Both gang members and those living in areas with high levels of gang activity are at higher risk of exposure to community violence (13). Between 75% and 85% of students interviewed at continuation high schools reported that they had been victimized in a gang-related incident (e.g., witnessing another's death, being stabbed, being shot).

Reactions to Community Violence Exposure

Posttraumatic stress disorder in children and adolescents presents in a manner similar to that in adults (14). The symptom constellation follows DSM-IV criteria (15). The DSM-IV indicates that a person's reactions may include intense fear, helplessness, or horror. However, this may manifest itself in children as disorganized or agitated behavior. Similarly, reexperiencing symptoms may appear as repetitive traumatic themes in children's play (16). Likewise, several factors including the intensity of the violence (17), physical proximity to the violence, and relationship of the youth to the target victim (18) influence the severity of the symptom response to violence exposure. For a detailed review of the etiology of PTSD in children and adolescents as well as which factors appear to be most traumagenic, readers are referred to Foy, Madvig, Pynoos, and Camilleri (19). Despite the remarkable similarities, there are some developmental considerations that differentiate PTSD in children and adolescents from that in adults. Developmental capabilities must be examined for each client. The clinician is encouraged to ask the following questions: 1) What level of cognitive development has the youth achieved and, given that level, how is he or she processing the violent event(s)? 2) What normal developmental tasks are the youth facing at the time of exposure that may be affected by the trauma? For example, is the youth in the process of forming a self-identity, establishing intimate relationships, or separating emotionally from parents. This type of assessment will help determine in what ways the trauma may interfere with social and cognitive development.

Children and adolescents exposed to community violence may also manifest other symptomatology besides PTSD. They may exhibit anxiety, depression, and acting out behaviors. In the investigator's study of inner-city junior-high-school students'

experiences with community violence, exposure was associated with symptoms of anxiety, depression, PTSD, anger, and dissociation (20).

Our recent data from 75 inner-city middle-school students indicated that witness and vicarious (i.e., knowing of another's victimization) exposure were both significantly related to anxiety levels [$r = .48$ and $.44$ respectively, $p < .001$; (21)]. Specifically, community violence exposure was significantly related to separation anxiety ($r = .43$, $p < .001$), overanxious disorder ($r = .44$, $p < .001$), and marginally related to social phobia ($r = .25$, $p = .06$). Findings are mixed regarding depression and school functioning. Some studies find links among community violence exposure and depression and academic functioning whereas others do not. In the middle-school study described above, direct exposure was marginally related to school functioning (e.g., suspensions, expulsions) ($r = .25$, $p < .10$), but not to academic functioning. One explanation of these inconsistencies is that there may be many pathways to depression and to academic difficulties; traumatic violence exposure may be one of many, thus, the associations are weakened.

Community violence exposure also can be associated with acting out or aggressive behaviors and with a general decrease in the ability to modulate emotions. Considering that emotional regulation is a task of development for both younger children and adolescents, traumatic victimization may greatly interfere with this growth process and the impact of community violence exposure on this area of functioning can be immense. Coupled with emotion modulation problems is behavior dysregulation. Children, and adolescents in particular, may engage in reckless and risky behavior subsequent to violence victimization. Two other areas of functioning are quite difficult to measure yet they may be significantly disrupted in mid-development. The first is the youth's sense of self and world view. The second can be called, generally, the youth's maturity level.

Adolescence, and particularly early adolescence, represents a time in the developmental process during which youth form identity and establish their sense of place in the world. When an intentional violent event occurs during this world view formation, it can dramatically alter the individual's perception of the world and subsequently, the adolescent's attitudes and behaviors. For example, our middle school research participants commonly state that after an incident of victimization, they changed their overall life perspective. Following the trauma, they believe that the world is an uncontrollable, dangerous place--they will probably get killed so there is no point in trying to achieve in school or stay out of trouble. They believe they will not live long enough to reap the benefits of efforts that delay gratification; therefore, what is wrong with living in the present and reacting to all immediate urges? Another commonly reported belief is that relationships and connections with other people are either hopeless or risky because they are likely to be killed, yielding yet another traumatic experience. These youth may disconnect from others emotionally in a seemingly protective effort. General maturity level refers to the level of emotional and behavioral functioning at which the child operates. Frequently when children and adolescents are victims of community violence they regress to less mature levels of behavior or emotions. This phenomenon is quite difficult to measure empirically as the manifestation of it is fairly it

unique to each individual and takes different forms for adolescents (e.g., may be more subtle) than it does for younger children.

Assessment of PTSD following Community Violence

Even more than adults, children and adolescents frequently may not connect their cognitive, emotional, and behavioral responses to the trauma. For example, a teen may not realize his agitated state is a result of his witnessing a shooting. A young child may not connect her recent bad dreams to her being robbed at gunpoint, because the content of the dreams does not always reenact the robbery. Moreover, most youth do not link their difficulty concentrating with their exposure to community violence. It seems both unfeasible and fairly irrelevant for youth victims to determine which symptom reaction results from one violent event versus another violent event. One needs to conceptualize community violence exposure as a cumulative and ongoing traumatic stressor rather than as unique events.

Several assessment measures and screening instruments are quite useful for clinical intake purposes (e.g., school nursing clinic, hospital pediatric care clinic). Also, we use self-report symptom checklists that can be administered in interview format. The following are some suggested instruments validated with both clinical and community samples:

- Community Violence Exposure - Adolescent Version (CVE-A)[22]. This new 20-item instrument based on the Survey of Children's Exposure to Community Violence (23) and the Survey of Children's Exposure to Community Violence - Revised (24). The CVE-A obtains information on adolescents' experiences with violence in the community, including frequency, severity, and modality of exposure.
- The Los Angeles Symptom Checklist - Adolescent Version (LASC-A)[25]. This adolescent version of the LASC assesses DSM criteria for PTSD.
- Posttraumatic Stress Inventory - Adolescent Version (PSI-A), [22]. This newly developed scale is based on experience with the PSI. The measure assesses Criterion A exposure and DSM-IV posttraumatic stress symptomatology related to traumatic events.

If time constraints do not allow the use of these brief screening questionnaires, then simply adding two questions to the intake interview can provide helpful information: (a) "Have you ever been in a situation when you thought that you might die or be seriously injured (hurt very badly)?" and (b) "Have you ever seen something terrible happen to someone else and you thought that the person might die or be seriously injured (hurt very badly)?" If the answer to either question is yes, then the clinician can follow up with questions obtaining a brief description of the event(s) and then probe for trauma symptoms.

Treatment of Traumatized Children and Adolescents

An important component of treatment for acute stress reactions to community violence is to educate the trauma victim. One integral message for trauma patients is that the stress reactions (i.e., bodily responses, ruminations, sleep problems) are normal difficulties following exposure to violence (26). Normalizing responses is particularly important for children and adolescents. This can be done individually or in a group setting.

Interventions for PTSD in children and adolescents should include components aimed at reducing PTSD symptoms and bolstering coping resources (27). The symptom reduction segment should include an exposure-based therapy and follow the segment in which adaptive coping is strengthened (26). Individual treatment allows the child or adolescent to proceed at his or her own pace and provides a controlled setting in which to conduct exposure therapy that is customized for that child.

The group setting can be especially powerful when youth see and hear that others had similar reactions and provides a forum for sharing feelings, working on modulating emotions and behaviors, and exploring interpersonal relationship issues.

Two models for group interventions can be conducted in clinic or school settings. The CUES Psychoeducational Counseling Groups coordinated by Dr. Jill Waterman (28) at UCLA are school-based groups for at-risk middle-school and high-school students. The empirically-tested program features a curriculum comprised of separate modules addressing community violence exposure, anger management, educational aspirations, ethnic identity, countering or preventing gang and peer pressure, and enhancing family relationships. The modules represent areas of functioning that appear to be especially vulnerable to the effects of community violence exposure.

The Group Cognitive-Behavioral Treatment Program (29) is a school-based intervention designed for fifth grade children exhibiting clinical levels of PTSD symptoms as a consequence of community violence exposure. The GCBT uses exposure-based exercises and cognitive-behavioral procedures to reduce posttraumatic stress symptoms, enhance adaptive coping strategies, and improve utilization of social support. Art-projects, modeling, role playing, contingency contracting and feedback are some of the behavioral techniques employed in the program. Participants were the direct victims of or witnesses to shootings, stabbings, muggings, physical assaults, murders, or suicides. Empirical evidence from the pilot groups indicated that participants PTSD symptom levels as measured by the Children's Post Traumatic Stress Reaction Index (30) decreased from the severe range ($M = 45$, $SD = 10.51$) to the moderate range ($M = 25$, $SD = 15.63$) after the six-week/12-session program. In addition, functioning was greatly improved as indicated by the increase in the mean Columbia Global Assessment Scale scores (57.33 [$SD = 8.98$] to 83.71 [$SD = 5.35$]). Presumably, the therapeutic gains would be significantly increased with parent involvement in therapy. Both of the above group interventions have collateral parent programs available but data are only available for the youth groups. The success of these empirically-tested group

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interventions as well as numerous individual case studies provide a blueprint for clinicians faced with youth experiencing the effects of community violence exposure.

Whereas medication is often used in the treatment of adult clients, it is a less viable option for children for three reasons. First, fewer investigations of medications have been conducted to determine both the efficacy and the safety of the relevant drugs in developing children. Second, parents are often reluctant to place children on medication when there is a suitable psychotherapeutic intervention available. Third, medication provides temporary symptom relieve but does not cure the trauma response and does not affect all of the reactions to violent victimization.

In summary, there is an alarmingly high number of youth exposed to violence who, in turn, suffer from post-traumatic stress. Standardized assessment measures are available and empirical studies of treatment interventions are beginning to appear in the literature. It would behoove all clinicians to be alert to this significant problem and the issues involved in treatment of young victims.

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Jacqueline Raia, Ph.D. is currently Assistant Professor and Graduate Director at William Paterson University in Wayne, NJ. Her primary areas of research are community violence, post-traumatic stress, child and adolescent mental health.

How can we prevent emotional disturbances in youth exposed to violence in schools?

LISA JAYCOX, PH.D. & BRADLEY STEIN, M.D., M.P.H.



Lisa Jaycox, Ph.D.

Today's youth are commonly exposed to violence in their homes, schools, and communities, affecting between 20 and 50% of American youth (1). Violence now touches the lives of more young people than ever before (2-4), both as victims, but even more commonly as witnesses (5-7).

The emotional impact of such experiences on youth may be profound. In children and adolescents, exposure to community violence has been associated with the development of PTSD at alarming rates (8-11). Many others develop substantial posttraumatic stress symptoms without the disorder itself, or develop related disorders such as depression, substance abuse, or other anxiety disorders.

Given the range of deleterious outcomes associated with trauma exposure, it is not unexpected that children receiving mental health treatment have higher rates of traumatic violence exposure than do the general population (12). One recent study found that 40.3% of children receiving mental health services had been previously exposed to a traumatic event, and of these, 42.9% had significant PTSD symptoms (13). Our own study examined rates of violence exposure and related distress among youth referred to school district mental health services. In a consecutive sample of 124 newly referred 4th - 8th graders, we found that 69% reported the personal experience of violence (ranging from being slapped/hit/punched to life-threatening events) in the past year, and that 93% reported witnessing these same types of violence. Children reported that physical violence and threats of violence happened more often at school than at home or in their neighborhoods. Eighty-nine (72%) of the children identified a specific "serious" trauma, and of these, 46% reported at least moderate PTSD symptoms related to that trauma.

Interventions for violence exposed children range from those designed to prevent problems to treatment for those with an identified disorders. Increasingly, there is evidence that children with PTSD can be effectively treated (14,15). Two controlled studies evaluated the efficacy of a cognitive behavioral therapy (CBT) program for child sexual abuse victims, and found reductions in PTSD symptoms and fewer inappropriate sexual behaviors than in control groups (16,17). A program for older children testing a school-based group treatment following a single-incident stressor found robust reductions in PTSD that

improved even more at follow-up (14), as well as reduced depression, anxiety, and anger. This recent progress is promising, as is the fact that a general consensus has been reached by many experts on the important components of PTSD treatment. These include providing the traumatized child with an opportunity to evaluate and reconsider the cognitive assumptions made with regard to the traumatic event, as well as including parents and /or supportive others in the treatment process (18). Psycho-education of the parents about their child's PTSD symptoms and suggestions concerning management of these symptoms is one common approach to involving the parents in the child's treatment (19-21).



Bradley Stein, M.D.

Children reported that physical violence and threats of violence happened more often at school than at home or in their neighborhoods.

Although treatment advances are promising, such treatments are rarely used in community settings, and frequently are limited to the relatively small number of individuals who have a diagnosable disorder. The opportunity to decrease rates of PTSD in children through prevention programs has been largely unexplored, although work with adults shows that prevention programs using CBT techniques are effective. A study of 20 female assault victims compared those who received a brief prevention program (4 individual therapy sessions) to those who underwent an assessment procedure only. Participants in the brief prevention program showed symptom reduction of 74%, as compared to a mean reduction of 33% in the control group (22). The prevention included education and brief practice with relaxation, imaginal exposure to the trauma, real-life exposure to trauma reminders, and cognitive restructuring for trauma-related cognitive distortions. Although preliminary, these findings are encouraging, and Foa and colleagues are continuing to study this program in a larger sample of traumatized women.

The high degree of overlap between symptoms of PTSD and depression suggests that programs developed to target depression may provide a roadmap for efforts to prevent emotional disturbance after violence. For instance, programs have been developed and proven effective in preventing depression among adolescents (23) and depressive symptoms among elementary school children (24). Both programs used cognitive-behavioral therapy techniques such as cognitive restructuring, social problem-solving, and social skills training.

Emotional disturbances related to violence exposure during critical developmental periods can alter life trajectories and create problems that last into adulthood. Research on the ways in which interventions can target trauma-related symptoms early, before they interfere with the important developmental processes during the transition to adulthood, is lacking. Given the research summarized above, a program that combines trauma-focused exposure and CBT skills to prevent depression and anxiety might be quite effective in reducing a wide array of trauma-related symptoms and associated dysfunction.

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Lisa Jaycox, Ph.D. is an Associate Behavioral Scientist at RAND (Santa Monica, CA) and a Clinical Psychologist (University of Pennsylvania, 1993). Dr. Jaycox is working on projects related to the treatment of adolescent depression in primary care settings, mental health consequences of community violence among young adults, evaluation of adolescent substance-abuse treatment programs, trauma-related distress among adolescent help-seekers in school mental health and substance abuse treatment settings, and the use of trauma-focused therapy to improve school-based mental health services for children.

Bradley Stein M.D, M.P.H. is Visiting Assistant Professor of Psychiatry at the University of Southern California, and a Faculty Scholar at the UCLA/RAND Research Center on Managed Care for Psychiatric Disorders. His current research focuses on the provision of school mental health services to children exposed to violence, in addition to studying the effects of managed behavioral health care on behavioral health service utilization among vulnerable populations.

NEW DIRECTIONS

Matthew J. Friedman, M.D., Ph.D.
Executive Director, NC-PTSD

PTSD as a Severe Mental Illness

At the annual meeting of the National Alliance for the Mentally Ill (NAMI), held in Chicago last July, Dennis Charney, Bob Rosenheck, Jackie Garrick (from the American Legion), and I had the opportunity to present a symposium entitled "PTSD: A Brain Disorder and Chronic Mental Illness."

In my opinion, this presentation reflects an important evolution for both NAMI and the PTSD field. NAMI is the most powerful American organization dedicated to mental health support, education, advocacy and research. Having begun 20 years ago, primarily as a group of parents of children with severe mental illness, NAMI now describes itself as "the nation's leading grassroots, self-help organization." It has played a major role in fostering legislative, public policy, professional and consumer initiatives on behalf of people with mental illnesses due to brain disorders such as schizophrenia and affective disorders. It has paid little official attention to PTSD in the past.

Similarly, the PTSD field has generally looked to affective and anxiety disorders as its frame of reference rather than to severe mental illness (SMI). In recent years, however, there has been a progressive convergence between the PTSD and SMI fields. That is why I think our NAMI symposium is noteworthy. It represents the mutual recognition that both NAMI and PTSD professionals must begin to work together to understand and assist SMI patients who have been previously or currently exposed to traumatic events.

Our NAMI symposium emphasized that: a) PTSD is associated with significant alterations in brain structure and function; b) people with severe, chronic incapacitating PTSD are often superficially indistinguishable from other SMI patients; and c) within the SMI population, trauma is ubiquitous and PTSD quite prevalent.

During the past few years brain imaging research has shown that people with PTSD exhibit abnormal blood flow when confronted with trauma-related stimuli or after they have received a drug (e.g., yohimbine) that activates adrenergic neurotransmission. Furthermore, the hippocampus, a key brain structure involved in learning and memory, has been shown to have reduced volume among adults whose PTSD is due to military trauma or childhood sexual abuse (1). These findings suggest that fundamental brain mechanisms that mediate perception, learning, and memory are significantly altered in PTSD.

Five years ago, Bob Rosenheck and I suggested that PTSD may sometimes become a persistent mental illness. We pointed out that although PTSD is not inherently a persistent mental disorder, some people with PTSD are severely and chronically incapacitated. They suffer from "severe and intolerable symptoms, marital, social, and vocational disability, and extensive use of psychiatric and clinical services...(They) can often be found on the fringes of society, in homeless shelters or enrolled in programs designed for patients with chronic mental illnesses such as schizophrenia" (2). We also showed that the intensity and pattern of clinical utilization, resembled that of SMI patients within the VA system of healthcare. We went on to recommend that social rehabilitation treatment approaches, such as case management, that have been developed for SMI patients, also be utilized for severe and incapacitating PTSD.

Finally, Kim Mueser and associates (3) assessed trauma exposure and PTSD prevalence among SMI patients in New Hampshire and Baltimore. They found that almost all (98%) of the 275 patients interviewed reported lifetime exposure to at least one traumatic event. Furthermore, almost half (43%) met diagnostic criteria for PTSD although only 2% had been so diagnosed in their clinical record. The most common traumatic experiences were: adult or childhood sexual assault, attack with a weapon, automobile or work accidents, physical attack without a weapon, and witnessing killing or serious injury of another. In short, both the lifetime prevalence of trauma exposure and PTSD is higher among SMI patients than among the general population.

Taken together, these findings indicate that we must expand the neurobiological, clinical, and conceptual context in which we seek to assist patients with PTSD. Advanced neuroimaging and other techniques have only begun to help us appreciate the disruption in brain function associated with this disorder. Case management, work therapy, and other psychosocial rehabilitation therapies may be the treatments of choice for severe, incapacitating PTSD with or without adjunctive cognitive-behavioral and pharmacotherapeutic approaches. Therefore, through collaborative initiatives, we must share our expertise with colleagues in the SMI field and let them teach us, in return, what they have learned about treatment of SMI patients so that we may provide better care for people with severe, incapacitating PTSD as well as for SMI patients with comorbid PTSD.

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WOMEN AND TRAUMA: A CLINICAL FORUM

Marie B. Caulfield, Ph.D., & Annabel Prins, Ph.D.

Finding Strength: Understanding the Function of Symptoms

Marie B. Caulfield, Ph.D.

Mental health care providers working with trauma survivors are often faced with an extensive array of presenting problems. Trauma survivors frequently have a wide range of psychopathology including depression, posttraumatic stress disorder, and substance abuse. In addition, they may present with practical problems such as unemployment, legal problems, and homelessness as well as serious safety issues such as self-mutilation, suicidality, and dangerous lifestyles. Finally, the provider may also be helping the client deal with a wide range of problems in relationships.

With all of these problems, mental health care providers often feel as if they have their hands full and may sometimes feel at a loss as to where to begin to intervene. For the benefit of both survivors and providers, it may be helpful for mental health care providers to systematically examine the client's strengths. Finding and highlighting a client's strengths may sound obvious, however, trauma survivors' strengths may be reflected in their symptoms. A therapist may highlight this by making explicit to clients that their reactions during the trauma were logical, beneficial, and perhaps even wise. For example, statements such as *"you did whatever you needed to do to get through the beatings;"* *"you did whatever you could to make life bearable until you could come home from a war you didn't understand anyway,"* can help to reframe the client's appraisal of their reactions. Moreover, in this supportive context, observations may lead to a discussion of how strategies that were functional at the time of the trauma may now be related to some of the client's current presenting problems.

Bratton's (1), work on recovery from child abuse takes this idea one step further. She describes part of the healing process as "understanding the brilliance of childhood defenses." She highlights the important process of discovering with the survivor that, not only were the childhood responses to trauma sensible, they were in fact creative, even "brilliant" solutions to an impossible and horrible situation. For example, a client may be "stuck" on the fact that they did not do anything to stop their abuse as a child. It may be critical to her recovery to help this client understand that she tolerated the abuse because the other choice was being abandoned or being hurt worse, and that she made a strategic decision to survive by not fighting back. Her ability to tolerate pain to prevent further suffering reflects a strength on which she can build. Similarly, for many clients who dissociate, dissociating during the abuse was not just avoidance but a brilliant way of maintaining some control over their world.

Gondolf and Browne (2) emphasize the need to recognize and highlight the strengths of domestic violence survivors because others, including the batterers, often negate these women's strengths. They describe how symptomatology or behaviors that might be described as pathological can also be considered coping strategies to endure abuse, escape abuse, or protect children from abuse. Gondolf and Browne (2) provide a model for working with a client to assess her strengths, how she has used these in the past, and any barriers to her using her strengths to achieve her goals. Although targeted for work with domestic violence, their model may be useful for work with any trauma survivors.

It is important for therapists not only to encourage clients to look at past behaviors as unique and creative coping strategies to intolerable situations, but also for therapists to work to understand these behaviors in this way themselves. Linehan's (3) successful treatment for clients with borderline personality disorder stresses the need for the therapist to believe that, at any point in time, the client is doing the best she can. Empathy and understanding of the client is enhanced when the care provider can understand the function of behavior in both past and current contexts as strategies to survive.

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ustice, Education, and Mental Health Partnerships: Creating a Safety Net for Children

JENIFER WOOD, PH.D. & WINIFRED REED, M.A.

At a time of intense public concern surrounding incidents of school violence, mental health professionals should be mindful that, just as they cannot bear the entire responsibility for predicting and preventing such incidents, they do not possess all the tools necessary to respond to and repair the social and emotional damage that has been done. The Columbine High School tragedy comes at a time of unprecedented awareness—on the Federal, State, and local levels—of the importance of community-wide, collaborative approaches to the issue of school safety, in particular, and preventing and responding to incidents of youth violence in general. This article summarizes some of the current thinking on the Federal level related to the promotion of school safety and highlights the role of mental health professionals within this integrated, collaborative framework.

In the recently announced combined federal grant program, “Safe Schools / Healthy Students,” the U.S. Departments of Justice, Education, and Health and Human Services have emphasized the importance of collaborative efforts which bring together justice system actors (including law enforcement), education personnel, and mental health professionals to enhance school safety and promote healthy child development. Another joint venture, “Early Warning, Timely Response: A Guide to Safe Schools,” was produced in response to a Presidential directive to help all adults “reach out” to children at risk for violence. This guide encourages the formation of local Prevention and Response Teams that include parents, mental health professionals, child welfare representatives, physicians, business leaders, members of the faith community, and juvenile justice system representatives, among others.

These Federal initiatives reflect a growing consensus that law enforcement, educators, and mental health professionals all have meaningful roles to play in both prevention and intervention related to incidents of violence in schools and communities. The development of partnerships between stakeholders as diverse as police departments, early childhood program staff, school administrators, community-based mental health providers, and youth advocates creates a safety net for children that independent, poorly integrated efforts cannot. The complementary roles of these partners in school safety promotion can be viewed within a risk and protective framework. That is, to the extent that children are securely embedded within a nested sequence of protective environments—the family, school, and larger community—their risk for negative outcomes, including school violence, is diminished.

...parents, teachers, and police officers can provide a context for children’s recovery from traumatic experiences that enhances the specialized work of trained mental health professionals.

By working together, through the development of a Prevention and Response Team, for example, mental health professionals and other adults within the community create this protective layering or “safety net” for children.

Each partner in such collaborative efforts brings a different type of expertise, and their involvement in children’s lives connotes a different meaning. Although the explicitly therapeutic contributions of teachers, police officers, and others may be limited, these individuals serve as important sources of social support, identifiers

of “warning signs,” and potential conduits to more specialized mental health services, as appropriate. Moreover, parents, teachers, and police officers can provide a context for children’s recovery from traumatic experiences that enhances the specialized work of trained mental health professionals. Law enforcement officers, in particular, may play an important, symbolic role in restoring children’s sense of safety and “connectedness” to social institutions after devastating events occur (1).

An example of a successful collaborative effort is the Child Development - Community Policing (CD-CP) Program, implemented by the Yale Child Study Center in partnership with the New Haven Police Department. The program provides police officers with training in child development and how to identify children at risk for adverse outcomes following exposure to community violence (2). Law enforcement officers responding to crime scenes in which children are victims, witnesses, or perpetrators are responsive to those children and proactive in getting them connected with appropriate mental health services. In addition, CD-CP has expanded their work to include intervention in the schools with children, parents, and school administrators. As part of the Community Outreach Police in Schools (COPS) Intervention, neighborhood police officers and clinicians co-lead therapeutic groups for elementary-school students who have been victims of or witnesses to crime. Work of this kind closes the gaps between law enforcement, mental health professionals, and schools to reduce the incidence and negative consequences of children’s exposure to potentially traumatic violence.

Although the terrain of these collaborative initiatives may be unfamiliar to many clinicians, mental health professionals have a key role to play. To summarize, clinicians interested in prevention and intervention around school and community violence might consider the following recommendations:

- Play an active role in building local partnerships between mental health, law enforcement, the schools, and other key stakeholders interested in children’s well being.
- Acknowledge the important functions that parents, teachers, law enforcement, and others fulfill in children’s lives. At the same time, assist these partners to recognize their limitations and feel comfortable about knowing when a referral for specialized mental health services is indicated.
- Work with these partners to incorporate targeted, clinical interventions within broader, universal interventions, such as violence prevention curricula and safe school policies. Too often, school-wide efforts that reach large numbers of children are not complemented by the availability of specialized mental health services for those students who need them.
- Create opportunities to educate others about child development and mental health. Clinicians may be more aware, for example, of “internalizing” problems and could play a valuable role in sensitizing educators and law enforcement to childhood depression, post-traumatic stress, etc. Mental health professionals bring a sophisticated understanding of risk factors—and particularly the risk imparted by being a victim of violence—that should inform the responses of other adults in the community as well.

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Jenifer Wood, Ph.D. received her doctorate in clinical psychology from UCLA and is currently the Director of Juvenile Justice and Mental Health at the National Mental Health Association. Formerly, Dr. Wood served as a social science analyst at the National Institute of Justice, focusing on issues related to mental health, substance abuse, and prevention.

Winifred L. Reed, M.A. is a Social Science Analyst in the Crime Control and Prevention Division, Office of Research and Evaluation at the National Institute of Justice. She has worked in a wide range of substantive areas during her 25 plus years of criminal justice experience including law enforcement, gangs, school-based programs, criminal careers, criminal behavior, and crime prevention.

For further information about U.S. Dept. of Justice initiatives, contact: Winifred Reed, Program Manager, National Institute of Justice, 810 Seventh Street NW, Washington DC 20531; phone: (202) 307-2952; fax: (202) 616-0275; email: winnie@ojp.usdoj.gov

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"GUNS, GANGS AND GIN"

DAVID W. FOY, PH.D.

RECOGNIZING ADOLESCENTS AT RISK FOR PERPETRATING COMMUNITY VIOLENCE

Among the poor in inner-city areas across the country, living day by day with the fear of life-threatening violence erupting within their neighborhoods has long been a fact of life. For others of us living in middle class suburban communities, the problem may have seemed remote. However, in the wake of the recent rash of actual and threatened school shootings and bombings, it seems timely to consider several key issues related to community violence (CV) that have been identified by recent research conducted with high risk inner city adolescents. School and mental health professionals now must be prepared for providing crisis services when community disasters occur, as well as taking necessary steps to prevent predictable human perpetrated acts of violence.

Since the problem has taken on epidemic proportions in recent years, adopting a public health model to conceptualize the factors involved has been useful. In this approach, CV-related variables are organized into three domains: **agent, host** and **environmental**. Agent factors refer to the types of weapons and their lethality, along with their cost and availability through legal and illegal sources. Host factors include relevant personal characteristics of those individuals who threaten or commit violence against others (e.g., male adolescent, disaffected, uninvolved in mainstream activities).

Environmental factors include the obvious family, school, peer group, and neighborhood factors, as well as information inputs such as advertising, movies, TV, internet, and video games. A primary advantage of using this multifactorial approach is that it requires simultaneous consideration of several risk factors, as well as situational variables, in our attempts to understand complex acts of violence and those who commit them, rather than using our personally held, single-factor theories (e.g., poor parenting, guns, or gangs are responsible).

Given the foregoing, risk screening to identify "troubled" youth can proceed along the lines of a public health approach. For example, by using the model, at-risk adolescents could be defined as those who: are members of known high risk groups; engage in high risk behaviors; and function in higher risk environments. In Table 1 let's consider several variables from each public health model domain that research has found to be associated with increased risk for being victimized or perpetrating violence.

While the list of risk factors is not meant to be exhaustive, it does illustrate how a confluence of factors, taken from the three public health domains, can present a formidable set of predispositions for an adolescent to carry into risk situations. On the positive side, many of the risk factors are modifiable behaviors, subject to prosocial change through active prevention efforts.

Immediate crisis intervention and short term treatment for residual PTSD symptoms are indicated for adolescents who have recently experienced a life-threatening episode of community violence. Individual treatment provides a controlled, supportive therapeutic environment, while group methods offer validation and normalization of traumatic experiences through sharing with other members.

Our violence prevention programs need to include intervention in children's social environments at home and at school, as well as specific efforts to reduce risk behaviors such as gang involvement, heavy drinking, and carrying handguns.

Table 1. Community violence risk domains & factors for adolescents

DOMAIN	FACTORS	DESCRIPTION
AGENT	1. Lethal weapons.	1. Personal possession or access; carrying a weapon; threatening to get or use a lethal weapon in a dispute.
	2. Substance abuse.	2. Alcohol in high doses; cocaine or other stimulants; sustained use or use in combination with other drugs.
HOST	1. Male gender.	1. Females far less risk for direct community violence exposure.
	2. Recent loss or betrayal or depression/other psychological disorder.	2. Impaired judgment and problem-solving.
	3. Prior violence/progression attitudes 4. History of traumatic victimization by community violence, domestic violence, or childhood physical/sexual abuse.	3. & 4. Justifies use of violence for revenge when disrespected; uses dehumanizing language to describe opponents.
ENVIRONMENTAL	1. Association with antisocial peer group.	1. Affiliated with a clique, gang, or set with deviant rules.
	2. Parental communication or monitoring lacking 3. Scapegoat or blacksheep in family system.	2. & 3. Family dysfunctional and inappropriate blaming of adolescent.
	4. Absence of supportive others in extended family.	4. Parent surrogates lacking
	5. Marginal investment in academics or extra-curricular activities.	5. Prosocial "contract" with society missing.

David Foy, Ph.D. is a professor of psychology at Pepperdine University, Graduate School of Education. He has served as a research consultant to the National Center for PTSD since 1991.

SCREENING FOR TRAUMA AND PTSD IN A PRIMARY CARE CLINIC

GREGORY A. LESKIN, PH.D.

For many inner city young adults, violence commonly occurs in the family, on the streets and in schools. Recent high profile school shootings have brought a renewed interest to closely examine the developmental impact of community violence and identify points for intervention. This article looks at trauma histories and symptoms of PTSD in ethnic minority, adult male medical patients interviewed in an inner-city primary care clinic.

The term “community violence” is defined here as intentional human acts that involve physical force or injury and may occur anywhere, including at home or in the community. Examples of community violence include physical and sexual assault at home, being shot at by a passing car or witnessing a homicide. Community violence is an overly inclusive term, but useful when working with traumatized individuals representing at-risk groups, such as young African-American males. When working with minority groups from lower social economic status with high rates of violence, a community violence model can provide mental health professionals a full perspective of the intensity and frequency of violence that permeates these young men’s lives. The primary care clinic may serve as an important “gateway” for identifying victims of crime who could benefit from psychological services and treatment.

Background

Even though violent crime rates appear to be decreasing, urban and suburban Americans still experience criminal violence at very high rates. Within the African-American communities, the violent crime rate is even higher. The Massachusetts Department of Public Health (1) reported that one in every 38 black male teenager (age 15-19) was shot or stabbed in 1994. The Massachusetts rate of nonfatal firearm assault injuries among African-Americans was 159.3 per 100,000 in 1994; for whites, the rate was 2.9 per 100,000; and for Hispanics, the rate was 75.3 per 100,000. This high level of violence continues to represent a major challenge,

not only for law enforcement, but also for the medical and mental health communities who treat the bodily injuries and human suffering caused by criminal violence.

*Research points to the possible
advantages of actively
identifying trauma patients for
clinical education and
treatment to reduce symptoms
associated with PTSD*

The interviews were conducted at Boston Medical Center’s Young Men’s Health Clinic. Boston Medical Center (BMC) is a 350 bed, urban hospital in eastern Massachusetts. BMC is the regional trauma center for the surrounding neighborhoods of Roxbury, Dorchester, and Mattapan. Together, these three areas comprise 90% of the city’s minority population. In 1995, these three districts together accounted for over 33% of all crime in the City of Boston; furthermore, 70% of all homicides in Boston involved African-American victims. The Young Men’s Health Clinic at BMC is a clinic focusing on providing primary care services to many adult males who live in these communities, which made it an ideal location for studying the emotional impact of urban crime and violence.

Thirty African-American males (age 18-32) were interviewed following their regularly scheduled medical visit. Each individual was asked about his history of criminal victimization, psychological problems related to urban violence, and functional health. We found very high rates of criminal victimization and related psychopathology in this population. Using the Survey

for Exposure to Community Violence Revised (2), the mean number of direct victimization experiences (e.g., being injured or having life threatened) was 21.2 (SD=15.0). The number of violent experiences ranged between 6 and 189 lifetime events.

Using the PTSD Symptom Scale (3), more than half of this group met diagnostic criteria for PTSD. In fact, the PTSD scores for this group were also high, making this group comparable to other studied trauma populations, such as an acute rape sample.

We also found a strong correlation between the level of violence exposure and psychopathology. The correlation coefficient between direct victimization and PTSD was .50 ($p < .001$). The study also examined the relationship between functional health (SF-12), and PTSD. The correlation between PTSD and overall mental health functioning was -.80, suggesting the presence of PTSD is related to decreased general mental abilities. The correlation between PTSD and physical health functioning was -.35. This correlation may indicate that individuals with PTSD may also suffer from physical health problems. These findings support a growing literature that draw a connection between PTSD and physical health problems (4).

Primary Care Models for Treating PTSD

The findings make it clear that many of the patients being treated for medical problems would also be well served if asked about their histories of abuse and trauma. The model used for the study was a collaborative model of behavioral healthcare. The primary care physician referred patients directly to a psychologist in the clinic for trauma screening and psychological evaluation. The primary care physician has a vested interest to treat both the medical and psychological problems of the patients in the Young Men's Health Clinic. Because of the physician's knowledge of the impact of trauma on development, he collaborated with a Ph.D. level clinician to measure the impact of trauma and PTSD. This close collaboration between primary and specialty care physicians with mental health professionals can be advantageous for overall patient care. Many trauma patients do not seek mental health services, but will request medical services for their bodily pains. The advantages of this integrated, multidisciplinary research points to the possible advantages of actively identifying trauma patients for possible clinical education

and treatment to reduce symptoms associated with PTSD. Such an approach might help to reduce an individual's risk for future victimization or violent acting out.

Summary

This article presented findings from a study that examined the rate of traumatic life events and PTSD in a primary care setting. The Young Men's Health Clinic was an ideal place to position mental health staff to interview medical patients and screen for trauma and PTSD. Many individuals visiting this setting were found to have high rates of previous community violence trauma, PTSD and related physical health problems. Hopefully, by educating patients and physicians in medical settings about the potential impact of traumatic stress, trauma professionals and mental health staff can help reduce health related consequences of violence.

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Greg A. Leskin, Ph.D. completed his NIMH post-doctoral fellowship at the National Center for PTSD Behavioral Science Division in 1998 and then joined the staff at the Education and Clinical Laboratory Division. His primary area of interest is behavioral integration in primary care.

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NC-PTSD Research Quarterly

The *Research Quarterly* reviews recent scientific PTSD literature. Telephone (802) 296-5132 for subscription information.

Disaster Mental Health Training and Consultation

Education staff provide training in disaster mental health services, including team development, interfacing with other agencies, on-site and off-site interventions, debriefing, and psychoeducational and treatment interventions with disaster survivors and workers. Telephone (650) 493-5000 ext. 22494 or email: bhb@icon.palo-alto.med.va.gov

Conferences and Training Events

The Menlo Park Education Team provides consultative support for the development of training in PTSD. Services include assistance in finding faculty and designing program content. Telephone (650) 493-5000 ext. 22673.

Clinical Training Program

The Education and Clinical Laboratory Education Division for the National Center for Post Traumatic Stress Disorder at the Palo Alto CA VAMC, in collaboration with the VA Employee Education System offers a Clinical Training Program (CTP). The training program is approved for 35 Category 1 CEUs for physicians, psychologists, social workers, and nurses.

Each year we welcome many mental health professionals from across the United States and from around the world. Most clinicians who enroll in the program have a working knowledge about treating the effects of trauma and PTSD and are looking to upgrade their clinical skills. The CTP offers a broad range of educational activities including:

- * Lectures
- * Clinical consultation
- * Clinical observation of group treatment
- * Group discussions facilitated by staff

Specific training topics include warzone trauma group treatment, treatment of women veterans, treatment of sexual assault related PTSD, relapse prevention, cross cultural treatment issues, assessment and treatment of families, disaster mental health services, cognition and PTSD, assessment of PTSD, and psychiatric assessment.

Training programs are scheduled for a minimum of one week, though longer programs are available if the applicant can justify an extended stay. Programs are scheduled nine times per year, generally on the third week of the month.

At present time, funding for attendance is not available from the National Center. There is no fee for the training program itself, but participants are responsible for providing their own transportation, lodging, and meals. Interested applicants are encouraged to explore funding options through their local medical centers or VA Employee Education System. For more information, or to request an application, please email: jir@icon.palo-alto.med.va.gov, or call FTS 700-463-2673, or commercial number 650-493-5000, ext. 22673.