

News You Can Use

Lucy Berliner
Ben Saunders

San Diego Conference on
Child Maltreatment
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PTSD is Important Risk Factor for Rape Among Young Women

National Survey of Adolescents - National probability sample of 4,023 adolescents between ages of 12-17.

Wave II follow-up survey 7 years later of 1,753 (44%) young adults, 872 females.

12.5% of females reported a new rape since Wave I.

Wave I predictors of new rapes:

- Caucasian
- Prior family drug problems
- Prior sexual assault reported at Wave I
- PTSD at Wave I

PTSD the biggest predictor of new rape assaults.

PTSD mediated relationship between CSA and new rape.

Treating PTSD can reduce risk of future sexual assaults.

Elwood, L.S., Smith, D.W., Resnick, H.S., Gudmundsdottir, B., Amstadter, A.B., Hanson, R.H., Saunders, B.E., & Kilpatrick, D.G. (2011). Predictors of rape: Findings from the National Survey of Adolescents. *Journal of Traumatic Stress, 24*(2), 166-173.

Trauma Research Participation Does Not Hurt Teenagers

NSA-R: 3 wave victimization study with a national probability sample of 3,614 youth aged 12-17.

Youth screened for history of sexual assault, physical assault, physical abuse, and witnessing violence with explicit, behaviorally specific questions.

Characteristics of up to 3 incidents assessed.

Debriefed and assessed for distress at the end of the interview.

5.7% said some questions had been emotionally upsetting to them.

0.2% (8) were still upset at the end of the interview and wished to be contacted by a counselor.

<0.1% (1) needed immediate attention from a counselor after the interview.

Girls more likely than boys to find questions distressing.

No impact of Wave 1 distress on study dropout in Wave 2.

Participation in trauma surveys does not appear to carry an undue risk of emotional distress for adolescent participants.

Zajac, K., Ruggiero, K.J., Smith, D.W., Saunders, B.E., & Kilpatrick, D.G. (2011).

Adolescent distress in traumatic stress research : Data from the National Survey of Adolescents-Replication. *Journal of Traumatic Stress, 24*(2), 226-229.

Trauma-Focused CBTs for PTS

Intervention packages based on CBT

- * Emphasize exposure and cognitive processing
- * Structured, focused, time-limited

TF-CBT: Effectiveness shown for even more groups

- * Exposure to DV (Cohen, Mannarino, & Eyengar, 2011)
- * Preschoolers (Scheeringa, Weems, Amaya-Jackson, & Guthrie, 2010)
- * International (Jenson, et al ISTSS 2011)
- * Low resource countries (Murray, Dorsey)

Other trauma-focused packages:

- * Former child soldiers [KidNet] (Ertl, Pfieffer, Schauer, Elbert, & Neuner, 2010)
- * Single incident-Israelis [Prolonged exposure for adolescents (PE-A)] (Gilboa-Schechtman, Foa, Shafran, Aderka, Powers, Rachamim, Rosenbach, Yadan, & Apter, 2010)

Key Adaptations

Preschoolers:

- * Parents in room for 3 sessions, observe all sessions; parents only ½ all sessions

DV (since many kids still in contact with offenders):

- * TN more focused on distinguishing reminders from real danger
- * Conjoint emphasize to enhance non-offending parental support and protectiveness

Ongoing trauma (Cohen, Mannarino, & Murray, 2011):

- * Safety education first
- * Engage with parents re their trauma
- * Distinguish real danger vs. reminders
- * Promote parental acceptance of child's experience

The Old Solutions Are the New Problem: How Do We Better Use What We Already Know About Reducing the Burden of Mental Illness?

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Kazdin and Blase (2011) assert that unless we make some major changes, our profession cannot meet the demand for mental health services in the U.S. or globally. They offer the idea of a portfolio of models, and we agree entirely that increasing the range of how existing treatments can be applied will help reduce the overall burden of mental health suffering. However, within the current zeitgeist, this could well mean that we will see 10 different versions of each protocol, each requiring 10 efficacy trials and 10 more effectiveness trials—essentially taking us from thousands of treatments to hundreds of thousands. This is certainly not what Kazdin and Blase intend, but we believe that without deliberate intervention, it is likely to be how the field responds.

We Need More and Better Ways to Organize and Move Knowledge

We see this as a knowledge management problem. That is, continued proliferation of knowledge about treatment will not help unless we get much, much better at summarizing, synthesizing, integrating, and delivering what we already have (Graham et al., 2006). The existing knowledge base is now too

large to comprehend and apply optimally by any psychologist. In our recent efforts to examine how to choose a set of evidence-based treatments (EBTs) that best fit an organization's service population (Chorpita, Bernstein, & Daleiden, in press), we discovered that simply selecting a set of no more than a dozen treatments from among all EBTs for children yields over 67 sextillion possibilities. To put this number in some perspective, if one were to write each unique set of 12 or fewer treatments on a single sheet of ordinary paper, the resulting pile would reach to the sun and back. Over 20 million times. Each of these sets has a unique composition and thus a potentially unique impact on the service population. Selecting an ideal array of treatments from among the promising possibilities is no longer a simple problem and it is approaching unsolvability. Although we know much about what works, we can no longer apply that knowledge efficiently.

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The Dilemma

Usual care-bx probs (Garland, Brookman-Frazee, Accurso, Zoffness, Haine-Schlagel, & Ganger, 2010)

- * Little of this, little of that; some evidence-supported strategies, many not; no strategies in depth
- * Modeling, practice-feedback, homework = rare

EBIs

- * Many packages
 - most target a single/specific outcome
 - many require developer endorsed training/consultation/certification
- * Low penetration/reach
 - costly and sustained investment required
 - unfeasible to offer large numbers of different packages
 - mismatch to client engagement/motivation for service use

Possible Solution

ORIGINAL ARTICLE



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ONLINE FIRST

Testing Standard and Modular Designs for Psychotherapy Treating Depression, Anxiety, and Conduct Problems in Youth

A Randomized Effectiveness Trial

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Context: Decades of randomized controlled trials have produced separate evidence-based treatments for depression, anxiety, and conduct problems in youth, but these treatments are not often used in clinical practice, and they produce mixed results in trials with the comorbid, complex youths seen in practice. An integrative, modular redesign may help.

Objective: Standard/separate and modular/integrated arrangements of evidence-based treatments for depression, anxiety, and conduct problems in youth were compared with usual care treatment, with the modular design permitting a multidisorder focus and a flexible application of treatment procedures.

Design: Randomized effectiveness trial.

Setting: Ten outpatient clinical service organizations in Massachusetts and Hawaii.

Main Outcome Measures: Outcomes were assessed using weekly youth and parent assessments. These assessments relied on a standardized Brief Problem Checklist and a patient-generated Top Problems Assessment (ie, the severity ratings on the problems that the youths and parents had identified as most important). We also conducted a standardized diagnostic assessment before and after treatment.

Results: Mixed effects regression analyses showed that modular treatment produced significantly steeper trajectories of improvement than usual care and standard treatment on multiple Brief Problem Checklist and Top Problems Assessment measures. Youths receiving modular treatment also had significantly fewer diagnoses than youths receiving usual care after treatment. In contrast, outcomes of standard manual treatment did not differ significantly from outcomes of usual care.

Weisz, Chorpita, Palinkas, Schoenwald, Miranda, Bearman, Dalieden, Ugueto, Ho, Martin, Gray, Alleyne, Langer, Southam-Gerow, Gibbons, & Research Network on Youth Mental Health, 2011

Components/modular approaches:

Systematically mix and match key ingredients of effective txs

Apply and switch based on assessment/measurement

Study design and results:

- * RCT comparing TAU vs. sequential manuals vs. systematically applied modules (including a PTS module)
- * Children in modularized condition improved more
- * Higher therapist acceptance

Kazdin Rebooting

Rebooting Psychotherapy Research and Practice to Reduce the Burden of Mental Illness

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Abstract

Psychological interventions to treat mental health issues have developed remarkably in the past few decades. Yet this progress often neglects a central goal—namely, to reduce the burden of mental illness and related conditions. The need for psychological services is enormous, and only a small proportion of individuals in need actually receive treatment. Individual psychotherapy, the dominant model of treatment delivery, is not likely to be able to meet this need. Despite advances, mental health professionals are not likely to reduce the prevalence, incidence, and burden of mental illness without a major shift in intervention research and clinical practice. A portfolio of models of delivery will be needed. We illustrate various models of delivery to convey opportunities provided by technology, special settings and nontraditional service providers, self-help interventions, and the media. Decreasing the burden of mental illness also will depend on integrating prevention and treatment, developing assessment and a national database for monitoring mental illness and its burdens, considering contextual issues that influence delivery of treatment, and addressing potential tensions within the mental health professions. Finally, opportunities for multidisciplinary collaborations are discussed as key considerations for reducing the burden of mental illness.

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Extending the Reach of Mental Health Services: Service Delivery Models

Most children who meet criteria for disorder do not receive mental health services

Of children who receive, more seen in non-specialty centers than specialty

Children do not benefit from services they do not receive

Most problems mild-moderate; may not need specialty care

Possibilities

Evidence-based services in schools (Jaycox, Cohen, Mannarino, Walker, Langley, Gegenheimer, Scott, & Schonlau, 2010) :

- * Trauma-focused CBTs following Katrina
- * Children assigned to CBITS (school) or TF-CBT (clinic)
 - Most received CBITS; few received TF-CBT
 - CBITS lower effect size; TF-CBT higher effect size

Integrated behavioral health in primary care (Kolko, Camp, Kilbourne, & Kelleher, 2011)

- * Doctor-Office Collaborative Care v s. Enhanced Usual Care for bx probs
- * DOCC = Case manager delivered, on site, collaborative team with PCP, family, back up psychiatrist
- * DOCC = Better service use, completion, and outcomes

Telephone delivered EBIs (McGrath, Lingley-Pottie, Thurston, MacLean, Cunningham, Waschbusch, Watters, Stewart, Bagnell, Santor, & Chaplin, 2011)

- * Strongest Families for bx probs and anxiety delivered by trained/supervised coaches over telephone; no in-person contact
- * Decrease in disruptive and anxiety disorder dx compared to usual care

Conceptual Integration

Evidence-Based Practice at a Crossroads: The Timely Emergence of Common Elements and Common Factors

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Kathryn S. Collins¹, Frederick Strieder¹, Bruce F. Chorpita²,
Kimberly D. Becker³, and Jacqueline A. Sparks⁴

Abstract

Social work is increasingly embracing evidence-based practice (EBP) as a decision-making process that incorporates the best available evidence about effective treatments given client values and preferences, in addition to social worker expertise. Yet, social work practitioners have typically encountered challenges with the application of manualized evidence-supported treatments. For social work, the path to implementing the delivery of science-informed practice remains at a crossroads. This article describes two emergent strategies that offer a plausible means by which many social workers can integrate an EBP model into their service delivery—common factors and common elements. Each strategy will be presented, and related evidence provided. Tools to implement a common elements approach and to incorporate client feedback consistent with a common factors perspective will also be described. These strategies will be placed in the broader context of the EBP framework to suggest possible advances in social work practice and research.

Keywords

child welfare, evidence-based practice, mental health

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Medication and Foster Children

GAO Report Psychotropic Medication Use by Foster Children

<http://www.gao.gov/assets/590/586570.pdf>

Antipsychotics (dosReis, Yoon, Rubin, Riddle, Noll, & Rothbard, 2011)

- * **.5 TANF** v 8% (foster care), 5% (foster care/adoption), 5% (foster care/TANF), 9% (SSI), 26% (foster care/SSI)
- * Foster children as likely to be on antipsychotics as SMI children; only 5% = schizophrenia
- * 25-35 % concomitant use; bx probs predicts
- * White youth 27% less likely

Medication Take Home

Foster children on multiple medications and antipsychotics at substantially higher rates than comparable poor children

Multiple antipsychotics relatively common; mainly associated with bx problems

Few have SMI, primary condition for which antipsychotics indicated

Are they getting EB standard of care tx?

- * Parent management training
- * Skill training

Workforce Development

Focus on competencies (Sburlati, Schniering, Lyneham, & Rapee, 2011)

Move from focus on knowledge and attitude change

Identify and measure key skill acquisition (via standard patient/behavioral rehearsal)

Skill acquisition requires active learning components (Beidas & Kendall, 2010)

Less info/more practicing (just like clients)

Exposure to Critical Incidents Influences Workers Assessment of Risk for Child Abuse

96 child protection workers (81% women) participated in 2 simulated interviews with standardized patients and then completed risk assessment measures.

Assessed previous history of traumatic exposure in the workplace, current levels of traumatic stress and depression.

85% exposed to at least 1 critical incident at work and 73% of these reported they had experienced distress as a result.

Number of critical incidents experienced negatively associated with level of risk assessed on standardized cases. Greater the number of incidents experienced, the lower the risk was judged to be.

Higher levels of traumatic stress symptoms also associated with lower levels of risk assessed.

Regehr, C., LeBlanck, V., Shlonsky, A., & Bogo, M. (2010). The influence of clinician's previous trauma exposure on their assessment of child abuse risk. *Journal of Nervous and Mental Disease, 198*(9), 614-618.

“Coordination Improves Outcomes for Children”

- National Survey of Child and Adolescent Well-Being
- N=1,613 children within 75 child welfare agencies over 36 months
- Examined **Interorganizational Relationships (IORs)**
 - Number of coordination approaches between each child welfare agency and mental health service providers
- Tested relationships between IORs, Service Use, and Outcomes
- **Greater intensity of IORs → greater likelihood of service use and mental health improvement.**
- Conclusions:
- Greater number of ties with mental health providers may help child welfare agencies improve children’s mental health service access and outcomes
- Encourage different types of organizational ties between child welfare and mental health systems

More Good News from the Crimes Against Children Center

Finkelhor, Wolack, Mitchell, Hamby

<http://www.unh.edu/ccrc/>

**CAN reports: Sexual abuse and physical abuse
continue to decline**

**Internet: Unwanted sexual solicitations and
exposure to pornography has declined**

**Sexting is relatively rare [1% kids appear in/produce
sexually explicit images; 6% receive, rarely
distribute]**