



Assessing stress-related treatment needs among girls at risk for poor functional outcomes: The impact of cumulative adversity, criterion traumas, and non-criterion events



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ABSTRACT

Despite growing recognition that cumulative adversity (total stressor exposure, including complex trauma), increases the risk for psychopathology and impacts development, assessment strategies lag behind: Adversity-related mental health needs (symptoms, functional impairment, maladaptive coping) are typically assessed in response to only one qualifying Criterion-A traumatic event. This is especially problematic for youth at-risk for health and academic disparities who experience cumulative adversity, including non-qualifying events (separation from caregivers) which may produce more impairing symptomatology. Data from 118 delinquent girls demonstrate: (1) an average of 14 adverse Criterion-A and non-Criterion event exposures; (2) serious maladaptive coping strategies (self-injury) directly in response to cumulative adversity; (3) more cumulative adversity-related than worst-event related symptomatology and functional impairment; and (4) comparable symptomatology, but greater functional impairment, in response to non-Criterion events. These data support the evaluation of mental health needs in response to cumulative adversity for optimal identification and tailoring of services in high-risk populations to reduce disparities.

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1. Introduction

Increasing evidence supports notable adversity exposure to stressful life events in child and adult community samples (Felitti, Anda, & Nordenberg, 1998; Lucenko, Sharkova, Mancuso, & Felver, 2012; Macdonald, Danielson, Resnick, Saunders, & Kilpatrick, 2010; Turner, Finkelhor, & Ormrod, 2010; Kilpatrick et al., 2003; Green, Goodman, & Krupnick, 2000), with extreme levels among marginalized populations, such as child welfare and juvenile justice system-involved youth (Greeson, Briggs, & Kisiel, 2011; Baglivio et al., 2014). Adversity exposure has been captured in research on 'Adverse Childhood Experiences' ('ACEs' include ten adversities: childhood physical, sexual or emotional abuse, emotional or physical neglect, household dysfunction related to divorce or a battered mother, a household member with substance abuse, mental illness and/or incarceration history) (Felitti et al., 1998; Edwards et al., 2005), Post-traumatic Stress

Disorder (PTSD, qualifying adversities are high-magnitude and typically 'life-threatening') (American Psychiatric Association, 2013), poly-victimization (adversity defined as multiple types of victimizations) (Turner et al., 2010), 'low magnitude' events (adversities such as death of a loved one) (Costello, Erkanli, Fairbank, & Angold, 2002), and microtraumas (accumulated adversities exceeding personal resources, with harm related to appraisals/interpretations: e.g., chronic bullying/humiliation) (Seides, 2010). *Complex trauma*, capturing ongoing/repeated, often early-onset, inescapable interpersonal traumas such as childhood maltreatment, which produce symptom complexity (Cloitre, Stolbach, & Herman, 2009; Ford and Courtois, 2013; van der Kolk, Pynoos, & Cicchetti, 2009; Herman, 1992; Pynoos, Steinberg, & Wraith, 1995; Shipman, Edwards, Brown, Swisher, & Jennings, 2005; Kisiel, Fehrenbach, & Torgersen, 2014) and *cumulative adversity* (total stressor exposure, ranging from microtraumas to ACEs and complex trauma exposure) (Turner & Lloyd, 1995) provide a theoretical framework that best captures the adversity pattern of delinquents, who experience numerous early-onset stressors.

Specifically, in large scale studies of detained youth, 45% of girls compared to 27% of boys experienced $\geq 5/10$ ACEs (Baglivio et al., 2014). Among delinquent youth, those with high cumulative adver-

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sity exposure have more severe emotional and behavioral problems relative to low exposure delinquents (Ford, Grasso, Hawke, & Chapman, 2013), and those identified as high-risk for reoffending (psychosocial indicators such as past criminality, aggression, substance use) (Baglivio et al., 2014) experienced significantly more adversities than delinquents identified as low-risk for reoffending. In addition to links with lifespan criminality (Duke, Pettingell, McMorris, & Borowsky, 2010; Reavis, Looman, Franco, & Rojas, 2013), cumulative adversity literatures indicate significant mental and medical public health concerns, which increase disadvantage and widen disparities.

The impact of cumulative adversity on disparities is demonstrated through a dose-response, graded relationship between number of adversities and severity of health problems (Anda, Felitti, & Bremner, 2006; Gilbert, Breiding, & Merrick, 2015). Further, more exposure to adversity is closely linked to more severe events, which impart the greatest morbidity (Schilling, Aseltine, & Gore, 2008). The experience of *multiple types of adversity* also increases the risk for psychopathology more than exposure to only one event-type, or even multiple instances of a single, very serious, event-type such as sexual abuse (Macdonald et al., 2010; Turner et al., 2010; Finkelhor, Ormrod, & Turner, 2009). Among youth, cumulative adversity is related to a range of poor outcomes, including negative neurological outcomes (e.g., smaller cerebral volume with maltreatment; reduced left pars opercularis surface area in delinquents with cumulative trauma, adversity and grief), cognitive dysfunction (e.g., poor attention), academic difficulties, mental health problems (e.g., anxiety, mood disturbance, suicidality), substance use, psychosocial issues (aggression, perpetration, victimization) and increased risk for PTSD in response to new stressors (Duke et al., 2010; De Bellis, 2005; Cohen, 2010; Lansing, Virk, Notestine, Plante, & Fennema-Notestine, 2016; Noble, Houston, & Brito, 2015; Zatzick, Kang, & Müller, 2002). These data indicate the urgency of directly addressing serious adversity among delinquent youth to reduce criminal engagement and promote optimal health.

Importantly, the cumulative adversity literatures have also expanded our understanding of what types of adverse experiences are linked to increased risk for serious health problems. In contrast, the Diagnostic and Statistics Manual [DSM] (American Psychiatric Association, 1980; 2000; 2013) has consistently utilized a relatively narrow definition of “traumatic” adversities (e.g., rape), with many events not qualifying as Criterion precipitating events (emotional neglect, parental incarceration). From a diagnostic standpoint, PTSD requires a qualifying precipitating event that involves direct, witnessed or indirect (learned about) exposure to “actual or threatened death, serious injury, or sexual violence” (Criterion-A, page 271) (American Psychiatric Association, 2013). Although Criterion-A modifications have occurred during DSM revisions (e.g., events are no longer required to be “outside the range of usual human experience”), the criterion event requirement still captures more extreme exposure-types and restricts diagnosis on event-type regardless of symptom severity or impairment. While narrowing the criteria to reduce over-pathologizing individuals is important, the result can be problematic because: (1) there is disagreement among clinicians and researchers with regards to whether some events qualify as Criterion-A (Van Hooff, McFarlane, Baur, Abraham, & Barnes, 2009); (2) research indicates that non-Criterion events are often associated with more PTSD-type symptomatology, greater symptom severity than Criterion-A qualifying events, and higher rates of PTSD “diagnosis” when Criterion-A requirements are disregarded (Van Hooff et al., 2009; Anders, Frazier, & Frankfurt, 2011; Long et al., 2008); and (3) some non-qualifying events occurring during childhood (e.g., neglect, extended separations from caregivers) may have profound developmental consequences (Ford and Courtois, 2013). This issue is especially salient in populations experiencing high cumulative

adversity, such as delinquents, whose adversities also include numerous non-Criterion events, which impact safety, security and livelihood (e.g., residential instability, death of a caregiver, poverty) (Lansing et al., 2016; Perkins-Dock, 2001; Dong, Anda, & Felitti, 2005; Evans & Kim, 2007; Jolleyman & Spencer, 2008). Current criteria, however, preclude querying potentially clinically meaningful symptomatology related to these non-qualifying adversity experiences.

Similarly, querying symptoms and impairment in response to a single adverse event may pose significant barriers to accurate detection and treatment in populations experiencing high cumulative adversity who may struggle to: (1) identify a single ‘worst’ event amongst a variety of adversities; (2) discern which symptoms are associated with, or exacerbated by, a single event; and (3) determine whether that single event-response is what imparts functional impairment. This assessment oversight is important as converging evidence simultaneously points to extremely elevated rates of cumulative adversity exposure (e.g., total stressor exposures that include criterion traumatic and non-criterion stressful events) (Edwards et al., 2005; Abram, Teplin, & King, 2013), and yet highly variable rates of trauma-related disorders, among delinquent youth. Specifically, PTSD estimates among delinquent populations range between zero and 48.9% using a variety of samples and methods (e.g., current versus lifetime focus; interviews versus self-reports; querying symptoms based on ‘worst’ event versus event-independent methods) (Abram et al., 2004; Cauffman et al. 1998; Duclos et al., 1998). For example, restricting diagnosis to a single Criterion-A worst event among detained (pre-sentence) youth resulted in 14.7% of girls and 10.9% boys meeting PTSD diagnostic criteria in the last year (Abram et al., 2004). In contrast, among adjudicated (post-sentence) youth, 48.9% of girls, and 32.3% of males, meet PTSD criteria in the last three months when querying symptoms independent of any specific event (Cauffman, Feldman, Waterman, & Steiner, 1998). Although both studies show higher rates of PTSD among delinquent girls than boys and much higher rates among delinquents than community samples (6.3% of females and 3.7% of males met criteria for PTSD in the past six months) (Seides, 2010), it is likely that actual symptom severity is underestimated when queries are limited to one Criterion-A worst event in a population experiencing cumulative adversities that include a range of event-types. Despite recognition of the relationship between cumulative adversity and psychiatric problems among children (Cloitre et al., 2009; Ford & Courtois, 2013; Benjet, Borges, & Medina-Mora, 2010; Cook, Blaustein, Spinazzola, & Van der Kolk, 2003), symptom and functional impairment levels related to the youths’ self-identified ‘Worst-Event’ have yet to be directly compared to their response to cumulative adversity. Further, few studies directly compare responses to Criterion-A and non-Criterion events, and those studies focus on adults and/or community populations (Anders et al., 2011; Long et al., 2008; Alessi, Meyer, & Martin, 2013). Because of the potential for traditional assessment strategies to perpetuate health disparities in underserved populations through methodologically-based under-identification of needs, the present study addressed three primary aims among those at heightened risk for adversity exposure and PTSD, delinquent girls.

First, a broad range of potential precipitating events (non-Criterion events: neglect, family separation, interrupted pregnancy, bullying, alongside Criterion-A events) were queried that represent adversity exposures relevant to high-risk populations such as delinquent girls. We hypothesized that delinquent girls would endorse high exposure to both Criterion-A and non-Criterion events. Second, we assessed their maladaptive coping strategies (e.g., self-injury) directly in response to their cumulative adversity exposure. We hypothesized that delinquent girls would evidence serious maladaptive coping strategies in response to their total

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