Published in final edited form as:

Child Adolesc Psychiatr Clin N Am. 2014 April ; 23(2): 167–184. doi:10.1016/j.chc.2013.12.003.

Epidemiology of Traumatic Experiences in Childhood

Benjamin E. Saunders, PhD^{*} and **Zachary W. Adams, PhD**

Department of Psychiatry and Behavioral Sciences, National Crime Victims Research and Treatment Center, Medical University of South Carolina, 67 President Street, MSC 861, Charleston, SC 29425, USA

Keywords

Traumatic events; Epidemiology; Child maltreatment; Polyvictimization

Introduction

Understanding the epidemiology of traumatic experiences in childhood is critical to conducting meaningful trauma research, developing effective trauma services and service delivery systems, and efficiently allocating resources for both activities. Without an understanding of the basic topography of these events in the lives of youth, there is a danger of overfocusing on extraordinary, emotionally gripping, or highly visible types of events and overlooking less obvious or dramatic, but perhaps highly significant forms of trauma. From a public health viewpoint, knowing the prevalence and incidence of trauma types can help increase the reach of interventions, programs, and services. Obtaining even a relatively modest effect with either prevention or intervention services can result in a large public health impact when applied to a highly prevalent form of trauma. Such information can help guide policy-makers as they direct resources, and program and intervention developers as they consider new approaches. Epidemiologic information allows the field to better understand the most critical and most common trauma types, and the most affected populations, thus to achieve the greatest impact with limited resources. Accurate epidemiologic information also can help with the attributive process of explaining associations between traumatic events and outcomes. Without an epidemiologic background on which to place these associations, faulty conclusions may be drawn. As the saying goes, “when you hear hoof beats in Wyoming, think horses not zebras.” Epidemiologic data provide the proper background for research, practice, and policy.

Prevalence and incidence of traumatic experiences among specified groups are the most basic pieces of epidemiologic information. Prevalence denotes the number of individual children experiencing a particular type of traumatic event within a certain time period, such as from birth to age 18 or within the past year. Incidence refers to the number of incidents or cases of a trauma type that occurs within a specified time period, such as within the past year, regardless of the number of affected people. Because children and youth may experience more than 1 incident over a time period, incidence rates usually exceed prevalence rates. For example, in a victimization survey of a nationally representative sample of 4008 adult women, 339 of the women indicated they had experienced at least 1 completed rape before the age of 18 years, a childhood rape prevalence rate of 85 per 1000

women.¹ However, because many had experienced more than 1 assault, the 339 victims described 438 incidents of completed rape in childhood, a childhood rape incidence rate of 109 per 1000 women. Therefore, distinguishing whether epidemiologic reports are describing prevalence or incidence rates occurring in which time periods is important to understanding and comparing results across studies.

Unfortunately, despite the importance of epidemiologic information, obtaining precise estimates of the prevalence and incidence of different types of potentially traumatic events that can occur in childhood is actually problematic. This difficulty is due to several factors, including the inherent nature of some of the types of traumatic events that children experience, the assets available to the field for detecting and counting events, and confounding methodological issues between studies. Understanding these problems is necessary to interpreting the available information and drawing proper conclusions. Some of the reasons for the difficulty in understanding the epidemiology of child trauma are discussed herein.

Traumatic Event Characteristics

Many forms of childhood trauma, particularly interpersonal violence, occur in private circumstances and rarely are observed by others. Frequently only perpetrators and children have knowledge of the events, and neither may want to reveal them. Offenders are fearful of the legal and social consequences if their behavior is discovered. Children often do not tell about incidents for many reasons, including being afraid of getting into trouble; a sense of stigmatization, shame, guilt, or self-blame about the events; fear of the offender; or fear of getting the offender into trouble. Some children (and some offenders) may not understand that what happened to them was wrong, or personally label the incidents as abuse or victimization. For example, a child may think that receiving a severe physical beating from a parent for misbehavior is appropriate, even though they were terrified during the experience.

For these and other reasons, interpersonal violence incidents involving children have very low rates of being officially reported to authorities such as law enforcement or child protective services.^{2,3} Studies dealing only with cases reported to authorities such as law enforcement or child welfare agencies will severely underestimate the frequency of these events. Moreover, it is likely that reported cases differ from unreported ones on key characteristics including demographics of the offender and victim, and the nature and severity of the abusive behaviors.⁴⁻⁷ Detecting interpersonal violence events in victimization surveys of community samples requires respondents to acknowledge them. Unfortunately, the same factors often inhibit disclosure of sensitive incidents even when careful and sophisticated screening approaches are used, also resulting in somewhat of an undercount of these types of events. Therefore, the secretive and stigmatizing nature of some types of traumatic events makes measuring their prevalence and incidence difficult.

These characteristics also may differentially affect responses by members of sub-populations. For example, males may be more concerned than females about revealing incidents of sexual assault, particularly assaults by male offenders, because of concerns about even greater perceived stigmatization. Girls from certain cultural or ethnic groups that value virginity more than others may be less likely to disclose sexual abuse. Children from geographic regions where severe physical punishment is the norm may be less likely to report physical abuse because they do not view it as out of the ordinary. Therefore, some of these challenges to obtaining accurate prevalence and incident rates may interact with factors such as gender, ethnicity, and regional cultures, resulting in differential undercounts for some subgroups. Further research is needed to better understand these relationships.

Inadequate Surveillance Efforts

For many forms of childhood trauma, there are few or inadequate ongoing national community surveillance efforts that can reveal basic prevalence, incidence, or case-characteristic trends. For example, in the United States the National Crime Victimization Survey (NCVS) is a very large ($N = >90,000$ households) nationally representative household victimization survey conducted annually by the US Department of Justice⁸ that collects information about the incidence of certain crimes among participants. Some of these crimes, such as sexual assault, intimate partner violence, and forms of community violence, are likely to be traumatic events for children if they are victims or are present when they occur. However, the presence of children who are not direct victims is not identified with these crimes. Most importantly, information about crimes against children younger than 12 years is not collected at all. In addition, the methods used for collecting information about sensitive types of crime such as rape and sexual assault have been criticized as inadequate, resulting in severe underestimates of the true incidence.⁹ This problem with the NCVS has been acknowledged by the Department of Justice and is receiving considerable study.¹⁰ Therefore some parts of the NCVS can be useful in estimating the incidence of some crimes against youth, but it misses a large portion of the types of victimizations of children that are frequently the most traumatic.

Other annual sources of national victimization information, such as the National Child Abuse and Neglect Data System (NCANDS),¹¹ and the Federal Bureau of Investigation Uniform Crime Reports (UCR) and National Incident-Based Reporting System (NIBRS),¹² collect information only about incidents reported to child protection agencies and law enforcement agencies, respectively. These data do not account for the large numbers of unreported cases of child victimization, and have significant overlap in the cases they detect because of cross-reporting requirements. Therefore, the 3 main federally sponsored surveillance systems for crime and abuse, the NCVS, NCANDS, and UCR/NIBRS, while offering some useful information, fail to give a complete picture of the prevalence and incidence of the victimization of children and youth in the United States.

Conceptual and Methodological Differences

Because of the lack of systematic, effective, and complete surveillance systems for the victimization of children and youth in the United States, most knowledge about the epidemiology of childhood violence and other traumatic events must be garnered from an essentially serendipitous collection of studies conducted for many different purposes. Because of the ad hoc nature of these studies, there is considerable variation among them regarding vital conceptual and methodological characteristics.¹³ These differences result in sometimes widely varying findings that are problematic to meld and interpret.² Accordingly, even simple questions, such as what is the annual incidence or childhood prevalence of sexual assault, physical abuse, or other important traumatic events among children, are amazingly difficult to answer. Advocates, service providers, policy-makers, and even some researchers frequently ask why prevalence and incidence estimates of childhood events vary so widely between studies. Most often, conceptual and methodological differences are the sources of most variation. Thus, to understand the epidemiology of childhood trauma properly, one must understand the challenges involved in gaining this information and the underlying reasons for differing results between studies. Several of the most important and common methodological issues that arise between studies are discussed in this section.

Definitions

There are many gray definitional areas in deciding exactly what situations and behaviors constitute potentially traumatic events for children. There is great consensus concerning

some types of events, such as violent rape by a stranger, witnessing severe violence in the home or community, or being involved in a serious natural disaster. However, there is debate as to whether some difficult childhood events such as divorce, natural death of a loved one, Internet harassment, or placement in foster care should be considered “traumatic” or should be more properly considered as stressful or distressing. Within event types generally agreed to be traumatic, there are discrepancies about the boundaries of the definitions. When does physical discipline cross the line and become physical abuse? When are parental arguments severe enough to constitute emotional abuse for a child? Exactly what behaviors and situations constitute a sexual assault? When do aggressive interactions between peers become bullying? Different conceptual and operational definitions between studies that supposedly are studying the same phenomenon lead to markedly different results. In general, studies that have broader conceptual and operational definitions of particular incident types will report larger prevalence and incidence rates than those with more conservative and restricted definitions, because more events will be captured by screening.¹⁴

Sampling Approach

The nature of the sample that participates in a study will affect the prevalence and incidence rates of childhood traumatic events found. Five sampling approaches are commonly used in studies of childhood trauma. Studies involving clinical or service-involved samples often report very high rates of childhood trauma, often 80% to 90%.^{15–19} Of course, these are participants who are having significant problems that may be the result of trauma experiences, which accounts for the high rates of reported trauma typically found in these studies. Results from clinical samples can help characterize treatment seekers, but are of little value in determining population estimates.

Similarly, studies of known or reported cases (eg, children in foster care), by definition, have high rates of exposure to trauma events.²⁰ Although they can provide information about cases detected by authorities, they are not helpful in understanding unreported cases or in making population estimates. Community convenience samples have unknown biases attributable to how they are constructed, which prevent the making of broader population estimates.^{15,21} More useful are limited community samples that are representative of a known sampling frame.^{22,23} For example, classrooms may be selected at random within a school district and students assessed. These results can be generalized to the population from which the sample was selected (eg, the school system), and the results can be useful when the population sampled is believed to be similar to other populations of interest (eg, children in similar school districts). However, making generalizations beyond the sampled populations can be misleading.

Most useful are studies that use nationally representative community samples.^{24–28} Depending on the specific population sampled and sample size, results from these studies frequently can be used to develop national estimates of the prevalence and incidence of traumatic events among children and youth and within important subgroups, such as by gender, race/ethnicity, or rural/urban. Results from these studies offer the broadest picture of the epidemiology of childhood trauma and serve as the best benchmarks for advocates, practitioners and policy-makers.

Respondent

Estimates of the prevalence of childhood trauma can vary significantly by the source of information. Some studies extract information from archival, administrative, or clinical records of service agencies.²⁹ This information can be useful in understanding service-involved populations if the agencies regularly use effective comprehensive screening

methods for many types of child trauma of interest, and accurately record and maintain that information in the record system. Unfortunately, many times these procedures are rarely in place. In addition, there usually is a confound between sampling approach and using agency records as the source of information, in that these cases most likely have been or will be reported to authorities if a service agency knows about it. Thus the results from these samples cannot be generalized to the broader population of youth.

The 4 National Incidence Studies of Child Abuse and Neglect have used “sentinels” as respondents.³⁰ These studies systematically sampled a set of counties nationwide, and professionals within those counties that would be likely to know about cases of child abuse. Researchers then surveyed the sentinels about abuse cases they knew about within the study period, whether or not they had been reported to authorities. This approach has yielded much higher estimates of abuse than known, reported samples. However, it still requires that someone other than the child or perpetrator knows about the abuse.

Parents or caregivers are a common source of trauma history information, and may know of many of the incidents of trauma a child may have experienced.^{26,28} For very young children, caregivers may be the only feasible source of information. For incidents that occurred when an older child was very young, parents also may be the only source of information. However, as children get older they likely will experience many events that are unknown by the parent, resulting in an undercount.

Individuals likely are best able to give the most complete report of the traumatic events they have experienced, at least past a certain age. Victimization studies have been conducted successfully using children as young as 10 years as respondents.^{26,28,31} However, personal trauma history information gathered from individuals also contains error. Beyond the already discussed reluctance to disclose sensitive events, individuals simply may not remember or may misremember events that occurred years ago. Research on the impact of trauma on memory has yielded mixed results, with some studies finding an enhanced memory for traumatic events and others finding memory problems associated with the use of defensive avoidance as a coping mechanism.³² However, it is clear that memory issues can affect individuals' ability to describe past events in general. Concerns about memory raise questions about studies that ask adults to recall incidents of trauma in childhood. Although adults are likely to remember the serious events that occurred in childhood, the details of the events may be less accurate, and they may not recall less serious incidents. In addition to potentially biased estimates associated with impaired long-term recall of childhood events, retrospective studies of adults actually describe the prevalence of childhood trauma decades in the past. For example, the average age of participants in the National Women's Study¹ and the National Violence Against Women Survey³³ was approximately 40 years, meaning that the incidents of childhood victimization reported occurred 20 to 30 years previously. These studies are useful in understanding more about adult populations and past prevalence rates of childhood victimization, but have little relevance to current epidemiology.

Therefore, studies asking about events that occurred in more time-proximate periods will be more accurate, suggesting that direct surveys of children, youth, and young adults are preferable when trying to determine incidence and prevalence rates of childhood events.

Screening Method

The methods and approaches used to screen for traumatic events in studies can have major effects on results. The impact of factors that inhibit disclosure in victimization surveys can be moderated by the use of more sophisticated screening methods. Self-report questionnaires usually produce lower prevalence estimates in comparison with personal interviews, either in person or by telephone. Techniques such as proper placement of sensitive questions

within an interview schedule, use of clarifying introductions to challenge stereotypes and cue the respondent's recall, avoiding single-item "gate" questions, using a larger number of screening questions, using behaviorally specific screening questions, avoiding undefined summary terms such as "abuse," and delaying follow-up questions until after screening questions are completed all contribute to greater disclosure rates.^{34–36} However, these techniques must be balanced with the time and resources available for assessment and respondent fatigue. Unfortunately, many studies do not use these techniques, reducing their accuracy.

Review of Important Literature

For the reasons already described, this review focuses on findings from methodologically rigorous studies using national samples of youth in the United States that assess the most serious forms of childhood trauma. These studies give the most generalizable estimates for the prevalence of childhood traumatic events. Findings from studies of more restricted populations carry known and unknown biases that can be misleading when applied to unrelated situations. Studies reporting prevalence estimates from limited populations such as particular service organizations, cities, states, or regions are not included, such as the ACE Study,³⁷ the Teen Dating Violence Study,³⁸ the Great Smokey Mountains Study,²³ the Adolescent Alcohol Related Sexual Assault Study,³⁹ and the Minnesota Student Survey.⁴⁰ Likewise, studies from other countries such as the Canadian Incidence Study of Reported Child Abuse and Neglect,⁴¹ the UK Victimization Study,⁴² and the Netherlands Prevalence Study on Maltreatment⁴³ are excluded. Furthermore, retrospective studies of adults^{1,33} are not included for the reasons described earlier.

Included studies for estimates of the prevalence of victimization and exposure to interpersonal violence in childhood are limited to those that used large, nationally representative samples of youth reporting on their own histories of trauma and victimization and parents of younger children, and that used methodologically sound screening methods. These studies included: (1) the National Survey of Children's Exposure to Violence²⁶ (NatSCEV: N = 4549, ages 0–17 years); (2) the National Survey of Children's Exposure to Violence II²⁸ (NatSCEV II: N = 4503, ages 0–17 years); (3) the National Survey of Adolescents^{24,44} (NSA: N = 4023, ages 12–17 years); (4) the National Survey of Adolescents—Replication^{45–47} (NSA-R: N = 3614, ages 12–17 years); and (5) the National Comorbidity Study—Adolescent supplement^{25,48} (NCS-A: N = 6483, ages 13–17 years). Where lifetime prevalence estimates are reported for age groups, data from adolescents rather than from younger children are used, because information from older youth give the best estimates of prevalence across all of childhood. For other types of potentially traumatic events for which national representative samples and self-report data are not available, data from rigorously designed national clinical samples are reported with appropriate caveats.

Sexual Victimization

The NatSCEV²⁶ study found that 6% of American youth aged 0 to 17 years had experienced at least 1 episode of sexual victimization (sexual assault, rape, sexual exposure by an adult, sexual harassment, statutory sexual offenses) within the past year, with girls being about 1.5 times more likely to have such a history. Adolescents aged 14 to 17 had much higher past-year (16%) and lifetime (28%) prevalence rates of any kind of sexual victimization than the full sample of children. More specifically, 11% of adolescents in that age cohort (19% of girls) reported experiencing at least 1 sexual assault involving physical contact, and 8% endorsed a history of at least 1 attempted or completed rape (14% of girls) during their lifetimes. Results from the NatSCEV II²⁸ essentially replicated these rates. Girls aged 14 to 17 had a past-year prevalence of 23% for any type of sexual victimization, 11% for a sexual assault, and 8% for attempted or completed rape. Lifetime prevalence rates for the 14- to 17-

year-old age group by gender for any sexual victimization was 20% for males and 35% for females; for any sexual assault, 4% for males and 17% for females; and for any attempted or completed rape, 3% for males and 13% for females.

Both the NSA^{24,44} and NSA-R^{45–47} studies used sample selection and interview methods similar to those of the 2 NatSCEV studies. However, the NSA and NSA-R had more limited definitions of sexual assault and a broader age range for the adolescents included (12–17 years). Accounting for these differences, the results were remarkably similar between the 2 NatSCEV and 2 NSA studies. The NSA found that an estimated 8% of adolescents, 13% of girls and 3% of boys, endorsed experiencing at least 1 lifetime sexual assault. Among adolescents who endorsed a history of sexual assault in the NSA study, nearly half (46%) reported that they were younger than 13 at the time of their first assault. Figures were similar in the NSA-R study, where 8% of all adolescents endorsed a history of sexual assault.

New analyses of the NSA-R data were performed for the 17-year-olds in the sample (N = 599). This age cohort would have nearly completed childhood, meaning their results provide a more comprehensive estimate of total childhood prevalence of sexual assault. The sample size is somewhat small, but is nationally representative. Within this age cohort, 12% (n = 74) of youth reported a lifetime history of sexual assault, which is similar to the rate found with the somewhat younger cohort of NatSCEV adolescents (11%). The 17-year-old girls reported a sexual assault lifetime prevalence rate of 20%, and the boys a 5% rate. These 74 victims described 113 lifetime sexual assaults, the characteristics of which are presented in Table 1. Teens were the offenders in 3 of 5 assaults, adults were the offenders in 2 of 5, and males perpetrated more than 4 of 5 assaults. Strangers committed only about 1 of 6 assaults. Similar-age friends, acquaintances, and dating partners were the most common offenders, committing nearly 3 of every 5 childhood sexual assaults. Relatives were the offenders in 13% of the assaults, and other adults committed 12%. Most sexual assaults (69%) occurred when the victim was an adolescent, and relatively few (7%) occurred in early childhood (age 0–5 years).

A type of sexual assault experienced by youth that is sometimes overlooked is drug- or alcohol-facilitated sexual assault (DAFSA). In these situations girls are sexually assaulted while intoxicated and incapacitated, either voluntarily or involuntarily, by drugs or alcohol. Using the NSA-R data, McCauley and colleagues⁴⁹ found that 2% of American adolescent girls had experienced a DAFSA. These types of assault accounted for 18% of all sexual assaults reported by girls in the NSA-R.

Considered together, conservative estimates would be that approximately 8% to 10% of American youth have experienced at least 1 sexual assault, with higher rates of sexual victimization among girls (13%–17%) relative to boys (3%–5%). Put more colloquially, at any point in time approximately 1 out of 6 American girls and 1 out of 25 boys have experienced a sexual assault involving some sort of physical contact. The rates increase to 1 out of 5 girls and 1 out of 20 boys when using data from a 17-year-old age cohort, the best estimate of the full risk during childhood. By far, the highest risk group is teenage girls being assaulted by peers and dating partners, with DAFSA being an important situational factor.

Physical Abuse and Assault

Findings for lifetime prevalence of physical abuse among adolescents were higher in NatSCEV (19%)²⁶ and NatSCEV II (18%)²⁸ than in NSA (9%)⁴⁴ and NCS-A (4%).⁴⁸ This discrepancy is primarily due to differences in how abuse was defined. In NatSCEV, any incidents whereby an adult hit, beat, kicked, or physically hurt a child in any way, aside from spanking on the bottom, were classified as physical abuse. In NSA, however, abuse

was defined more conservatively as incidents that required youth to see a doctor, spanking that resulted in noticeable marks, bruises, or welts, or punishments that included burning, cutting, or tying up a youth.²⁴ Thus, the lower lifetime prevalence estimates in NSA reflect only severe forms of physical punishment and abuse, a more stringent threshold than was used in NatSCEV and NatSCEV II. In addition, the inclusion of younger adolescents in the NSA sample may have suppressed the overall lifetime estimates of childhood physical abuse because younger children would have lower prevalence rates. Indeed, among youth aged 10 to 13 in the NatSCEV sample, lifetime prevalence was lower, at 10%, than among the older children.²⁶ These trends underscore the importance of considering how victimization definitions and the ages of respondents affect results when comparing prevalence findings across studies.

With regard to physical assault, estimates varied across studies, ranging from 17% lifetime prevalence in NSA²⁴ to 71% lifetime prevalence among adolescents in NatSCEV.²⁶ NatSCEV II found a similar rate of 69%.²⁸ Again, these disparate estimates between studies stem from differences in the criteria used to define physical assault. For instance, in NSA, physical assault was defined by incidents whereby adolescents were attacked either with or without a weapon when intent to kill or injure was still present, threatened with a gun or knife, or beaten to the point of serious injury.²⁴ In NatSCEV, on the other hand, physical assaults included incidents with and without weapons, with and without injuries, and without perceived life or injury threat.²⁶ These estimates did not include other forms of threats or harassment, such as teasing or emotional bullying, which was endorsed by 29% of youth in the NatSCEV sample.²⁶

Witnessed Violence

In addition to violence directly experienced by youth, witnessing violence perpetrated against others has also been linked to a range of deleterious outcomes.⁵⁰ Thus, epidemiologic studies of child victimization have assessed the prevalence of witnessed violence in the home and community. In the NSA-R, approximately 2 of 5 adolescents (38%) reported ever witnessing 1 or more serious incidents of community violence, and 1 in 10 (9%) had witnessed serious violence between parents or caregivers.⁵¹ Boys were more likely than girls to endorse witnessing most forms of violence, including seeing someone shot with a gun, stabbed or cut with a knife, mugged or robbed, or threatened with a weapon. However, 4% of girls, compared with 2% of boys, reported witnessing someone being sexually assaulted. In the NatSCEV sample, 70% of adolescents aged 14 to 17 endorsed a history of any witnessed violence, and approximately one-third reported witnessing family violence.²⁶ Rates were very similar in NatSCEV II.²⁸ Again, differences in the types of violence included in these categorizations likely account for these differences in findings. As with several other forms of victimization, rates of past-year witnessed violence were highest among older adolescents, supporting the notion that teens are particularly vulnerable to trauma exposure.

Traumatic Death of a Loved One

Violent death of a loved one can also be a serious trauma for children. Using the NSA-R data, Rheingold and colleagues⁵² found that nearly 1 in 5 (18%) of American adolescents had lost a family member or friend to some type of homicide. Of the adolescents, 9% were the survivors of criminal homicide and 7% of vehicular homicide, and 2% reported surviving both types of loss. Of the survivors, 53% had lost a close friend, 42% a nonimmediate family member, and 5% a close family member.

Internet-Assisted Victimization

Another form of interpersonal victimization that has emerged over the past several years is Internet-assisted victimization. According to data from the NatSCEV study, 6% of youth experienced some form of online victimization in the past year, with 9% endorsing a lifetime history of online victimization.⁵³ These estimates span a range of incidents, including online sexual harassment (6% lifetime prevalence) and online sexual solicitation (5% lifetime prevalence). Given the ubiquity of the Internet and mobile devices today, there is a great need to continue to monitor and build our understanding of this form of victimization and its impact on young people.

Other Potentially Traumatic Events

Disaster—On average, a disaster (natural or man-made) occurs somewhere in the world every day.⁵⁴ Although several studies have estimated the prevalence of mental health problems following disasters, few have considered the prevalence of disaster exposure. Responses from the NSA sample, however, indicated that approximately one-quarter of adolescents had been involved in a natural disaster in their lifetimes, among whom approximately 1 in 3 feared that they would be seriously injured or killed in the event.⁵⁵ These data generally align with those from a large (N = 935), national sample of adults, which yielded a lifetime prevalence estimate of 22% for exposure to at least 1 disaster.⁵⁶

Motor vehicle accidents—Motor vehicle accidents (MVAs) represent another common form of potentially traumatic event encountered by youth. Unfortunately, the prevalence of these events typically has not been assessed as rigorously as interpersonal victimization. In the NSA sample, 21% of adolescents endorsed lifetime involvement in a serious accident, which could have occurred in a motor vehicle or in another setting.⁵⁵ In NSA-R, approximately 10% of adolescents reported a lifetime history of any MVA involvement (Williams JL, Rheingold AA, Knowlton AW, et al, unpublished manuscript, 2013). Other estimates of MVA and other injury incidence and prevalence are available from the National Electronic Injury Surveillance System All Injury Program (NEISS-AIP), operated by the US Consumer Product Safety Commission.⁵⁷ This source provides national estimates of various types of fatal and nonfatal incidents that lead to treatment in hospital emergency departments. Data for the NEISS-AIP are gathered from a subsample of a stratified national probability sample of United States hospitals that have at least 6 beds and provide 24-hour emergency department service, and are weighted to produce national estimates. Although figures are likely to underestimate the total number of children and teens who experience MVAs, including those that do not require youth to seek medical attention but may have been psychologically traumatic, the severity of incidents measured increases the likelihood of capturing accidents that may have been perceived as traumatic. According to the NEISS-AIP, in 2011 there were an estimated 310,568 episodes of treatment in United States emergency departments for children younger than 18 years whose injuries occurred while they were occupants during MVAs. This figure corresponds to a rate of 420 incidents per 100,000 children in this age cohort. When other forms of transportation-related injuries were included (eg, bicycle injuries, pedestrian injuries), the estimate rose to 808,721 (approximately 1100 per 100,000 youth).

Other accidents and animal attacks—According to the NEISS-AIP,⁵⁷ in 2011 the most common type of injuries treated in emergency departments for children younger than 15 was unintentional falls (2,411,097 estimated falls), followed by unintentionally being struck by or against another person or object (1,461,985 incidents). Among adolescents aged 15 to 24 the ranking was reversed, with an estimated 1,039,781 unintentional struck by/against incidents and 921,958 unintentional falls. Animal bites and stings, which also may

be traumatic for children, accounted for an estimated 460,233 episodes of treatment in United States emergency departments for young people (<14 years).

Polyvictimization

There is substantial research demonstrating that exposure to multiple forms of trauma in childhood is very common. In the NSA, 20% of all youth and 41% of the victims of any of the 4 types of victimization measured had experienced more than 1 type.⁵⁸ In NatSCEV II, 48% of youth had experienced 2 or more of the 50 types of victimization measured, 15% endorsed 6 or more, and 5% reported exposure to 10 or more different types of victimization.²⁸ In NatSCEV, 10% of adolescents aged 15 to 18 years had experienced 15 or more types of victimization.⁵⁹

Ford and colleagues⁶⁰ applied latent class analysis to the NSA sample and identified 6 distinct victimization classes. Four of these classes, comprising approximately one-third of the total sample, were characterized by polyvictimization. Higher degrees of polyvictimization have been linked to more severe and impairing forms of distress in adolescents.^{59–61} Furthermore, different polyvictimization profiles appear to be associated with different patterns of behavioral and emotional outcomes,⁶⁰ highlighting the importance of assessing multiple forms of trauma in assessment protocols and considering the impact of cumulative forms of victimization and adversity on youth's functioning.

Application in Clinical Practice

As noted earlier, clinicians should be aware of the basic epidemiology of childhood trauma because it serves as a background for assessment, intervention selection, and service-program development. Several points from the foregoing review can be applied to clinical practice.

Knowing High-Risk Populations

Clinicians should be aware of populations of youth at particularly high risk. Different forms of trauma are more or less prevalent among certain populations. Some are obvious, such as that children living in high-crime areas are more likely to be exposed to community violence. However, 2 characteristics seem to cut across many types of trauma, age, and gender. First, as children get older the cumulative burden of trauma increases. Because they have lived longer, older children are more likely to have experienced more trauma types, and exposure to a greater number of trauma types is associated with more serious problems.^{20,59} Second, adolescence is a particularly dangerous period for many new traumatic events, often rapidly adding to the trauma burden. In addition, girls bear a substantial additional risk primarily because of their high rates of sexual assault, anywhere from 3 to 4 times greater than boys. From the epidemiologic data, it could be argued that teenage girls represent the highest risk group for trauma.

Need for Screening

The significant prevalence and mental health impact of different forms of childhood traumatic events strongly suggest that clinicians should be screening child and youth patients for their lifetime histories of traumatic events as part of everyday practice. Without an understanding of the full scope of trauma experienced, clinicians risk having an incomplete history, misdiagnosing, and ultimately inadequately treating their child and youth patients. Trauma screening should be part of every assessment.

Screening Techniques

Clinicians should be aware of the threats to validity of trauma screening described earlier, and should use screening approaches and techniques that are likely to produce the most accurate data. Principles such as using explanatory introductions, behaviorally specific questions, and multiple screening items apply to both clinical assessment and research. Although busy clinicians must account for time demands when making assessment choices, good screening can be done in a time-efficient manner. Many of the tools used in the research described in this article are available and can be adapted for clinical use.

Case Formulation

As noted by the prevalence rates described, many children seen in clinical service settings will have histories of serious traumatic events, and a large proportion of them are likely to have experienced multiple types.²⁰ However, they are often referred for services because of an emergent report of one type of trauma and are identified by that moniker (eg, “sexual abuse victim”). There is an understandable tendency to attribute nearly all the problems and difficulties experienced by a child to their exposure to trauma, particularly the events leading to referral. However, clinicians should remember that many children are resilient and that not every episode of violence or other trauma causes serious problems.⁶² Clinicians should not assume a child has serious problems based solely on the trauma history. Moreover, clinicians should not assume that the incident leading the child to be referred to services is the most critical one on their trauma history. Building a timeline of traumatic events and difficulties and placing a child's history in an epidemiologic context can help with case formulation, narrow down which events may be the most important to a child with a complicated history of multiple types of victimization, help focus treatment on the most important incidents, and help prevent misattribution of causality.⁶³

Tools for Practice

Two tools used in some of the research described here may be useful to clinicians. Versions of the Juvenile Victimization Questionnaire⁶⁴ were used in the NatSCEV and NatSCEV II studies. Versions of the Event History Interview for Children & Adolescents⁶⁵ were used in the NSA and the NSA-R surveys. Each can be used to conduct an assessment of the victimization history of youth. Although both are fairly long (30–40 minutes) and somewhat complicated to administer, each produces comprehensive and detailed information about a youth's history and incident characteristics that are directly related to mental health problems. When time is a serious concern, briefer screening tools can be used, such as the Traumatic Events Screening Inventory for Children (TESI)⁶⁶ and the UCLA Posttraumatic Stress Disorder Reaction Index.⁶⁷

Future Directions

Understanding the true epidemiology of childhood traumatic experiences is challenging for many reasons, including conceptual, definitional, and methodological problems encountered. Fortunately, some of these problems are being moderated as new work incorporates the ideas and techniques of studies such as the NSA and NatSCEV series of studies. In the future, greater methodological consistency will aid in cross-study comparisons. However, new complications are emerging. A serious methodological challenge is the increase of exclusive usage of cell phones. Many of the best studies to date have used random-digit dialing selection and telephone interviewing methods. Indeed the NCVS now has incorporated this technology as well. However, using this approach when a large and growing proportion of households in the United States do not have landline phones is more challenging and more expensive. In addition, response rates have decreased over time owing to societal concern about telephone fraud, identity theft, and other technology

issues, which further affects the external validity of findings. Therefore, some of the most cost-effective methods are becoming more difficult and expensive to use. New technologies, such as online surveys and the use of standing national panels, hold some promise but also present their own challenges to accuracy and generalizability.

A second major issue is the amount of available information about the importance of the many forms of trauma children many experience. A single survey can only assess a limited amount of trauma types, leaving others unassessed. Only a restricted number of incident characteristics can be evaluated, even though many may be known to be significant predictors of outcomes. Each unassessed item is a potential confound to any conclusions. However, developing a survey that adequately assesses and is able to control for the entire spectrum of important trauma types is simply not feasible at this juncture. Therefore, future work will have to make critical judgments about what to include in individual studies, and accounting for previous data will be even more critical to building a useful epidemiologic literature of child trauma.

Finally, the field would benefit from an improved national surveillance system for childhood traumatic events. Current efforts are simply inadequate given the need. The field needs access to consistent incidence data about important forms of traumatic experiences to detect trends and the overall range of child trauma.

Summary

Over the past 2 decades, the importance of psychological trauma in response to exposure to violence and other events has emerged as a vitally important area of research and practice. Research has found that trauma exposure is a key element in child development, psychopathology, and functioning. Consequently, policy-makers, service systems, and individual professionals concerned with children are seeking to become “trauma-informed” and to implement evidence-based programs and interventions for trauma-related problems. Knowing the epidemiology of traumatic experiences in childhood is a fundamental requirement for accomplishing this change effectively. It is fair to say that our current knowledge is based on the handful of rigorous, nationally representative studies completed to date. It is now known that a large proportion of children have had traumatic experiences, many of whom experience multiple types and incidents of traumatic events, and that adolescence is a particularly risky developmental period for trauma. However, considerably more research is needed to answer other important and fundamental questions with precision and authority.

References

1. Saunders BE, Kilpatrick DG, Hanson RF, et al. Prevalence, case characteristics, and long-term psychological correlates of child rape among women: a national survey. *Child Maltreat*. 1999; 4(3): 187–200.
2. Gilbert R, Widom CS, Browne K, et al. Burden and consequences of child maltreatment in high-income countries. *Lancet*. 2009; 373:68–81. [PubMed: 19056114]
3. MacMillan HL, Jamieson E, Walsh CA. Reported contact with child protection services among those reporting child physical and sexual abuse: results from a community survey. *Child Abuse Negl*. 2003; 27:1397–408. [PubMed: 14644057]
4. Drake B, Lee SM, Jonson-Reid M. Race and child maltreatment reporting: are blacks overrepresented? *Child Youth Serv Rev*. 2009; 31(3):309–16.
5. Hanson RF, Resnick HS, Saunders BE, et al. Factors related to the reporting of childhood rape. *Child Abuse Negl*. 1999; 23(6):559–69. [PubMed: 10391513]

6. Hanson RF, Kievit LW, Saunders BE, et al. Correlates of adolescent reports of sexual assault: findings from the National Survey of Adolescents. *Child Maltreat*. 2003; 8(4):261–72. [PubMed: 14604174]
7. Ruggiero KJ, Smith DW, Hanson RF, et al. Is disclosure of childhood rape associated with mental health outcome? Results from the National Women's Study. *Child Maltreat*. 2004; 9(1):62–77. [PubMed: 14870998]
8. Truman, J.; Langton, L.; Planty, M. Criminal victimization, 2012 (NCJ 243389). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2013.
9. Kilpatrick, DG.; McCauley, J. Understanding national rape statistics. Harrisburg (PA): VAWnet, a project of the National Resource Center on Domestic Violence; 2009. Available at: <http://www.vawnet.org> [Accessed November 11, 2013]
10. Kruittschmitt, C.; Kalsbeek, WD.; House, CC. Estimating the incidence of rape and sexual assault: panel on measuring rape and sexual assault in Bureau of Justice Statistics household surveys. Washington, DC: The National Academies Press; 2013. Available at: http://www.nap.edu/catalog.php?record_id=518605 [Accessed November 19, 2013]
11. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. [Accessed November 15, 2013] Child maltreatment 2011. 2012. Available at: <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>
12. U.S. Department of Justice, Federal Bureau of Investigation. Washington, DC: Author; 2013. Summary of the Uniform Crime Reporting (UCR) program. Available at: <http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2012/crime-in-the-u.s.-2012/resource-pages/about-ucr/aboutucrmain.pdf/view> [Accessed October 4, 2013]
13. Fallon B, Trocme N, Fluke J, et al. Methodological challenges in measuring child maltreatment. *Child Abuse Negl*. 2010; 34(1):70–9. [PubMed: 20053453]
14. Finkelhor, D. Childhood victimization: violence, crime, and abuse in the lives of young people. New York: Oxford University Press; 2008.
15. Ford JD, Gagnon K, Connor DF, et al. History of interpersonal violence, abuse, and nonvictimization trauma and severity of psychiatric symptoms among children in outpatient psychiatric treatment. *J Interpers Violence*. 2011; 26:3316–37. [PubMed: 21362676]
16. Jaycox LH, Ebener P, Damesek L, et al. Trauma exposure and retention in adolescent substance abuse treatment. *J Trauma Stress*. 2004; 17:113–21. [PubMed: 15141784]
17. King DC, Abram KM, Romero EG, et al. Childhood maltreatment and psychiatric disorders among detained youths. *Psychiatr Serv*. 2011; 62:1430–8. [PubMed: 22193789]
18. Louwers EC, Korfage IJ, Affourtit MJ, et al. Effects of systematic screening and detection of child abuse in emergency departments. *Pediatrics*. 2012; 130:457–64. [PubMed: 22926179]
19. Muesser KT, Taub J. Trauma and PTSD among adolescents with severe emotional disorders involved in multiple service systems. *Psychiatr Serv*. 2008; 59:627–34. [PubMed: 18511582]
20. Grasso DJ, Saunders BE, Williams LM, et al. Patterns of multiple victimization among maltreated children in Navy families. *J Trauma Stress*. 2013; 26(5):597–604. [PubMed: 24114860]
21. Khoury L, Tang YL, Bradley B, et al. Substance use, childhood trauma experience, and posttraumatic stress disorder in an urban civilian population. *Depress Anxiety*. 2010; 27:1077–86. [PubMed: 21049532]
22. Centers for Disease Control and Prevention. Web-based injury statistics query and reporting system (WISQARS) [online]. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer); 2003. Available at: www.cdc.gov/ncipc/wisqars
23. Copeland WE, Keeler G, Angold A, et al. Traumatic events and posttraumatic stress in childhood. *Arch Gen Psychiatry*. 2007; 64:577–84. [PubMed: 17485609]
24. Kilpatrick, DG.; Saunders, BE.; Smith, DW. Research in brief: youth victimization: prevalence and implications (NCJ 194972). Washington, DC: National Institute of Justice, U.S. Department of Justice; 2003.

25. Kessler RC, Avenevoli S, Costello EJ, et al. Design and field procedures in the U.S. National Comorbidity Survey Replication Adolescent Supplement (NCS-A). *Int J Methods Psychiatr Res.* 2009; 18(2):69–83. [PubMed: 19507169]
26. Finkelhor D, Turner HA, Ormrod R, et al. Violence, abuse, and crime exposure in a national sample of children and youth. *Pediatrics.* 2009; 124:1411–23. [PubMed: 19805459]
27. Walsh K, Danielson CK, McCauley JL, et al. National prevalence of posttraumatic stress disorder among sexually revictimized adolescent, college, and adult household-residing women. *Arch Gen Psychiatry.* 2012; 69(9):935–42. [PubMed: 22566561]
28. Finkelhor D, Turner HA, Shattuck A, et al. Violence, crime, and abuse exposure, in a national sample of children and youth: an update. *JAMA Pediatr.* 2013; 167(7):614–21. [PubMed: 23700186]
29. McIntyre JK, Widom CS. Childhood victimization and crime victimization. *J Interpers Violence.* 2011; 26(4):640–63. [PubMed: 20505112]
30. Sedlak, AJ.; Mettenburg, J.; Basena, M., et al. Fourth national incidence study of child abuse and neglect (NIS-4): report to Congress. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families; 2010.
31. Bony-McCoy S, Finkelhor D. Psychosocial sequelae of violent victimization in a national youth sample. *J Consult Clin Psychol.* 1995; 63:726–36. [PubMed: 7593865]
32. Goodman GS, Quas JA, Ogle CM. Child maltreatment and memory. *Annu Rev Psychol.* 2010; 61:325–51. [PubMed: 19575622]
33. Tjaden, P.; Thoennes, N. Full report of the prevalence, incidence, and consequences of violence against women: findings from the National Violence Against Women Survey. Washington, DC: U.S. Department of Justice, National Institute of Justice; 2000.
34. Testa M, Livingston JA, VanZile-Tamsen C. The impact of questionnaire administration mode on response rate and reporting of consensual and nonconsensual sexual behavior. *Psychol Women Q.* 2005; 29(4):345–52.
35. Fisher BS. The effects of survey question wording on rape estimates: evidence from a quasi-experimental design. *Violence Against Women.* 2009; 15(2):133–47. [PubMed: 19126832]
36. Hamby SL, Koss MP. Shades of gray: a qualitative study of terms used in the measurement of sexual victimization. *Psychol Women Q.* 2003; 27(3):243–55.
37. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in Adults: the Adverse Childhood Experiences (ACE) Study. *Am J Prev Med.* 1998; 14(4):245–58. [PubMed: 9635069]
38. Banyard VL, Cross C. Consequences of teen dating violence: understanding intervening variables in ecological context. *Violence Against Women.* 2008; 14:998–1013. [PubMed: 18703772]
39. Young A, Grey M, Abbey A, et al. Alcohol related sexual assault victimization among adolescents: prevalence, characteristics, and correlates. *J Stud Alcohol Drugs.* 2008; 69(1):39–48. [PubMed: 18080063]
40. Eisenberg ME, Ackard DM, Resnick MD. Protective factors and suicide risk in adolescents with a history of sexual abuse. *J Pediatr.* 2007; 151:482–7. [PubMed: 17961690]
41. Trocmé NM, Tourigny M, MacLaurin B, et al. Major findings from the Canadian incidence study of reported child abuse and neglect. *Child Abuse Negl.* 2003; 27(12):1427–39. [PubMed: 14644059]
42. Radford L, Corral S, Bradley C, et al. The prevalence and impact of child maltreatment and other types of victimization in the UK: findings from a population survey of caregivers, children and young people and young adults. *Child Abuse Negl.* 2013; 37:801–13. [PubMed: 23522961]
43. Euser S, Alink LR, Pannebakker F, et al. The prevalence of child maltreatment in the Netherlands across a 5-year period. *Child Abuse Negl.* 2013; 37:841–51. [PubMed: 23938018]
44. Kilpatrick, DG.; Saunders, BE. Prevalence and consequences of child victimization: results from the national survey of adolescents, final report. Washington, DC: US Department of Justice, Office of Justice Programs; 1997.
45. Kilpatrick, DG. Complex patterns of exposure to interpersonal violence and comorbid mental disorders among adolescents and young adults. Presented at the 17th Annual Kent State Psychology Forum; Kent. April 22–25, 2007;

46. Wolitzky-Taylor KB, Ruggiero KJ, McCart MR, et al. Has adolescent suicidality decreased in the United States? Data from two national samples of adolescents interviewed in 1995 and 2005. *J Clin Child Adolesc Psychol.* 2010; 39:64–76. [PubMed: 20390799]
47. McCart MR, Zajac K, Danielson CK, et al. Interpersonal victimization, posttraumatic stress disorder, and change in adolescent substance use prevalence over a ten-year period. *J Clin Child Adolesc Psychol.* 2011; 40:136–43. [PubMed: 21229450]
48. McLaughlin KA, Green JG, Gruber MJ, et al. Childhood adversities and first onset of psychiatric disorders in a national sample of US adolescents. *Arch Gen Psychiatry.* 2012; 69(11):1151–60. [PubMed: 23117636]
49. McCauley J, Conoscenti L, Ruggiero KJ, et al. Prevalence and correlates of drug/alcohol-facilitated and incapacitated sexual assault in a nationally representative sample of adolescent girls. *J Clin Child Adolesc Psychol.* 2009; 38(2):295–300. [PubMed: 19283607]
50. Jaffee SR, Moffitt TE, Caspi A, et al. Influence of adult domestic violence on children's internalizing and externalizing problems: an environmentally informative twin study. *J Am Acad Child Adolesc Psychiatry.* 2002; 41(9):1095–103. [PubMed: 12218431]
51. Zinzow H, Ruggiero K, Resnick H, et al. Prevalence and mental health correlates of witnessed parental and community violence in a national sample of adolescents. *J Child Psychol Psychiatry.* 2009; 50(4):441–50. [PubMed: 19220624]
52. Rheingold AA, Zinzow H, Hawkins A, et al. Prevalence and mental health outcomes of homicide survivors in a representative sample of adolescents: data from the 2005 National Survey of Adolescents. *J Child Psychol Psychiatry.* 2012; 53(6):687–94. [PubMed: 22211367]
53. Mitchell KJ, Finkelhor D, Wolak J, et al. Youth internet victimization in a broader victimization context. *J Adolesc Health.* 2011; 48:128–34. [PubMed: 21257110]
54. Norris F, Friedman M, Watson P, et al. 60,000 disaster victims speak: part I. An empirical review of the empirical literature, 1981-2001. *Psychiatry.* 2002; 65:207–39. [PubMed: 12405079]
55. Kilpatrick, DG.; Saunders, BE. [Accessed November 8, 2013.] National survey of adolescents in the United States, 1995 [Data file]. 1995. Available at: <http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/2833#dev>
56. Briere J, Elliott D. Prevalence, characteristics, and long-term sequelae of natural disaster exposure in the general population. *J Trauma Stress.* 2000; 13(4):661–79. [PubMed: 11109238]
57. U.S Consumer Product Safety Commission. [Accessed November 11, 2013] National Electronic injury Surveillance System. 2013. Available at: <http://www.cpsc.gov/en/Research-Statistics/NEISS-Injury-Data>
58. Saunders BE. Understanding children exposed to violence: toward an integration of overlapping fields. *J Interpers Violence.* 2003; 18(4):356–76.
59. Finkelhor D, Ormrod RK, Turner HA. Lifetime assessment of poly-victimization in a national sample of children and youth. *Child Abuse Negl.* 2009; 33:403–11. [PubMed: 19589596]
60. Ford JD, Elhai JD, Connor DF, et al. Poly-victimization and risk of posttraumatic, depressive, and substance use disorders and involvement in delinquency in a National Survey of Adolescents. *J Adolesc Health.* 2010; 46:545–52. [PubMed: 20472211]
61. Finkelhor D, Ormrod RK, Turner HA. Poly-victimization: a neglected component in child victimization. *Child Abuse Negl.* 2007; 31:7–26. [PubMed: 17224181]
62. Masten AS. Resilience in children threatened by extreme adversity: frameworks for research, practice and translational synergy. *Dev Psychopathol.* 2011; 23(2):493–506. [PubMed: 23786691]
63. Saunders, BE. Determining the best practice for treating sexually victimized children. In: Goodyear-Brown, P., editor. *Handbook of child sexual abuse.* Hoboken (NJ): John Wiley & Sons; 2012. p. 173-97.
64. Hamby, S.; Finkelhor, D.; Turner, H., et al. [Accessed November 22, 2013] The Juvenile victimization questionnaire toolkit. 2011. Available at: <http://colahttps://cola.unh.edu/ccrc/juvenile-victimization-questionnaire.unh.edu/ccrc/juvenile-victimization-questionnaire>
65. National Crime Victims Research and Treatment Center, Medical University of South Carolina. Event history interview for children & adolescents Ver 1.02. Charleston (SC): Author; 2007.

66. Ribbe, D. Psychometric review of traumatic event screening instrument for children (TESI-C). In: Stamm, BH., editor. Measurement of stress, trauma, and adaptation. Lutherville (MD): Sidran Press; 1996. p. 386-7.
67. Steinberg, A.; Brymer, M. The UCLA PTSD reaction index. In: Reyes, G.; Elhai, J.; Ford, J., editors. Encyclopedia of psychological trauma. New York: John Wiley & Sons, Ltd; 2008. p. 673-4.

Acronyms

DAFSA	Drug or alcohol facilitated sexual assault
MVA	Motor vehicle accident
NatSCEV	National Survey of Children's Exposure to Violence
NCANDS	National Child Abuse and Neglect Data System
NCS-A	National Comorbidity Study-Adolescent supplement
NCVS	National Crime Victimization Survey
NEISS-AIP	National Electronic Injury Surveillance System All Injury Program
NIBRS	National Incident-Based Reporting System
NSA	National Survey of Adolescents
NSA-R	National Survey of Adolescents-Replication
TESI	Traumatic Events Screening Inventory for Children
UCR	Uniform Crime Reports

Key Points

- Understanding the epidemiology of traumatic experiences in childhood is critical to conducting meaningful trauma research, developing effective trauma services and service delivery systems with the greatest reach, and efficiently allocating resources.
- There are many serious challenges to understanding the epidemiology of childhood traumatic events, including the nature of many forms of traumatic experiences, inadequate national surveillance efforts, and conceptual and methodological differences between studies.
- Studies directly interviewing nationally representative samples of older youth are the most useful in understanding the epidemiology of childhood traumatic events.
- Depending on how various traumatic experiences are defined, 8–12% of American youth have experienced at least one sexual assault; 9–19% have experienced physical abuse by a caregiver or physical assault; 38–70% have witnessed serious community violence; 1 in 10 has witnessed serious violence between caregivers; 1 in 5 has lost a family member or friend to homicide; 9% have experienced Internet-assisted victimization; and 20–25% have been exposed to a natural or man-made disaster.
- Exposure to multiple types of victimization and trauma is very common among youth, characterizing 20% to 48% of all youth depending on the number of victimization types measured.
- Clinicians are encouraged to incorporate effective victimization and other traumatic event screening into their everyday practice.

Table 1
National survey of adolescents—replication: sexual assault incident characteristics for 17-year-old respondents

Characteristic	Number	Percentage
Offender Age		
Adult	40	35.4
Teen	67	59.3
Child	5	4.4
Don't know	1	0.9
Offender Gender		
Male	93	82.3
Female	17	15.0
Don't know	3	2.7
Offender Relationship to Victim		
Stranger	18	15.9
Friend/acquaintance	54	47.8
Dating partner	11	9.7
Father	1	0.9
Brother	9	8.0
Other relative	5	4.4
Babysitter	2	1.8
Other adult	12	10.6
Refused	1	0.9
Assault Location		
Home	28	24.8
School	14	12.4
Neighborhood	15	13.3
Community	20	17.7
Elsewhere	35	31.0
Not sure	1	0.9
Age of Victim (y)		
0–5	7	6.5
6–11	26	24.3
12–17	74	69.2
Don't know	6	5.6
Mean (SD); median	12.9 (4.3); 14.0	

Data from Refs. 45–47