ASSESSING CHILD TRAUMA EXPOSURE AND RESPONSE

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Measurement Related Publications

- Bell, D. & **Allwood, M**. Posttraumatic stress disorder. In M. Hersen & J. C. Thomas (Eds). Handbook of Clinical Interviewing with Children. Thousand Oaks, CA: Sage Publications Ltd; 2007:172-195.

- March, S., DeYoung, A., Dow, B., & **Kenardy, J**. Assessing trauma-related symptoms in children and adolescents. In J. G. Beck & D. M. Sloan (Eds). The Oxford Handbook of Traumatic Stress Disorders. Oxford University Press. 2013:

Assessment Tools & Strategies

- Clinical Interviews
- Clinician administered questionnaires
- Self-report questionnaires
- Brief screeners
- Behavioral observations (supplemental information)

DSM-5

- **Trauma- and Stressor-Related Disorders**
  - Reactive Attachment Disorder
  - Disinhibited Social Engagement Disorder
  - Posttraumatic Stress Disorder in Preschool Children
  - Acute Stress Disorder
  - **Posttraumatic Stress Disorder**
  - Adjustment Disorders
  - Other Specified Trauma- or Stressor- Related Disorder
  - Unspecified Trauma- or Stressor- Related Disorder

POSTTRAUMATIC STRESS DISORDER

One of many possible outcomes in the aftermath of trauma

A. **Exposure to actual or threatened death, serious injury, or sexual violence in one following ways:**

1. Directly experiencing the traumatic event(s)
2. Witnessing in person the event as it occurred to others
3. Learning that the traumatic event(s) occurred to a close family member or close friend (must have been sudden, violent, or accidental)
4. Experience repeat or extreme exposure to adverse details of the traumatic event (e.g., police officers)

Note: Does not apply to exposure through media, pictures (unless work related, such as reviewing graphic pictures of crime scenes)

B. Intrusive Symptoms (at least one)

1. Recurrent, involuntary and intrusive distressing memories of the event(s). **For children older than 6 this may occur as repetitive play with themes of the event**.
2. Recurrent or distressing dreams in which the content or affect of the dream are related to the event(s). **In children the content of the frightening dreams may not be recognizable.**
3. Dissociative reactions in which the child acts like the trauma tis recurring. **For children this may be trauma specific reenactment in play**.
4. Intense prolonged psychological distress at exposure to internal or external cues of aspects of the event.
5. Marked physiological reaction to those internal/external cues.

C. **Persistent avoidance of stimuli associated with the event, beginning after the even occurred and evidenced by one of the following:**

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the event(s).
2. Avoidance of efforts to avoid external reminders (people places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the event(s).

D. Negative alterations in cognitions and mood associated with the event(s), beginning or worsening after event(s)

1. Inability to remember an important part of the event(s)
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (I'm bad, ruined, defective… The world is dangerous…)
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that leads to blame of self or others
4. Persistent negative emotional state (e.g., fear, guilt, shame, anger, horror)
5. Markedly diminished interest in or participation in significant activities
6. Feelings of detachment and estrangement from others
7. Persistent inability to experience positive emotions

E. Marked alterations in arousal and reactivity following the event(s):

1. Irritability and anger outbursts
2. Reckless and destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance

Specify whether:

With dissociative symptoms: The individual's symptoms meet criteria for Posttraumatic Stress Disorder, and in addition, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Posttraumatic Stress Disorder (DSM-5)

4 Clusters

- Intrusion (Reexperiencing)
- Avoidance
- Negative Mood and Cognitions (alterations)
- Arousal / Reactivity

- Present for at least one month, Impairs functioning
- Not attributable to use of substances

Functional Impairment

Dependent on Developmental Stage

- Relationship with parents, siblings, peers
- School functioning
- Chores, occupation
- Self-Care
- Maintenance of skills achieved prior to event

CONDUCTING ASSESSMENTS

Measurement Concerns

Psychometrically sound measures

- Validity of measurement tools for developmental stage
- Reliability
  - Internally consistent
  - Reliable across informants
  - Reliable across ages and stages of development
- Language and translations

Clinical Interviews

- Interviewing in preferred language
- Multi-informant
  - Parent and child-report
  - Parent vs. child-report
  - Interviewing with or without parent present
- What we know about disclosure
  - Building rapport
  - Monitoring mood states
  - Consider consequences of disclosure

Clinical Interviews

- Assessment is ongoing, even after interviews
  - The easiest response is “No”
- Child and adolescent assessments include assessment of entire systems (e.g., family)
- Assess for legal issues, such as whether CPS should be contacted
- Legal intervention should not override clinical intervention

Strength-Based Assessments

Strength in Adversity

Gather Information regarding both symptomology and strength-based responses

- Protective factors information
- Parental responses
- Parental monitoring
- Supportive systems
- Engagement in interview process
- Interest in treatment
- Academic, behavioral, emotional strengths
- Past accomplishments

Interviews, Preschool

PTSD

- PTSD Semi-structured Interview and Observational Record for Infants and Young Children (Scheeringa & Zeanah, 1994)

Broader Mental Health

- Preschool Age Psychiatric Assessment (PAPA; Egger et al., 2006) [ages 2 to 5]
- Diagnostic Infant and Preschool Assessment (DIPA; Scheeringa, 2004)

Interviews, Preschoolers

- Associated symptoms include:
  - Separation anxiety
  - Developmental regression (e.g., back to bed wetting, baby talk, co-sleeping…)
  - Night terrors

Interviews, School Aged

- Clinician Administered PTSD Scale for Children and Adoelscents (CAPS-CA; Newman et al. 2004)
- Kiddie Schedule of Affective Disorders and Schizophrenia (K-SADS; Kaufman, 2013)
- Anxiety Disorders Interview Schedule (ADIS; Silverman & Albano, 1996)
- Children’s PTSD Inventory (Saigh et al.)

Interviews, School Aged

- Associated Symptoms
  - Shift in cognitions about self and the world, particularly for adolescents
  - Self-conscious, “humiliation”

Questionnaires

Preschool

- Young Child PTSD Checklist (Scheeringa, 2013)
- Young Child PTSD Screen (Scheeringa, 2010)

Preschool thru School-Aged

- Trauma Symptoms Checklist (Briere, 1996, 2005)
- Traumatic Events Screening Inventory (TESI-C; Ippen, 2002)
- UCLA PTSD Reaction Index (Pynoos et al.)
  - Use of the most updated version
- Child PTSD Symptom Scale (CPSS, Foa et al., 2001)
- Acute Stress Checklist for Children (ASC-Kids, Kassam-Adams, 2006)

Brief Screeners

Common Assessment Concerns

Multiple Traumas

- Which trauma to query?
- What if the indexed trauma is ongoing?
  - (e.g., caring for parent with disease – bandages, “grotesque”

- Severity
- Chronicity

Purpose or interview? (Clinical or research)

Common Assessment Concerns

Traumatic Injury as Defuse Injury

- Affecting emotional, cognitive, physiological, neurological, endocrinological systems
- As such, Traumatic Injury takes on many forms and PTSD can be considered one of these forms
- However, PTSD itself is a complex structure

Heterogeneity of PTSD

- PTSD does not manifest as a single disorder

PTSD

- Many amalgamations of symptoms
- Highly comorbid with other disorders
  - Depression (over 40%)
  - Anxiety Disorders (Panic, GAD)
  - Substance Use Disorders
  - Conduct Disorder
  - Attention Deficit Hyperactivity Disorder

Comorbidity

Proposed Subtypes of PTSD (Miller et al., 2003, 2004; Allwood et al., 2008)

- Internalizing
  - Depression, Anxiety, Social Avoidance, Withdrawal
- Externalizing
  - Antisocial behaviors and related personality disorders (e.g., narcissism), substance use
- Low Pathology

Post-Trauma vs. Ongoing Trauma

- Safety Assessments
  - Perceived Safety vs. Objective Safety
- Can you achieve safety without confidentiality?
  - Mandated reporting
  - Agent of the courts
- How do you build trust under these conditions?

THANK YOU!

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Trauma Treatments

- Preschool PTSD Treatment (PPT)
- Attachment, Self-Regulation, and Competency (ARC)
- Families OverComing Under Stress (FOCUS)
- Integrative Treatment of Complex Trauma (ITCT)
- Structured Psychotherapy for Adolescents Recovering from Chronic Stress (SPARCS)
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Trauma Focused Cognitive Behavior Therapy (TF-CBT)
- Trauma and Grief Components Therapy (TGCT)
- Trauma Systems Therapy (TST)