Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway (TAP)

Chadwick Center for Children & Families

Chadwick Center for Children and Families, Rady Children's Hospital, San Diego

The Chadwick Center for Children and Families is a Child Advocacy Center and department of Rady Children's Hospital and Health Center in San Diego, CA. It is one of the largest centers of its kind and is staffed with more than 120 professionals and paraprofessionals in the field of medicine, social work, psychology, child development, nursing, and education technology. The Chadwick Center has made lasting differences in the lives of thousands of children and families since opening its doors in 1976. The staff is committed to family-centered care and a multidisciplinary approach to child abuse and family violence. The center's mission is to promote the health and well-being of abused and traumatized children and their families. This is accomplished through excellence and leadership in evaluation, treatment, prevention, education, advocacy, and research. The center's vision is to create a world where children and families are healthy and free from abuse and neglect.

The National Child Traumatic Stress Network (NCTSN)

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

The Network is funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services through a congressional initiative: the Donald J. Cohen National Child Traumatic Stress Initiative. As of April 2010, the Network comprises 63 members. Affiliate members—sites that were formerly funded—and individuals currently or previously associated with those sites continue to be active in the Network as affiliates.

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Preface and Acknowledgements

The Chadwick Center for Children and Families, formerly known as the Center for Child Protection, is a department of San Diego's Rady Children's Hospital and Health Center that specializes in the evaluation and treatment of trauma victims. The Chadwick Center has been providing trauma counseling to victims of physical, sexual and emotional abuse, as well as to minors exposed to domestic violence and other forms of trauma since 1985. In the early 1990s, Center leadership initiated efforts to objectively evaluate the efficacy of the treatment provided in its mental health program. These early efforts evolved into a formal treatment outcome program, in which clients and their parents were administered a battery of standardized assessment measures before, during, and upon completion of treatment. The measures captured a variety of clinical domains, including many specific to trauma, and assessed parental and family functioning. The assessment results were used in many ways, foremost of which was to assist in tracking client progress and directing treatment goals. Over the years, the assessment protocol has been modified based on the needs of clinicians and clients. New measures were adopted as additional needs were identified, and measures that were not clinically useful were discontinued. The resulting protocol proved to be valuable in many ways that were not initially foreseen. For example, the information gathered assisted staff in justifying the Center's services to funding sources, helped direct program planning and staffing needs, and identified potential referral sources. The plethora of data obtained has become a powerful and empowering tool for clinicians and clients, as well as for the administrative staff and the research team.

In 2002, the Chadwick Center became a member of the National Child Traumatic Stress Network (NCTSN). The Substance Abuse and Mental Health Services Administration (SAMHSA, Grant #1 U79 SM54289-01) funds activities related to the NCTSN. It is an unprecedented collaboration among over 60 child trauma organizations across the country, with a mission "to raise the standard of care and

improve access to services for traumatized children, their families and communities throughout the United States.” The grant provided an opportunity for the Chadwick Center to transform its existing assessment-based treatment model into a replicable format, refining and standardizing procedures, and ultimately sharing this model with other trauma counseling sites across the country.

This manual is the result of extensive discussions, planning, and work discussions among clinicians, researchers, and administrators in the Trauma Counseling Program at the Chadwick Center. As the manual for the TAP model was developed, several predictable debates occurred. One of these was over the relative significance of research and clinical efforts in the development of the manual. An additional debate occurred regarding the utilization of only evidence-based treatments compared with a process that allowed for more choices among therapeutic interventions. As these dialogues were resolved, the TAP model evolved into one in which the clinician is able to select from among evidence-based and evidence-informed interventions and as well as promising practices.

We would like to acknowledge the many people who have helped us through the development of this model. First and foremost, we would like to thank the children and their families who received services at the Center for guiding and teaching us in our work with them. Secondly, we would like to thank the clinicians who work so hard on a daily basis providing trauma-counseling services to the families in need.
Our deepest thanks are extended to the following people who have given us their time and wisdom throughout the development of this manual:

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Introduction Introduction

Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway (TAP) is an intervention model for assessing and treating children and adolescents between 2 and 18 years of age who have experienced any type of trauma. TAP incorporates assessment, triage, and essential components of trauma treatment into clinical pathways. This manual will explain the theory and mechanics underlying TAP and provide an in-depth description of the model as well as instruction regarding implementation. The goals of this manual include:

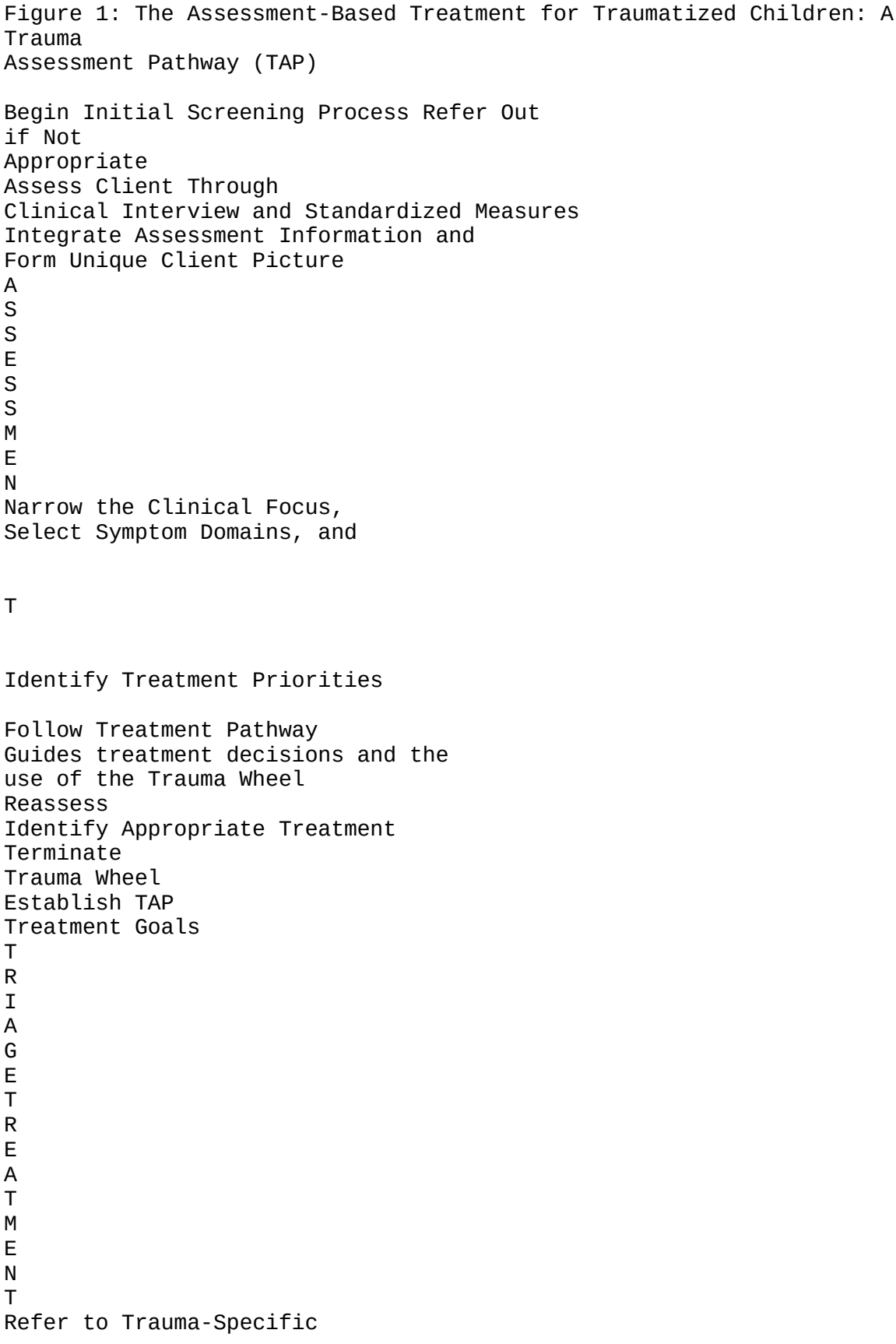
1) Providing treatment center staff with the knowledge and steps to incorporate standardized assessments into the intake process.

2) Providing a model for the treatment of trauma guided by assessment.

3) Providing a treatment model that is directed by the uniqueness of the child and his or her family.

Part I of the manual describes the assessment process, how to triage, when to make referrals, and how to develop a Unique Client Picture. Part II of the manual focuses on trauma treatment including the Trauma Wheel and the TAP Treatment Clinical Pathway. Figure 1 demonstrates the overall view of the TAP model. Each step of the pathway presented in Figure 1 will be discussed and case examples are provided.

Figure 1: The Assessment-Based Treatment for Traumatized Children: A Trauma
Assessment Pathway (TAP)



Treatment Model and/or
Specialized Program
Services
(AND/OR)
Refer to TAP Treatment
Model
Trauma Assessment Pathway (TAP) 2 Chadwick Center for Children & Families

Definition of Trauma

Psychological trauma is often understood in the context of post-traumatic stress disorder (PTSD), as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, APA, 2000). It is referred to as a psychologically distressing event that is outside the range of usual human experience and often involves a sense of intense fear, terror, and helplessness (APA, 2000). A similar definition is provided by National Child Traumatic Stress Network (NCTSN, 2005). They report:

In traumatic situations, we experience an immediate threat to ourselves or to others, often followed by serious injury or harm. We feel terror, helplessness, or horror because of the extreme seriousness of what is happening and the failure of any way to protect against or reverse the harmful outcome. These powerful, distressing emotions go along with strong, even frightening physical reactions, such as rapid heartbeat, trembling, stomach dropping, and a sense of being in a dream.

The DSM-IV-TR indicates that traumatic events can include a wide range of occurrences that are experienced, learned of, or witnessed. Table 1 includes a summary of the DSM-IV-TR list of traumatic events. For the purpose of this manual, traumatic events are defined as those described in Table 1 as well as child maltreatment. Child maltreatment includes neglect; physical, sexual, and psychological abuse; and family, school, and community violence (U. S. Department of Health and Human Services, 2009).

Table 1: Traumatic Events as Characterized by the DSM-IV-TR (APA, 2000)

Traumatic Events Experienced	Traumatic Events Witnessed	Traumatic Events Experienced by Others
• Military Combat • Sexual Assault • Physical Assault • Robbery • Mugging • Being Kidnapped		

- Being Taken Hostage
- Terrorist Attack
- Torture
- Incarceration as a Prisoner of War
- Manmade Disasters
- Severe Automobile Accidents
- Being Diagnosed with a Life-Threatening Illness

For Children: Sexual Assault can occur without threatened or actual violence or injury.

Observation of the Serious Injury or Unnatural Death of Another Person Due to:

- Violent Assault
- Accident
- War
- Disaster
- Unexpectedly Seeing a Dead Body or Body Parts

Learning of or as Experienced by a Close Family Member or Close Friend:

- Violent Personal Assault
- Serious Accident
- Serious Injury
- Being Diagnosed with a Life-Threatening Illness

Level of Traumatic Exposure

In addition to being categorized into types of events, traumatic events are also grouped in terms of single-event vs. long-term exposure. Lenore Terr (1991) suggested two types of trauma. Type I trauma includes trauma reactions as a result of an unanticipated single event, whereas Type II trauma includes trauma reactions as a result of long-term or repeated exposure to extreme external events. Reactions to these types of traumas can be quite different. Type I trauma, or single event trauma, can evoke reactions typical of posttraumatic stress disorder such as re-experiencing the trauma, avoidant behavior, and hyper-arousal. In contrast, children exposed to long-term trauma (Type II) frequently experience fundamental personality changes. These changes are often associated with long-term coping mechanisms such as denial, repression, dissociation, and identification with the aggressor in order to “survive” the ongoing traumatic experiences. In the context of trauma, this reaction is adaptive. However, in the long-term, these methods of coping create maladaptive changes in character and personality (Terr, 1991).

A group of experts within the NCTSN is dedicated to identifying treatment modalities for children who have experienced multiple forms of trauma or who have long-term trauma histories. This Complex Trauma Taskforce defines complex trauma as exposure to multiple traumatic events that occur within the family and community systems. The taskforce suggests that complex trauma exposure is the “simultaneous or sequential occurrences of child maltreatment…that are chronic and begin in early childhood” (Cook, Blaustein, Spinazzola, & van der Kolk, 2003, p. 3). They further suggest that the impact is greater because the trauma occurs within the family and community, systems that are generally a source of safety, support, and stability. Problems with emotional dysregulation, loss of safety, and an inability to detect and respond appropriately to signs of danger are also sequelae of this type of trauma exposure (Cook et al., 2003). Although posttraumatic stress-

related symptoms are seen in children exposed to complex trauma, PTSD does not
appear to fully depict the developmental consequence of complex trauma. The
impairments reported by the Complex Trauma Taskforce are summarized in Table

2.

Table 2: A Summary of Impairments in Children Exposed to Complex Trauma as
Reported by the NCTSN Complex Trauma Taskforce in 2003

Area of Impairment	Specific Impairments
Attachment	• Boundary Problems • Social Isolation • Difficulty Trusting Others • Interpersonal Difficulty
Biology	• Sensorimotor Developmental Problems • Hypersensitivity to Physical Contact • Somatization • Increased Medical Problems • Problems with Coordination and Balance
Affect Regulation	• Problems with Emotional Regulation • Difficulty Describing Emotions and Internal Experiences • Difficulty Knowing and Describing Internal States • Problems with Communicating Needs
Behavioral Control	• Poor Impulse Control • Self-Destructive Behavior • Aggressive Behavior • Oppositional Behavior • Excessive Compliance • Sleep Disturbance • Eating Disorders • Substance Abuse • Reenactment of Traumatic Past • Pathological Self-Soothing Practices
Cognition	• Difficulty Paying Attention

•
Lack of Sustained Curiosity
•
Problems Processing Information
•
Problems Focusing on and Completing Tasks
•
Difficulty Planning and Anticipating
•
Learning Difficulties
•
Problems with Language Development
Self-Concept •
Lack of Continuous and Predictable Sense of Self
•
Poor Sense of Separateness
•
Disturbance of Body Image
•
Low Self-Esteem
•
Shame and Guilt

(Cook, Blaustein, Spinazzola, & van der Kolk, 2003)

Assessment-Based Treatment

Historically, treatment outcome programs were developed to assess whether agencies or individuals were meeting their specified goals. In the area of mental
health treatment, the primary goal is usually to measure individual client progress.

However, outcome data can serve many other purposes. A few examples include gathering information related to satisfaction with treatment, utilization of services, and specific symptom improvement after treatment. Chadwick Center staff began providing overall pre-post treatment data to funding sources as a means of justifying requests for extra funds. Demographic data was used to identify gaps in center resources and untapped client populations (Gothard, Ryan, & Heinrich, 2000). Researchers used outcome information to answer questions concerning different populations and their specific treatment needs.

Over time, the focus in programs using assessment measures has shifted from treatment outcomes to using the assessment information clinically. In 2004, the social work field defined the clinical use of assessment measures as "assessmentbased treatment:"

[Assessment-based treatment refers to the] development of an integrated plan of prioritized interventions, that is based on the diagnosis and psychosocial assessment of the client, to address mental, emotional, behavioral, developmental and addictive disorders, impairments and disabilities, reactions to illnesses, injuries, and social problems (New York State United Teachers, 2008) (p. 3).

Consistent with this shift, the Chadwick Center staff have shaped the existing mental health treatment programs to more precisely reflect the title and definition of "assessment-based treatment." They have accomplished this by integrating assessment information into all phases of the clinical process:

- Developing a comprehensive understanding of the client.
- Identifying high-risk clients.
- Establishing treatment goals.
- Selecting appropriate treatment interventions.
- Monitoring and re-evaluating client functioning throughout the course of therapy.

By incorporating assessment data into the clinical process and implementing clinical

pathways, clinicians are able to identify the needs of each individual child and use
the most effective types of clinical interventions.

Clinical Pathways

The TAP model uses clinical pathways to guide choices about clients' treatment.
Within the TAP model, "pathway" refers to a sequence that clinicians follow in
making assessment, triage, and clinical decisions. This process is increasingly used
in the medical field to standardize the management of medical and mental ailments, with the ultimate goal of improving care and reducing unnecessary costs.
An evaluation of an asthma pathway at UCLA in 1998 revealed that use of this
guide resulted in substantial cost savings to the hospital, and improved adherence
to standards (Bailey, Weingarten, Lewis, & Mohsenifar, 1998). Rady Children's
Hospital-San Diego has successfully developed over 40 pathways, ranging from an

asthma pathway developed in 1994 to a domestic violence pathway completed in 2001. Within TAP, clinical pathways are used to help make decisions regarding assessment and treatment at each stage of intervention. The clinical components of these pathways are based upon research on complex trauma and the current research on efficacious treatment modalities.

Chadwick Center's Philosophy: Understanding the Child and Resolving Trauma

The Chadwick Center's philosophy of trauma treatment for children involves gaining a thorough understanding of the child and his/her family and social environment with an ultimate goal of helping the child resolve issues surrounding the traumatic event(s). The TAP model utilizes clinical pathways and assessment-based treatment to help guide the decisions made throughout the course of treatment for any individual child. This allows for decisions regarding assessment and treatment interventions to be tailored to the individual needs of each child receiving services through this model.

The TAP model operates with the understanding that every child comes to treatment with a unique history, a unique family system, and a unique level of developmental, cognitive, and emotional functioning. Cultural factors at the child, family, and community level also must be considered. Understanding the child through the use of a comprehensive evaluation that incorporates a clinical interview, observation, and standardized assessments is the first step in effectively treating the child. This solid understanding becomes the basis for identifying an effective individualized treatment intervention for the child. In some circumstances, time-limited, manualized approaches will meet the child's clinical needs effectively. Such approaches can be tailored to fit the unique client picture, including cultural issues. For example, a child who was sexually abused and is having flashbacks, but has a solid family support system, is a good candidate for Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT). A child with multiple traumas and multiple symptoms who moves from foster home to foster home might

not be appropriate for TF-CBT. For that child, the clinician may want to customize the treatment plan, strategically using treatment techniques shown to be effective in treating traumatized children. The result is a more individually designed approach to the child's healing process.

Regardless of the child's unique history, trauma resolution will be a central goal of treatment. Trauma resolution involves not only making sense of the traumatic event, but also helping a child learn to regulate their emotions, working with the family to establish a safe environment, and enhancing the child's resiliency and social supports (Cook et al., 2003). Because many of these goals relate to the child's environment, it is important, whenever possible, to engage the family or other supportive individuals in the child's life, teaching them how to support the child through the therapeutic process. In resolving trauma, some experts emphasize using a trauma narrative or having the child re-tell the traumatic event to help the child understand and integrate the experience (Cohen, Mannarino, &

Deblinger, 2006). Others believe that the therapeutic alliance helps the child create
new experiences that can redefine the original traumatic experience for the child
(Perry & Pollard, 1998).

Part I: Assessing the Traumatized Child

Part I: Assessing the Traumatized Child

Chapter 1:
Setting up an Assessment-Based Treatment Program

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In order for a center to begin effectively assessing the traumatized child and using that information in a meaningful way, it needs to take the time to create an assessment-based treatment program. An assessment-based treatment program systematically incorporates standardized assessment measures into treatment to improve the effectiveness of the assessment process and to track client outcomes. The type of data collected within an assessment program is specific to the goals of the program.

Standardized Assessment Choices

Within a mental health treatment setting, the assessment data usually includes a combination of measures that assess symptoms and behaviors commonly exhibited by the targeted population as well as systemic or environmental influences. Both standardized (validated paper and pencil measures) and non-standardized methods (clinical interview and observation) of assessment are recommended. Standardized assessments allow clinicians to gather information in a more efficient and time-effective manner while non-standardized methods can be more individualized. The combination of standardized measures and clinical judgment increases the thoroughness and accuracy of the treatment planning process.

Identifying Areas of Concern for the Center’s Trauma-Treatment Clientele

Prior to making measurement choices, the treating clinicians should identify common areas of concern for their population to guide them in selecting appropriate assessment measures. For instance, if reducing sexual reactivity, sexual behaviors, and sexually intrusive thoughts are within the agency’s scope of service, an assessment protocol should incorporate measures that assess sexual reactivity and concerns. Exercise 1, “Defining Your Center’s Scope of Service” on the next page, can serve as a guide to help define the specific needs of the

individual treatment center prior to selecting measures. A completed example of the “Scope of Service” worksheet is on the following page. Although this treatment manual refers to integrating TAP in “treatment centers,” this model can be implemented in private practice settings that provide trauma counseling for children as well.

Exercise 1: Defining Your Center’s Scope of Service

Scope of Service Worksheet - Blank

Define your center’s scope of service. What types of problems are you trying to resolve with your clients?

Complete the following steps to identify which domains to assess:

Step 1
Agency Name:

Step 2
Mission Statement:

Step 3
Program Description:

Step 4
Describe your program’s overall goals:

Step 5
How would you know if these goals were met?

Step 6
Select the areas of concern for your clientele:

•
Anxiety
•
Depression
.. Trauma Symptoms
.. Sexual Behaviors
.. Behavioral Problems
•
Family Stress and Parenting Concerns
•
Other (List:_____, _____, _____)
Step 7
What would indicate that your clients are improving?

Step 8
Who would be the best person(s) to inform you about whether your clients are improving?

.. Child .. Caretaker .. Teacher .. Other:_____
Step 9
Do any standardized measures exist to assess your goal?

Step 10 Are these measures (if they exist) sensitive to change?

For traumatized children, the scope of service may be reduction of trauma-related

symptoms and building family support for traumatized children. Given this, posttraumatic
stress symptoms, general symptoms, family dynamics, and parenting skills might be
important areas to assess.

Scope of Service Worksheet - Sample

Define your center’s scope of service. What types of problems are you trying to resolve with your clients?

Complete the following steps to identify which domains to assess:

Step 1
Agency Name: Chadwick Center for Children & Families

Step 2
Mission Statement: We will promote the health and well-being of abused and traumatized children and their families. We will accomplish this through excellence and leadership in evaluation, treatment, prevention, education, advocacy, and research.

Step 3
Program Description: The Trauma Counseling Program is committed to treating the after-effects of a child’s traumatic experience. In addition, the program works to support the recovery of family members and to improve their ability to support the child. Interventions include individual, group, and family therapy. The staff’s expertise is in treating childhood traumatic events including neglect; physical and sexual abuse; sexual assault; domestic, school, and community violence; and natural disasters. Treatment for the psychological aspects of medical trauma and chronic pain is also available.

Step 4
Describe your program’s overall goals (use as few words as possible). Reduce trauma-related symptoms and build family support primarily for child maltreatment victims.

Step 5 How would you know if these goals were met? Reduction of trauma symptoms and reports of better family functioning
Step 6 Select the areas of concern for your clientele:

Anxiety

Depression

Trauma Symptoms

Sexual Behaviors

Behavioral Problems

Family Stress and Parenting Concerns

Other (List:_____, _____, _____)

Step 7
What would indicate that your clients are improving? Reduced symptoms per parent and child report.

Step 8
Who would be the best person(s) to inform you about whether your clients are improving?

Child
Caretaker
Teacher
Other:_____
Step 9
Do any standardized measures exist to assess your goal?

Child Behavior Checklist for Children (CBCL)
Youth Self-Report (YSR)
Trauma Symptom Checklist for Children (TSCC)
Trauma Symptom Checklist for Young Children (TSCYC)
Parenting Stress Inventory (PSI)
Family Assessment Measure III (FAM-III)

Step 10 Are these measures (if they exist) sensitive to change? Yes

Literally hundreds of standardized assessment measures exist. Narrowing down the measures that will be most beneficial to the center often seems like a daunting task, requiring the clinician to balance the information they want to gather without overwhelming the children and families they serve. Exercise 1 provides some guidance to help navigate this process. It is tempting to want to gather information that may not be directly relevant to the symptoms the center treats. The center should begin by identifying its scope of service. The scope of service will help the center determine its goals and which problems to target, and identify what would signal improvement in its clients. Factoring in the developmental and intellectual abilities of the center's clientele will help the clinicians select measures that are feasible for their clients. For traumatized children, the scope of service may be reduction of trauma-related symptoms and building family support for traumatized children. Given this, posttraumatic stress symptoms, general symptoms, family dynamics, and parenting skills might be important areas to assess.

Once the clinician has identified the problems and what would constitute improvement, he/she should search for appropriate measures to capture this information. The clinician should review the measures that are available, and assess if they have solid psychometric properties. Further discussion on psychometric properties will be presented later in this chapter.

Multiple Individuals Assessing the Client's Problems

Because caretakers, the child, and other significant individuals in the child's life do not always agree on the problems the child displays (Achenbach, McConaughy, & Howell, 1987; Handwerk, Larzelere, Soper, & Friman, 1999), having different individuals report on the same symptoms is beneficial. This multi-informant approach also reduces the likelihood that significant symptoms or problems will be overlooked or assigned undue significance. In addition, with different individuals who interact with the child reporting on the child's functioning, the clinician will have information from multiple sources that can aid in obtaining a full

understanding of the system dynamics and the child's level of functioning in different environments (Achenbach et al., 1987; Taylor, 2002).

A common cross-informant dynamic within traumatized samples is for the caretaker to report more symptoms than the child reports (Handwerk et al., 1999; Taylor, 2002). There are many theories for this phenomenon. Some suggest that children may be more likely to minimize or deny problems (Kolko & Kazdin, 1993). Others suggest that some of the differences may be due to the different settings in which the behavior is observed (Achenbach et al., 1987). Caretakers may see the child through "abuse-colored" glasses (Taylor, 2002), believing that the child must be experiencing psychological or behavioral problems after having a traumatic experience.

When making decisions about which adult caretaker will provide information on a child, factors such as availability of the adult, accuracy of his/her report, and the age of the child will arise. A child may be brought to treatment by his/her foster

parent or social worker who may have only known the child for a short period of time, potentially invalidating the measures. While this adult may not be the best source of information, he/she may be the only source. If no other adult with a longer history with the child is available, interpret the test results with caution.

Another problem can occur when the caretaker has personal difficulties that interfere with his/her ability to accurately report on his/her child's functioning. If the clinician suspects such a problem with the validity of the report, consider assessing the caretaker's functioning as well. This can be done via an interview, observation, and measures assessing caretaker functioning (i.e., caretaker depression, parenting stress, caretaker trauma history, and trauma reactions).

A final issue impacting the role of adult informants is the age of the child. Many measures are validated for children as young as 7 years of age. However, for younger children, clinicians will have to rely on the primary caretaker to complete the assessment measures. There is also the possibility of including teachers or other important caretakers (i.e., grandparents, stepparents, etc.) that spend significant amounts of time with the child.

Once the areas of concern have been identified, and there is an understanding of what would constitute improvement in the client, it is time for the clinician to identify existing measures that assess the areas he/she is targeting. Appendix A presents examples of possible areas of concern for traumatized children, along with a few potential measures to use to assess these areas with different informants. Appendix B includes information for obtaining these measures. A comprehensive list of measures that are frequently used by trauma-focused treatment centers is available in a searchable database created by the NCTSN (www.nctsn.org). This database also includes information on psychometric properties, length, administration, informant information, scoring and interpretation guidelines, as well

as cultural and language options for over 100 measures that are often used with
trauma populations.

Psychometric Properties

The process of initial measure selection includes a review of the psychometric
properties of the measures under consideration. Two important factors for the
clinician to consider are the reliability (i.e., is the measure providing consistent
results?) and the validity (i.e., does the measure assess what it is supposed to be
assessing?) of the measure. Another issue for the clinician to consider is the base
rate of the domain being measured, in other words, the true proportion of people in
the general population who have scores similar to the score obtained by clients at
the center. There are two kinds of errors that can be made by tests: failing to
identify someone who has a symptom (more likely if the symptom is uncommon) or
incorrectly identifying someone as having a symptom that does not have the
symptom (more likely if the symptom is common). By understanding base rates for
the measures he/she selects, the clinician can make more educated decisions about
whether a specific score is accurate for a client.

It is also important for the clinician to know if the measure is available in the native language of the client. For some measures, there is evidence that the measure is valid in English, but it has not been studied adequately with other ethnic groups. At the most basic level, there are often difficulties with language and translation quality. To correct this problem, some measures go through initial translation, followed by back translation, or translating the measure back to English to ensure that the meaning is consistent. At a deeper level, there are concerns regarding whether the measure is assessing the same thing when administered to a different cultural group. Clinicians should seek clarification if they have doubts that their client and/or caretaker is fully grasping the meaning of any given assessment item. Further research is often done to assess this information. Unfortunately, for many measures, resources are not available to adequately validate measures on diverse populations.

Existing clinical cutoff scores and their meaning is another important psychometric consideration. What score does someone need to obtain before the clinician identifies that the client is experiencing distress in that area? Some measures provide a raw score, but do not include an interpretation or clinical cutoff. This makes it much more difficult to make sense of assessment results. For these measures, clinicians often look at individual items to make sense of the data, but do not have an overall assessment of the client’s level of distress.

Other measures utilize standardized scores, such as T-scores (Mean of 50, standard deviation of 10), so that one client’s score can be compared to another client’s score. There are general guidelines in the literature that scores 1.5 standard deviations above the mean are clinically elevated. Nevertheless, manuals should always be consulted when interpreting measures to ensure that the clinician is using the correct clinical cutoff score.

In addition, some measures can be clinically interpreted if the person has a high

score or a low score. The Family Assessment Measure III (FAM-III; Skinner, Steinhauer, & Santa-Barbara, 1994) is an example of this type of measure. On the FAM-III, low scores are typically considered strengths and high scores are considered weaknesses. For this reason, it is important for clinicians to receive training on different strategies for interpreting assessment information to complement the information they receive from the assessment manuals.

In terms of identifying danger to self and others, some items that identify safety concerns or risks, called critical items, should be looked at individually. Endorsement of critical items, such as suicidal ideation or intent, triggers a risk assessment process. Other measurement considerations include time to administer, training needed to administer or interpret, and cost to purchase the measures.

Assessment Pathway

Once the center selects a small, core set of measures that assess symptoms common among most of the clientele, an assessment pathway should be created. Time and funding restrictions usually make it impractical to administer all measures to all clients, so incorporating an assessment pathway into the interview and intake process can assist in measurement selection. A structured interview also helps the clinician identify additional (i.e., “non-core”) problematic areas of functioning for the individual client. These non-core areas of concern can then be explored in greater depth using additional, more targeted assessment measures. Figure 2 presents an example of how to identify areas that would benefit from more in-depth assessment. For example, when a clinician identifies an area of concern, such as parenting or boundary problems, they probe more deeply using measures that are specifically created to assess those problems. If parenting is the specific problem identified, a measure of parenting stress can be administered to help identify which aspects of parenting are overwhelming to the caretaker. This, in turn, can help the clinician get a better understanding of the family dynamics and identify the appropriate aspect of treatment in which to initially focus.

Figure 2: Example of How to Identify Areas that Would Benefit from More In-Depth Assessment

8. Developmentally Inappropriate Sexualized
Behavior (saying or doing things about sex that
children his/her age don’t usually do or know)
Very much/often a problem Administer CSBI
- Not a problem Therapist:
- Somewhat/Sometimes a problem If YES-

9. Alcohol or Substance Abuse (any use of alcohol or other drugs):
Alcohol used by child? .. No .. Yes
Drugs used by child? .. No .. Yes
- Not a problem
- Somewhat/Sometimes a problem

Very much/often a problem
Therapist:
If YES-
Administer
AUDIT or
DAST
10. Attachment Problems, Relationship Concerns, • Not a problem Therapist:
or Boundary Concerns? (difficulty forming or • Somewhat/Sometimes a problem If YES-
maintaining trusting relationships with other people) • Very much/often a problem Administer
PSI
11. Criminal Activity (activities that have resulted in being stopped by the police or arrested)
• Not a problem
• Somewhat/Sometimes a problem
• Very much/often a problem
12. Running Away from Home (staying away for at least one night)
• Not a problem
• Somewhat/Sometimes a problem
• Very much/often a problem

An assessment pathway can help identify areas for further investigation

Providing Assessment Feedback to Clinicians

Once measures are chosen and implemented, a process for scoring assessment measures and providing user-friendly assessment results/feedback to the treating clinicians must be created and maintained. One method of scoring the measures is to have each clinician refer to the individual manual, which instructs them on how to score each measure. A faster, but more expensive, option is to order the computer scoring programs from the assessment companies. If the center is large or has decided to use many assessment measures, the clinician would have to use many different scoring programs. Although time consuming, a center staff member may be able to create a database using programs such as HTML, SPSS Builder, Microsoft Access, or FoxPro that includes all assessments and demographic forms used at the center. Use of such databases allows for streamlined data entry as well as scoring.1

Providing the measures' scores in an easy to read and timely manner promotes more clinical integration of the assessment results. The scores can be handwritten into a user-friendly form, typed up in Microsoft Word, or created by computer-generated reports. Figure 3 presents a sample of streamlined assessment feedback that provides the clinician with feedback on standardized measures in which clinical cutoffs are identified and where critical items are highlighted. This figure also denotes changes in symptom levels from the start of treatment and at Time 2. This can be especially helpful in tracking client change over the course of treatment and can help guide clinical intervention decisions. The streamlined presentation of scores with indicators of clinical levels helps clinicians make sense of the data quickly and easily, focusing on the most significant areas of concern.

1 NOTE: Creation of these databases sometimes requires special permission from publishers. Check with the publisher(s) of each measure prior to reproducing copyrighted materials within a database.

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Figure 3: Streamlined Assessment Feedback Form

Displays clinical cutoffs, critical items, and symptom change over time

TIME 2

RID: 1457.2 Child’s Name: X Child’s Age: 12 Gender: Female

Assessment Measure Baseline Time 2
Child Depression Inventory
(CDI)
(61-65=Border; >65=Clinical)
Suicidal Ideation Endorsed?
85
Intent
55
Trauma Symptom Checklist for
Children (TSCC)
(*>64=Clinical, **>70=Clinical)
Underreporting* 56 45
Hyperreporting* 50 52
Anxiety* 70 C 65 C
Depression* 62 B 50
Anger* 45 50
Post Traumatic Stress* 65 C 50
Dissociation* 62 C 54
Overt Dissociation* 45 47
Dissociation/Fantasy* 65 C 49
Sexual Concerns** 50 75 C
Sexual Preoccupation** 47 60 C
Sexual Distress** 49 49
TSCC Critical Items:
(See Items 20, 21, 50, 52)
Time 2: None Endorsed

Critical
Item

Elevated
Scores

Symptom
Change
Over Time

Chapter 2:
Using a Comprehensive Assessment Process to Create the Unique Client Picture

Chapter 2:
Using a Comprehensive Assessment Process to
Create the Unique Client Picture

After the center has created a system for administering and scoring assessment measures, the next step is to apply that system to the individual clients who are receiving services. The TAP model provides a structure and framework for understanding the child as a unique individual and for applying intervention techniques. The first component of the model is conducting a thorough assessment. This process includes telephone screening, the clinical interview, observation, and completing standardized assessment measures. Through the assessment process, clinicians formulate a Unique Client Picture and gain a multidimensional understanding of the child that guides and informs their intervention decisions.

Initial Screening and Referral

The first step in TAP is to identify any contraindications for a potential new client. Because TAP is trauma-focused, children who do not present with trauma-related treatment concerns are referred to more appropriate services. High-risk clients, or clients who pose an immediate threat to themselves or others, must be thoroughly assessed to determine whether they require a higher level of care than an outpatient trauma-focused treatment program offers. In this case, in addition to following established professional standards for high-risk clients, clinicians should refer to their state’s laws regarding suicidal and homicidal threat and the specific protective duties they may need to fulfill.

In other cases, it may be clear that a child would benefit from a specialized service that is outside of the scope of the center’s current treatment program. For these clients, a referral is appropriate, whether to an outside agency or, if available, to another program within the agency. In some circumstances, a child will benefit from specialized services at the same time as they receive trauma-treatment at the center. For example, a child who has to testify may benefit from a court preparation program in addition to trauma counseling services.

Figure 4 illustrates the triage process and provides examples of problems that
should trigger a referral to resources outside of the trauma treatment center.
Clients who are referred out may be able to re-enter the trauma assessment
pathway within the TAP model once they become stabilized and other issues are no
longer a barrier to trauma-focused treatment.

Figure 4: Initial Screening and Referral

Comprehensive Assessment Process

Conducting a comprehensive assessment is a process that involves gathering
information from multiple sources and integrating the information in order to
understand a child and his/her family. Forms and measures can guide clinicians,
helping them create a mental template about the kinds of information that they

want to know, but the information gathered will not be helpful unless it is integrated in some manner that helps them more effectively treat their clients.

Intake or demographic forms provide a structure for the clinical interview to help ensure that the clinician does not forget pertinent information relevant to these domains during the intake process. A sample demographic form (adapted from the NCTSN) is attached in Appendix C. This form includes sections on basic demographics, trauma history, development, symptoms and problems, mental health and psychiatric history, family, peers, etc. One key informant usually provides this information during an initial interview. Over time, the clinician continues to expand his/her knowledge of the child, relying on information from the child directly, from the caretaker, and from other individuals who interact with the child frequently.

The use of standardized assessment measures helps the clinician gather information about specific domains such as symptoms or family functioning from different reporters' perspectives more thoroughly and quickly than can usually be done in a clinical interview. Standardized measures also provide a different context in which a child and family member can respond. This is helpful because sometimes children or caretakers are not comfortable stating problems out loud, but they are willing to endorse items on a paper and pencil measure. For instance, a child who has sexual concerns may be hesitant to tell the clinician directly, but may be willing to check a box indicating that this is a problem. Similarly, a parent might feel shame for some of his/her child's behaviors, and be uncertain about how to bring up difficult problems with the clinician. When asked on a paper and pencil form, he/she may feel more at ease.

Forms and measures are necessary, but not sufficient for understanding a child. Listening to the child's story from his/her perspective and from the caretaker's perspective provides another important piece of information. It is important to understand how the client and family perceive the trauma and its effects from a

cultural perspective. Body language, affect, and choices about what he/she shares
and what he/she does not share provides input into how the child is coping, how
open he/she is to receiving help, and into the attributions he/she makes concerning
the traumatic experience. Watching the child and family members together
provides information on family roles, development, and attachment.

Conducting a Culturally Sensitive and Appropriate Assessment

Given the growing population of ethnic groups within the United States, it becomes
critically important to emphasize the importance of considering the cultural context
within which the family exists and adapting the assessment process with these
families accordingly (Carlson, 1997). Knowledge about cultural differences in
symptom presentation, nonverbal and verbal communication styles, and family
interaction patterns are essential to an accurate and culturally competent
assessment. For example, traumatic events that occur during the immigration
process will likely not be reported unless children are specifically asked about such
events during assessment (de Arellano, Danielson, Rheingold, & Bridges, 2006).

The following list includes some recommendations on conducting a culturally sensitive and appropriate trauma-informed assessment with ethnic populations (adapted from the Workgroup on Adapting Latino Services, 2008).

- Investigate the intended population. Dedicate some time to learn about the intended culture through a variety of resources. In order to know what clinical questions must be asked in a trauma assessment and how to ask such questions, a working understanding of the intended population is necessary (de Arellano & Danielson, 2008).
- Navigate new ways of delivering assessment services. Upon investigating the intended population, modifications should be made to the way the assessment is introduced and conducted to better accommodate individual's needs and characteristics. Often, this involves introducing the assessments in a sensitive manner, and navigating such obstacles as distrust of providers and language and logistical barriers.
- Further assess caregiver, extended family members, and other collateral sources. Consistent with the family-focused or group (vs. individualistic) orientation often ascribed to many ethnic cultures (e.g., Marín & Triandis, 1985), it is important to consider the potential value of collecting information from a broad range of informants (e.g., extended family, other members of the community).
- Organize background assessment to better accommodate the intended population. A careful assessment of relevant background information can provide a better understanding of the context in which the victimization or other traumatic event occurred. Areas for the background assessment typically include social, educational, legal, medical, and mental health history. Having a solid understanding of the family's culture can help guide interview questions about potential background events (e.g., frequent moves and changing living arrangements for recent immigrant families who must migrate often for employment).
- Recognize and broaden the range of traumatic events to be assessed. Questions in an assessment of traumatic experiences should be behaviorally specific in order to increase the validity of the assessment (Resnick, Kilpatrick,

Dansky, Saunders, & Best, 1993). In addition to commonly assessed traumatic events, a broad range of other traumatic events that occur more frequently within a particular population can be added, depending on the family's background. Some examples include:

- Political trauma (e.g., political violence among families from Chile [Allodi, 1980]).
- Immigration-related crime (e.g., human trafficking among Mexican and Central American immigrant women [Farley, 2003]).
- Natural disasters (e.g., hurricanes in Puerto Rico and other Latin American countries in the Caribbean).

• Incorporate the use of cultural measures into the assessment process. These include measures of acculturation and acculturative stress.

•

When conducting assessments with a translator, it is critical to define exactly what the clinician means. Specifically, for some clients, what a clinician may see as a traumatic experience may be viewed by the client as a "part of life." It is important for the clinician to clearly and concretely describe the events he/she is referring to in the assessment.

Interpreting Standardized Assessment Measures

Before client information can be interpreted, the clinician should fully understand the meaning of the scores on the measures being used. Psychometric properties will help the clinician identify limits to the information, and validity data will help him/her understand the meaning of the scores for his/her particular client.

Creating a "cheat sheet" for the measures can help facilitate an understanding of the scores. Worksheet 1 can assist the clinician in creating this "cheat sheet." It is only necessary to complete this worksheet once, since each standardized assessment measure selected should be entered in the table. Clinicians can then refer to the worksheet when they are interpreting the scores for their particular client. There may be circumstances in which the clinician must refer to the measurement's manual for interpretive information. For example, if the client belongs to an ethnic or socioeconomic group that is different from those for whom the test manual was created, the scores may have a different meaning. Clinicians need to take these issues into careful consideration when interpreting assessment results.

Worksheet 1: Clinician Worksheet-Making Sense of Standardized Measures

Clinician Worksheet
Making Sense of Standardized Measures

Step 1: What information are you getting from your measures? Does the measure
score clients in a consistent manner (reliability)?

1. Does the measure assess what it is meant to assess (validity)?
2. Refer to base rates from the manual.
In the general population, how many
children will have scores similar to the score your client received?
Step 2: Review assessment measures for endorsement of critical items (i.e.,
suicidal ideation, homicidal ideation, sexual reactivity, etc.) that might impact
child’s safety.

Step 3: Identify Clinically Elevated Scores
To identify which scores indicate distress, always refer to the manual. Some
general rules of thumb follow:

1. T-scores are typically considered elevated if they are at or above a score of 65
2. Some measures can be interpreted if you obtain a high or a low score. Make
sure you consider both when making interpretations.
Measure Cheat Sheet

Measure/Scale Name	Who Completes Measure?	Clinical Cutoff	Scale Meaning
SAMPLE: TSCC, Sexual Concerns Scale	Child, ages 8-16	T >=70	Reflects distress or conflict associated with sexual matters or experiences. High scorers generally involve sexual fears and unwanted or ego-dystonic sexual feelings and behaviors. Seems to especially increase in the presence of sexual abuse.
1.			
2.			

3.
4.
5.
6.
7.

Making Sense of Assessment Information

Integrating information can be a simple process when the assessment results and clinical observations support one another. Other times, integrating this information may be more challenging due to differences in the way reporters characterize the child's functioning, and because of the complexity of many children's traumatic experiences, histories, and presentations. The clinician is often charged with the task of identifying treatment goals when the caretaker and child disagree about the symptom presentation. When a clinician encounters inconsistent reports of problem areas for a child, they must draw upon other sources of information such as clinical interview, observation, and collaborating sources to determine which report most accurately reflects the child's current functioning. In some situations, safety, family dynamics, or personal boundaries are the primary concerns. However, in other situations, the child's symptoms are the primary treatment needs. When the clinician cannot decipher which report is more accurate, it is probably prudent to err on the side of caution. In general, maltreated children generally report fewer symptoms than their caregivers. When a caretaker denies problems that a child reports, it should be considered a red flag for the clinician to immediately address systemic needs.

Worksheet 2 provides an example of how one clinician made sense of information gathered from standardized measures, clinical interview, and observation. A blank copy of this form, Worksheet 3, is also provided and can be used by a clinician when completing a comprehensive client assessment.

Worksheet 2: Clinician Worksheet: Making Sense of Assessment Results, Sample

Clinician Worksheet
Making Sense of Assessment Results, Sample

Client Information (age, gender, and referring issue): 11-year-old female sexual
abuse victim

Information Source or Measure/Scale Name	Caretaker Information	Child Information
1. Clinical Interview	Caretaker denies problems	Child states she is afraid to share feelings with mother
2. TSCC, Sexual Concerns	N/A – child measure	T = 75 (clinically elevated)
3. TSCYC, Sexual Concerns	Not significant	N/A – caretaker measure
4. Family Assessment Measure – Communication	50, not significant	T = 80, problems with communication.

Identify Discrepancies:

Caretaker and child do not agree on sexual concerns elevations. Child reports
thinking about sex frequently and reports fears concerning sexuality. Child states
that she is afraid to share feelings with mother because her mother gets upset.
Mother does not recognize child’s concerns and does not feel there is a problem
with communication.

Other Considerations:

Parents moved to the United States from China 10 years ago. Mother learned
English in school. She believes that elders are to be respected and not questioned
and structure and tradition are central to her belief system. Sexuality is not openly
discussed in her culture.

Integrate Information (What do scores mean?):

Child is keeping concerns from mother to protect mother. Child is experiencing
sexual concerns, and family dynamics suggest problems with communication.
Within China, discussion of issues related to sexuality is not encouraged. For this
reason, it is not uncommon for children to refrain from discussing concerns around
issues related to sexuality with their parents.

Worksheet 3: Clinician Worksheet: Making Sense of Assessment Results, Blank
Clinician Worksheet
Making Sense of Assessment Results, Blank
Client Information (age, gender, and referring issue):

Information Source or
Measure/Scale Name
Caretaker Information Child Information
1.
2.
3.
4.
5.
6.
7.
8.

Identify Discrepancies:

Other Considerations:

Integrate Information (What do scores mean?):

Using Assesment Domains to Create the Unique Client Picture

Conducting a comprehensive assessment involves gathering information from multiple sources. Forms and measures can guide the clinician, but the information gathered will not be helpful unless it is integrated in some manner that helps him/her more effectively treat his/her client. Within TAP, the clinician uses the assessment process to formulate a Unique Client Picture: a multidimensional understanding of the child that guides and informs his/her intervention decisions.

Figure 5 presents a strategy for organizing information into domains in order to gain a Unique Client Picture. It includes four general domains to consider when assessing a child:

- Trauma History - What types of trauma has the child experienced? How complex were the trauma experiences? Has the child experienced multiple forms of trauma? Has the trauma been experienced on multiple occasions?
- Symptom Presentation - What symptoms are the child currently experiencing, and how severe are these symptoms?
- Relevant Contextual History - How does the child's environment support him/her or create additional stress for him/her? Specifically, how does the child's family, social support system, community, and cultural system influence him/her?
- Developmental History - How does the child's developmental level influence his/her reaction to his/her experiences, and the way that he/she will heal from traumatic experiences? How old is the child chronologically? How old is the child developmentally? Consider the child's attachment to important individuals in his/her life.

Figure 5: Unique Client Picture

Synthesizing Information and Generating Clinical Hypotheses

Once the Unique Client Picture is formed, the clinician's objective is to synthesize the information gathered thus far and generate clinical hypotheses. To help narrow the treatment focus, the clinician should review the primary areas of concern identified during the assessment process. Hypotheses about the primary causes of a child's problems are created by synthesizing all information regarding the child. A clinician should approach the task of generating clinical hypotheses by searching for patterns among the child's behaviors, reactions, and emotional responses. He/she should explore clinical questions with the child (if developmentally appropriate) and with his/her caretaker about the causes of these patterns.

As the clinician tries to make sense of this information, he/she should consider the
following questions:

1. Do any problematic behaviors/emotional responses appear to be associated
with specific times, places, events, noises, people, or other stimuli?
2. Is there a temporal pattern that can be identified?
3. Did problematic behaviors/emotional responses become more pronounced following one or more traumatic experiences?
4. Did problematic patterns develop during a specific developmental period?
5. Do problems appear to be associated with family or system dynamics?
6.
How are problems viewed by the client, family, and his/her community culture?
When forming hypotheses, the clinician should consider alternative explanations for
the problem he/she is identifying, and remember that hypotheses are not static.
They may change or evolve as the clinician gains a greater understanding of the
child. This process of forming a clinical hypothesis will identify which symptom area
is the most problematic for the child:

- Dysregulation of affect
- Maladaptive cognitions
- Behavioral problems
- Unresolved trauma
- System dynamics.

Targeting the identified area will have the most impact on the child’s healing.

It is important for the clinician to share the results of the assessments and his/her
clinical hypotheses with the child (if the child is old enough to understand) and with
his/her family. The client and his/her family will spend a great deal of time
completing the assessment measures and will likely be invested in understanding
the results. Providing feedback in an appropriate way is crucial to setting the tone
of therapy, opening the lines of communication about the treatment process and
treatment planning, as well as increasing child and family buy-in to treatment.

These results should be used to formulate treatment goals together. By setting goals together, the child and family can have a sense of ownership in the treatment process. This is also likely to increase motivation and reduce resistance, cancellations, and “no-show” appointments (Hawley & Weisz, 2005).

Developing Treatment Goals and Treatment Planning

After approximately three sessions, the clinician should have completed the assessment, and created the Unique Client Picture. The clinician should have also placed the primary concern(s) into domains, and developed hypotheses regarding the root cause of the child’s distress. The next step is for the clinician to work with the child and family to set effective and accurate treatment goals in order to guide

treatment. When setting treatment goals within this model, it is important to keep in mind that the treatment plan is two-tiered. The primary purpose of the treatment plan is to reduce symptoms and/or eliminate identified areas of concern, specifically the selected domains. The secondary objective is for the child to experience resolution related to the trauma or traumas that brought him/her into treatment. As part of this secondary process, the child and his/her family should acquire an understanding of the traumatic event, make links among cognitive attributions, behavior, and emotions, and gain skills in areas such as safety, socialization, and communication.

Worksheet 4 is a tool designed to help the clinician summarize the process of narrowing the clinical focus by:

- Identifying treatment domains
- Prioritizing concerns
- Hypothesizing about the root of the problem
- Making referrals
- Developing treatment goals.

This worksheet can be used whenever the client’s trauma-related difficulties (i.e., domains) are re-assessed in the course of treatment.

Worksheet 4: Synthesizing Information

Synthesizing Information - Worksheet

Step 1: Identify High-Risk Concerns.

a. Safety First b. Risk
•
Suicidal Ideation •
Drug/Alcohol Use
•
Homicidal Ideation •
Health Risk from Eating Disorder
•
Psychotic or Manic Episodes
•
Dissociation
Step 2: Select the Domain(s) that Identifies Areas of Concern for Your Client from
the List Below. Rank the 5 Most Concerning Areas from 1 to 5 with 1 Being the

Most Concerning Area for Your Client.

Mood Problems
___ Depressive Symptoms
___ Suicidal Ideation
___ Mood Fluctuations (Mania)
___ Other Mood Problems

Dissociative Problems
___ Severe
___ Mild to Moderate

Attachment Problems
___ Inhibited/Fails to Initiate and Respond___ Disinhibited/Lack of Selectivity

Systemic Problems
___ Parent-Child Interaction
___ Systemic Boundary Problems
___ Social Problems
___ Inconsistent/Absent Parent
___ Other Systemic Problems

Anxiety Problems
___ PTSD-Re-Experiencing
___ PTSD-Avoidance
___ PTSD-Increased Arousal
___ Generalized Anxiety
___ Phobia___ Other Anxiety Problems

Behavioral Problems
___ Self-Injurious (Cutting, Picking)
___ Eating Disorders
___ Resistant/Avoidant Behavior
___ Rule-Breaking/Delinquency
___ Sexually Related Behavior
___ Aggressive Problems
___ Other Behavioral Problems

Trauma-Specific Problems
___ Personal Boundary Problems
___ Sexual Concerns/Preoccupation
___ Experience of Trauma

Step 3: Formulate Clinical Hypothesis about Symptoms and the Cause of the Distress:

Step 4: Formulate Treatment Goals:

Chapter 3: Triaging Clients

Chapter 3:
Triaging Clients

At this point in the TAP process, the clinician should have a clear idea of the clinical focus and have identified any contraindications for treatment. In addition, the clinican should know more clearly if TAP is adequate to meet the child's needs, if more specialized referrals should be made, or if adjunct services will enhance the TAP treatment process for that client.

Generalized Triage: Center-Wide Triage Considerations

Based on the clinical focus of treatment, a referral to a specialized service may be indicated (see Figure 6). Referrals to specialized services are often merited based upon high-risk and immediate concerns. This referral process may involve internal agency services as well as the use of outside community resources depending on the center's scope of practice.

Figure 6: Additional Referrals

Individual Triage

There are many treatment models, with varying degrees of evidence, which are used by centers that treat child trauma or related issues. There are two steps the center should follow to research the most appropriate models:

1. Review Scope of Service. The center should review its Scope of Service worksheet (Exercise 1 in Chapter 1) that helped it identify the types of problems that the center is trying to resolve with its clients. This information will help the center limit and focus its review of the treatment models available to match its needs.
2. Identify Accessible and/or Appropriate Treatment Models that are Available in the Center or the Community to Treat the Clientele. There are many treatment models, with varying degrees of evidence, which are used by centers that treat child trauma or related issues. These resources may already be available in the center or the community, or the center may consider new treatment modalities that are not currently available in the community. It is also important to consider if there are any adaptations to the model that exist that might apply to the center's clientele. For instance, Parent-Child Interaction Therapy (PCIT; Eyberg, 1988) has been adapted for use with Latino and Native American Families. The following resources provide summary information about existing treatment models for problems commonly seen by child trauma victims:

1. National Child Traumatic Stress Network Fact Sheets for Empirically Supported Treatments and Promising Practices (http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom) - This website provides information on over 32 different promising practices, including TAP. Some of these have strong evidence that shows the practice provides benefit; others have an emerging body of support that they are beneficial. Links to additional resources are included within the fact sheets.

2. The California Evidence-Based Clearinghouse for Child Welfare (CEBC; www.cebc4cw.org) - This website provides information and reviews on a variety of different interventions used within the child welfare system and by their community partners. The interventions are rated based upon the amount of published, peer-reviewed evidence the practice has supporting its benefit. The database continues to grow, and includes treatments in over a two dozen different topic areas related to child welfare including domestic

violence victim and batterer programs, parent training, adult substance abuse treatment, and trauma treatment for children among others.
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3.
NREPP: SAMHSA’s National Registry of Evidence-Based Programs and Practices (www.nrepp.samhsa.gov) - This is a searchable database of interventions for the prevention and treatment of mental and substance use disorders.
4.
Blueprints for Violence Prevention (http://www.colorado.edu/cspv/blueprints/) - This website describes 11 prevention and intervention programs that meet a scientific standard of program effectiveness. These programs have been effective in reducing adolescent violent crime, aggression, delinquency, and substance abuse. The website also provides information on other programs that are viewed as promising practices.

Once the center has identified the interventions it will use or refer to, it should create two types of pathways: A Global Pathway and A Specific Pathway.

A Global Pathway: Overview of Multiple Interventions

This first pathway allows the center to see all of the options that are available at the center or in the community at a glance. This pathway can help the center decide which interventions should be considered in greater detail. Based on the sample pathway, centers can create their own global pathway that reflects the interventions available at their center or in their community.

Figure 7 includes a sample global pathway with options for some commonly used manualized evidence-based treatment protocols. The global pathway is organized according to the problem that is treated by the protocol and includes some global criteria for selecting the treatment. If a model looks like a possible treatment option to address the problem on the global pathway, the clinician should refer to the specific treatment pathway for more specific information. This sample global pathway includes:

- Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT2; Kolko & Swenson, 2002)
- Child-Parent Psychotherapy (CPP; Lieberman & Van Horn, 2005)
- Losing a Parent to Death in the Early Years Model (Lieberman, Compton, Van

Horn & Ippen, 2003)

- Parent-Child Interaction Therapy (PCIT; Eyberg, 1988)
- Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006)

2 Formerly referred to as “Abuse-Focused Cognitive-Behavioral Therapy”

Figure 7: Global Pathway

Specific Pathways for Each Intervention

During the next step of the process, specific pathways are created for each intervention to help the clinician assess in greater detail if this intervention is a good match for the client's needs. The decision about whether or not a specific evidence-based practice is appropriate for an individual child can sometimes be challenging. Appendices D through H contain more detailed pathways with criteria for triaging clients to the same practices shown in the Global Pathway. These are:

- Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)
- Child-Parent Psychotherapy (CPP)
- Losing A Parent to Death in the Early Years
- Parent-Child Interaction Therapy (PCIT)
- Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

These pathways are designed to provide a snapshot of some of the most commonly used manualized, evidence-based treatment protocols. This snapshot can help centers determine if they should consider implementing one or more of these treatment modalities at their center. It is important to review research on existing modalities on an ongoing basis (sources such as the CEBC will do this) and update triage trees accordingly. Many evidence-based or promising treatment modalities are continuing to gather research data to support their model, or are gathering data on various adaptations of their models that can be used with culturally diverse populations.

The clinician should remember that assessing the need for adjunct services should continue throughout the entire assessment process and, in fact, the entire course of treatment. For some children, the need for additional services may be determined later in the course of TAP treatment. For example, children who are scheduled to testify in court may benefit from a court preparation program, or during the course of treatment it may become clear that a child requires medication management or a more complete psychological evaluation in addition to trauma treatment.

Part II: Treating the Traumatized Child

Part II:
Treating the
Traumatized Child

Chapter 4:
The TAP Treatment Component
Chapter 4:
The TAP Treatment Component
Sometimes, following a thorough assessment and the creation of the Unique Client Picture, it will become clear that the child is not appropriate for any of the specific evidence-based practices outlined previously. In these cases, it is most appropriate to triage the child into the Treatment Component of the TAP model. The TAP Treatment Component is a versatile model that can be used with a variety of different populations to treat a variety of different problems. It incorporates the core components of good trauma treatment and helps clinicians work with children who have complex trauma histories. To use the TAP Treatment Component, a child must:

- Be between 2 and 18 years of age.
- Have experienced at least one traumatic event.
- Be experiencing behavioral or emotional problems as a result of traumatic events.

It is not appropriate to use the TAP Treatment Component if the child:

- Is not capable of engaging in the therapeutic process.
- Has high-risk suicidal ideation.
- Is actively psychotic.
- Has substance abuse as his/her primary problem.
- Has developmental delays which prevent him/her from interacting with a clinician.

The TAP Treatment Component may be especially helpful if the child has inconsistent caregivers, has experienced multiple changes in residence, comes from a diverse cultural background, or has experienced complex trauma - through either ongoing maltreatment or multiple different traumatic experiences. Just like the specific treatment pathways for the other treatment models mentioned in Chapter 3, the TAP Treatment Component specific treatment pathway assists clinicians in

the process of examining the inclusion criteria in greater detail. The Pathway for
Triage to TAP Treatment Component is contained in Appendix I.

Modalities of Treatment

The TAP model is designed for use with different modalities of treatment including
individual, group, and family therapy. The primary modality to be used is determined by the Unique Client Picture and the clinician’s hypotheses concerning
the root cause of the child’s distress. For many clients, a combination of treatment
types will best serve the needs of the child and their particular family system.

Individual Therapy

Individual therapy is usually important in trauma-focused treatment in that it helps the client address individual problems stemming from the trauma, and resolve emotions surrounding the traumatic experience. It is a component of most evidence-based treatment models, whether alone or in combination with other treatment modalities (Cohen et al., 2006; Kolko & Swenson, 2002). Several review studies have found that individual therapy alone is effective in helping children (Casey & Berman, 1985; Weisz, Weiss, Alicke, & Klotz, 1987). Kazdin (1991) demonstrated that individual psychotherapy surpasses changes that occur simply by the passage of time in the absence of treatment; Lanktree and Briere (1995) examined the outcome of abuse-focused treatment of sexually abused children and found that over a one-year period, the children participating in individual therapy sessions scored better on multiple measures than those not continuing in therapy.
Individual therapy may not be merited if the child is very young or if the primary problem involves system dynamics exclusively.

Family Involvement in Therapy

Trauma does not simply affect the child who experienced the trauma - it affects the entire family. Cook and colleagues (2003) assert that family involvement and support throughout treatment is crucial to the child's progress and overall outcome in therapy. They emphasize the importance of including the family in treatment to address trauma-related issues of other family members and to increase their ability to support the primary victim, whenever possible (Cohen & Mannarino, 1996, 1998; Browne & Finkelhor, 1986). Deblinger and Heflin (1996) found that children improve more when their caretakers are involved in treatment.

The level of family members' involvement in therapy will depend upon the Unique Client Picture. For a resilient child, conjoint sessions to help educate and communicate information to family members may be adequate. A caretaker may

meet with a traumatized child in therapy to enable them to process feelings about the trauma and to improve comfort in discussing difficult issues (Cohen et al., 2006). A more dysfunctional family might require family therapy to restructure boundaries or to improve communication patterns and family dynamics. In some cases, the abuse might involve family members, and the level of risk within the home will be an important factor in determining the extent of family involvement. It may be advantageous to see caretakers alone if they need help resolving their own issues that might interfere with their ability to be supportive of their child (Deblinger & Heflin, 1996). In other instances, teaching a caretaker parenting skills in an individual session will give him/her confidence in his/her ability to manage his/her child's behavior at home.

Family engagement must be done in a culturally competent manner. The level of stigma associated with trauma and mental health services in the client's family's culture must be taken into account. Stigma and other attitudinal barriers of family members will impede treatment unless dealt with appropriately from the outset.

Family support regarding the treatment process must be assessed. Family engagement may need to extend beyond the parents to other influential family members in the child's life (McCabe, 2002).

Group Therapy

Traumatic experiences often influence a child's social interaction with family and friends, leaving him/her feeling isolated, alone, and different than others. For these children, involvement in group therapy can be a powerful resource. There is significant evidence that group therapy combined with individual is helpful for victims of all types of trauma (Keyser, Seelaus & Kahn, 2000) in enhancing their coping and improving their overall outcomes. On an abuse-specific level, research has demonstrated that sexual abuse victims involved in both group therapy and individual therapy have better long-term coping and a greater reduction in their symptoms than those in individual therapy alone (Nolan, Carr, Fitzpatrick et al., 2002). Several studies suggest that group therapy works well with children and adolescent victims, as well as with adults who were victimized as children (Ellensweig-Tepper, 2000; McGain & McKinzey, 1995; Simmer-Dvonch, 1999; Westbury & Tutty, 1999; Nisbet Wallis, 2002). Socialization and peer confrontation are important considerations in deciding whether or not a child would benefit from group interventions (Goldstein, 1999). Some children may not be appropriate for group due to limited developmental and/or social levels of sophistication, and some may not be emotionally ready to process traumatic events in a group situation. In the latter case, the clinician may want to re-assess appropriateness for group treatment as the child progresses in therapy.

The Trauma Wheel

The Trauma Wheel is a central feature of the TAP Treatment Component. Most experts agree upon many of the core components of trauma treatment with children (Berliner, 2005; Lieberman, 2005), although clinicians and researchers may differ in their terminology and definitions. The Trauma Wheel in the TAP

model depicts these primary mechanisms of treatment (See Figure 8), and each aspect of the wheel is based in psychological theory. The foundation of the Trauma Wheel requires the application and awareness of developmental, relational, and cultural dynamics. The therapeutic relationship and understanding of relevant cultural issues are the tire and the rim that hold the wheel together and keep treatment moving forward. The spokes of the wheel, and required areas of treatment, include: psychoeducation and skill building, addressing maladaptive cognitions, affect regulation, trauma integration, and system dynamics. The child's developmental functioning is the driving force of the wheel and will determine how the client moves through the treatment spokes. This section includes brief definitions of the treatment components and implications for trauma treatment, as well as some suggested treatment tasks.

Figure 8: The Trauma Wheel

Child Development

Practical uses of the Trauma Wheel are driven by the child's developmental level, as understood through the Unique Client Picture. By understanding the child's intellectual, cognitive, and social levels of functioning, developmentally appropriate treatment plans can be formulated (Cross, Leavey, Mosley, White, & Andreas, 2004), improving the likelihood that interventions will be effective. A child with a learning deficit may have trouble learning new skills or integrating these skills into other areas in his/her life. In this case, a parent can be encouraged to become more actively involved in monitoring change in therapy. For another child, communication strategies can be adapted to ensure that information is communicated in ways that the child can comprehend. Simple phrases and words should be used with children who do not understand complex language. For some children, play therapy strategies can help the clinician communicate information metaphorically, without relying on words. This is true for young and

developmentally immature children, as well as for children who learn visually or tactically as opposed to verbally (Gardner, 1993).

When considering a child's developmental level, be aware that it may be impacted by his/her traumatic history. Research indicates that for children who have experienced a single trauma or multiple traumas, developmental progression is distorted and often arrested (Pynoos, Steinberg, & Wraith, 1995). Ford, Mahoney, and Russo (2004) and van der Kolk, Roth, Pelcovitz, Sunday, and Spinazzola (2005) suggest that a traumatized child's body redirects resources normally used for growth to survival. Thus, traumatized children are often seen as developmentally "stuck" and delayed in their maturity. Part of the trauma treatment process involves not only assessing the child's developmental level, but also helping the child move forward to a more age appropriate developmental stage.

Relationship Building

Researchers suggest that the therapeutic relationship is the key to a positive outcome in therapy (Shirk & Karver, 2003). Relationship building in the therapeutic environment creates a trusting connection between the client and the clinician that allows for safety and security so clinical work can take place (Hawley & Weisz, 2005). It is considered the "glue" of therapy. This is especially true in treating a child trauma victim, where trust has often been violated. In working with a child trauma victim, it is additionally important for the clinician to establish a strong relationship with the child's caretaker(s) regardless of whether he/she participates in therapy. Without buy-in and trust, the caretaker(s) will be less likely to bring his/her child to therapy regularly, resulting in inconsistent attendance at therapy sessions and lack of commitment to the therapy process (Shuman, 1998).

Cultural competence plays an important part in the relationship building process. The clinician must be able to communicate effectively with the child client and caretaker(s) and to have sufficient knowledge about the values and experiences of

the family’s cultural group (NASW, 2001). The clinician needs to convey acceptance, respect, and understanding of the client and his/her culture.

According to Herman (1992), creating new connections can help resolve trauma by reducing feelings of disconnectedness. The therapeutic relationship helps a child re-create a sense of trust, safety, security and control, in addition to re-establishing healthy boundaries and developing solid attachments (Herman, 1992; Lieberman & Van Horn, 2005). A child’s ability to attach and appropriately interact with others influences how he/she engages in therapy and in other areas of his/her life. For child trauma and maltreatment victims, attachment patterns are often disrupted because of the traumatic experience or poor relationships associated with the trauma (Lieberman & Van Horn). Various insecure attachment styles such as avoidant, ambivalent, and disorganized (Ainsworth, Blehar, Waters, & Wall, 1978) are found in maltreated children and in children exposed to multiple or complex traumas (APA, 2000; Cook et al., 2003). Reactive Attachment Disorder (APA) is

frequently seen in these children. These attachment patterns have a devastating and long-term effect on subsequent relationships. Children with disrupted attachment patterns may require more time establishing a therapeutic alliance.

Creating a safe environment in which the child and clinician can build a secure relationship is perhaps the most important aspect of treatment for traumatized children, especially for those with attachment problems (Lieberman, 2004).

Finally, relationship building helps a child re-establish trust in the "social contract." For many children who experience a traumatic event, the safe and nurturing world they once knew no longer exists. They may lose trust in the social systems and individuals that they once believed would keep them safe, a phenomenon known as a "violation of the social contract" (Pynoos et al., 1995). For instance, if a child calls 911 and the police do not respond in time, resulting in a traumatic death, the social contract has been violated and the child will no longer trust the 911 emergency response system. A goal of therapy with traumatized children is to help them re-establish the social contract through the therapeutic relationship (Pynoos et al., 1995). Some suggested treatment tasks for building a therapeutic relationship are presented in Table 3.

Table 3: Suggested Treatment Tasks for Relationship Building

Treatment Tasks for Relationship Building
The clinician should:
• Establish a working relationship with client (using unconditional positive regard, genuineness, empathic understanding)
• Establish a working relationship with caretaker (using unconditional positive regard, genuineness, empathic understanding)
• Develop trust, feelings of safety and security
• Help client develop sense of control
• Educate and model appropriate boundaries
• Address attachment needs and establish relationship that will enhance clinical work

- Develop cultural competence for all client populations served

Culture

Culture refers to “beliefs, attitudes, values and standards of behavior that are passed from one generation to the next” (Abney, 2002, p. 477). Cultural groups can include, but are not limited to, people identifying with various racial and ethnic groups, age groups, religious affiliations, and genders. Cultural groups can also include gay, lesbian, bisexual, and transgender groups (Hoban & Ward, 2003). Understanding the client from a cultural perspective and exploring how his/her culture, the family’s culture, and their level of acculturation impacts their perceptions of the world, is important to the therapeutic process (Fontes, 2005). A client’s cultural identity is dynamic, contextual, and may incorporate aspects from

his/her ancestors' ethnic cultures as well as the host culture in which he/she lives (Parra Cardona, 2004). Specifically, culture can influence how the client and family are impacted by trauma, how they understand the trauma, and how they perceive therapy and relate to the clinician. This is especially true for immigrant families, who transmit the immigration experience (which is often traumatic) across generations (Parra Cardona, 2004) and often have distrust of institutions (Family Violence Prevention Fund, 2005). Such intergenerational trauma affects a family's ability to cope with the child's trauma and the family's attitude toward treatment programs.

Culture may impact the development, presentation, and reporting of trauma-related symptoms (Cohen et al., 2006). For example, when something frightening occurs, some Latino children may believe that their soul leaves their body (APA, 2000; Cohen et al., 2006). They call this soul loss or "susto." Without an understanding of this potential cultural belief, attempts to help a child process some PTSD-related symptoms might be misguided. The core Latino value of familismo emphasizes the family as a close-knit support system, which is a strength but may also inhibit some Latino families from seeking help outside the family (Dingfelder, 2005). A culturally competent clinician is aware of these issues and engages the client and family from a strengths perspective. Such a clinician tailors his/her treatment approaches to fit the individual client and family and always maintains knowledge and respect for diverse cultures.

Because of the potentially significant impact of one's culture on his/her traumatic response, clinicians must be culturally aware and competent in treating children and families from diverse backgrounds. Cultural competency can be as basic as ensuring that the clinician can communicate with a client using words that are understandable to both individuals, and as sophisticated as learning about the client's perception of his/her cultural group and how it influences him/her as an

individual. If at any point a clinician feels unable to treat a child due to diversity-
related issues, it is important to seek supervision and/or make appropriate
referrals. Table 4 suggests some treatment tasks for cultural awareness and
competency.

Table 4: Suggested Treatment Tasks for Cultural Awareness and Competency

Treatment Tasks for Cultural Awareness and Competency
The clinician should:

- Assure language needs are met
- Determine and consider the client's values and spirituality needs
- Evaluate and consider the client's level of acculturation/cultural identity
- Understand the client's view of therapeutic process
- Modify communication style to meet the client's needs
- Assess differing meaning of therapeutic terms for different cultural groups
- Understand and consider the client's view of relationships and roles
- Assess intergenerational/cultural transmission of trauma
- Demonstrate knowledge of diverse cultures and seek to understand the client's experiences

Trauma Integration

Trauma integration is the process through which traumatic memories, thoughts, feelings, and behaviors related to the trauma are understood, accepted, and integrated within the client's view of himself/herself and the world around him/her (Cook et al, 2003). The concept of integrating trauma emerges from the literature on anxiety and posttraumatic stress disorder (DeBellis, Keshavan, & Shifflett, 2002; Cohen et al., 2006; van der Kolk, 2003). Trauma integration reduces anxiety related to the traumatic experience through gradual exposure (Abueg & Fairbank, 1992; Cohen et al.; Deblinger & Heflin, 1996). By gradually re-experiencing the traumatic incident, with the least stressful memories being explored first and the most frightening aspects of the trauma being explored later, the emotional charge related to the traumatic experience is reduced. One task that accomplishes this is the creation of a trauma narrative (Cohen et al., 2006). A trauma narrative is a type of systematic desensitization (Wolpe, 1958) wherein the child tells his/her

trauma story in a safe environment to help reduce anxiety related to the traumatic event. This narrative can then be shared with important individuals in the child's system (following preparation for the sharing) to help them integrate the traumatic experience as well (Cohen et al., 2006). Some researchers have expressed concern that this process of exposing a client to past trauma may increase the risk of retraumatization (Pine & Cohen, 2002). However, researchers using this technique have found this strategy to be effective and the children to be resilient through the process (Cohen et al., 2006). In addition to desensitizing emotions around the trauma, the process of trauma integration also helps the client make sense of the trauma experience. Several suggested treatment tasks for trauma integration are presented in Table 5.

Table 5: Suggested Treatment Tasks for Trauma Integration

Treatment Tasks for Trauma Integration
The clinician should help the client:
•
Tell the story of the trauma through various mediums
•
Integrate the traumatic experience into cognitive schema
•
Experience a full range of emotions associated with trauma experience and reminders of the trauma
•
Allow for corrective emotional re-working of the trauma
•
Reduce emotional charge related to the trauma
•
Process grief and loss associated with the trauma
•
Identify physical reactions to the traumatic experience and process

Affect Regulation

Affect regulation, also called emotional regulation, can be defined as the ability to tolerate and cope effectively with distress (Linehan, 1993). For some traumatized children, affect dysregulation (or the disruption of cognitive, affective, and behavioral processes) occurs because they have never learned appropriate self-regulation skills (Ford et al., 2004). This is most likely to occur when a child lacks an appropriate caregiver during the early years when he/she is forming attachments. The ability to regulate affect can also be disrupted when an individual experiences a trauma. From a biological standpoint, fear causes an automatic, rapid protective response enabling the individual to escape immediate danger. This is called the “fight or flight” response (Feldman, 2002). Researchers are now finding that these changes can be permanent (De Bellis, Baum, Birmaher et al., 1999). In practical terms, a child who is traumatized may experience physiological changes that he/she is unable to label or to understand. This can be quite distressing.

Children frequently have many emotions resulting from their traumatic experiences and often have difficulty making sense of their feelings, managing them, and

accepting them. This emotional confusion can remain specific to the traumatic incident, or more likely, may cross into other domains of the child's life. The clinician's task is to help the child improve affect regulation. This can be accomplished by helping the child identify and label his/her emotions, identify obstacles to changing emotions, reduce vulnerability to extreme emotions, increase frequency of positive emotions, and develop the ability to experience emotions without judging or rejecting experienced emotions (Linehan, 1993). The clinician must help the child learn to manage his/her feelings appropriately and regain a sense of emotional equilibrium. The ultimate goal is to help the child develop positive self-feelings and to accept and cope with troubling emotions regarding others.

Specific skills to increase affect regulation include distracting oneself, thinking about the pros and cons of a behavior, and learning to self-soothe through relaxation and deep breathing (Linehan, 1993). Several suggested treatment tasks for affect regulation are presented in Table 6.

Table 6: Suggested Treatment Tasks for Affect Regulation

Treatment Tasks for Affect Regulation
The clinician should help the client:
• Identify and label feelings
• Express feelings congruent with feelings he/she is identifying
• Experience and communicate feelings
• Learn to appropriately manage a range of emotions
• Develop positive self-feelings
• Resolve troubling emotions
• Integrate feelings

Addressing Maladaptive Cognitions

Cognitive treatment approaches help clients think more adaptively by changing the way they view the world and themselves (Feldman, 2002). Helping the child cognitively understand the connection among thoughts, feelings, and behaviors is an initial component of the cognitive treatment approach (Cohen et al., 2006). Research suggests that cognitive treatments are among the most effective interventions for a variety of mental disorders, including depression, anger, anxiety, and post-traumatic stress symptoms (Cohen & Mannarino, 1998; Craske, 1999; Jarrett et al., 1998). Clinicians utilizing a trauma-specific approach help clients identify the following: maladaptive cognitions (i.e., inaccurate cognitions or thinking errors) related to the traumatic experience, false beliefs about the traumatic event, and beliefs about the self and the world that have been altered because of a traumatic event (Resick & Schnicke, 1993). Examples of some of these beliefs are, “It’s my fault,” “I should have done something,” or “I could have saved her.”

Cognitions can also be true but “unhelpful” to the child (Cohen et al., 2006), such as “my mother must be so upset,” or “he must have been so scared.” By addressing maladaptive cognitions, the clinician can provide cognitive corrections, insight, and alterations of the cognitive schema created by the trauma experience (Briere, 1996; Cohen et al.; Resick & Schnicke). By changing his/her thoughts, the child can change feelings and behaviors as well.

A child’s developmental level becomes important once again when addressing maladaptive cognitions, because it guides how to provide cognitive-behavioral interventions. For example, a very young child will not have the developmental skills to process information cognitively (Piaget, 1970). For these children, clinicians can use trauma-focused play and other mediums to help the child work through his/her incorrect perceptions. The child’s cognitive ability and

understanding will also determine how much time to spend addressing cognitive distortions and attributions related to traumatic experiences, and the most appropriate mediums for processing cognitions. Suggestions for treatment tasks for treating maladaptive cognitions are presented in Table 7.

Table 7: Suggested Treatment Tasks for Treating Maladaptive Cognitions

Treatment Tasks for Treating Maladaptive Cognitions
The clinician should help the client:
• Identify thinking distortions
• Re-define attributions
• Identify linkage between thoughts, feelings, and behaviors
• Process guilt and self-blame
• Identify link between behaviors and personal experiences (includes triggers)
• Enhance understanding that client has control over choices – self-power
• Provide cognitive corrections when needed

Skill Building and Psychoeducation

Skill building and psychoeducation are integral parts of trauma treatment. Skill building allows children and their families to learn new, more adaptive skills and the therapy setting provides a safe place to practice those skills. Psychoeducation is the provision of education within the therapeutic environment. Children and their families enter treatment with a need to make sense of the trauma. By taking the time within therapy to share information, children and their families gain knowledge of issues related to trauma (Cohen et al., 2006). This process can validate and normalize the child’s experience of trauma. Through psychoeducation, caretakers and children learn what to expect during the course of treatment and why different types of trauma or abuse occur. They also learn about common reactions to trauma, boundaries, healthy relationships, and age-appropriate development. Psychoeducation is helpful in assisting caretakers to maintain a healthy environment for their children as well as guiding them in making age-appropriate

decisions for their children. Finally, by learning skills such as relaxation techniques, anger management, and social and safety skills, children and their families are better able to handle their environment and their reactions to trauma.

Like anything new, the effective use of newly acquired skills requires practice. To help ensure that children have the opportunity to practice these skills in a safe and supportive environment, caretakers (when available) also participate in some skill building. Parenting skills, such as behavioral management, setting boundaries, and positive discipline, are often a focus of caretaker skill-building activities. When parents implement general and/or trauma-specific parenting skills, children can feel understood and safe at home (Kazdin, Siegel, & Bass, 1992). Parallel involvement of parents in skill-building exercises allows children to smoothly transfer skills from the therapy sessions to their homes and extended environments.

When treating traumatized children, clinicians must identify behaviors that are no longer useful and help the children replace them with more appropriate and adaptive behaviors. Children react to trauma in a variety of different ways, either by turning inward or by acting out (Cook et al., 2003). Some children may become compulsive, rigid, and unable to deal with change while others may be quite impulsive and have difficulty planning and anticipating consequences. The NCTSN Complex Trauma Taskforce (Cook et al., 2003) suggests that these behaviors are actually defense mechanisms to help the child cope with the environment or trauma. At the time the trauma occurs, these behaviors are adaptive and serve the child well. However, if the behaviors remain following the trauma, they can become problematic. For example, if a young girl is beaten by her father when she leaves her room, she may become conditioned to stay in her room in order to avoid the violence. Realistically, this behavior may keep her safe when her father is violent; however, if she continues to stay in her room after the dangerous situation is removed (father is removed from the home), she may become increasingly isolated and develop problems in other areas of her life. Some suggested treatment tasks for skill building and psychoeducation are presented in Table 8.

Table 8: Suggested Treatment Tasks for Skill Building and Psychoeducation

Treatment Tasks for Skill Building and Psychoeducation
For Skill Building, the clinician should:
• Teach and reinforce behavior management techniques
• Develop safety plans
• Teach safety skills
• Teach coping skills
• Teach and enhance positive behaviors/social skills
• Teach relaxation techniques
• Teach and improve communication skills
For Psychoeducation, the clinician should:
• Educate on the dynamics of abuse

- Educate regarding healthy relationships
- Educate on age-appropriate developmental norms
- Educate regarding normal reactions

Systemic Dynamics

System dynamics refers to the many different “systems” in which the child lives. These can be the family (immediate and extended), the school, the community, and any other system in which the child belongs (McDermott, 2004). Minuchin (1974) suggested that the family is a structured group of subsystems with boundaries, while Satir (1983) stated that healthy families maintain open and reciprocal sharing of affection, feelings, and love. It is always in the child’s best interest to involve

non-offending (i.e., non-perpetrator) family members in some way. The amount of time spent addressing systemic issues depends largely upon the family's existing dynamics. Some family members are very willing to participate in treatment with their child, whereas other family members want their child to "be fixed," but are unwilling to make changes themselves. Cook and colleagues assert that the caretaker's involvement is crucial to the child's recovery. At times, the involvement includes joint sessions used for sharing thoughts, feelings, and the trauma narrative (Cohen et al., 2006). At other times, the family will be involved in a more traditional family therapy venue (Lieberman & Van Horn, 2005; Minuchin, 1974).

Issues such as believing the child, tolerating and managing the child's reactions, and establishing a safe environment and clear familial boundaries are common functions of family systems therapy that arise following a traumatic event.

Some children have difficulty making progress in treatment without complementary changes being made in the family system. The child's developmental level will determine how the clinician addresses systemic dynamics when family members are not available. However, if a child is in foster care or the family is unavailable for treatment, family system concerns may be addressed with the child in individual and/or group therapy in order to promote the child's understanding of appropriate and healthy relationships, power distribution, physical and emotional boundaries, and roles.

Research on resiliency, or the ability to adapt in the face of challenges and adversity, emphasizes the importance of children having environmental supports and opportunities. These supports can come from family, school, or the community. Whenever possible, consider involving a child's school system (i.e., teachers and social workers) in his/her treatment. Teachers and peers interact with children in a different context than the family, and often face other challenges (Achenbach & Rescorla, 2001). Many children act out in school or withdraw as a

result of traumatic experiences (Kendall-Tackett, Williams, & Finkelhor, 1993). These traumatic reactions might be misinterpreted as inappropriate conduct or ADHD (Weinstein, Staffelbach & Biaggio, 2000). School personnel who are involved in the child's treatment may be able to provide opportunities for the child to succeed and build new resources to help the child cope with the day-to-day stressors faced at school.

Within the community, religious organizations, cultural groups, and community centers can all provide support and structure to traumatized children. Social contacts, mentor programs, sports activities, and creative outlets are often available through these organizations (Benard, 2005). Some suggested treatment tasks for treating system dynamics are presented in Table 9.

Table 9: Suggested Treatment Tasks for Treating Systemic Dynamics

Treatment Tasks for Treating Systemic Dynamics
For the Family, the clinician should:
•
Share trauma integration with appropriate system people, as needed
•
Assure that the caretaker has necessary resources
•
Help the caretaker develop parenting skills
•
Help the caretaker implement and maintain appropriate boundaries as they work with other systems
•
Improve the caretaker’s communication skills and understanding of the developmental and emotional needs of the child
For the School and Community, the clinician should:
•
Communicate with school (i.e., teachers, counselors)
•
Gain support of appropriate community resources
For the Client, the clinician should:
•
Educate the client about availability and use of community resources
•
Work with the client to help him/her re-gain faith in the community and address areas where the client might feel betrayed or lack trust due to the
traumatic incident or events following it.

Chapter 5: Using the Trauma Wheel via a Treatment Pathway

Chapter 5:
Using the Trauma Wheel via a Treatment
Pathway

The Trauma Wheel identifies core components and tasks of trauma treatment. The tasks under each spoke of the wheel are addressed during the course of treatment. The child's Unique Client Picture will determine the order of the specific tasks, and the depth in which they are addressed. There is consensus in the literature that treatment should be phase-based or sequential in nature. Earlier phases provide information that is built upon later in treatment. Phase-based treatment will also prevent children from feeling overwhelmed or "over-loaded" with information that they may not be developmentally capable of processing (Cook et al., 2003).

NCTSN experts specify that this phase-based process is not linear, and that "it is often necessary to revisit earlier phases of treatment in order to remain on the overall trajectory" (Cook et al, p.29). Similarly, in the current model, as the clinician works through each segment of the wheel, the child will build upon skills learned in previous segments.

The TAP Treatment Clinical Pathway (Figure 9) is designed to help connect symptom presentation and the root of each problem to the treatment components identified in the Trauma Wheel. Beginning at the top of the pathway and moving outside the wheel, the clinician links his/her hypotheses and understanding of the child to treatment components inside the wheel.

Figure 9: The TAP Treatment Clinical Pathway

As demonstrated on the wheel, safety and high-risk issues identified in the assessment process must be addressed first. Once the child is stable and safe, the treatment pathway continues with a series of five primary questions. These questions hone in on various sources of distress that could be tied to the child's symptom presentation. Because the five components of trauma treatment apply to all trauma cases, each of these questions will be asked with every client. The treatment pathway provides an organizational structure for doing so. For instance, the clinician would ask the question, "Is dysregulation of affect the primary cause of the child's distress?" If the answer is yes, he/she would begin by focusing on the treatment tasks related to affect regulation. The clinician would continue moving around the wheel to determine if other aspects relate to a client's problems. As causes of distress are identified, the specific spokes that correspond with those causes of distress direct the treatment process. Depending on the answers to the questions, the color-coding of the wheel helps direct the clinician to the appropriate

treatment tasks in the center of the Trauma Wheel. For example, if safety and risk concerns are identified, the clinician would focus on treatment tasks under system dynamics (blue) and psychoeducation and skill building (green). It is possible the clinician would work on multiple areas of the wheel simultaneously, or that he/she would return to previously covered areas of the wheel as new tasks and problems arise. The clinician should be mindful that the work he/she does will build upon skills that have been established through previous clinical work. During the course of treatment, each aspect of the Trauma Wheel will be addressed.

The general assumptions underlying each primary question in the treatment pathway and their link to the Trauma Wheel components are discussed below.

Safety and High-Risk Concerns

Any issue a clinician determines to be high-risk, that might pose a direct threat to a child's safety, should be a priority in the treatment pathway. However, dangerously high-risk issues such as suicidal intent, homicidal intent, or violence in the home should have already been identified during the assessment and/or triage phases and treated accordingly. If any of these high-risk issues become evident during the development of treatment strategies, the triaging process should be revisited. At this stage, examples of high-risk concerns include: cutting on oneself, eating disorders, manic or psychotic episodes that have been evaluated but do not warrant hospitalization, and dissociative states. In cases such as these, treatment begins by educating the child and/or family, teaching coping skills or modifying behaviors as needed, and assuring external support from others to minimize risk of harm. In the model, this would entail moving within the Psychoeducation and Skill Building and Systemic Dynamics spokes of the Trauma Wheel (see Treatment Tasks on pages 51 and 53).

The current model assumes that children should not be expected to resolve high-risk issues independently. All children with safety and risk issues who have family

available will benefit from family or caretaker involvement in order to ensure that such concerns are addressed and that the child is in a protective environment. With young children, because of their lack of maturity and developmental capacity (Feldman, 2002), it is the responsibility of the surrounding adult system to care for and protect them. With adolescents who are attempting to individuate and become more independent, greater focus should be placed upon self-protection and care, and less on the caretaker's responsibility to intervene. Adolescents are developmentally able to understand, learn, and apply appropriate coping skills, and are able to integrate these new skills into their daily lives. Regardless of age, if a child is unable to keep himself/herself safe, his/her caretaker(s) must be involved in the child's treatment in order to ensure his/her safety.

Identifying Primary Concerns through Assessment

After the safety and high-risk issues are addressed, it is recommended that the clinician identify the area of primary distress based on the results of the assessment. There are potentially five areas of primary distress: affect regulation, maladaptive cognitions, problematic behaviors, disruptions in the family system, and unresolved trauma. This section will help the clinician ascertain which of these areas is the primary cause of distress and is the appropriate starting point in treatment.

Affect Regulation

Dysregulation of affect is identified as the primary concern when the child has difficulty identifying, coping, and managing feelings in a healthy, productive, and appropriate manner (Cook et al., 2003). The child may be unable to inhibit inappropriate behaviors in response to positive or negative affect, have difficulty using self-soothing techniques, and be unable to focus and organize emotions in order to cope with feelings (Katz & Gottman, 1991). Layne, Saltzman, Pynoos, and Steinberg (2002) suggest that to decrease the intensity and intrusiveness of emotions, feelings must be processed by identifying, experiencing, and expressing those emotions in a safe environment. This allows for the resolution of negative feelings associated with an event(s). It may be that these feelings, when left unresolved, underlie the child's current affect dysregulation. For some children, the difficulty in regulating affect stems from an inability to express any specific feeling within a range of emotions. (Damasio, 1998). For these children, the goal of regulating affect will be to widen their emotional repertoire.

When the client has difficulty regulating affect, follow the treatment tasks suggested in the Affect Regulation spoke of the Trauma Wheel on page 49. Cohen et al., (2006) suggest that feeling identification is typically a safe starting point with children. The clinician is able to assess the child's verbal and emotional ability to

accurately identify and express a range of emotions, while building rapport with the
child, and increasing his/her sense of safety and ability to trust. As trust develops,
the child will be able to share the full range of emotions experienced at the time of
the traumatic event. The assumptions of affect regulation in trauma treatment
include the following:

a) Successful resolution of a trauma involves an emotional processing of the

experience.

b) Behaviors are associated with underlying feelings and impact future behavior

and social relationships (Garber & Dodge, 1991).

c) Symptoms are associated with underlying experiences and related feelings.

d) There is a need to validate, understand, and experience feelings before

resolution can occur.

Maladaptive Cognitions

Maladaptive cognitions, also known as cognitive distortions, are identified as the primary concern when the child makes thinking errors (“inaccurate cognitions”) or exhibits thought patterns that may be accurate or inaccurate, but are unhelpful to the child (Cohen et al., 2006). These cognitive distortions can be corrected by helping the child understand that thoughts, feelings, and behaviors are related, and that by changing his/her thoughts he/she can change his/her feelings and behaviors (Cohen et al.). The connection between thoughts, feelings, and behaviors is known as the cognitive triangle (Feldman, 2002).

Figure 10: The Cognitive Triangle

Feelings

Behaviors Thoughts

Following a traumatic event, many children experience maladaptive cognitions surrounding the trauma and their responsibility and role in the traumatic experience. When the client is experiencing difficulty with maladaptive cognitions and thinking errors; is unable to make the connections between thoughts, feelings, and behaviors; or does not understand the link between the trauma and his/her level of distress, follow the treatment pathway to the Addressing Maladaptive Cognitions spoke of the Trauma Wheel, and the associated treatment tasks on page

50. The following assumptions guide cognitive treatment techniques in trauma treatment:

a) Successful resolution of a trauma involves a cognitive reprocessing of the

experience.

b) Maladaptive thoughts about an experience prohibit resolution of that

experience and may sustain the trauma related symptoms.

c) Thinking errors occur with limited awareness and information.

d) When inaccurate or maladaptive attributions are challenged and replaced

with accurate and beneficial thoughts, the child’s feelings and behaviors can

become more positive and adaptive (Deblinger & Heflin, 1996).

Finkelhor and Berliner (1995) emphasize the importance of addressing maladaptive attributions of responsibility for the trauma. Correction of these misattributions can repair or prevent the development of adverse psychological responses.

Problematic Behaviors

Behavior problems are identified as the child's primary concern for treatment when the child's behavior problems overshadow other treatment issues, and prevent a client and his/her family from focusing on other treatment issues. The American Psychiatric Association (2000) in the DSM-IV-TR describes behavior problems as recurrent patterns of negative, defiant, disobedient, and hostile behavior toward authority figures. Such behaviors can include temper tantrums, arguing with adults, actively defying requests, refusing to follow rules, deliberately annoying other people, blaming others for one's own mistakes or misbehavior, being touchy, easily annoyed, easily angered, resentful, or vindictive. Other behavioral problems may be more risky and can include avoidant behaviors, sexual reactivity or sexual acting out behavior, stealing, cutting, or any other self-destructive behaviors.

If the client displays maladaptive behaviors or if behaviors are the cause of the client's or the family's distress, the treatment pathway directs the clinician to the Systemic Dynamics and Psychoeducation and Skill Building spokes of the Trauma Wheel (see Treatment Tasks on pages 51 and 53). It is assumed that when a child exhibits unmanageable behavior problems, the child and the child's family lack the skills to effectively cope with child's behavioral problems. In this case, an increase in information and skills will serve to normalize the child's experience. Because behavioral problems are frequently reactions to trauma, children can be educated about the link between their behaviors and their traumatic experience. Caretakers can be taught skills to help manage children's behavior, including behavioral management charts or techniques for implementing time outs effectively. For this

reason, when behavior problems are the primary cause of distress, treatment
focuses on family dynamics, skill building, and psychoeducation.

Family System or Other System Dysruption

The family system (or other system influencing the child) is identified as the
primary concern for treatment of the child when there are significant problems in
roles, boundaries, and/or relationships that are influencing the child's ability to heal
from the traumatic experience. Because of the trauma, the system has lost its
internal balance of roles, positions, and relationships that maintain the system's
homeostasis.

When family problems or other problems involving important individuals in the
child's community or school are the central focus of treatment, the treatment
pathway directs the clinician to the treatment tasks under the Systemic Dynamics
spokes of the Trauma Wheel on page 53.

Several assumptions guide the clinician treating the family system of a traumatized child:

a) The child requires a family system to keep him/her safe and to provide support and nurturance throughout trauma treatment (Cook et al., 2003).

b) Including a caretaker(s) in treatment reinforces the child's improved or newly-learned coping skills and behaviors.

c) The caretaker(s) and other significant individuals in a child's life can help challenge inaccurate cognitive attributions about responsibility regarding the trauma (Cohen et al., 2006; Cook et al.)

d) The behavior of any family member greatly influences the behaviors of other family members (Minuchin, 1974).

e) Addressing systemic dynamics can change an unhealthy system into a more effective system that better meets the needs of its members.

Unfortunately, many children have been victimized by their own family members or other individuals known to them. Whether it is a member of the nuclear family, a close relative, or a known person in the community, the system that is responsible for protecting the child has failed (Cook et al., 2003). The clinician has the task of helping the family regain its equilibrium. This can occur through changing maladaptive roles (i.e., problem or parentified child), changing problematic behaviors (i.e., attention-seeking, neglectful, or abusive), altering the distribution of power within the family, improving communication patterns, and/or solidifying healthy and supportive relationships within the family. In these ways, the clinician can help the family create an adaptive, supportive, and healthy system that can support the child in his/her recovery from the trauma (Barrett & Trepper, 2002).

In some cases, the traumatic incident or events following the traumatic incident may have involved perceived failures on the part of community agencies such as police, school personnel, emergency workers, or the courts. Children of different cultural groups, especially children of immigrants, may have learned to mistrust and/or fear authorities prior to the trauma. If the child perceives that agencies failed to protect him, he will experience a loss of faith and trust in the system (Pynoos et al., 1995) or confirmation that the system cannot be trusted. In cases such as this, the clinician will work with the client to re-gain faith or trust in the community, and with the system to support and protect the child.

Unresolved Trauma

The traumatic experience is identified as the primary concern for treatment when unresolved issues related to the traumatic experience are impairing the child's ability to function appropriately and causing problematic symptoms for the child. In practical terms, the child might experience feelings, thoughts, and behaviors associated with the traumatic experience that have not been identified, processed, and/or understood by the child and family. Briere's (1996) Self-Trauma Model explains how the child is impacted by stating "…the relative failure of internal capacities to resolve overwhelming trauma produces a psychological imbalance that, in turn, triggers intrusive posttraumatic responses such as flashbacks,

nightmares, and other re-experiencing phenomena" (p. 141). The Self-Trauma Model proposes that these posttraumatic responses are not pathological, but rather, adaptive responses to reduce the "internal impact of the trauma." Although they serve an adaptive purpose, these responses to the trauma can impede the child's development (Briere, 1996; Cicchetti, Toth, & Maughan, 2000), hinder the child's struggles to organize his/her feelings internally, impair the child's ability to regulate affect, and reduce his/her ability to maintain appropriate boundaries and relationships (Linehan, 1993).

Helping the child integrate the trauma is accomplished through the creation of a trauma narrative or detailed recounting of the trauma. This therapeutic task is based upon the following assumptions:

a) Creating a trauma narrative helps change cognitive misattributions and

decreases the intensity of reminders and negative emotions such as terror,

horror, extreme helplessness, and rage (Cohen et al., 2006)

b) Exposure to traumatic details and related feelings (i.e., anxiety and fear)

allows the child to gain a greater sense of control, learn new coping skills,

and gain an understanding of the traumatic event and his/her own reactions

to the trauma (Blanchard & Hickling, 2004; Layne et al., 2002).

c) Making sense of the trauma allows the child and his/her family to have a

more positive view of themselves, their future, and the community in which

they live. Trauma integration promotes resiliency and integration into the

social network (Cook et al., 2003).

The Trauma Integration spoke of the Trauma Wheel identifies treatment tasks related to trauma resolution (see page 47). Every client seeking treatment for a

traumatic experience must spend enough time processing and integrating the traumatic experience in order to resolve the thoughts, feelings, and behaviors associated with the trauma. The Unique Client Picture and the client's existing coping skills determine when the clinician addresses the issues associated with this spoke of the Trauma Wheel. For example, some traumatized children have very few adaptive coping mechanisms and may have difficulty talking about the traumatic experience. These children require treatment via other spokes such as Psychoeducation and Skill Building (see page 51) or may need additional time building a therapeutic relationship before attempting to integrate the traumatic experience. However, other children who have excellent coping skills and supportive family members are better equipped to handle talking and integrating the traumatic experience and are more likely to enter this spoke earlier than children who are having additional difficulties as a result of the traumatic experience.

Asymptomatic Clients

One of the most challenging situations is when the family presents for treatment because a trauma has occurred, but neither the child nor the caretaker reports behavioral problems or other concerns. This is a fairly common phenomenon. In

fact, depending on the measure and the reporters, anywhere between 20% and 49% of different trauma populations show no behavioral or psychological problems prior to starting treatment (Taylor, 2002). This has been extensively researched in the sexual abuse literature (Conte & Schuerman, 1987a; Conte & Schuerman, 1987b; Finkelhor & Berliner, 1995; Kendall-Tackett et al., 1993; Taylor). Possible explanations noted in the literature to explain the absence of behavioral or psychological problems include insensitivity of the psychometric measures, sleeper effects (i.e., symptoms may not appear until the child reaches a certain developmental level), defense mechanisms, the child's experience of the intensity of the trauma, and the psychological health of the child (Kendall-Tackett et al.). In these instances, observation, and clinical judgment play a crucial role in helping the clinician determine the primary treatment concern.

If it is determined that the child is truly "asymptomatic" and he/she has a supportive family and strong coping skills, treatment will be briefer and will focus on psychoeducation, safety planning, and trauma integration. If, however, there is clinical evidence that despite the overt denial of problems, the child is experiencing some dissociation, avoidance behaviors, or other problems, then the child and/or the family are likely avoiding or denying feelings, thoughts, or situations associated with the trauma. Depending on the cause of the avoidance behaviors, treatment will focus more on the hypothesized cause of the asymptomatic presentation. In this case, address avoidant behavior, build coping resources, reduce dissociation, and build up the child's support system to allow him/her the resources to face the traumatic experience.

Chapter 6:
Monitoring Progress in Treatment
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Monitoring Progress in Treatment
To assure that each stage of treatment reflects the unique needs of the client, assessment must be an ongoing process. This occurs through in-session evaluation, periodic re-administration of measures, and supervision.

Ongoing Assessment

The TAP model uses a series of pathways to direct assessment, triage, and intervention. To assure that each stage of treatment reflects the unique needs of the client, assessment must be an ongoing process. This occurs in a number of ways. Clinical interview questions and observations are incorporated into each session with a child or the child’s caretaker(s). Additionally, standardized measures are periodically re-administered. By continuing to gathering information, the clinician is able to respond to changing client needs by updating the working clinical hypotheses, redirecting the course of treatment, and monitoring progress in treatment. Newly identified issues prompt the clinician to ask, “Is the working premise accurate?” The response will either strengthen the existing clinical hypotheses or lead to modified hypotheses.

If the Unique Client Picture changes as the client progresses in treatment, goals may be altered or added. A change in the source of symptom distress and/or the primary treatment concern may require a different treatment pathway. New safety and/or risk concerns should always be a priority and addressed immediately upon presentation. While not all new information will change the Unique Client Picture, the primary treatment focus may be altered for a limited time.

Periodic Re-administration of Standardized Measures

Periodic re-administration of standardized measures ensures that the client’s progress is being monitored during treatment, and that no emerging problems are overlooked as the clinician focuses on existing treatment tasks. Researchers recommend re-assessing clients every three months, although some centers find

the short turn-around time to be difficult pragmatically and therefore select longer
assessment intervals. The re-assessment process allows changes to be incorporated into treatment planning and ensures that the clinician is selecting
appropriate clinical interventions (Gothard et al., 2000). To track changes
appropriately, it is important for the same measures to be administered at each
time period and for the same reporter to complete the measures, if at all possible.

Although symptom reduction is the ultimate goal, at times, clinicians will note an
increase in certain symptoms in the follow-up assessments. For example, Gomes-

Schwartz, Horowitz, Cardarelli, and Sauzier (1990) found that 18 months into treatment with sexually abused children, fighting with siblings and parents increased. Similarly, Lanktree and Briere (1995) found a marginally significant increase in anger at one year and a significant increase in sexual concerns after nine months in sexual abuse treatment. Some researchers have found that these symptoms increase and then decline over the course of therapy. Finkelhor and Berliner (1995) refer to this as a “reverse-sleeper effect,” or “deterioration that is a sign of later improvement” (p. 1417). This is especially common with sexual concerns, which tend to increase when the clinician is working with the client on the trauma narrative, and with anger, which increases as the child becomes more in touch with his/her feelings and is better able to express them. Clients who are not displaying clinical improvement on the assessment measures, or whose symptoms are increasing, may require modified working hypotheses and/or clinical interventions.

Regardless of whether the scores increase or decrease, the assessment results provide concrete feedback to the clinician to re-evaluate the working hypotheses. The information helps determine the treatment pathway and assists the clinician in identifying which tasks on the Trauma Wheel need additional work. Re-assessment periods present a good opportunity for clinicians to re-evaluate whether a client would benefit from different treatment modalities, such as family or group therapy, or if an assessment for medication, psychiatric consultation or psychological testing is warranted.

Assessment of Client Progress and Readiness for Termination

The assessment and reassessment process continues until it is determined that the client is ready for termination from treatment. Readiness is based upon clinical observation, information gathered in therapy and interviews, and reduction in symptom levels on the assessment measures. Other indicators of readiness to

terminate treatment include completion of all components of the Trauma Wheel,
and achievement of all the treatment goals. The clinician should conduct a final
standardized assessment battery prior to termination in order to validate clinical
impressions and to provide the family with concrete feedback about progress in
treatment and post-treatment recommendations. If all sources of information
suggest that the client is ready to end treatment, then termination should be
discussed with the client and his/her family. Proper steps that will facilitate a
positive termination process include talking about the therapeutic relationship, revisiting
the information learned during treatment, discussing the progress made by
the client, and being able to say “good-bye.”

Clinical Supervision

Regardless of the experience level of the clinician, supervision is an important component of work with cases involving child trauma. Just as the relationship between the client and clinician forms the glue that allows the clinical work to take place, the relationship between the clinician and supervisor creates a safe environment in which a clinician can discuss the complexities and the intricacies of these difficult cases, track treatment progress, and process counter-transference issues. According to the Mental Health Care Task Force for Child Crime Victims (Winterstein & Scribner, 2001), these cases are often highly charged and "…this can cause problems for clinicians who are susceptible to splitting, or parallel process, rescuing, collusion, and other dysfunctional behaviors. Clinicians working with child trauma cases must understand the dangers of unhealthy interactions with family members involved in these cases" (p. 5). The use of peer-review processes and/or supervision protects clinicians from what could be negative outcomes of counter-transference feelings (Gillies, 2001). In addition, when supervision and/or peer review occurs, there is increased certainty that the clinical work will remain on task as defined by treatment goals.

Supervision also can be used to ensure the accurate implementation of the TAP model. In order to simplify this process, the manual includes a Supervision Log to help clinicians and supervisors review the significant components of the model (See Worksheet 5). The Supervision Log should be used while training on and implementing the TAP model. Once clinicians are trained on the TAP model, they might consider using the Supervision Log with each client on a monthly basis, with randomly selected clients as a self-auditing technique, or with case presentations during a group supervision process. The Supervision Log is divided into six sections:

1. Assessment
2. Unique Client Picture
3. Narrowing the Clinical Focus

4. Establishing Treatment Goals and Treatment Plan
5. Treating the Child
6. Reassessment

Each of these areas should be addressed in supervision. The use of best practice treatments, triage to specialty services, change of treatment modalities, and movement within the Trauma Wheel are also highly recommended as discussion topics in the supervision process.

Worksheet 5: Supervision Log
Supervision Log

Supervisor: _____ Date: _____
Clinician: _____ Case: _____

Step I: Assessment

Relevant History:
_____

_____
_____
Use of assessment pathway evident? YES .. NO ..
Elevated Scores on Standardized Measures:
_____
_____
_____
Step II: Unique Client Picture:

Integration of Information:
_____

_____
_____
Hypothesis developed:
_____
_____
_____
Step III: Narrowing the clinical Focus (use worksheet)

Selected symptom
domains:_____

(Mood, Anxiety, Dissociative, Behavioral, Attachment, Systemic, Trauma Specific, other)
Concerns Prioritized: Safety .. Risk ..
Triage and referral occurred as appropriate: YES ..NO ..
What is the Primary Question (or root of the problem) currently being addressed?
_____
_____
Step IV: Establishing treatment goals and treatment plan

Do goals reflect reduction of symptoms? YES .. NO ..
Do goals address an increase in skills and knowledge? YES .. NO ..
Are goals linked to TAP Treatment interventions? YES .. NO ..
Step V: Treating the child

Use of Treatment Pathway evident: YES ..NO ..
Are Components of the Trauma Wheel being used in treatment: YES ..NO ..
Which have been used:
_____

Which components of the wheel remain to be treated:
_____
_____
_____
Relationship issues evident: (Transference and Counter-transference discussed)? YES ..NO ..
Step VI: Reassessment

Are there changes in pathway and treatment direction? YES .. NO ..
Based on: Weekly interviews/Observation: YES .. NO .. Follow-up measures: YES .. NO ..
Is there a change in treatment modality? YES .. NO .. If yes, what modality_____
_____
_____
Referral made to specialized services or triaged out of TAP? YES .. NO ..
If yes, where?
_____
_____
Is this evident in Progress Notes? YES .. NO ..

Chapter 7:
Conclusion

Chapter 7:
Conclusion

The TAP model has been created with the overall goal of providing the best possible services available to traumatized children. Three mission statements have served as comprehensive guides to us in this process:

1. The mission statement of Rady Children's Hospital: "To restore, sustain, and enhance the health and developmental potential of children through excellence in care, research, and advocacy."
2. The mission statement of the Chadwick Center for Children and Families: "We will promote the health and well-being of abused and traumatized children and their families. We will accomplish this through excellence and leadership in evaluation, treatment, prevention, education, advocacy, and research."

3. The mission statement of the National Child Traumatic Stress Network "To raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States." (NCTSN, 2010)

While these statements serve as overarching global goals, transforming them into reality requires a more concrete step-by-step action plan. Having the best possible services available for the individual, vulnerable child victim, and family, who presents at the Chadwick Center's offices is a more obtainable goal. This manual provides a step-by-step guide to offering services that will have outcomes that can be measured through the use of standardized assessment tools.

The TAP model combines assessment-based treatment, the creation of a Unique Client Picture, development of a unifying clinical hypothesis, formation of treatment goals, the use of the Trauma Wheel in guiding the treatment progression, reassessment, and termination in a structured logarithm or "pathway," within which there is substantial room for choice of treatment interventions. TAP emphasizes the importance of flexibility, clinical judgment, and individual client need in determining the most appropriate treatment pathway for a traumatized child. The model's adaptability also allows for change in the treatment course when warranted by events in the client's life.

The TAP model consolidates several primary tenets in providing therapy to traumatized children. First and foremost, the solid foundation of the TAP model is
its assessment base. The Chadwick Center Trauma Counseling staff has over fifteen years of experience completing assessments as clients enter the treatment
program, and reassessing client progress at periodic intervals during the treatment
process. To capitalize on this extensive experience, that has become a recognized
strength of the program, emphasis was placed on using the outcomes of standardized assessment tools and other clinical assessments to select treatment

approaches for a client through the development of a Unique Client Picture.
Standardized assessment tools quickly focus treatment planning and immediately highlight high-risk safety issues during the early triage stage. These tools are then utilized throughout the treatment process to measure client progress made through the selected interventions, thus reducing the subjectivity and risk of provider bias and error.

The second primary principle of TAP is that the developmental level of the child is considered in the assessment, treatment planning, and treatment implementation components of the model. Next, the TAP model emphasizes the importance building a therapeutic relationship that respects the client's culture while executing any chosen intervention. Furthermore, in treating a traumatized child, the child's family, social, and other support systems must be assessed, engaged, and restructured to enhance the child's treatment. The final primary tenet of the TAP model is the importance of involving the client and his/her family, as appropriate, in treatment planning and understanding presenting symptoms.

The model also stresses the importance of working with a client and his/her family in the development of the clinical hypotheses that synthesize all of the information obtained on a client. While this process can be a unifying and focusing experience for the client, it may also present an ideal opening for providing both the client and his/her family with a more in-depth understanding of the client's current situation.

This manual is only one of many resources available on the TAP model. Other resources include the TAP Online training (www.taptraining.net) and in-person training. Organizations interested in receiving advanced, in-person training on the TAP Model should contact the Chadwick Center. Training is offered in:

- Administration, scoring, and interpreting assessment measures
- Using TAP to triage to various Evidence-Based Practices (EBPs)
- Key components of trauma treatment
-

Ongoing consultation regarding implementation of the TAP model
The significance and benefit of this model are yet to be determined. All children,
especially traumatized children, have the right to receive the highest quality
services in existence in promoting their healing from traumatic events. The
expectation is that the TAP model will facilitate the recovery of traumatized
children. In so doing, children will have the most effective and most enduring
recovery possible.

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Glossary Glossary
Abuse Types

Community Violence

- This category is intended to capture episodic or pervasive violence in the youth’s community that have not been captured in other categories.
- Includes extreme violence in the community (i.e., neighborhood violence).
- Exposure to gang-related violence should be recorded here (though specific incidents of gang-related violence [e.g., homicide, assaults] should also be recorded under those more specific headings).

Domestic Violence

- Exposure to emotional abuse, actual/attempted physical or sexual assault, or aggressive control perpetrated between a parent/caretaker and another adult in the child victim’s home environment.
- Exposure to any of the above acts perpetrated by an adolescent against one or more adults (e.g., parent, grandparent) in the child victim’s home environment.

Neglect

- Failure by the child victim’s caretaker(s) to provide needed, age-appropriate care although financially able to do so, or offered financial or other means to do so. Includes:
- Physical neglect (e.g., deprivation of food, clothing, shelter).
- Medical neglect (e.g., failure to provide child victim with access to needed medical or mental health treatments and services; failure to consistently disperse or administer prescribed medications or treatments [e.g., insulin shots]).
- Educational neglect (e.g., withholding child victim from school; failure to attend to special educational needs; truancy).

Physical Abuse

- Physical maltreatment/abuse refers to acts by an adult or older youth who is playing a caretaker role for the youth (e.g., parent, parent-substitute, babysitter, adult relative, teacher, etc.). Physical pain and/or injury by others (i.e., non-caretakers) should be classified as ‘physical assault.’
-

Actual or attempted infliction of physical pain (e.g., stabbings; bruising;
burns; suffocation) by an adult to a minor child with or without use of an
object or weapon and including use of severe corporeal punishment.
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Physical Assault

- Physical assault includes infliction of physical pain/bodily injury by perpetrators who are not in a caretaking role with the youth (such actions by caregivers should be recorded as ‘physical maltreatment/abuse’).
- Actual or attempted infliction of physical pain (e.g., stabbings; bruising; burns; suffocation) by another child, or group of children to a minor child with or without use of an object or weapon.

Psychological Abuse

- Acts of commission against a minor child, other than physical or sexual abuse, that caused or could have caused conduct, cognitive, affective, or other mental disturbance. These acts include:
  - Verbal abuse (e.g., insults; debasement; threats of violence).
  - Emotional abuse (e.g., bullying; terrorizing; coercive control).
  - Excessive demands on a child’s performance (e.g., scholastic; athletic; musical; pageantry) that may lead to negative self-image and disturbed behavior.
- Acts of omission against a minor child that caused or could have caused conduct, cognitive, affective, or other mental disturbance. These include:
  - Emotional neglect (e.g., shunning; withdrawal of love).
  - Intentional social deprivation (e.g., isolation; enforced separation from a parent, caregiver or other close family member).

Sexual Abuse

- Sexual maltreatment/abuse refers to acts by an adult or older youth who is playing a caretaker role for the youth (e.g., parent, parent-substitute, babysitter, adult relative, teacher, etc.). Sexual contact/exposure by others (i.e., non-caretakers) should be classified as ‘sexual assault/rape.’
- Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-inappropriate sexual material or environments (e.g., print, internet or broadcast pornography; witnessing of adult sexual activity) by an adult to a minor child.
-

Sexual exploitation of a minor child by an adult for the sexual gratification
or financial benefit of the perpetrator (e.g., prostitution; pornography; orchestration of sexual contact between two or more minor children).

- Unwanted or coercive sexual contact or exposure between two or more minor children.

Sexual Assault

- Sexual assault/rape should include contact/exposure by perpetrators who are NOT in a caretaking role with the youth (sexual misconduct by caregivers should be recorded as ‘sexual maltreatment/abuse’).
- Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-inappropriate sexual material or

environments (e.g., print, internet or broadcast pornography; witnessing of
adult sexual activity) by an adult to a minor child.

- Sexual exploitation of a minor child by an adult for the sexual gratification
or financial benefit of the perpetrator (e.g., prostitution; pornography;
orchestration of sexual contact between two or more minor children).
- Unwanted or coercive sexual contact or exposure between two or more minor.

School Violence

- This category is intended to capture violence that occurs in the school setting and that has not been reported in other categories.
- It includes, but is not limited to, school shootings, bullying, interpersonal
violence among classmates, and classmate suicide.

Acculturation

- A process in which members of one cultural group adopt the beliefs and behaviors or another group. Although acculturation is usually in the direction
of the newly immigrated group adopting habits and language patterns of the
mainstream group, acculturation can be reciprocal – that is, the mainstream
group also adopts patterns of the newly immigrated group. Acculturation level
may vary among family members.

Acculturative Stress

- Refers to the psychological, somatic, and social difficulties that maybe accompany the acculturation process.

Assessment-Based Treatment

- Refers to an integrated plan of prioritized interventions, based on the diagnosis
and psychosocial assessment of the client, to address mental, emotional, behavioral, developmental and addictive disorders, impairments and disabilities, reactions to illnesses, injuries, and social problems.

Base Rates

- The true proportion of a population having some condition, attribute, or disease. For example, the proportion of people with schizophrenia is about
0.01.

Clinical Pathway

- A clinical pathway is a patient-focused tool, which describes the timeframe and sequencing of routine, predictable multidisciplinary interventions and expected patient outcomes, for a group of patients with similar needs. Clinical pathways Trauma Assessment Pathway (TAP) 77 Chadwick Center for Children & Families

are used to describe and implement clinical standards, in support of quality and
efficiency in patient care.

Complex Trauma

- The experience of multiple simultaneous or sequential traumatic events, occurring within the home environment, and typically including emotional abuse, neglect, sexual abuse, physical abuse, and witnessing domestic violence. Traumatic exposure is usually chronic and begins early in childhood.

False Positive

- Occurs when an assessment procedure returns a positive result while the true
state of the person is negative. For example, if a measure of depression says
the patient is depressed when in fact he or she is not, then the error in classification would be called a false positive.

Miss

- Occurs when a measure returns a negative result, but the true state of the
person is positive. For example, if a person has depression and the measure
fails to indicate it, then a miss has occurred.

Reliability

- The degree to which results from a measure are consistent over time.

Unique Client Picture

- Through the use of standardized assessment, a thorough clinical interview, and
behavioral observations, the clinician integrates information from several
critical areas including: the child’s trauma history, presenting symptomatology,
relevant contextual history, and developmental history. From this, a complete
picture of the client is formed prior to identifying treatment needs and setting
goals.

T-Scores

- T-scores are standardized scores, with a mean of 50 and a standard deviation
of 10. Thus, a score of 60 is one standard deviation above the mean. Typically,

the cutoff score indicating someone has scored in the clinical range on a measure is 65, or 1.5 standard deviations above the mean.
Trauma Wheel

•
The Trauma Wheel is a therapeutic guide, which delineates the required areas
of child trauma treatment, including: Psychoeducation and skill building; addressing maladaptive cognitions; affect regulation; trauma integration; and
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system dynamics. Each of the key components is grounded in theory and requires awareness of the child's developmental, relational, and cultural dynamics. The developmental functioning of the child and the therapeutic relationship are also important components of the Trauma Wheel.

Treatment Outcome Program

- Program designed to provide standardized assessment of treatment-related outcomes. The measures administered can capture a variety of clinical domains, including trauma-specific, parental, and family functioning. The assessment results can be used to assist in tracking client progress over time and in directing treatment goals.

Type I Trauma

- A term created by Lenore Terr to describe the different types of trauma. A single traumatic event, such as an earthquake or a single rape episode is considered Type I. According to Terr, individuals with Type I trauma usually have more psychological resources and support to assist in their coping with the trauma.

Type II Trauma

- Also created by Lenore Terr, Type II trauma refers to more severe repeated, prolonged trauma, such as extensive child abuse. Individuals with Type II trauma are more likely to have PTSD symptoms and often keep the abuse secret, resulting in fewer support systems and the use of less effective coping mechanisms.

Validity

- The degree to which a measure can be used for the purpose it is intended for.

Appendices Appendices

Appendix A

Example of Some Standardized Measurement Options
Based Upon Domain and Reporter

Areas of Concern Informants
Child Caretaker Clinician Other
Trauma History UCLA PTSD
Index
UCLA PTSD
Index
Caretaker
Trauma: TSI
Interview
Trauma Symptoms UCLA PTSD
Index
TSCC
UCLA PTSD
Index
TSCYC
CDC
CSBI
Interview
Observation
General Symptoms YSR
CDI
BAIC
BASC
CBCL
BASC
Interview
Observation
TRF
BASC
Relevant
Contextual History
Family
Dynamics:
FAM-III
FRI
FACES
Peers:
YSR
Family
Dynamics:
FAM-III
FRI
FACES
Parenting:
PSI
Peers:
CBCL

Interview
Observation
Developmental
History/Intellectual
Functioning
WISC-IV
K-BIT
Stanford Binet
ITSEA
BITSEA
Denver II
BSID-II
Observation

Measure Abbreviations and Names:

BSID-II = Bayley Scales of Infant Development, Second Edition; BAIC = Beck Anxiety
Inventory for Children; BASC = Behavior Assessment System for Children; BITSEA = Brief
Infant-Toddler Social and Emotional Assessment; CBCL = Child Behavior Checklist; CDI =
Children's Depression Inventory; CDC = Child Dissociative Checklist; CES-D = Center for
Epidemiological Studies on Depression; CSBI = Child Sexual Behavior Inventory; Denver
II = Denver Developmental Screening Test II; ITSEA = Infant-Toddler Social and
Emotional Assessment; FACES-II or III = Family Adaptability and Cohesion Evaluations
Scale ; FAM-III = Family Assessment Measure; FRI = Family Relationship Index; K-BIT =
Kauffman Brief Intelligence Test; PSI = Parenting Stress Inventory; Stanford Binet =
Stanford Binet Intelligence Scales, Fifth Edition; TRF = Teacher Report Form; TSCC =
Trauma Symptom Checklist for Children; TSCYC = Trauma Symptom Checklist for Young
Children; TSI = Trauma Symptom Inventory; UCLA PTSD Index = UCLS PTSD Reaction
Index for DSM-IV; YSR = Youth Self Report; WISC-IV = Wechsler Intelligence Scale for
Children, IV

Appendix B: Resources for Ordering Assessment Measures

Some of the measures in this resource are listed in detail on the National Child Traumatic Stress Network's (NCTSN) Measure Review Database and some are listed and rated for reliability and validity on the California Evidence-Based Clearinghouse for Child Welfare (CEBC) website. Please check these two resources for additional information.

Title of Measure	Author	Publisher	Ordering Information	Cost
Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2)	Glenn A. Miller	The SASSI Institute	Ph: 800-726-0526 or http://www.sassi.com/products/SASSIA2/shopSA2.shtml	Manual: $45 Forms: $1.30 to $2.00 each depending on quantity (min. 25)
Alcohol Use Disorders Identification Test (AUDIT)	Thomas F. Babor, John C. Higgins-Biddle, John B. Saunders, and Maristela G. Monteiro	World Health Organization (WHO)	http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf	Free: Link in previous box goes to a PDF version of the manual. The AUDIT form is on page 30 of the manual.
Beck Anxiety Inventory (BAI)	Aaron T. Beck, MD	Pearson Assessments	Ph: 800-211-8378 or 210-339-8190 or http://pearsonassess.com/haiweb/cultures/enus/productdetail.htm?pid=015-8018-400	Manual: $65 Form: $1.96 each (min. 25)
Beck Youth Inventories, 2nd Edition (BYI)	Judith S. Beck, PhD, Aaron T. Beck, MD, and John B. Jolly,			

PsyD
Pearson Assessments Ph: 800-211-8378 or
210-339-8190 or
http://pearsonassess.com/HA
IWEB/Cultures/enus/
Productdetail.htm?Pid=01
5-8014-197&Mode=summary
Starter Kit (manual plus 25 five
inventory booklets): $199
All Five Inventories: $5.96 per
booklet (min. 25)
Depression: $1.84 per form
(min. 25)
Anxiety: $1.84 per form (min.
25)
Anger: $1.84 per form (min. 25)
Disruptive Behavior: $1.84 per
form (min. 25)
Self-Concept: $1.84 per form
(min. 25)

Title of Measure	Author	Publisher	Ordering Information	Cost
Beck Depression Inventory, 2nd Edition (BDI-II)	Aaron T. Beck, Robert A. Steer, and Gregory K. Brown	Pearson Assessments	Ph: 800-211-8378 or 210-339-8190 or http://psychcorp.pearsonassessments.com/haiweb/cultures/enus/productdetail.htm?pid=015-8018370&Community=CA_Psych_Settings_Health	Manual: $65 Form: $1.96 each (min. 25)
Behavior Assessment System for Children (BASC)	Cecil R. Reynolds & Randy W. Kamphaus	Pearson Assessments	Ph: 800-627-7271 or http://pearsonassessments.com/basc.aspx	Manual: $91.75 Parent form: $1.38 each (min. 25) Teacher form: $1.38 each (min. 25) Self-Report form: $1.38 each (min. 25)
Behavioral and Emotional Rating Scale, 2nd Edition (BERS-2)	Michael H. Epstein	Pro-Ed, Inc.	Ph: 800-897-3202 or http://www.proedinc.com/customer/ProductView.aspx?ID=3430	Manual: $62 Parent Rating Scale: $1.32 each (min. 25) Youth Rating Scale: $1.32 each (min. 25) Teacher Rating Scale: $1.32 each (min. 25)
Brief Infant-Toddler Social and Emotional Assessment (BITSEA)	Margaret Briggs-Gowan and Alice Carter	Pearson Assessments	Ph: 800-211-8378 or	

210-339-8190 or
http://pearsonassess.com/haiweb/cultures/enus/productdetail.htm?pid=015-8007-352
Manual: $55.50
Parent form: $1.56 each (min. 25)
Caregiver form: $1.56 each (min. 25)

Title of Measure	Author	Publisher	Ordering Information	Cost
Brief Symptom Inventory (BSI)	Leonard R. Derogatis	Pearson Assessments	Ph: 800-627-7271 or go to http://psychcorp.pearsonassessments.com/haiweb/cultures/en-us/productdetail.htm?pid=PAbsi&Community=CA_Psych_Settings_Health	Manual: $37.50 Form: $1.08 each (min. 25)
Center for Epidemiological Studies on Depression (CES-D)	L. S. Radloff	Public Domain	NIMH e-mail: nimhinfo@nih.gov Free – email the address in previous box for a copy of the scale.	
Child Behavior Checklist (CBCL) *See also Youth Self Report (YSR) and Teacher Report Form (TRF)	Thomas Achenbach	Achenbach System of Empirically Based Assessment (ASEBA)	Ph: 802-656-5130 or http://www.aseba.org/products/forms.html	School Age and Preschool Manuals: $40 each CBCL (6-18) form: $0.50 each (min. 50) CBCL (1.5-5) form: $0.50 each (min. 50)
Children’s Depression Inventory (CDI)	Maria Kovaks, PhD	Multi Health Systems, Inc. (MHS)	Ph: 800-456-3003 or https://www.mhs.com/product.aspx?gr=edu&prod=cdi&id=overview	Complete CDI package (Manual and 25 of each form listed below): $213 CDI Quickscore Form: $1.88 each (min. 25) CDI – Short Quickscore Form: $1.80 each (min. 25) CDI – Parent Quickscore Form:

$1.72 each (min. 25)
CDI – Teacher Quickscore Form:
$1.72 each (min. 25)
Child Dissociative
Checklist (CDC)
Frank Putnam, PhD Public Domain NIMH e-mail:
nimhinfo@nih.gov
Free – email the address in
previous box for a copy of the
scale.

Title of Measure	Author	Publisher	Ordering Information	Cost
Child Sexual Behavior Inventory (CSBI)	William Friedrich, PhD, ABPP	Psychological Assessment Resources, Inc. (PAR)	Ph: 800-331-TEST or http://www3.parinc.com/products/product.aspx?Productid=CSBI	Manual: $52 Test Booklet: $2.56 each (min. 25)
Drug Abuse Screen Test (DAST-20)	Harvey Skinner, PhD	Centre for Addiction and Mental Health (formerly the Addiction Research Foundation)	Ph: 800-661-1111 or http://www.hospitalsoup.com/listing/45704-addictionresearch-foundation then click “Visit Website” and search for the DAST.	Questionnaire: $0.13 each (min. 100)
Eyberg Child Behavior Inventory (ECBI)	Sheila Eyberg, PhD	Psychological Assessment Resources, Inc. (PAR)	Ph: 800-331-TEST or http://www3.parinc.com/products/product.aspx?Productid=ECBI	Manual: $49 Test Sheet: $1.52 each (min. 25)
Family Assessment Measure III (FAM-III)	Harvey A. Skinner, PhD, Paul D. Steinhauer, MD, & Jack Santa-Barbara, PhD	Multi-Health Systems, Inc. (MHS)	Ph: 1-800-456-3003 or http://www.mhs.com/product.aspx?gr=edu&prod=famiii&id=overview	

Technical Manual: $74
General Scale QuickScore form:
$1.76 each (min. 25)
Dyadic Relationship QuickScore
form: $1.76 each (min. 25)
Self-Report QuickScore form:
$1.76 each (min. 25)
Infant-Toddler Social
and Emotional
Assessment (ITSEA)
Alice Carter and
Margaret Briggs-
Gowan
Pearson Assessments Ph: 800-211-8378 or 210339-
8190 or
http://pearsonassess.com/hai
web/cultures/enus/
productdetail.htm?pid=01
5-8007-387
Manual: $89
Parent Form: $1.96 each (min.
25)
Childcare Provider Form: $1.96
each (min. 25)
Michigan Alcoholism
Screening Test
(MAST)
Melvin L. Selzer, MD Melvin L. Selzer, MD Email Melvin L. Selzer, MD at
jmslzr@aol.com or send
request to:
6967 Paseo Laredo,
La Jolla, CA 92037
Ph: 858-459-1035
Form: $40 for a copy, no fee for
use after that

Title of Measure	Author	Publisher	Ordering Information	Cost
Parenting Stress Index, 3rd Ed. (PSI)	R. R. Abidin, EdD	Psychological Assessment Resources, Inc. (PAR)	Ph: 800-331-TEST or http://www3.parinc.com/products/product.aspx?Productid=PSI for PSI forms or http://www3.parinc.com/products/product.aspx?Productid=PSI-SF for PSI Short Forms (PSI-SF)	Manual: $62 Reusable Item Booklets: $1 each (min. 10) Hand-Scorable Answer Sheet: $2.56 to $2.72 each depending on quantity (min. 25) Short Form (PSI-SF) Hand-Scorable Questionnaire: $2.56 to $2.72 each depending on quantity (min. 25)
State-Trait Anxiety Inventory for Children (STAIC)	Charles D. Spielberger, C. D. Edwards, J. Montuori, & R. Lushene	Mind Garden, Inc.	Ph: 650-322-6300 or http://www.mindgarden.com/products/staisch.htm	Manual: $40 Form: $0.60 to $1.00 each depending on quantity (min. 100 permissions)
Strengths and Difficulties Questionnaire (SDQ)	Robert Goodman, PhD	Youthinmind	Web site: www.sdqinfo.com	Free PDF downloads, however, no alteration to the PDF can be made.
Substance Abuse Subtle Screening Inventory (SASSI)	Glenn A. Miller	The SASSI Institute	Ph: 800-726-0526 or http://www.sassi.com/products/SASSI3/shopS3.shtml	

Manual: $45
Forms: $1.30 to $2.00 each depending on quantity (min. 25)

Sutter-Eyberg Student Behavior Inventory (SESBI)
Sheila Eyberg, PhD Psychological Assessment Resources, Inc. (PAR)
Ph: 800-331-TEST or http://www3.parinc.com/products/product.aspx?Productid=ECBI
Manual: $49
Test Sheet: $1.52 each (min. 25)

Teacher Report Form (TRF)
*See also Child Behavior Checklist (CBCL)and Youth Self-Report (YSR)
Thomas Achenbach Achenbach System of Empirically Based Assessment (ASEBA)
Ph: 802-656-8313 or http://www.aseba.org/products/forms.html
School Age Manual: $40 each
TRF (6-18) form: $0.50 each (min. 50)

Title of Measure	Author	Publisher	Ordering Information	Cost
Temperament and Atypical Behavior Scale (TABS)	Stephen J. Bagnato, EdD, NCSP, John T. Neisworth, PhD, John J. Salvia, DEd, & Frances M. Hunt, PhD	Paul H. Brookes Publishing Co., Inc.	Ph: 800-638-3775 or http://www.brookespublishing.com/store/books/bagnatotabs/index.htm	Manual: $50 TABS Screener: $0.50 each (min. 50) TABS Assessment Tool: $1.00 each (min. 30)
Trauma Symptom Checklist for Children (TSCC)	John Briere, PhD	Psychological Assessment Resources, Inc. (PAR)	Ph: 800-331-TEST or http://www3.parinc.com/products/product.aspx?Productid=TSCC	Manual: $49 TSCC Test Booklets: $2.36 each (min. 25)
Trauma Symptom Checklist for Young Children (TSCYC)	John Briere, PhD	Psychological Assessment Resources, Inc. (PAR)	Ph: 800-331-TEST or http://www3.parinc.com/products/product.aspx?Productid=TSCYC	Manual: $49 TSCYC Reusable Item Booklets: $1.20 to $1.28 each depending on quantity (min. 25) TSCYC Hand-Scorable Answer Sheets: $1.68 to $1.76 each depending on quantity (min. 25)
Trauma Symptom Inventory (TSI)	John Briere, PhD	Psychological		

Assessment Resources,
Inc. (PAR)
Ph: 800-331-TEST or
http://www3.parinc.com/pro
ducts/product.aspx?Productid
=TSI
Manual: $51
TSI Reusable Item Booklets:
$4.20 (min. 10)
TSI Hand-Scorable Answer
Sheets: $2.00 to $2.16 each
depending on quantity (min. 25)
UCLA PTSD Reaction
Index for DSM-IV
(Revision 1)
Ned Rodriguez, PhD;
Alan Steinberg, PhD;
& Robert S. Pynoos,
MD
Public Domain, UCLA
Trauma Psychiatry
Service
Ph: 310-206-8973 or contact
Alan Steinberg via e-mail:
asteinberg@mednet.ucla.edu
Free - email the address in
previous box for a copy of the
scale.
Youth Self-Report
(YSR)
*See also Child Behavior
Checklist (CBCL) and
Teacher Report Form (TRF)
Thomas Achenbach Achenbach System of
Empirically Based
Assessment (ASEBA)
Ph: 802-656-8313 or
http://www.aseba.org/produc
ts/forms.html
School Age Manual: $40 each
YSR (11-18) form: $0.50 each
(min. 50)

Appendix C
Core Clinical Characteristics Form
Appendix C
Core Clinical Characteristics Form
Core Clinical Characteristics
Intake

Assessment Office Use only:
Child ID: _____

Duke Study .. Child Initials __ __ __

Child’s Name: ___ ___ ___ ___ ___ ___ ___ ___ Therapist: Team:
Siblings who were, are, or will be in treatment at Chadwick

I. Center Information [Caretaker Completes]
1. Facility name: The Chadwick Center for Children and Families
2. Name of person completing this form:
Relationship:
3. Phone number:
II. Demographic Information [Caretaker Completes]
1. Child’s date of birth: ___ ___ / ___ ___ / ___ ___ ___ ___
99 Unknown (Specify Age: _____)
2. Child’s Gender:
1 Male
2 Female
3. Has this child been seen at this center for a previous episode(s) of care?
Assessment Office/Duke Study Use only:

0 No

1 Yes

If the child has been seen at this center
for a previous episode of care, were

Duke consents signed for the child back
then (check the Ridmaster)?

4. Date of today’s visit: ___ ___ / ___ ___ / ___ ___ ___ ___
5. Is this the child’s first visit at this center for the current episode of care?
0 No •
If No: How many visits (including today’s visit) has the child had at your center for
0 No

1 Yes – Give the form to Robyn or

the current episode of care? Number of Visits _____

Jennifer.

1 Yes
6.
What is your relationship to the child/adolescent (check only one)?
1 Parent 6b. If the child does not live with you full-time, what percentage of the time
2 Other adult relative does the child live with you? _____
3 Foster parent
4 Agency staff
5 Child/Adolescent/Self
98 Other, (specify):
7. Are you the client’s legal guardian?
0 No
1 Yes
99 Unknown

If you have joint legal custody, please list the name and telephone number of the child’s other legal guardian:

8. If no, who is currently the legal guardian for this child?
1 Parent
2 Other adult relative
3 State
4 Emancipated Minor (self)
98 Other, (specify):
99 Unknown

9.
Child’s Ethnicity (check only one):
1 Hispanic or Latino
2 Not Hispanic or Latino
99 Unknown

10.
Child’s Race (if multiracial, check all that apply):
1 American Indian or Alaska Native
2 Asian
3 Black/African American
4 Native Hawaiian or other Pacific Islander
5 White
99 Unknown
11.
Was the child born in the United States?
0 No •
If No: In what country was the child born? ____
1 Yes
99 Unknown
12. Is the child (and/or family) a refugee, asylum seeker, or immigrant with a history of exposure
to community violence?
0 No
1 Yes
99 Unknown

13. Is this child currently participating in the NCTSN Cross-Site longitudinal outcome
evaluation?
0 No
1 Yes
99 Unknown

Assessment Office/Cross-site Study Use only:

13a. If yes, were all of the standard assessments (CBCL, PTSD-RI, &/or TSCC-A) completed within the timeframe allowed by the Cross-Site Evaluation (30 days from intake or visit date specified for question 3 above)

1 Yes

0 No .. If no: Please provide visit date(s) the standard assessments were administered.

Date: ___/___ / __ __ Assessment: _____
Date: ___/___ / __ __ Assessment: _____
Date: ___/___ / __ __ Assessment: _____

Assessment Office/Duke Study Use only:

Please provide the mnemonic for the health care provider currently caring for this child:

III. Demographic Environment [Caretaker Completes]
1. Where is the child’s current primary residence (check only one)?
1 Independently (alone or with peers) 4 Regular foster care

7 Correctional facility

99 Unknown
2 Home (with parent(s))
5 Treatment foster care

8 Homeless
3 With relatives or other family

6 Residential treatment center

98 Other (specify):

2.
How long has child been living in above setting?
(enter # of months or “0” if less than one month)

1 Entire life
99 Unknown

99 Unknown

3.
Please specify zip code of child’s current residence: ___ ___ ___ ___ ___
(5 digit zip code) OR
4. Primary language spoken at home (check only one):
1 English 3 French

5 Cantonese

7 Japanese

9 Russian

11 Tagolog
2 Spanish

4 Mandarin

6 Navaho

8 Korean

10 Vietnamese

98 Other (specify):
99 Unknown

If child is living in a family setting (i.e., “Home” or “With relatives or family”), complete the following questions.
If the child is NOT living in a family setting go to “Insurance” section.
5. What types of adults live in the home with the child? (check all that apply)
Mother (biological or adopted) Grandparent

Other (specify):
Father (biological or adopted)

Other adult relative

Unknown
Parent’s spouse/partner/significant other

Other adult non-relative

6.
Total number of adults living in child’s home:
99 Unknown
7.
Total number of children (including client) living in child’s home:
99 Unknown
8.
What is the total income for the child’s household for the past year, before taxes and including all sources:
$ (US$)
99 Unknown
9.
Which category best describes the highest educational level earned by any of the child’s caretaker(s)? (check only one)
Some grade school
Some high school
Some college
Graduate School
Grade school graduate
High School graduate
College graduate

10.
Which category best describes the primary caretaker‘s employment status? (check all that apply)
Full-time
Full-time homemaker

Retired

Disabled
Part-time
Unemployed

Full-time student

If caretaker is employed:

11. What is caretaker(s) job title or what type of work does caretaker do? (i.e., file clerk, elementary school teacher, construction worker, etc.)
_____

12. In what kind of business or industry is caretaker employed? (i.e., hospital, school, insurance, manufacturing, etc.)
IV. Insurance and Referral Information [Caretaker Completes]
1. Is the child currently covered by any type of public or private health insurance?
99 Unknown
0 No
1 Yes •
If Yes: Specify type (check all that apply):
Public:

Private:
Medicare
HMO
Medicaid/Medi-Cal

PPO
Indian health service

Fee-for-service
CHIP

Other private, (specify):
Other public, (specify):

Insurance information unknown

2. Is the child’s parent/guardian covered by any type of insurance?

99 Unknown
0 No
1 Yes •
If Yes: Specify type (check all that apply):
Public:

Private:
Medicare
HMO
Medicaid/Medi-Cal

PPO
Indian health service

Fee-for-service
CHIP

Other private, (specify):
Other public, (specify):

Insurance information unknown

3. How will current therapy be funded? (Check all that apply)
Victim Witness funding

Public Insurance

Self-Pay
Primary
Family member (i.e., sibling, parent)

Private Insurance

Grant (specify: _____)

Other (Please specify:_____)

4. Who referred client to therapy?
Children’s Services Bureau/Child Protective Services/Department of Human Services/Health and Human Services Agency
Chadwick Center Evidentiary/Forensic Staff
Other Children’s Hospital program (Please identify program: _____)
Self-referred
Physician/Health Care Provider
Mental Heath Care Provider
School Personnel
Law Enforcement Official
District Attorney’s Office

Personal referral (friend, neighbor, co-worker)
Family Justice Center (FJC)
Other (Please list: _____)

5. Is therapy voluntary or mandated?
Voluntary
Court-ordered or CPS Mandated
Unknown

V. Academic Information [Caretaker Completes]
1. Name of current School:
_____
Grade:_____
2. Teacher: _____
Phone Number:_____
No
Yes (IEP Date:_____)
3. Does the child have an IEP (If you do not know what this is, please mark “No”):
VI. Medical History [Caretaker Completes]
a. Primary Physician
(name): _____ (phone #): _____
b.
Other Providers/Medical: (name): _____ (phone #): _____
Alternative: (name): _____ (phone #): _____
c.
Does he/she have any medical problems, disability or injuries? (chronic or recurrent condition)
No
Yes
d. How do these affect the child’s ability to function)?
e.
Not a problem
Somewhat/sometimes a problem
Very much/often a problem
f.
Past/current illnesses and medical conditions (include previous hospitalization):
g.
Current medication/previous medication (include all prescribed, over the counter medications & holistic/alternative remedies):
h.
Name Dosage Date Started Last Date Helpful? Side Effects
No Yes
No Yes
No Yes
No Yes
No Yes
No Yes
No Yes

g.
Allergies: _____
h.
Date of last physical exam: _____ Date of last dental exam:_____

VII. Presenting Problem [Therapist completes with Caretaker]
Current presentation (include symptoms, behaviors, onset, duration, severity, and family response to
current situation.):

VIII. NCTSN Breakthrough Series/Learning Collaborative [BSC Therapists Complete]
1.
Is this child/family receiving a treatment from a therapist participating in a breakthrough series or learning collaborative for that treatment?
0 No [Skip to next section]
1 Yes .. If Yes: Please complete the requested information for each treatment the child/family is receiving through a breakthrough series or learning collaborative.

1a. What treatment is this child/family receiving through a therapist participating in a breakthrough series or other learning collaborative?

1 TF-CBT (Trauma-Focused Cognitive Behavioral Therapy)
2 Life Skills/Life Story
3 SPARCS (Supportive Psychosocial Treatment for Adolescents responding to Chronic Stress)
4 TARGET (Trauma Adaptive Recovery Group Education and Therapy)
5 TST (Trauma Systems Therapy)
6 CPP (Child Parent Psychotherapy)
7 CBITS (Child Behavioral Interventions for Trauma in Schools)
98 Other, Specify name of treatment:

2. Date this treatment began: ___ ___ / ___ ___ / ___ ___ ___ ___
IX. Brief Intervention Services Information [Therapist Completes]
Brief Intervention refers to the number of sessions that a child/family may receive. If a child/family is only receiving 3-6 sessions, then complete the
following.

1. Is this child/family receiving brief intervention services?
0 No [Skip to next section]
1 Yes •
If Yes: Please complete the requested.
Assessment office/Duke Study Use Only: If this is answered
yes, please email Robyn and Jennifer.
1a. What treatment components are the child/family receiving for this episode of care? (Check all that apply)

1 Screening

8 Psychoeducation
2 Assessment

9 Safety Planning
3 Case Consultation

10 Individual Therapy
4 Case Management

11 Family Therapy
5 Child and Family Traumatic Stress Intervention (CFTSI)

12 Group Therapy
6 Crisis Management

13 Support Group
7 Referral Services

98 Other, Specify name of treatment: _____

2. Date the treatment component(s) began: __ __/ __ __/ __ __ __ __

X. Indicators of Severity of Problems [Caretaker and Therapist Complete]
This section relates to the types of problems and experiences the ‘child’ might have experienced. Indicate if the child experienced these types of problems
within the past month (within the last 30 days). Please answer each question.

Respondent: Parent/Adult respondent
Indicator of Severity for problems experienced
within the past month?
1. Academic problems (problems with school work or grades): 0 Not a problem
1 Somewhat/sometimes a problem
2 Very much/often a problem
99 Unknown
2. Behavior problems in school or daycare (getting into trouble, detention, suspension, expulsion): 0 Not a problem Therapist:
1 Somewhat/sometimes a problem If YES-
2 Very much/often a problem Optional
99 Unknown TRF
3. Problems with skipping school or daycare (where he/she skipped at least four days in the past 0 Not a problem
month, or skipped parts of the day on at least half of the school days):
1 Somewhat/sometimes a problem
2 Very much/often a problem
99 Unknown
4. Behavior problems at home or in the community (violent or aggressive behavior; breaking rules; 0 Not a problem
fighting; destroying property; or other dangerous or illegal behavior) 1 Somewhat/sometimes a problem
2 Very much/often a problem
99 Unknown
5. Suicidality (thinking seriously about killing him/herself or actually attempting to do so): 0 Not a problem
None Ideation Plan Intent w/o means Intent w/means 1 Somewhat/sometimes a problem
Ideation in past year Attempt in past year Family history of completed suicide 2 Very much/often a problem
99 Unknown
6. Other self-injurious behaviors (cutting him/herself, pulling out his/her own hair): 0 Not a problem
1 Somewhat/sometimes a problem
2 Very much/often a problem
99 Unknown
7. Developmentally inappropriate sexualized behaviors (saying or doing things about sex that
children his/her age don’t usually do or know):
0 Not a problem
1 Somewhat/sometimes a problem
2 Very much/often a problem
99 Unknown
If YES-
Administer
CSBI

8. Alcohol use (e.g., Use of alcohol):0 Not a problem If YES-
Alcohol Used by Child? No Yes 1 Somewhat/sometimes a problem
2 Very much/often a problem
Administer
Substance
Abuse
Note: Originally, Alcohol and Substance use were combined. 99 Unknown
Scrnr and
AUDIT
9. Substance use (e.g., Use of illicit drugs or misuse of prescription
medication): 0 Not a problem If YES-
Drugs Used by Child? No Yes 1 Somewhat/sometimes a problem Administer
2 Very much/often a problem
Substance
Abuse
99 Unknown Scrnr and
DAST
10. Attachment problems, Relationship Concerns, or Boundary Concerns
(difficulty forming or
maintaining trusting relationships with other people):
0 Not a problem
1 Somewhat/sometimes a problem
2 Very much/often a problem
99 Unknown
If YES-
Administer
PSI

Respondent: Parent/Adult respondent
Indicator of Severity for problems experienced
within the past month?
11. Criminal activity (activities that have resulted in being stopped by the police or arrested): 0 Not a problem
1 Somewhat/sometimes a problem
2 Very much/often a problem
99 Unknown
12. Running away from home (staying away for at least one night); 0 Not a problem
1 Somewhat/sometimes a problem
2 Very much/often a problem
99 Unknown
13. Prostitution (exchanging sex for money, drugs, or other resources) 0 Not a problem
1 Somewhat/sometimes a problem
2 Very much/often a problem
99 Unknown
14. Child has other medical problems or disabilities (e.g., Chronic or recurrent condition that affect
the child’s ability to function):
0 Not a problem
1 Somewhat/sometimes a problem
2 Very much/often a problem
99 Unknown
15. Homicidality (thinking seriously about killing someone else):
None Ideation Plan Intent w/o means Intent w/means
Ideation in past year
0 Not a problem
1 Somewhat/sometimes a problem
2 Very much/often a problem
99 Unknown
16. Other (specify):
_____ 0 Not a problem
1 Somewhat/sometimes a problem
2 Very much/often a problem
99 Unknown

XI. Relevant History: Precipitating event and other significant life events leading to current situation
This section identifies stressful events that occur within a family that can influence how someone progresses in treatment. Please indicate the types of events
that occurred in the child’s immediate family during the past year. Please answer each question.

Endorse items below if the item is an environmental or psychosocial problem that is related to the context
in which the child's difficulties have developed, and/or that may affect the diagnosis, treatment, and
prognosis of the child.
In the past year
(Check all that apply)

1. Problems with primary support group:
1a. Changes in Family Constellation (i.e., divorce, marriage, birth, death, adoption or foster placement)
IF YES-
Administer
CESD, PSI
and/or
FAM-III
1b. Severe conflict or disruption within the family (i.e., explosive arguments, drug and alcohol problems)
IF YES-
Administer
CESD, PSI
and/or
FAM-III
1c. Other problems with primary support group: _____
IF YES-
Administer
CESD, PSI
and/or
FAM-III

Endorse items below if the item is an environmental or psychosocial problem that is related to the context
in which the child's difficulties have developed, and/or that may affect the diagnosis, treatment, and
prognosis of the child.
In the past year
(Check all that apply)
2. Problems related to social environment (i.e., problems related to level of acculturation; changes in
social support system outside of family)
If YES –
optional
ARSMA
2a. Problems related to peers and friendships
If YES –
optional
YSR
3. Educational Problems (i.e., discord with teachers, serious discord with classmates, change in
school or childcare, or inadequate school services)
If YES –
optional
TRF
4. Caretaker occupational problems or changes
If YES –
Administer
CESD
5. Housing problems
If YES-
Advocacy/provide case
management
5a. Change or disruption in housing, inadequate housing, overcrowding
5b. Unsafe neighborhood
5c. Other housing problems
6. Health problems
6a. Inadequate health care (i.e., services or insurance)
6b. Serious injury or medical illness of child
6c. Serious injury or medical illness of person close to child
7. Problems related to legal system/crime (i.e., incarceration, involvement in litigation, victim of
crime)
If YES- optional
referral to KIC
7a. Child is directly involved with legal system
7b. Person close to child is involved with legal system
8. Other Environmental or Psychosocial Stressor:
_____

XII. Developmental History (For each section, include any significant culturally related rites of passage, rituals, ceremonies, etc.)
a. Prenatal/birth/childhood information (include pregnancy, developmental milestones, and other significant events):
Pregnancy/Delivery
Problems in pregnancy or delivery?
(e.g., illness, bed rest, medications, amniocentesis, premature, Cesarean section, breech, etc.) No Yes
Adequate Prenatal care?: No Yes
Full Term Born Premature: _____ Months
Mother's alcohol, cigarette or substance use during pregnancy with client No Yes Type: _____
Serious illness, accident or stressors during pregnancy No Yes
Complications Post-natal (within 1st month) (e.g., low birth weight, infections, jaundice, heart, breathing, eating, sleeping)
No Yes: including the following: low birth weight trouble feeding trouble sleeping colic
Milestones
Has a doctor or any other professional ever expressed concern about child's development:
Motor development (e.g., sitting, crawling, walking, toilet training) No Yes
Speech and language development (e.g. first words, first phrases) No Yes
Comment:_____
_____
_____
_____
_____
_____

b.
Genetic Predisposition to Psychiatric Illness and Substance Abuse
Bio Mom Bio Dad Client's Sibling/Offspring
None
1st o

2nd o

1st o

2nd o

1st o

Psychiatric hospitalization

1st o

2nd o

1st o

2nd o

1st o

Psychotherapy

1st o

2nd o

1st o

2nd o

1st o

Psychotropic medication

1st o

2nd o

1st o

2nd o

1st o

Major mood problems

Disorder (if known): _____

1st o

2nd o

1st o

2nd o

1st o

Anxiety problems

Disorder (if known): _____

1st o

2nd o

1st o

2nd o

1st o

Psychotic symptoms

Disorder (if known): _____

1st o

2nd o

1st o

2nd o

1st o

Attention Problems

Disorder (if known): _____

1st o

2nd o

1st o

2nd o

1st o

Drug/Alcohol problems

1st o

2nd o

1st o

2nd o

1st o

Criminal behavior

1st o

2nd o

1st o

2nd o

1st o

Other known psych disorder

Disorder (if known): _____

[note: 1st degree = mother, father, sibling, offspring 2nd degree = grandparent, aunt, uncle, first cousin]

Caretaker’s Relationship History:

Additional Information on Family History:

XIII. Use of Other Services [Therapist Completes]
BASELINE INSTRUCTIONS: This section relates to the types of problems and experiences the ‘child’ might have experienced. Has the child received any
of these services or been placed in any of the following (excluding today’s visit) within the past month (within the past 30 days)? These may include
services provided by your Center as well as services provided by any other clinician, setting, or sector. Also, indicate if the child received these types of
services EVER. Please answer each question.

Source: Child and Adolescent Services Assessment (CASA)
Received any services Within the Past Month? (i.e., past 30 days)
(Check all that apply)
Received any services EVER?
(Check all that apply)
1. Inpatient psychiatric unit or a hospital for mental health problems 0 No 1 Yes 99 Unknown
2. Residential treatment center (a self-contained treatment facility where
the child lives and goes to school) 0 No 1 Yes 99 Unknown
3. Detention center, training school, jail, or prison 0 No 1 Yes 99 Unknown
4. Group home (a group residence in a community setting) 0 No 1 Yes 99 Unknown
5. Treatment foster care (placement with foster parents who receive special training and supervision to help children with problems) 0 No 1 Yes 99 Unknown
6. Probation officer or court counselor 0 No 1 Yes 99 Unknown
7. Day treatment program (a day program that includes a focus on therapy and may also provide education while the child’s there) 0 No 1 Yes 99 Unknown
8. Case management or care coordination (someone who helps the child get the kinds of services he/she needs) 0 No 1 Yes 99 Unknown
9. In-home counseling (services, therapy, or treatment provided in the child’s home) 0 No 1 Yes 99 Unknown
10. Outpatient therapy other than at this clinic (from psychologist, social
worker, therapist, or other counselor) 0 No 1 Yes 99 Unknown
11. Outpatient treatment from a psychiatrist 0 No 1 Yes 99 Unknown
12. Primary care physician/pediatrician for symptoms related to trauma or emotional/behavioral problems (excluding in an emergency room)
0 No 1 Yes 99 Unknown
13. School counselor, school psychologist, or school social worker (for behavioral or emotional problems) 0 No 1 Yes 99 Unknown
14. Special class or special school (for all or part of the day) 0 No 1 Yes 99 Unknown
15. Child welfare or departments of social services (include any types of contact) 0 No 1 Yes 99 Unknown
16. Foster care (placement in kinship or non-relative foster care)

Approximate Number of Placements (If applicable): _____ 0 No 1 Yes 99 Unknown
17. Therapeutic recreation services or mentor 0 No 1 Yes 99 Unknown
18. Hospital emergency room (for problems related to trauma or emotional or behavioral problems) 0 No 1 Yes 99 Unknown
19. Self-help groups (e.g., A.A., N.A.) 0 No 1 Yes 99 Unknown

Source: Child and Adolescent Services Assessment (CASA)
Received any services Within the Past
Month? (i.e., past 30 days)
(Check all that apply)
Received any services
EVER?
(Check all that apply)
20. Medication management 0 No 1 Yes 99 Unknown
21. Crisis Services 0 No 1 Yes 99 Unknown
22. Psychological Assessment or Testing 0 No 1 Yes 99 Unknown

XIV. Trauma Information [Therapist and Caretaker Complete Together]
For each trauma that the child has experienced, please complete the following information.

Trauma Type
Has the child experienced this trauma (answer all Trauma Types)
Age
Age in years:
(Check all ages that apply) Frequency
Type(s) of exposure
(Check all that apply)
What reportedly happened?
(Check all that apply)
Setting(s) of experience
(Check all that apply)
Perpetrator(s)
(Check all that apply)
Legal Action Regarding Trauma
(Check all that apply)
1. Sexual maltreatment/ abuse:
(History of actual or attempted sexual molestation, exploitation, or coercion by an adult or older youth in a caretaking role)
When was this trauma revealed/known to the clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17

8 18
9
Unknown
1 One time
event
2 Repeated
exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced
or Sibling of
abuse victim)
4 Unknown
Was serious injury inflicted?
0 No
1 Yes
99 Unknown
If yes, to whom (check all that
apply):
Child
Parent
Other adult relative
Unrelated (but identifiable)
adult
Sibling
Other youth
98 Other, specify:
_____
Did this abuse ever involve
oral, vaginal, or anal
penetration?
0 No
1 Yes
99 Unknown
1 Home
2 School
3 Community
98 Other,
specify:
_____
99 Unknown
1 Parent
2 Other adult
relative
3 Unrelated (but
identifiable)
adult
4 Sibling
5 Other youth
6 Stranger
99 Unknown

Perpetrator
Gender:
Male
Female
Was a report filed? (e.g.
Police, Child Protective
Services)
0 No
1 Yes
99 Unknown
If a CPS report was
filed, was it:
0 Not Substantiated
1 Substantiated
99 Unknown
2. Sexual assault/rape:
(Actual or attempted sexual
molestation, exploitation, or
coercion not by a caregiver
and not recorded as sexual
abuse)
When was this trauma
revealed/known to the
clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time
event
2 Repeated
exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced
or Sibling of
abuse victim)
4 Unknown
Was serious injury inflicted?

0 No
1 Yes
99 Unknown
If yes, to whom (check all that apply):
Child
Parent
Other adult relative
Unrelated (but identifiable) adult
Sibling
Other youth
98 Other, specify: _____
Was a weapon used?
0 No
1 Yes
99 Unknown
Did this assault ever involve oral, vaginal, or anal penetration?
0 No
1 Yes
99 Unknown
1 Home
2 School
3 Community
98 Other, specify: _____
99 Unknown
1 Parent
2 Other adult relative
3 Unrelated (but identifiable) adult
4 Sibling
5 Other youth
6 Stranger
99 Unknown
Perpetrator Gender:
Male
Female
Was a report filed? (e.g. Police, Child Protective Services)
0 No
1 Yes
99 Unknown
If a CPS report was filed, was it:
0 Not Substantiated

1 Substantiated
99 Unknown

Trauma Type
Has the child
experienced this
trauma (answer
all Trauma Types)
Age
Age in years:
(Check all
ages that
apply) Frequency
Type(s) of
exposure
(Check all that
apply)
What reportedly
happened?
(Check all that apply)
Setting(s) of
experience
(Check all that
apply)
Perpetrator(s)
(Check all that
apply)
Legal Action Regarding
Trauma
(Check all that apply)
3. Physical maltreatment/
abuse:
(History of actual or
attempted infliction of
physical pain or bodily injury
by an adult or older youth in
a caretaking role)
When was this trauma
revealed/known to the
clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time

event
2 Repeated
exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
abuse victim)
4 Unknown
Was serious injury
inflicted?
0 No
1 Yes
99 Unknown
If yes, to whom (check all
that apply):
Child
Parent
Other adult relative
Unrelated (but
identifiable) adult
Sibling
Other youth
98 Other, specify:
_____
Was a weapon used?
0 No
1 Yes
99 Unknown
1 Home
2 School
3 Community
98 Other,
specify:
_____
99 Unknown
1 Parent
2 Other adult
relative
3 Unrelated (but
identifiable)
adult
4 Sibling
5 Other youth
6 Stranger
99 Unknown
Perpetrator
Gender:
Male
Female
Was a report filed? (e.g.

Police, Child Protective Services)
0 No
1 Yes
99 Unknown
If a CPS report was filed, was it:
0 Not Substantiated
1 Substantiated
99 Unknown
4. Physical assault: (Actual or attempted infliction of physical pain or bodily injury not by a caregiver and not recorded as physical abuse)
When was this trauma revealed/known to the clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time event
2 Repeated exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious (Indirectly experienced or Sibling of abuse victim)
4 Unknown
Was serious injury inflicted?
0 No
1 Yes
99 Unknown
If yes, to whom (check all

that apply):
Child
Parent
Other adult relative
Unrelated (but identifiable) adult
Sibling
Other youth
98 Other, specify: _____
Was a weapon used?
0 No
1 Yes
99 Unknown
1 Home
2 School
3 Community
98 Other, specify: _____
99 Unknown
1 Parent
2 Other adult relative
3 Unrelated (but identifiable) adult
4 Sibling
5 Other youth
6 Stranger
99 Unknown
Perpetrator Gender:
Male
Female
Was a report filed? (e.g. Police, Child Protective Services)
0 No
1 Yes
99 Unknown

Trauma Type
Has the child
experienced this
trauma (answer
all Trauma Types)
Age
Age in years:
(Check all
ages that
apply) Frequency
Type(s) of
exposure
(Check all that
apply)
What reportedly
happened?
(Check all that apply)
Setting(s) of
experience
(Check all that
apply)
Perpetrator(s)
(Check all that
apply)
Legal Action Regarding
Trauma
(Check all that apply)
5. Emotional
abuse/Psychological
maltreatment:
(Emotional abuse, verbal
abuse, excessive demands,
emotional neglect)
When was this trauma
revealed/known to the
clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time
event

2 Repeated
exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
abuse victim)
4 Unknown
Please identify the type of
maltreatment involved
(Check all that apply)
Emotional abuse
Emotional neglect
Verbal abuse
Excessive demands
Other, specify:
_____
Unknown
1 Home
2 School
3 Community
98 Other,
specify:
_____
99 Unknown
1 Parent
2 Other adult
relative
3 Unrelated (but
identifiable)
adult
4 Sibling
5 Other youth
6 Stranger
99 Unknown
Perpetrator
Gender:
Male
Female
Was a report filed? (e.g.
Police, Child Protective
Services)
0 No
1 Yes
99 Unknown
If a CPS report was
filed, was it:
0 Not Substantiated
1 Substantiated
99 Unknown
6. Neglect

(Physical, medical, or
educational neglect)
When was this trauma
revealed/known to the
clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time
event
2 Repeated
exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
abuse victim)
4 Unknown
Please identify the type of
neglect involved (Check
all that apply)
Physical
Medical
Educational
Other, specify:
_____
Unknown
1 Home
2 School
3 Community
98 Other,
specify:
_____
99 Unknown
1 Parent
2 Other adult
relative
3 Unrelated (but

identifiable)
adult
4 Sibling
5 Other youth
6 Stranger
99 Unknown
Perpetrator
Gender:
Male
Female
Was a report filed? (e.g.
Police, Child Protective
Services)
0 No
1 Yes
99 Unknown
If a CPS report was
filed, was it:
0 Not Substantiated
1 Substantiated
99 Unknown

Trauma Type
Has the child experienced this trauma (answer all Trauma Types)
Age
Age in years: (Check all ages that apply) Frequency
Type(s) of exposure (Check all that apply)
What reportedly happened? (Check all that apply)
Setting(s) of experience (Check all that apply)
Perpetrator(s) (Check all that apply)
Legal Action Regarding Trauma (Check all that apply)
7. Domestic Violence (Exposure to physical, sexual, and/or emotional abuse directed at adult caregiver(s) in the home)
When was this trauma revealed/known to the clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9 Unknown
1 One time event
2 Repeated

exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
abuse victim)
4 Unknown
Was serious injury
inflicted?
0 No
1 Yes
99 Unknown
If yes, to whom (check all
that apply):
Child
Parent
Other adult relative
Unrelated (but
identifiable) adult
Sibling
Other youth
98 Other, specify:
_____
Was a weapon used?
0 No
1 Yes
99 Unknown
1 Home
98 Other,
specify:
_____
99 Unknown
1 Parent
2 Other adult
relative
3 Unrelated (but
identifiable)
adult
4 Sibling
5 Other youth
6 Stranger
99 Unknown
Perpetrator
Gender:
Male
Female
Was a report filed? (e.g.
Police, Child Protective
Services)
0 No
1 Yes

99 Unknown
If a CPS report was filed, was it:
0 Not Substantiated
1 Substantiated
99 Unknown
8. War/Terrorism/Political violence inside the U.S.: (Exposure to any of these events inside the U.S.)
When was this trauma revealed/known to the clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time event
2 Repeated exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious (Indirectly Experienced or Sibling of trauma victim)
4 Unknown
Was serious injury inflicted?
0 No
1 Yes
99 Unknown
If yes, to whom (check all that apply):
Child
Parent
Other adult relative
Unrelated (but identifiable) adult
Sibling

Other youth
98 Other, specify:
_____
Please indicate the type of weapons used. (Check all that apply)
Conventional (e.g., shootings, bombings, 9/11, Oklahoma City)
Chemical
Radiological
Biological
Unknown
1 Home
2 School
3 Community
98 Other, specify:
_____
99 Unknown

Trauma Type
Has the child
experienced this
trauma (answer
all Trauma Types)
Age
Age in years:
(Check all
ages that
apply) Frequency
Type(s) of
exposure
(Check all that
apply)
What reportedly
happened?
(Check all that apply)
Setting(s) of
experience
(Check all that
apply)
Perpetrator(s)
(Check all that
apply)
Legal Action Regarding
Trauma
(Check all that apply)
9. War/Terrorism/Political
violence outside the U.S.:
(Exposure to any of these
events outside the U.S.)
When was this trauma
revealed/known to the
clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time
event
2 Repeated
exposure

99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
trauma victim)
4 Unknown
Was serious injury
inflicted?
0 No
1 Yes
99 Unknown
If yes, to whom (check all
that apply):
Child
Parent
Other adult relative
Unrelated (but
identifiable) adult
Sibling
Other youth
98 Other, specify:
_____
10. Illness/Medical
Trauma:
(Life threatening or
extremely painful illness or
medical procedure)
When was this trauma
revealed/known to the
clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time
event
2 Repeated
exposure
99 Unknown

1 Experienced
2 Witnessed
3 Vicarious (Indirectly experienced or Sibling of trauma victim)
4 Unknown

Was the child’s condition life-threatening?
0 No
1 Yes
99 Unknown

1 Home
2 Hospital
3 Extended care facility
98 Other, specify: _____
99 Unknown

Trauma Type
Has the child experienced this trauma (answer all Trauma Types)
Age
Age in years:
(Check all ages that apply) Frequency
Type(s) of exposure
(Check all that apply)
What reportedly happened?
(Check all that apply)
Setting(s) of experience
(Check all that apply)
Perpetrator(s)
(Check all that apply)
Legal Action Regarding Trauma
(Check all that apply)
11. Serious Injury/Accident:
(Unintentional accident or injury)
When was this trauma revealed/known to the clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time event
2 Repeated exposure

99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
trauma victim)
4 Unknown
Was permanent
disability/death inflicted?
0 No
1 Yes
99 Unknown
If yes, to whom (check all
that apply):
Child
Parent
Other adult relative
Unrelated (but
identifiable) adult
Sibling
Other youth
98 Other, specify:
_____
Please specify type of
accident/injury(s): (Check
all that apply)
Motor vehicle
Dog bite
Near drowning
Accidental shooting
Other, specify:
_____
Unknown
1 Home
2 School
3 Community
98 Other,
specify:
_____
99 Unknown
12. Natural disaster:
(Major accident or disaster
that is the result of a natural
event)
When was this trauma
revealed/known to the
clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown

0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time
event
2 Repeated
exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
trauma victim)
4 Unknown
Was serious injury
inflicted?
0 No
1 Yes
99 Unknown
If yes, to whom (check all
that apply):
Child
Parent
Other adult relative
Unrelated (but
identifiable) adult
Sibling
Other youth
98 Other, specify:
_____
1 Home
2 School
3 Community
98 Other,
specify:
_____
99 Unknown
Please specify type of
disaster(s) involved. (Check
all that apply)
Earthquake
Hurricane
Flood
Tornado

Fire
Industrial
98 Other, specify:
_____
Unknown
Did the child/family evacuate their home?
0 No
1 Yes
99 Unknown
Was the child’s home severely damaged or destroyed?
0 No
1 Yes
99 Unknown

Trauma Type
Has the child experienced this trauma (answer all Trauma Types)
Age
Age in years: (Check all ages that apply) Frequency
Type(s) of exposure (Check all that apply)
What reportedly happened? (Check all that apply)
Setting(s) of experience (Check all that apply)
Perpetrator(s) (Check all that apply)
Legal Action Regarding Trauma (Check all that apply)
13. Kidnapping: (Unlawful seizure or detention against the child’s will)
When was this trauma revealed/known to the clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9 Unknown
1 One time event
2 Repeated exposure

99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
trauma victim)
4 Unknown
Was a weapon used?
0 No
1 Yes
99 Unknown
1 Parent
2 Other adult
relative
3 Unrelated (but
identifiable)
adult
4 Sibling
5 Other youth
6 Stranger
99 Unknown
Perpetrator
Gender:
Male
Female
14. Traumatic loss or
bereavement:
(Death or separation of a
primary caregiver or sibling;
the unexpected, or premature
death of a close relative or
close friend)
When was this trauma
revealed/known to the
clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time

event
2 Repeated
exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
trauma victim)
4 Unknown
Please identify the people
lost. (Check all that apply)
Parent
Other adult relative
Unrelated (but identifiable)
adult
Sibling
Other youth
Stranger
Unknown
Was the loss/bereavement
due to death?
0 No – see last column
1 Yes
99 Unknown
If yes, specify cause (check all
that apply):
Natural causes/illness
Violence
Accident
Disaster
Terrorism, War, Political
violence
98 Other, specify:
_____
Was the child removed
from the home (foster
care, other out of home)?
0 No
1 Yes
99 Unknown
If not due to death, was
the caregiver(s) removed
from home?
0 No
1 Yes
99 Unknown
If yes, specify reason:
Divorce
Incarceration
Hospitalization (medical
or psychiatric)

98 Other, specify:
_____

Trauma Type
Has the child experienced this trauma (answer all Trauma Types)
Age
Age in years:
(Check all ages that apply) Frequency
Type(s) of exposure
(Check all that apply)
What reportedly happened?
(Check all that apply)
Setting(s) of experience
(Check all that apply)
Perpetrator(s)
(Check all that apply)
Legal Action Regarding Trauma
(Check all that apply)
15. Forced displacement:
(Forced relocation due to political reasons)
When was this trauma revealed/known to the clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time event
2 Repeated exposure
99 Unknown

1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
trauma victim)
4 Unknown
16. Impaired Caregiver:
(History of exposure to
caretaker depression, other
medical illness, or
alcohol/drug abuse)
When was this trauma
revealed/known to the
clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time
event
2 Repeated
exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
trauma victim)
4 Unknown
Please identify the
impaired caregiver(s)
(Check all that apply)
1 Parent
2 Other adult relative
3 Unrelated (but
identifiable) adult
4 Sibling
5 Other youth

6 Stranger
99 Unknown
The impairment was due to? (Check all that apply):
Drug use/abuse/addiction
Caregiver medical illness
Other
Unknown
Was a report filed? (e.g. Police, Child Protective Services)
0 No
1 Yes
99 Unknown
If a CPS report was filed, was it:
0 Not Substantiated
1 Substantiated
99 Unknown

Trauma Type
Has the child
experienced this
trauma (answer
all Trauma Types)
Age
Age in years:
(Check all
ages that
apply) Frequency
Type(s) of
exposure
(Check all that
apply)
What reportedly
happened?
(Check all that apply)
Setting(s) of
experience
(Check all that
apply)
Perpetrator(s)
(Check all that
apply)
Legal Action Regarding
Trauma
(Check all that apply)
17. Extreme interpersonal
violence (not reported
elsewhere):
(e.g., Homicide/suicide)
When was this trauma
revealed/known to the
clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time
event
2 Repeated
exposure

99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
trauma victim)
4 Unknown
Please indicate the types of
violence. (Check all that
apply):
Robbery
Assault
Homicide
Suicide
98 Other, specify:
_____
Unknown
Was serious injury inflicted?
0 No
1 Yes
99 Unknown
If yes, to whom (check all that
apply):
Child
Parent
Other adult relative
Unrelated (but identifiable)
adult
Sibling
Other youth
98 Other, specify:
_____
Was a weapon used?
0 No
1 Yes
99 Unknown
1 Home
2 School
3 Community
98 Other,
specify:
_____
99 Unknown
1 Parent
2 Other adult
relative
3 Unrelated (but
identifiable)
adult
4 Sibling
5 Other youth
6 Stranger

99 Unknown
Perpetrator
Gender:
Male
Female
18. Community violence
(not reported elsewhere):
(e.g., Gang-related violence,
neighborhood violence)
When was this trauma
revealed/known to the
clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time
event
2 Repeated
exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
trauma victim)
4 Unknown
Was anyone seriously injured
or killed?
0 No
1 Yes
99 Unknown
If yes, to whom (check all that
apply):
Child
Parent
Other adult relative
Unrelated (but identifiable)
adult
Sibling

Other youth
98 Other, specify:
_____
Was the violence gang-related?
0 No
1 Yes
99 Unknown
2 School
3 Community
98 Other, specify:
_____
99 Unknown

Trauma Type
Has the child experienced this trauma (answer all Trauma Types)
Age
Age in years:
(Check all ages that apply) Frequency
Type(s) of exposure
(Check all that apply)
What reportedly happened?
(Check all that apply)
Setting(s) of experience
(Check all that apply)
Perpetrator(s)
(Check all that apply)
Legal Action Regarding Trauma
(Check all that apply)
19. School violence (not reported elsewhere):
(e.g., School shooting, bullying, classmate suicide)
When was this trauma revealed/known to the clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown
1 One time event
2 Repeated exposure

99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
trauma victim)
4 Unknown
Please identify the type(s)
of violence. (Check all
that apply)
School shooting
Bullying
Classmate suicide
Other, specify:
_____
99 Unknown
Was serious injury
inflicted?
0 No
1 Yes
99 Unknown
If yes, to whom (check all
that apply):
Child
Teacher/staff
Sibling
Other youth
98 Other, specify:
_____
20. Other Trauma (not
reported elsewhere)?
Please Specify:
_____
When was this trauma
revealed/known to the
clinician?
Baseline
0 No
1 Yes
2 Suspected
99 Unknown
0 10
1 11
2 12
3 13
4 14
5 15
6 16
7 17
8 18
9
Unknown

1 One time
event
2 Repeated
exposure
99 Unknown
1 Experienced
2 Witnessed
3 Vicarious
(Indirectly
experienced or
Sibling of
trauma victim)
4 Unknown

21. Primary focus of current treatment? (Select only one)
1 Sexual maltreatment/abuse
2 Sexual assault/rape
3 Physical maltreatment/abuse
4 Physical assault
5 Emotional abuse/Psychological Maltreatment
6 Neglect
7 Domestic Violence
8 War/Terrorism/Political violence inside the U.S.
9 War/Terrorism/Political violence outside the U.S.
10 Illness/Medical Trauma
11 Serious injury/Accident
Please check each problem/symptom/disorder currently displayed by this child.

12 Natural Disaster
13 Kidnapping
14 Traumatic loss or bereavement
15 Forced Displacement
16 Impaired Caregiver
17 Extreme interpersonal violence (not reported elsewhere)
18 Community Violence (not reported elsewhere)
19 School Violence (not reported elsewhere)
20 Other Trauma (not reported elsewhere)
21 Other (not reported elsewhere)
XV. Problems/Symptoms [Clinician Completes following assessment]
Child has/exhibits this problem?
Assessment
Pathway
(Required)
Optional
Measures
(Use CASA to assess
strengths)
1. Acute stress disorder: 0 No 1 Probable 2 Definite STAIC
2. PTSD: 0 No 1 Probable 2 Definite STAIC, CDC
3. Traumatic/complicated grief: 0 No 1 Probable 2 Definite CDI
4. Dissociation: 0 No 1 Probable 2 Definite CDC
5. Somatization: 0 No 1 Probable 2 Definite
6. Generalized anxiety: 0 No 1 Probable 2 Definite STAIC
7. Separation disorder: 0 No 1 Probable 2 Definite STAIC, PSI, FAM-III
8. Panic disorder: 0 No 1 Probable 2 Definite STAIC
9. Phobic disorder: 0 No 1 Probable 2 Definite STAIC
10. Obsessive Compulsive Disorder (OCD): 0 No 1 Probable 2 Definite STAIC
11. Depression: 0 No 1 Probable 2 Definite CDI
12. Attachment, family, parenting or systems problems: 0 No 1 Probable 2 Definite
PSI, FAM-III or
TSI – see
pathway
13. Sexual behavioral problems: 0 No 1 Probable 2 Definite CSBI
14. Oppositional Defiant Disorder (ODD): 0 No 1 Probable 2 Definite TRF, YSR

15. Conduct disorder: 0 No 1 Probable 2 Definite TRF, YSR
16. General behavioral problems: 0 No 1 Probable 2 Definite TRF, YSR
17. ADHD: 0 No 1 Probable 2 Definite TRF, YSR
18. Suicidality: 0 No 1 Probable 2 Definite In-depth risk assessment

Child has/exhibits this problem?
Assessment
Pathway
(Required)
Optional
Measures
(Use CASA to assess
strengths)
19. Substance abuse: 0 No 1 Probable 2 Definite In-depth risk assessment
20. Sleep disorder: 0 No 1 Probable 2 Definite
AUDIT /DAST/
Substance Use
Screener
21. Homicidality: 0 No 1 Probable 2 Definite
22. Eating Disorders: 0 No 1 Probable 2 Definite
23. Adjustment Disorder 0 No 1 Probable 2 Definite
24. Other Specify:_____) 0 No 1 Probable 2 Definite Assessment Office/Duke Study Use Only:
If question 21, 22, or 23 answered, please type Homocidality, Eating Disorders, or Adjustment Disorder in the blank provided in Question 21 in Inform.
25. Please indicate the primary problem/symptom/disorder currently displayed by this child (Select only one)
1 Acute stress disorder 8 Panic disorder 15 Conduct disorder
2 Post traumatic stress disorder (PTSD) 9 Phobic disorder 16 General behavioral problems
3 Traumatic/complicated grief 10 Obsessive compulsive disorder (OCD) 17 Attention deficit hyperactivity disorder
4 Dissociation 11 Depression 18 Suicidality
5 Somatization 12 Attachment problems 19 Substance abuse
6 Generalized anxiety 13 Sexual behavioral problems 20 Sleep disorder
7 Separate disorder 14 Oppositional defiant disorder (ODD) 21 Other

XVI. DSM-IV-TR Diagnosis: [Clinician completes following assessment]
Axis I:
_____
_____
Axis II:
_____
_____
Axis III:
_____
_____
Axis IV:
_____

_____

_____

Axis V (GAF):

_____

XVII. Comments (optional) [Clinician Completes following assessment]
Please provide any details you think would be helpful in the interpretation of your answers on the previous 24 pages.
Also, any feedback to the Data Core on this form and/or the data collection process would be appreciated.

_____
_____

_____
_____

_____
_____

_____
_____

_____
_____

_____
_____

Therapist Signature_____
Date_____

XVII. Definitions XVII. Definitions
Please use definitions provided on this form when completing the report. Many of the definitions appear in the body of the form, additional definitions for your reference are included below. These definitions will be used across all Network data collection activities whenever possible, and
are consistent with external data collection efforts to allow comparability of results.

Center ID Number2 – Refer to the Site ID List for your sites unique numeric identifier. This number is used to identify all the data provided by your
site as part of the National Child Traumatic Stress Initiative. Your site will remain consistent for each data collection activity that occurs within the
Network.

Race & Ethnicity3

The standards have five categories for data on race: American Indian or Alaska Native, Asian, black or African American, Native Hawaiian or Other Pacific Islander, and White. There are two categories for data on ethnicity: “Hispanic or Latino,” and “Not Hispanic or Latino.”

American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including
Central America), and who maintains tribal affiliation of community attachment.
Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro”
can be used in addition to “Black or African American.”
Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other
Pacific Islander.
White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

External references for specific definitions:

1 Center for Mental health Services, Uniform Data Definition
2 NCTSN custom data definition
3 Office of Management and Budget data definition

* Definitions for Trauma Types (based on National Child Abuse and Neglect Data Systems (NCANDS) glossary)
1.
SEXUAL MALTREATMENT/ABUSE
i.

Note: Sexual maltreatment/abuse refers to acts by an adult or older youth who is playing a caretaker role for the youth (e.g., parent, parent-substitute, babysitter, adult relative, teacher, etc.). Sexual contact/exposure by other s(i.e., non-caretakers) should be classified as ‘sexual assault/rape’.

ii. Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-in-appropriate sexual material or environments (e.g., print, internet or broadcast pornography; witnessing of adult sexual activity) by an adult to a minor child

iii. Sexual exploitation of a minor child by an adult for the sexual gratification or financial benefit of the perpetrator (e.g., prostitution; pornography; orchestration of sexual contact between two or more minor children)

iv. Unwanted or coercive sexual contact or exposure between two or more minor children

2. SEXUAL ASSAULT/RAPE

i. Note: Sexual assault/rape should include contact/exposure by perpetrators who are NOT in a caretaking role with the youth (sexual misconduct by caregivers should be recorded as ‘sexual maltreatment/abuse’.

ii. Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-inappropriate sexual material or environments (e.g., print, internet or broadcast pornography; witnessing of adult sexual activity) by an adult to a minor child

iii. Sexual exploitation of a minor child by an adult for the sexual gratification or financial benefit of the perpetrator (e.g., prostitution; pornography; orchestration of sexual contact between two or more minor children)

iv. Unwanted or coercive sexual contact or exposure between two or more minor

3. PHYSICAL ABUSE/MALTREATMENT

i. Note: Physical maltreatment/abuse refers to acts by an adult or older youth who is playing a caretaker role for the youth (e.g., parent, parent-substitute, babysitter, adult relative, teacher, etc.). Physical pain and/or injury by others (i.e., non-caretakers) should be classified as ‘physical assault.’

ii. Actual or attempted infliction of physical pain (e.g., stabbings; bruising; burns; suffocation.) by an adult, another child, or group of children to a minor child with or without use of an object or weapon and including use of severe corporeal punishment

iii.

Does not include rough and tumble play or developmentally normative fighting between siblings or peers of similar age and physical capacity (e.g., assault of a physically disabled child by a non-disabled same-aged peer would be included in this category of trauma exposure)

4. PHYSICAL ASSAULT

i. Note: Physical assault should include infliction of physical pain/bodily injury by perpetrators who are not in a caretaking role with the youth (such actions by caregivers should be recorded as ‘physical maltreatment/abuse’).

ii. Actual or attempted infliction of physical pain (e.g., stabbings; bruising; burns; suffocation.) by an adult, another child, or group of children to a minor child with or without use of an object or weapon and including use of severe corporeal punishment

iii. Does not include rough and tumble play or developmentally normative fighting between siblings or peers of similar age and physical capacity (e.g., assault of a physically disabled child by a non-disabled same-aged peer would be included in this category of trauma exposure)

5. EMOTIONAL ABUSE/PSYCHOLOGICAL MALTREATMENT
i.
Acts of commission against a minor child, other than physical or sexual abuse, that caused or could have caused conduct,
cognitive, affective or other mental disturbance. These acts include:
o
Verbal abuse (e.g., insults; debasement; threats of violence)
o
Emotional abuse (e.g., bullying; terrorizing; coercive control)
o
Excessive demands on a child’s performance (e.g., scholastic; athletic; musical; pageantry) that may lead to
negative self-image and disturbed behavior
ii.
Acts of omission against a minor child that caused or could have caused conduct, cognitive, affective or other mental
disturbance. These include:
o
Emotional neglect (e.g., shunning; withdrawal of love)
o
Intentional social deprivation (e.g., isolation; enforced separation from a parent, caregiver or other close family
member)
6.
NEGLECT
i.
Failure by the child victim’s caretaker(s) to provide needed, age-appropriate care although financially able to do so, or
offered financial or other means to do so. Includes:
o
Physical neglect (e.g., deprivation of food, clothing, shelter)
o
Medical neglect (e.g., failure to provide child victim with access to needed medical or mental health treatments
and services; failure to consistently disperse or administer prescribed medications or treatments (e.g., insulin
shots))
o
Educational neglect (e.g., withholding child victim from school; failure to attend to special educational needs;
truancy)
7.
DOMESTIC VIOLENCE
i.
Exposure to emotional abuse, actual/attempted physical or sexual assault, or aggressive control perpetrated between a
parent/caretaker and another adult in the child victim’s home environment
ii.
Exposure to any of the above acts of perpetrated by an adolescent against one or more adults (e.g., parents, grandparent)
in the child victim’s home environment
8.
WAR/TERRORISIM/POLITICAL VIOLENCE INSIDE THE U.S.
i.

Exposure to acts of war/terrorism/political violence on U.S. soil (including Puerto Rico). Same as above, only in U.s.
Historical examples include attacks of 9-11, Oklahoma bombing, and anthrax deaths.
ii.
Includes actions of individuals acting in isolation, e.g. sniper attacks, school shootings if they are considered to be
political in nature.
9.
WAR/TERRORISIM/POLITICAL VIOLENCE OUTSIDE THE U.S.
i.
Exposure to acts of war/terrorism/political violence, including living in a region affected by bombing, shooting, or looting
other than in the U.S.
ii.
Accidents that are a result of terrorist activity (e.g. bridge collapsing due to intentional damage, hostages who are injured
during captivity) outside the U.S.
10.
ILLNESS/MEDICAL
i.
Having a physical illness or experiencing medical procedures that are extremely painful and/or life-threatening
ii.
The event of being told that one has a serious illness
iii.
Examples of illnesses include cancer or AIDS. Examples of medical procedures include changing burn dressings or
undergoing chemotherapy.
iv.
Does NOT include medical injuries that would otherwise be classified under Injury/accident (e.g. a child who is burned in
a fire would be designated as experiencing an accident/injury trauma; however, if they then had to undergo repeated,
painful dressing changes theyw would also qualify for illness/medical trauma).
11.
INJURY/ACCIDENT
i.
Injury or accident such as car accident, house fire, serious playground injury, or accidental fall down stairs.
ii.
Does NOT include injury or accident caused at the hands of another person who is intending harm of any type (e.g. a child
who falls down the stairs after a parent pushes him would be classified under physical maltreatment/assault, even if the
parent didn’t intend for the push to lead to the fall).
iii.
Key concept here is “Unintentional”.
12.
NATURAL DISASTER
i.
Major accident or disaster that is an unintentional result of manmade or natural event, e.g. tornado, nuclear reactor

explosion.
ii.
Does NOT include disasters that are intentionally caused (e.g. Oklahoma City Bombing, bridge collapsing due to intentional damage), which would be classified as acts of terrorism/political violence.
13.
KIDNAPPING
i.
Unlawful seizure or detention against the child’s will
ii.
May include kidnapping by non-custodial parent as well as by stranger.
14.
TRAUMATIC LOSS OR BEREAVEMENT
i.
Death of a parent, primary caretaker or sibling
ii.
Abrupt, unexpected, accidental or premature death or homicide of a close friend, family member, or other close relative
iii.
Abrupt, unexplained and/or indefinite separation from a parent, primary caretaker, or sibling, due to circumstances beyond the child victim’s control (e.g., contentious divorce; parental incarceration; parental hospitalization; foster care placement)
15.
FORCED DISPLACEMENT
i.
Forced relocation to a new home due to political reasons. Generally includes political asylees or immigrants fleeing political persecution. Refugees or political asylees who were forced to move and were exposed to war may be classified here and also under war/terrorism/ political violence outside US.
ii.
Does NOT include immigrants who move voluntarily (e.g. moving due to poverty of home country), or families who are evicted.
iii.
Does NOT include homelessness.
iv.
The key concept here is “Political”.

16.
IMPAIRED CAREGIVER
i.
Functional impairment in at least one of child’s primary caregivers that results in deficient performance of the caretaking role (i.e., inability to meet the child’s needs).
ii.
Impairment means that caregiver(s) were neither able to provide children with adequate nurturance, guidance, and support nor attend to their basic developmental needs due to their own mental illness, substance abuse, criminal activity or chronic overexposure to severe life stressors (e.g., extreme poverty, community violence).
iii.
Impairment may be due to various causes (e.g., medical illness, mental illness, substance use/abuse, exposure to severance life stressors (e.g., extreme poverty, community violence))
iv.
If impairment results in additional trauma (e.g., neglect, emotional abuse/psychological maltreatment), BOTH ‘impaired caregiver’ and the more specific type of trauma should be reported.
17.
EXTREME PERSONAL/INTERPERSONAL VIOLENCE (NOT REPORTED ELSEWHERE)
i.
Includes extreme violence by or between individuals that has not been reported elsewhere (hence, if the child witnessed domestic violence, this should be recorded as “domestic violence” and NOT repeated here)
ii.
Intended to include exposure to homicide, suicide and other similar extreme events
18.
COMMUNITY VIOLENCE (NOT REPORTED ELSEWHERE)
i.
This category is intended to capture episodic or pervasive violence in the youth’s community that have not been captured in other categories.
ii.
Include extreme violence in the community (i.e., neighborhood violence)
iii.
Exposure to gang-related violence should be recorded here (though specific incidents of gang-related violence (e.g., homicide, assaults) should also be recorded under those more specific headings.
19.
SCHOOL VIOLENCE
i.
This category is intended to capture violence that occurs in the school setting and that has not been reported in other categories.
ii.
It includes, but is not limited to, school shootings, bullying, interpersonal violence among classmates, classmate suicide.
20.

OTHER TRAUMA
i.
Any other type of trauma that is not captured by this list. Please describe.
Other Definitions primarily based on National Child Abuse and Neglect Data System (NCANDS) Glossary:

VICARIOUS Experienced or realized through imaginative or sympathetic participation in the experience of another. Siblings of child maltreatment victims are included in this category.

Appendix J: Case Examples

Example 1: Differential Triage

Two children of the same age with trauma histories may benefit from very different treatment approaches based upon the assessments and interview.

Case A

Reason for referral: Both biological parents present at the intake appointment seeking treatment for their 4-year-old boy, whom the mother states is at risk of losing placement at his current daycare, the 2nd in two months. Child has a history of exposure to domestic violence between his parents. He is described as being aggressive with peers, nonresponsive to his childcare provider's direction, and unable to follow directions.

Clinical interview: The child's parents have been separated for the last three months. He lives with his mother and visits with his father. Both parents acknowledge a history of mutual verbal abuse and domestic violence (DV). The child has witnessed some of the verbal and physical altercations. At intake, both parents minimize the possible impact the DV has had on their child. The mother discusses her frustration with her son's inability to complete behavioral sequences, specifically around the issue of potty training. He has not mastered this developmental task. During the intake, it was observed that the mother did not follow through on directions given or requests made of the child. She allowed him free range of the office, setting only minimal limits upon his behavior. He ignored her requests. The father did not react to the child's behavior. Neither parent was able to provide detailed information on the child's routines or examples of parent-child interactions, including the ways in which behavioral concerns were managed.

Standardized Assessment Scores: Due to the child's age, only the caretaker measures were completed in the assessment process.

Caretaker Report Measures:
UCLA PTSD Index: No clinical elevations.
Child Behavior Checklist (CBCL): Scores were in the borderline clinical range in Social (T=63) and Attention problems (T=62).
Trauma Symptom Checklist for Young Children (TSCYC): Scores were not elevated (all scores were $T < 58$).

Decision Point: The interview and observation raise clinical concerns about
the family’s functioning. Move into the assessment pathway to probe more deeply into this issue.

Assessment Pathway: Following the TAP Assessment Pathway, a measure of parenting
skills was administered to explore in greater depth the parenting strengths and
weaknesses of the parents and family functioning. The Parenting Stress Index
(appropriate for 2-12 year olds) was selected.

Parenting Stress Index (PSI):
Father scored in the 85th percentile on defensiveness (elevated)
Mother scored in the 97th percentile for difficult child (elevated)
Mother scored in 82nd percentile for parental distress (elevated)

Mother scored in 84th percentile on parent-child dysfunctional interaction
(elevated)

Creating the Unique Client Picture:
Treatment domains: After collecting the assessment information, symptoms and
concerns were placed in the domains as illustrated below.

Mood Symptoms
Yes ..
No •
Anxiety Problems
Yes ..
No •
Dissociative Problems
Yes ..
No •
Behavioral Problems
Yes ..
No •
Noted on PSI and in interview only.
Attachment Problems
Yes ..
No •
System Problems
Yes ..
No •
Social problems on CBCL and family problems on PSI
Trauma Specific Problems
Yes •
No •

Minimized
or denied by
parents.

Clinical Hypotheses: The client’s parents appear to lack knowledge of developmentally
appropriate parenting skills. This lack of knowledge results in behavioral concerns at
home, daycare, and in potty training attempts.

Decision Point: Triage this child to PCIT (appropriate age, behavioral problems,
available parent, trauma is not currently the primary presenting problem). Refer
to Appendix E for complete triage pathway.

Case B
Reason for referral: A foster mother is seeking treatment for her 4-year-old foster
daughter to help her work through the impact of a wide range of traumatic experiences
and placement issues.

Clinical interview: The foster mother reports that the child had a history of sexual
abuse, possible physical abuse, homelessness, and neglect. This is this child’s third
placement with foster parents within the past 6 months. Placements have occurred
subsequent to several removals from her mother’s care and reunifications. Immediately
following each removal, the child was placed in a short-term receiving home. The child
hoards food, spaces out frequently, has trouble bonding, and acts frightened in unfamiliar
settings.

Standardized Assessment Scores: Due to the child’s age, only the caretaker measures
were completed in the assessment process.

Caretaker Report Measures:
UCLA PTSD Index: Scores were in the clinically distressed range with a likely
diagnosis of PTSD.
TSCYC: PTSD (T = 68) and Dissociation (T = 80) scores were in the clinical range.
CBCL: Scores on internalization were in the clinical range (T=72)

Decision Point: Assessment of family functioning was not administered in this
case because of the lack of availability of the child’s mother and the instability of
the foster home placements.

Creating the Unique Client Picture:
Treatment domains:

Mood
Symptoms
Yes ..
No •
Anxiety
Problems
Yes ..
No •
Dissociative
Problems
Yes ..
No •
Elevation on
TSCYC DIS and
interview.
Behavioral
Problems
Yes •
No •
Attachment
Problems
Yes •
No •
Per interview
System
Problems
Yes ..
No •
Per
interview
Trauma
Specific
Problems
Yes •
No •
Elevation
on TSCYC
and UCLA
PTSD and
interveiw

Clinical Hypotheses: This child has experienced multiple traumas and has lacked a
stable home environment. She experiences attachment difficulties as well as trauma

associated behaviors and symptoms.

Decision Point: This child is experiencing trauma symptoms. Because a stable caregiver is not available, the child is not appropriate for TF-CBT or another manualized treatment option. Continue through the treatment pathway of the TAP model.

Example 2: Teasing apart Inter-rater Differences

Often children and caretakers do not agree about the problems that the child is experiencing. One of the challenges for a clinician is deciding how to make sense of contradictory information.

Reason for referral: A 10-year-old female is referred for therapy after an incident in which her father shot her. The shooting resulted in the loss of one of her arms and one kidney.

Clinical interview: The incident was described as accidental, although, there was evidence to suggest that the father had exposed his children to other high-risk situations in the past. He was subsequently charged with child endangerment. The child has a history of other traumas, including having been in a serious car accident. Her mother is a recovering substance abuser. At the time of the shooting, the mother was in recovery and living in a halfway house. The father was described as also having a long history of untreated drug abuse. Before the shooting, the child had been living with her father. The mother stated that prior to the shooting, the child presented as healthy and symptom-free. At the time she entered treatment, the child was living with her mother. During the assessment process, the child presents with appropriate affect. She states, “Everything is fine. I am OK. I don’t need therapy.” She is doing well in school, has friends, and is functioning appropriately in day-to-day life.

Standardized Assessment Scores:

Child Report Measures:
Trauma Symptom Checklist for Children (TSCC): Scores were all in the non-clinical range, but critical items of fear of harm, fear somebody will kill her, and wishing bad things had never happened were endorsed. The validity scales were not elevated, suggesting that she was not minimizing her symptoms.
UCLA PTSD Reaction Index: Child checked items related to her experiences, but did not endorse any symptoms related to her experiences.

Caretaker Report Measures:
Trauma Symptom Checklist for Young Children (TSCYC): scores indicated

PTSD distress (T=65), anxiety (T=68), and depression (T=68) within the clinical range. The atypical response scale of TSCYC that measures over reporting was also elevated (T=70), questioning the validity of the mother's report.
UCLA PTSD Reaction Index: Mother checked items related to child's experiences and scores indicated that she had a clinically significant PTSD reaction.

Decision Point: The parent reported multiple symptoms that the child denied.
Sometimes the parent's own psychological functioning may influence how they perceive his/her child (i.e., depression or his/her own personal trauma history).
Also, sometimes a child may deny problems to protect loved ones (in this case her father). To tease this out, move into the assessment pathway to probe more deeply into this issue.

Child Report Measures:
Family Assessment Measure III: No clinical elevations
Child Depression Inventory (CDI): T=45; not clinically elevated

Caretaker Report Measures:
Center for Epidemiological Studies – Depression (CES-D): Scores indicated a
clinical level of depression for the mother.

Family Assessment Measure III (FAM-III):
Communication: T = 63; problem area
Affective Expression: T=66; problem area

Creating the Unique Client Picture:
Treatment domains

Mood Symptoms
Yes •
No •
Denied by child; reported by mother
Anxiety Problems
Yes ..
No •
Denied by child; reported by mother
Dissociative Problems
Yes ..
No •
Denied by child; reported by mother
Behavioral Problems
Yes ..
No •
Attachment Problems
Yes ..
No •
System Problems
Yes ..

No •
Family
problems
and parent
functioning
per
interview
and
measures
Trauma
Specific
Problems
Yes ..
No •
Interview
and mother
assessment

Clinical Hypotheses:
Hypothesis 1: The mother appeared to be experiencing depression and dealing with issues related her own reactions to her child’s trauma as well as her struggles with sobriety. This may have affected her perception of her daughter’s behaviors and symptom presentation, which may have interfered with her ability to be an accurate reporter.
Hypothesis 2: Although the child denies any trauma-related symptoms or problems, the mother did report concerns for her daughter since the shooting. It is possible that the child is denying problems to protect her father (the perpetrator) or even herself from the shooting experience.

Decision point: (1) The mother was referred to individual treatment to deal with her own depression, feelings about the shooting, and to learn ways to help or become more supportive of her daughter. (2) The child was not appropriate for other manualized treatments because she presented as asymptomatic and her mother could not participate in conjoint treatment due to her depression and other needs. Instead, the child continued treatment through the TAP model, beginning with psychoeducation and skill building to help deal with the loss of her limb and father (no longer primary caregiver). (3) Reassessment will be very important to determine if symptoms arise for the child as she begins to trust the clinician and gets comfortable with the therapeutic process.

Example 3: Reassessment and its importance to the Pathway Process

Reason for referral: A 5-year-old child was referred to treatment by a county Social Worker, and was brought to the intake appointment by her mother. Her biological father had molested her two older half sisters. She was referred as a secondary victim because she was reportedly experiencing symptoms related to the absence of her father.

Clinical interview: Once her sisters made disclosures, the child's father reportedly left the country to avoid arrest. The child was living with her mother and siblings at the time of the intake. The mother had not told the child that her siblings had been molested. She reported that the child was confused about where her father was and why she could not see him. The child reportedly searched for him and photos of him almost daily and became extremely upset when she could not locate him or the pictures. During the intake, the mother denied any history of DV or other family abuse. She described her own feelings as overwhelmed and guilty.

The child appeared as stated, confused, saddened, and anxious about her father's absence. She reportedly did not understand why her father left and showed concerns as to where he went and when she would see him again.

Standardized Assessment Scores: Due to the child's age, only the caretaker measures were completed in the assessment process.

Caretaker Report Measures:
UCLA PTSD Index: No clinical elevations.
Child Behavior Checklist (CBCL): Scores were within the normal range (T< 50).
Trauma Symptom Checklist for Young Children (TSCYC): No clinical elevations (T< 60).

Decision Point: The interview and observation raise clinical concerns about the family's functioning. Move into the assessment pathway to probe more deeply into this issue.

Additional Caretaker Report Measures:
Family Assessment Measure-III (FAM-III): Scores indicated defensive responding on the Defensiveness scale (T= 65).

Parenting Stress Index (PSI):.All clinical scales were elevated including Total
Stress with all scores above the 80th percentile.

Creating the Unique Client Picture:
Treatment domains

Mood
Symptoms
Yes •
No •
Anxiety
Problems
Yes ..
No •
Dissociative
Problems
Yes ..
No •
Behavioral
Problems
Yes ..
No •
Attachment
Problems
Yes ..
No •
System
Problems
Yes ..
No •
Trauma
Specific
Problems
Yes ..
No •

Clinical Hypothesis:
Hypothesis 1: The child appeared to be experiencing confusion, anxiety, and depression as a result of her father's absence and lack of explanation given to her.

Decision Point: Although her anxiety problems appeared to be the primary area of concern, the way the family system (her mother) was handling the absent father was most likely related to the child's anxiety. Family therapy including an age-appropriate explanation of the molest and the absence of her father.

Reassessment: Once initial treatment began the child started reporting domestic violence she had observed within the home. The treatment goals and area of focus within the treatment pathway were redirected.

Note: The TAP model emphasizes the importance of re-assessment through standardized measurement, interview, and behavioral observation as new information is often disclosed throughout the therapy process. Treatment progress, symptom change, and newly reported traumatic experiences can be monitored and dealt with in treatment most effectively based upon the Unique Client Picture and integration of additional assessment information.