

Conducting a Trauma-Informed Mental Health Assessment



Why is it important to conduct an assessment prior to beginning therapy with abused children?

Assessments are to therapy as MRIs are to surgery—the evaluation or assessment guides the intervention. The assessment process assists the clinician in identifying the client’s symptoms and assists in prioritizing intervention strategies. Clinicians do not treat abuse; they treat the symptoms which arise from the abuse, its investigation, the impact on the family, and in turn the effect of on the child victim.

However, not all assessments are evidence-based. Clinical interviews are the most common approach used prior to therapy, but the research has found them to lack thoroughness and to be subject to clinician bias. A clinical interview that assesses contextual variables like the family, developmental history, medical history, school history, and prior mental health services remains a necessity; however, it alone is not sufficient.

What is an evidence-based assessment?

The fields of child trauma and child abuse now recognize that treatments provided to children should be evidence-based—including attributions like superiority to some other treatment or waitlist (control group), delivered with fidelity (consistency), random assignment to treatment, and replication. Similarly, evidence-based treatment requires certain psychometric qualities of a test, assessment, or measure. That is, the assessment should be reliable (e.g., consistent within the items assessing a measured construct like anxiety or sexual concerns, consistent between two administrations proximal in time), valid (i.e., actually measuring the construct which it purports to measure), and standardization or norming of scores (converting raw scores into standardized scores (e.g., T scores) which allow comparisons or adjustments based on age or gender and which establish which raw scores are within normal expectations and which ones are high or low.

Many “research instruments” have been developed that can provide some evidence for reliability and some for validity; however, few measures generally have established norms, and only three measures of abuse- and trauma-related symptoms have norms.

What are some of the instruments to use in evidence-based assessment?

There are several broad-band assessments which simultaneously assess a variety of general symptoms like depression, anxiety, and oppositionality. Also, there are unidimensional measures which assess single constructs like depression (e.g., the Children’s Depression Inventory–2). These measures can provide excellent information on a single construct. However, there are some specific symptoms which research tells us are common outcomes for abused children. Some of those symptoms are related to trauma—post-traumatic stress (PTS) and dissociation; others are not and include sexual concerns, depression, anxiety, and anger. The broad-band measures assess anger, depression, and anxiety, but fail to assess PTS, dissociation, and sexual concerns.

Finally, a good assessment of a child should include ratings provided by a caregiver familiar with the child (e.g., a parent/caregiver form) and child self-report. Children and their parents contribute meaningful, but not always overlapping information.

Only two measures assess relevant abuse and trauma-related symptoms, include forms for self-report and caregiver report, are reliable and valid, and are normed. These measures are the Trauma Symptom Checklist for Children (TSCC; 54 items; ages 8-16) and the Trauma Symptom Checklist for Young Children (TSCYC; 90 items; completed by caregivers for ages 3-12) developed by Dr. John Briere and available for purchase from the publisher, Psychological Assessment Resources, Inc.

As noted, the TSCC and TSCYC do not map directly onto to DSM diagnoses. Structured and semi-structured clinical interviews exist and demonstrate reliability and, to some degree, occasionally of validity. However, these approaches, while resulting in a diagnosis (or multiple diagnoses) are time-consuming, subject to clinician judgment and bias, and generally suffer from poor psychometric properties.

How do you know which symptoms to look for when doing an assessment?

Trauma-related symptoms are not the only symptoms evident in abused children that deserve attention. Some children act out, are depressed, or have sexualized behavior problems. There are those circumstances where sexually abused children have not been traumatized, but may become sexualized. When trauma does occur, symptoms of post-traumatic stress or dissociation may occur. Dissociative symptoms lie along a continuum from mild interference with functioning to disabling. As DSM-V notes, dissociative symptoms (mild) often occur with PTS symptoms.

The primary symptoms of PTSD include physiological hyperarousal resulting in concentration problems (sometimes misdiagnosed as ADHD or as a symptom of depression), irritability (often labeled as oppositional or misdiagnosed as the irritability of depression), sleep difficulties (often triggered by memories of abuse at bedtime), exaggerated startle (sometimes accompanied by re-experiencing and mislabeled as bipolar), and physiological reactivity (like sweating). Re-experiencing symptoms include reactions to reminders, stimuli, or triggers which may be consciously associated with the abuse or unrecognized by children and their caregivers as stimuli associated with the abuse. Once the child is safe, these symptoms may persist and result in “dysfunction” or the next cluster, which is avoidance of all stimuli, reminders, events, memories, and so forth, associated with the traumatic abuse.

Misdiagnosis may result from a lack of training and be unintentional, but missing the trauma diagnosis or misdiagnosing it as something else may result in inappropriate treatment. Thus, assessment can help to accurately identify trauma and its symptoms. As discussed, children can be sexually abused and NOT be traumatized, so clinicians should not automatically assign a diagnosis of PTSD at the mere mention of abuse. It is important to screen for other co-occurring, potentially traumatic events such as other forms of child maltreatment, domestic violence, community violence, etc.