CHAPTER 15

Traumatic Events

While many children experience stressful life events such as poor sibling/peer relationships, divorce, death of significant others, or medical illnesses, these events are not usually considered traumatic (American Psychiatric Association [APA], 2013; Cohen, Mannarino, & Deblinger, 2017). Factors that have been identified by the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), to distinguish traumatic events include directly experiencing actual or threatened severe violence or death, recurrent distress about the event, extreme avoidance, and alterations in mood and/or arousal due to the event (APA, 2013). Traumas that have the highest prevalence rates for children include the violent death of a family member or peer, physical or sexual abuse, serious accident, and natural disaster (Copeland, Keeler, Angold, & Costello, 2007). Even though 70–80% of children may experience a traumatic event by age 17 years, a much smaller percentage go on to develop severe problems following the trauma (Copeland et al., 2007; Turner, Finkelhor, & Ormrod, 2010). This chapter provides the clinician with empirically based information about the complex area of childhood trauma. The professional literature on the topic of childhood trauma is overwhelmingly large and diverse, including clinical case studies, observational studies, empirical research, and comprehensive reviews and meta-analyses. We have condensed this large volume of work to focus on the issues we view as central to assessing and treating children who experience traumatic events.

Research on trauma in children has focused primarily on the reactions of children to specific traumas (e.g., sexual abuse, natural disasters). It is only in the past 10 years, with the federal establishment of the National Child Traumatic Stress Network and website (*www.nctsn.org*), that there has been more focus on common experiences and reactions across different traumas and the combined effect of experiencing multiple types of trauma. Findings have shown that there are more similarities than differences in children's reactions to traumatic experiences. Therefore, it is important

to identify traumatic experiences and factors that may cause a proportion of children to show more significant trauma symptoms. In this section, we discuss diagnostic criteria for different reactions to traumatic experiences, prevalence of different traumas, similar risk and protective factors across traumatic experiences, and, where appropriate, unique reactions of children to particular traumas.

TRAUMA- AND STRESSOR-RELATED DISORDERS

DSM-5 (APA, 2013) categorizes trauma and stress-related disorders in several ways. These disorders are distinct from other disorders, in that experiencing a traumatic event is a requirement within the criteria for the disorder. The most common of these disorders in children are posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorder.

Posttraumatic Stress Disorder

Central features of PTSD in DSM-5 (APA, 2013) include (1) experiencing or witnessing an event involving threatened or actual death or grave injury to self or others; (2) intrusive symptoms related to the event (e.g., nightmares, trauma-specific reenactment in play); (3) avoiding stimuli associated with the trauma (e.g., not talking about the event or refusing to go to the place where the trauma occurred); (4) problematic changes in thoughts or mood (e.g., trouble remembering parts of the event, or persistent fear or blaming self about the event); and (5) hyperarousal (i.e., startle responses, hypervigilance, inattentiveness, irritability or anger, and/or trouble sleeping). In recognizing that young children may experience traumatic symptoms differently, DSM-5 has separate criteria for children age 6 years and younger. Several of the criteria are similar to those listed earlier, with modifications for young children: (1) experiencing or witnessing an extreme event but excluding the option of repeated exposure to details in work, such as for first responders; (2) the same criteria for intrusive symptoms related to the event; (3) combining into one category the avoidance of stimuli associated with the trauma and problematic changes in thoughts or mood; and (4) similar criteria for hyperarousal except that it does not include the possible criteria of reckless or self-destructive behavior. For all children, the clinician should also specify whether the child experiences dissociative symptoms, which could be either *depersonalization*, a feeling of being detached from the body, or *derealization*, a feeling that experiences in the world are not real or are distorted in some way. In addition, the symptoms should persist for at least a month and cause clinically significant impairment. There is also a specifier acknowledging that children may have *delayed expression*, which is defined as not meeting full criteria of symptoms until at least 6 months after the trauma. Part of the change in these symptom criteria for children is the acknowledgment that children often experience significant functional impairments even if they do not meet all criteria for PTSD (Cohen et al., 2010).

Acute Stress Disorder and Adjustment Disorder

Acute stress disorder is distinguished from PTSD in that the symptoms start 3 days after the trauma and remit after 1 month. *Adjustment disorder* is distinguished from

PTSD in that the stressor does not meet the severity level of PTSD or the child experiences a severe trauma but does not experience other symptoms needed for a PTSD diagnosis (APA, 2013).

Prevalence

In a national study of 4,053 children, ages 2–17, Turner et al. (2010) reported that 80% of children had experienced some type of victimization, 66% of the sample was exposed to more than one type of victimization, 30% experienced five or more types, and 10% experienced 11 or more types of victimization in their lifetimes. They reported peer/sibling (79%) and physical assault (73.3%) as the highest victimizations, followed by exposure to community violence (51.4%), property damage (47%), bullying (26%), witnessing family violence (20%), sexual victimization/assault (11%), and physical abuse (6%). In addition, experiencing different types of victimization, termed *polyvictimization* (e.g., experiencing both physical abuse and bullying), was more highly related to trauma symptoms than experiencing multiple instances of the same type of trauma.

These results are consistent with a longitudinal study by Copeland et al. (2007) involving 1,420 children from a community sample. They found that almost 70% of children reported at least one traumatic event by 16 years of age, with very few of these children meeting criteria for a disorder. Lifetime prevalence rates were 32.8% for injuries/trauma (e.g., serious accident, natural disaster), 24.7% for the category of violence (e.g., violent death of family member/peer, physical abuse), 23.7% for witnessing an event happening to another, 21.4% for learning about an event happening to another, and 11% for sexual trauma. In the same study, overall rates of PTSD diagnosis (DSM-IV; APA, 1994) for children experiencing one or more of these events was 0.5%. By the age of 16, there were similar percentages of children who reported no event exposure (32.2%), exposure to one event (30.8%), or exposure to multiple events (37.0%). The rates of impairment increased with the number of traumatic events children experienced; also, the likelihood of a child evidencing PTSD symptoms increased with the number of events experienced. In addition, the Adverse Childhood Experiences (ACEs) study showed that the effect of these stressors can last into adulthood (Centers for Disease Control, 2017). As the number of childhood stressors increased, the more likely adults would show negative health outcomes, including drug use, depression, obesity, cancer, and heart disease.

The national report on child abuse and neglect data from 2009 to 2013 (U.S. Department of Health and Human Services [USHHS], 2015), reported that overall rates of reported maltreatment declined from 9.3 to 9.1% over this time period. The largest number of child victims were neglected (79.5%), followed by physically abused (18%), sexually abused (9%), and psychologically maltreated (8.7%). The majority of victims were European Americans (44%), followed by Hispanics (21.2%) and African Americans (22.4%). For 2013, national statistics indicated that 1,520 children died from abuse and neglect; 78.9% of these deaths were caused by one or both parents, and 73.9% of the children were younger than 3 years of age (USHHS, 2015).

Overall, the data not only show a broad range of traumatic experiences for children but they also suggest that the number of traumas can affect children as much as the different types of traumatic events.

CHILDREN'S ADJUSTMENT TO TRAUMA

Short-Term and Long-Term Reactions

Most children experience initial symptoms after a traumatic event. Psychological distress is a normative reaction after experiencing an unexpected or terrifying event (Cohen et al., 2010). However, for a significant proportion of children, the symptoms discontinue after a month, and most recover from acute symptoms within 3 months after the trauma, even without treatment (APA, 2013). Osofsky, Osofsky, Weems, King, and Hansel (2015) found that four different trajectories of symptoms for children exposed to trauma can potentially be used to help plan interventions. They found that the highest number of children (52%) experienced stable-low symptoms and were described as children who showed resilience after the trauma; the next group (21%) evidenced initial symptoms but then the symptoms dissipated, with the children described as experiencing recovery; a third group (9%) of children who continued to experience symptoms that got worse were described as experiencing more chronic symptoms; and a fourth group of children (18%) who displayed symptoms after a period of time were described as experiencing delayed distress. The first two groups of children may be those that already have enough support to deal with the trauma and resume their daily routine with little to no difficulties. It is the third and fourth groups of children that continue to show increasing symptoms that need intervention.

It is not surprising that children who have more severe reactions to traumatic events are also more likely to experience depression, anxiety, behavioral problems, and PTSD (Cohen et al., 2010; Copeland et al., 2007). In addition, children who have been emotionally, physically, and/or sexually abused are more likely to demonstrate risky sexual behavior (Norman et al., 2012; Putnam, 2003). Several pre- and post-trauma factors have been examined across a range of traumatic events in order to predict which children will experience more severe symptoms, such as PTSD (Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012). These factors can be grouped by demographic factors, individual child factors, characteristics of the environment (e.g., family factors), and specific trauma event characteristics (see Table 15.1).

Demographic Factors

Demographic variables have shown inconsistent findings across studies. Some studies have found no or small effects for race, minority status, and age as risk factors for PTSD but others have found that older children experience more symptoms (Alisic, Jongmans, van Wesel, & Kleber, 2011; Copeland et al., 2007; Trickey et al., 2012). In addition, female gender, low intelligence, and low socioeconomic status (SES) have also been shown to have small to medium effects on traumatic reactions (Alisic et al., 2011; Trickey et al., 2012). This suggests that traumatic reactions may be explained not by simple demographic factors but the combination of different aspects of stressors (Alisic et al., 2011). For example, Trickey et al. (2012) found that young age was unrelated to developing PTSD, but that there was a stronger relationship between PTSD and younger age when the trauma was unintentional versus intentional. In addition, their results suggested younger children may experience more PTSD symptoms when they experience the trauma in a group versus individually. There was also a small effect of female sex being a risk factor, but it was stronger in older children

TABLE 15.1. Factors That Influence Traumatic Reactions

Source	Factor
Demographics	Age
	Gender
	Intelligence
	SES
Child	Severity of trauma
	Comorbid psychological problems
	Reactions during event
	Coping strategies used after event
	PTSD/panic reactions
Environment	Low social support
	Poor family functioning
	Parent psychopathology
	Parental trauma symptoms
	Continued experience of stressors
	Parental mental health
	Difficulties parenting
Abuse characteristics	Severity of abuse
	Multiple types of abuse
	Relationship with perpetrator
	Frequency and duration
	Physical evidence
	Use of force
	Maternal support
Natural disaster characteristics	Amount of destruction/death
	How close to disaster
	Loss of loved one
	Severity of injuries
	Length of hospital stay

and adolescents when the trauma was unintentional. Trauma severity has also been shown to be related to development of symptoms, but, again, the effect of this has varied across studies. Therefore, the findings indicate that there is not a direct relationship between demographic factors and subsequent problems.

Individual Child Factors

Individual factors before, during, and after the event have been shown to play a role in children's experience of trauma. Children's comorbid psychological problems, such as anxiety or depression, have been shown to exacerbate trauma reactions, with depression being the most predictive of PTSD symptoms (Alisic et al., 2011; Trickey et al., 2012). Reactions *during* the event, such as fear and perceived life threat, as

well as higher initial heart rate directly after the trauma, and use of strategies *after* the event, such as social withdrawal, the use of distraction, and thought suppression, have also been related to more difficulties (Alisic et al., 2011; Furr, Comer, Edmunds, & Kendall, 2010; Trickey et al., 2012). Thus, it is important to assess the child's status before the trauma, his or her experience during the trauma, and ongoing coping strategies. These results also suggest that a cognitive model is helpful in looking at how children are coping with the event; distraction and thought suppression may be functional strategies for the short term but may become more unmanageable for children if they have unresolved issues, particularly when accompanied by low support from families or poor modeling from adults in terms of how to handle stressors. In addition, children's reports have been shown to be significantly more related to postdisaster symptoms than parent's reports, indicating that children may be better reporters of the effects of the disaster on their own functioning (Furr et al., 2010).

Children's initial PTSD reactions after the event also strongly predict later PTSD symptoms (Alisic et al., 2012; Trickey et al., 2012), which suggests that initial screenings of symptoms right after the event may be very predictive of continued symptoms. Researchers have found a strong relationship between panic symptoms during and after the initial trauma associated with the development of acute stress reactions. Sinclair, Salmon, and Bryant (2007) found that 100% of children who experienced trauma symptoms and panic attacks also developed acute stress reactions, while only 24% of children without panic symptoms experienced acute stress. It is possible that panic symptoms may play a role in the conditioning of a fear response and maintaining these symptoms for children. In addition, younger children experienced more acute stress symptoms. Younger children may have less coping skills to buffer themselves when experiencing symptoms and may also rely more on parents as guides to how they should cope with the situation.

Characteristics of the Environment

Aspects of the child's environment have produced large effects, such as low social support and poor family functioning (Trickey et al., 2012). Parent psychopathology and their own reports of posttrauma symptoms have also predicted children's long-term symptoms (Alisic et al., 2011). These results suggest that several family environment areas be targeted in early intervention for children after a traumatic event. In addition, examination of family resources and support may be key to a child's interpretation of the event. For example, trauma can cause subsequent changes, such as breakup of the family, a change of residence, and changes in financial status, which may cause new stressors to develop. Trickey et al. (2012) found that poor family functioning was an even stronger predictor of PTSD than parental mental health, which suggests that how the family copes with the trauma and how much the child's normal routine is disrupted can significantly affect the child's day-to-day functioning. This can be particularly true in natural disasters such as Hurricane Katrina. The large-scale displacement of families and disruption of typical activities for an extended amount of time contributed to aggravated symptoms for children and their families (Madrid & Grant, 2008). In addition, results about family functioning support a relational model of trauma and the moderating effects of parental reactions on children and their own adaptation to trauma (Scheeringa & Zeanah, 2001). The relational aspect may be more important to younger children, who depend on their

parents more for basic needs and cues about emotional responding. Therefore, when parents are affected by trauma, their children may be influenced by their emotional reactions and the more limited parenting or care they provide. In looking at children's long-term reaction to Hurricane Katrina, Moore and Varela (2010) found that 33 months after exposure to the hurricane, 46% of the sample still experienced moderate to severe levels of symptoms. They also found that low social support, as well as other negative life events (e.g., living in shelters) posttrauma, led to continued experiencing of symptoms.

Specific Trauma Event Characteristics

Aspects of the trauma itself can also influence the child's reactions. Severe abuse and those experiencing multiple types of maltreatment are at increased risk of developing more problematic symptoms (Norman et al., 2012). In addition, increased difficulties are evidenced by children who have been sexually abused when additional factors are present, including: 1) a close relationship with the perpetrator; 2) high frequency and long duration of sexual encounters; 3) physical evidence of oral, anal, or vaginal penetration; and 4) use of force (Beitchman et al., 1991; Kendall-Tackett, Williams, & Finkelhor, 1993; Putnam, 2003). Moreover, maternal support, especially at the time of disclosure, has consistently been found to be related to a child's adjustment. This should not be surprising, because children who are caught in the midst of family turmoil surrounding the disclosure of abuse are most likely going to suffer more than children whose families support them.

In studying the effects of natural and man-made disasters, in a meta-analysis of 38 distinct disasters, Furr et al. (2010) found that the type of disaster is not as significant as the amount of destruction and death, how close the child was physically to the disaster, and the experience of losing a loved one. In addition, the severity of the child's injuries and length of hospital stay also predicted more problematic reactions (Alisic et al., 2011).

Thus far, risk factors have been studied more often than protective factors (Alisic et al., 2011) for children. However, it is also important to look at resilience, and the term *posttraumatic growth* (PTG) describes positive changes that develop after trauma, and how children and families can transform traumatic experiences into areas of strength for children. For example, a study of children's experience after Hurricane Katrina showed that children experienced not only trauma symptoms but also PTG after the event (Kilmer & Gil-Rivas, 2010). In addition, they found that rumination, either positive or negative, was significantly positively related to PTG. This suggests that some repetitive thoughts that are either deliberate or uncontrolled may actually help a child to find meaning in the difficulties experienced. They also found that children's positive future expectations approached significance but noted that the extreme disruption in family life due to the hurricane may have made it difficult for them to maintain optimism about the future (Kilmer & Gil-Rivas, 2010).

ASSESSMENT OF TRAUMATIC EVENTS

Assessment of children exposed to trauma is challenging due to the different types of experiences and outcomes for children. Since there are many types of possible

traumatic experiences and varying reasons for requesting an assessment, it is very important to clarify the purpose of the assessment. For example, assessing whether abuse *has occurred* is a very different question than assessing the effects of the abuse on the child; since assessing whether abuse has occurred involves specific skills, we cover factors related to this type of assessment in a later section. In addition, it is important to know whether there may be possible legal issues involved with the case, such as insurance or injury claims. There is also a more likely chance of the clinician needing to report to child protective services (CPS) if the trauma includes violence to the child or putting the child in dangerous situations (see Chapter 2). A child may also be referred because someone is concerned about the effects of his or her experiencing a trauma such as a car accident, abuse, or witnessing domestic violence. It is important to remember that just because the child has experienced a trauma, it should not be assumed that the child is experiencing significant reactions.

Since traumatic experiences have become increasingly common for children and families, the Substance Abuse and Mental Health Services Administration (SAMHSA) has recommended that clinicians and organizations adopt a *trauma-informed* approach that incorporates three key elements: (1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; and (3) responding by putting this knowledge into practice (SAMHSA, 2012, p. 4). Within this framework, it is important for clinicians to approach a child and family with respect and recognize that traumatic events may influence a child's response at all levels of assessment and services, even if the clinician is not informed of the trauma (SAMHSA, 2014b). Therefore, the clinician should create a trauma-informed environment, filled with compassion and support, which helps the client be more comfortable with the situation and avoid retraumatization. Also, the clinician should understand which types of assessment and trauma-specific treatment would be appropriate to foster positive outcomes. In this section, we discuss the most recent literature on assessment of traumatic experiences and interpret this within the Comprehensive Assessment-to-Intervention System (CAIS; see Chapter 2).

Step 1: Initial Contact

The Referral

CLARIFYING THE REFERRAL QUESTION

Children who have experienced abuse or a trauma can be referred by many different people, including parents, CPS workers, police, physicians, insurance companies, attorneys, and judges. In assessing these cases, it is most important to clarify the referral question(s), so that the clinician and the referring person(s) are in agreement about the focus of the assessment. The clinician must then decide which questions can be reasonably answered according to the facts of the case, and carefully focus the assessment on only those questions. If a clinician does not have specialty training in assessment of allegations of abuse, we recommend that the clinician refer the case to someone who has this specialty. The assessment process presented here is pertinent when a child is referred for treatment because of adjustment issues that appear to be due to a traumatic experience. For example, a child may have experienced a natural disaster, such as a hurricane or tornado, and is having severe anxiety reactions. A

child may also be referred because of substantiated abuse and he or she is experiencing depressive symptoms. In addition, a child may be referred for treatment because a parent is worried that abuse may have happened, because their child is having behavior problems. The focus of assessment in this instance should be on the behaviors of concern, *without* the assumption that abuse has occurred. It is imperative in these cases that the clinician maintain a neutral attitude toward the possibility of abuse. Clinicians may also be asked to see a child for treatment when there is an ongoing investigation for abuse. Generally, we recommend that treatment not begin until a case has been investigated and substantiated or unsubstantiated. However, sometimes investigations can last for long periods of time and children may have symptoms that need to be addressed. Children may also have observed violence toward others, such as family members, and are having symptoms due to this but are also being asked to testify in court against the aggressor. In addition, a clinician may have a case in which there is no referral issue of trauma, but during assessment or treatment a traumatic event is revealed or experienced. The clinician should be sure to appropriately document information for all cases and clarify with the family whether this information may need to be used for legal documentation.

GATHERING BACKGROUND INFORMATION

Before interviewing the child and/or family, the clinician should contact all persons involved in the case (using appropriate releases of information) to determine their roles, to find out what information has already been gathered, and to promote collaboration. If children are referred from outside agencies, such as the court, it is also important to contact the individual who made the referral. The information to be gathered at this stage in the assessment process includes the child's developmental and family history; the type of trauma; in the case of abuse, the nature of the child's initial disclosure (or, if there is no disclosure, the reason why abuse is suspected); and behavioral changes evidenced by the child since the traumatic event. Table 15.1 presents many of the risk factors associated with poor outcomes in families in which trauma has occurred. Information about each of these factors should be gathered during the assessment and used to address how the family has responded since the trauma and the potential need for treatment. The presence of any one or two factors may not necessarily be of concern. Rather, the accumulation and interaction of risk factors determine outcome in most cases.

Questionnaires

There has been an increase in questionnaires and checklists for children and families to screen for exposure to traumatic experiences and resulting symptoms (Ohan, Myers, & Collett, 2002; Strand, Sarmiento, & Pasquale, 2005). Also, questionnaires specific to particular traumatic experiences have been developed (see Strand et al. for a comprehensive review). The questionnaires mentioned here are those we have found most useful in a general psychology clinic.

The General Parent Questionnaire (see Appendix B) provides information about the family constellation and the parents' perceptions of the problem. In addition, there are specific questions about types of trauma the child may have experienced that can be followed up in the parent interview if the parent indicates that the child

has experienced them. The Child Behavior Checklist (CBCL; Achenbach, 2013; Achenbach & Rescorla, 2001a, 2001b) has been used in research addressing symptoms of trauma and emotional or behavioral problems with mixed results (Loeb, Stettler, Gavila, Stein, & Chinitz, 2011; Milot et al., 2013; Rosner, Arnold, Groh, & Hagl, 2012; Sim et al., 2005). Wolfe and Birt (1997) used the CBCL to describe PTSD symptoms by selecting items that represented DSM-IV criteria; they suggested that this measure could serve as an adjunct to the regular scoring of the CBCL. These items are shown in Table 15.2. Studies have shown differences between children who have experienced trauma and typical populations on this scale, but not between those experiencing trauma and psychiatric populations, which suggests that the PTSD scale may pick up more general emotional distress and that trauma symptoms overlap with other disorders (Rosner et al., 2012; Sim et al., 2005). Therefore, the scale may help to screen for problems, especially if it is the only one that is used in a particular setting, but other questionnaires should be used to establish particular diagnoses. In addition, a revision of the Screen for Child Anxiety-Related Disorders (SCARED; Birmaher et al., 1997, 1999; Muris, Merckelbach, Korver, & Meesters,

TABLE 15.2. Child Behavior Checklist (CBCL) Posttraumatic Stress Disorder (PTSD) Items

DSM-5 PTSD symptom domain	CBCL items
Reexperiencing	9. Obsessive thoughts
	13. Confused; seems in a fog
	14. Cries a lot
	17. Daydreams
	47. Nightmares
	71. Self-conscious
	112. Worries
Fears and avoidance	11. Clings to adults
	29. Fears certain animals, situations, or places
	30. Fears going to school
	31. Fears doing something bad
	45. Nervous, high strung
	50. Fearful, anxious
	69. Secretive
	111. Withdrawn
Hyperarousal	3. Argues a lot
	8. Can't concentrate
	10. Can't sit still, restless
	41. Impulsive
	56f. Stomachaches
	86. Irritable
	87. Moody
	100. Trouble sleeping

Note. Data from Wolfe and Birt (1997).

2000b) includes a Traumatic Stress Disorder scale to use as an initial screen, along with other anxiety symptoms, for detecting children who have been confronted with traumatic life events and may be at risk for developing PTSD (Muris et al., 2000a). Also, the Parenting Stress Index, Fourth Edition (PSI-4; Abidin, 2012) provides preliminary information about the child's temperamental characteristics and sources of stress for the child's parent(s) separate from the trauma.

Other screeners look specifically at trauma experience (see Appendix A). The UCLA PTSD Reaction Index (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick,1998) is a revised version of a widely used and researched measure that screens for the presence of a traumatic event and associated PTSD symptoms. This measure, which has been used with the National Child Traumatic Stress Network database, has shown good internal and convergent validity, and models factors for a DSM PTSD diagnosis (Elhai et al., 2013; Steinberg et al., 2013). It is for children ages 7–12 years, as well as adolescents, and has both parent and child forms. The Pediatric Emotional Distress Scale (PEDS; Saylor, Swenson, Reynolds, & Taylor, 1999; Spilsbury et al., 2005) was devised to detect symptoms after a traumatic event for children as young as 2 years to those that are 10 years old. It is a shorter screen that discriminates between those who have experienced a trauma and those who have not. Also, the Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001), a child version of a trauma scale developed for adults, has a parent-report form for children ages 8–18 years. This scale asks about symptoms, gives severity scores, has been translated into several languages, and has suggested cutoffs of severity scores for a diagnosis of PTSD (Gudiño & Rindlaub, 2014; Nixon et al., 2013).

The Child Sexual Behavior Inventory (CSBI; Friedrich, 1997, Friedrich et al., 2001) has been shown to be useful in documenting unusual sexual behaviors. It consists of questions about specific types and frequencies of sexual behavior exhibited by children. This instrument has been standardized and validated by comparing responses of parents of sexually abused children (ages 3–12) with those of parents of nonabused children of the same ages. Sexualized behavior is often thought to be an indication that a child has been sexually abused. Indeed, many sexual behaviors (e.g., asking to engage in sex acts, putting mouth on sex parts, masturbating with objects) have been shown to occur more frequently among children who have been sexually abused than among those who have not (Friedrich et al., 2001). But not all children who exhibit these types of behaviors have been sexually abused; conversely, many children who have been abused do not exhibit sexualized behavior (Silovsky & Niec, 2002). Nonetheless, sexualized behavior that interferes with other age-appropriate activities is a warning signal that a child may have other problems. The possibility that the child may have been sexually abused should be explored (but, if possible, without raising unnecessary concern). For example, two brothers, ages 3 and 5 years, were referred for assessment of suspected abuse because their grandmother caught them behind the sofa touching each other's penises. Among children at these ages, this behavior does not necessarily indicate sexual abuse.

Several sources that are available to clinicians are helpful in distinguishing normal sex play from that which might indicate a more serious problem. Gil and Shaw (2013), for example, provide a framework that focuses assessment of sexual behaviors on factors such as differences in age, size, and relative status or authority between the child and other person; consistency with developmental norms; and

presence or absence of coercion. The Association for the Treatment of Sexual Abusers (ATSA) Task Force on Children with Sexual Behavior Problems (Chaffin et al., 2008) provides criteria for child sexual behaviors that fall outside the norm. This includes children under age 12 years who initiate behaviors involving sexual body parts (i.e., genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others. In order to make this distinction, the clinician should know developmentally appropriate sexual behavior for age (see Chapter 1), developmental stage and culture, whether the behavior has become a preoccupation for the child, whether the child responds to appropriate adult correction, and whether the behavior causes impairment and/or physical injury (Lyon & Silovsky, 2008).

Step 2: Initial Intake Interview

Parent Interview

When the purpose of assessment is to plan a treatment program, we usually interview the parents with the child present. In order to decrease the pressure on the child, we ask the parents to tell us the details of the trauma, while checking periodically with the child to verify the information. This informs the child that it is OK to talk about the trauma. Reactions of the parents and other family members to the trauma should be noted as an indication of their ability to provide support for the child. In addition, it may also be relevant to briefly assess the parents' own experience of trauma and reactions to the present trauma. If it appears that the parents are having strong reactions to the trauma, it may be more appropriate to have this discussion without the child present. In cases of sexual abuse, the parents should also be asked what sexuality education (if any) the child has received and what terms for sexual body parts are used by the family.

In gathering information about the child's traumatic reactions, diagnostic interviewing can be helpful in reviewing a range of symptoms the child may have experienced since the event. The Anxiety and Related Disorders Interview Schedule for DSM-5, Child and Parent Versions (ADIS-5 C/P; Albano & Silverman, in press), the most frequently used semistructured interview for anxiety disorders, has a section for Posttraumatic Stress Disorder that lists a range of traumas a child may have experienced, and the clinician asks the parent to describe what happened during the event. Subsequently, the parent is asked about potential PTSD symptoms and to rate the degree to which the symptoms have interfered with the child's everyday life. The Schedule for Affective Disorders and Schizophrenia for School-Age Children—Present and Lifetime Version DSM-5 (K-SADS-PL; Kaufman et al., 2016), also a semistructured interview, asks specific questions about PTSD and assesses current functional impairment of the child.

Child Interview

ESTABLISHING RAPPORT

Regardless of the referral question, the clinician must establish rapport with the child before discussion of sensitive issues will be productive. It is important that the child be informed of the reason for the interview, what will happen during the session(s),

and what is expected of him or her. If the child was present in the initial interview with the parents, they should have an idea of the purpose for the visits. However, the clinician can still start the discussion by stating, "Your parents [teachers, doctors] are concerned that you have been having trouble with sleeping [touching yourself in public, not wanting to visit Daddy, not wanting to go to school, or whatever behavior is of concern]. I talk with lots of children who are having the same problem(s). Together we will try to understand what is troubling you and what we can do to make things better for you. Today I would like to get to know you better and ask you some questions about your school, friends, and family."

DEVELOPMENT

Regardless of the referral question, the child's developmental status should be assessed—formally, if there appears to be some concern in this area (e.g., the child has documented learning or language problems), or informally, if the child appears to be developing typically. Areas to assess include language comprehension and expression, intellectual level, memory skills, emotional status, and, for sexually abused children, knowledge of sexuality. This assessment provides a framework for deciding how questions will be asked, what child-appropriate materials (e.g., puppets, dolls, playhouse) will be used, and how the child's responses will be evaluated. Yuille, Hunter, Joffe, and Saparniuk (1993) suggest that the child be asked to describe two specific past experiences (e.g., a birthday or last Christmas), the details of which can be verified by parents. This allows the clinician to model the form of the interview (e.g., asking questions) and lets the child practice giving complete descriptions; however, the clinician should be aware that, for children under the age of 5 years, free recall of details is more difficult than it is for older children. Specific questions, such as "Tell me one thing you got for your last birthday," are easier for younger children to answer than open-ended questions, such as "Tell me about your last birthday."

The language used in the interview must be consistent with the comprehension level of the child. This is particularly important for most preschool children, who have trouble with vocabulary, multiple-syllable words, and syntax. The clinician should find out what the child actually understands, since children often think that they know the meaning of a word or a question when, in fact, they do not, or they have only a partial understanding. To assess the child's understanding, the clinician could request definitions or explanations rather than accepting "Yes" responses to "Do you understand?" When changing the topic, the clinician must make sure the child is aware of the transition.

The knowledge of sexuality in children who have been sexually abused or exhibit inappropriate sexual behaviors is an important area of development to assess. We assess knowledge in the following areas: body parts and functions (including sexual and nonsexual body parts), gender differences and gender identity, pregnancy and birth, sexual behavior (masturbation and sexual intercourse), and abuse prevention (e.g., "What are the private parts?"; "What should you do if someone tries to touch your private parts?"). Young children respond better to concrete stimuli, so we may use pictures of nude boys and girls and nude men and women as we ask questions in these areas. Assessment of sexual knowledge often elicits emotional reactions from a

child who has been sexually abused, and sometimes spontaneously precipitates discussion of the child's sexual experience.

Assessment of the child's current emotional status, as well as status prior to the trauma, is important. The existence of recent emotional problems, such as unusual fears, anxiety, guilt, and poor self-esteem, can provide corroborative evidence regarding trauma. Additional information can be obtained by observing the child's play and noting unusual themes (e.g., aggression, fear, guilt), over- or underactivity, and intense or unusual reactions to ordinary stimuli (e.g., cars, due to car accident; forks, because one was embedded in the child's arm during a tornado; plates, because Dad hit Mom with them). The clinician can assess the child's general perceptions of family members through a variety of methods, and this information can be particularly informative if a family member is suspected of causing the trauma. With preschool children, family drawings or dollhouse play can be used as stimuli for discussion about what the child likes and dislikes about each person, and what kinds of things they do together. Extreme or intense reactions (fear, anger, hostility, etc.) to one or more specific family member(s) is especially important to assess. For instance, in a case we assessed, a 4-year-old girl was so afraid of her grandfather (who allegedly had molested her) that she could not draw a picture of him and refused to talk about him. At the same time, she was very open and expressed positive feelings about other family members. In another case, an 8-year-old boy was angry toward his father, because his father didn't go back into their burning house to save the family dog after the father barely got the son out and both received severe burns.

QUESTIONING ABOUT TRAUMA

When the interview involves questions specific to traumatic experiences, the clinician should begin with a brief statement that he or she does not know what happened, so it would be helpful for the child to provide as much detail as possible. The interview should begin with open-ended questions (e.g., "Tell me about things that were happening the day of the tornado"; "Tell me about how you and your stepfather usually get along and things you do together"; "Tell me where you were driving to the day of the car accident"). This is important, because the types of questions asked are directly related to the accuracy and completeness of the child's recall, as well as the clinician's (and others') perceptions of the credibility of the child's report, which can be particularly important if the child will be presenting testimony in court. Preschool children require more direct and specific questions, but their responses to these questions may be difficult to interpret. In particular, "yes–no" questions are problematic for preschoolers, and the validity of their responses to such questions must be viewed cautiously (Gordon & Follmer, 1994). As the child is describing the experience, it is important to note his or her emotional expression during the discussion (e.g., whether the child remains calm, speaks in a monotone, or is very expressive in the discussion). This may help to assess the child's understanding of the event. In addition, it will be important to assess the child's current perceptions of the event, symptoms, and impairment in daily activities. For example, one 10-year-old child who had experienced a tornado hitting his neighborhood, ceased participating in any outdoor sports after the event, even though he had loved playing soccer, baseball, and tennis before the event happened.

Step 3: Observation of Behavior

Observation of the child's behavior during the interview is a critical component of the assessment, and we covered it to some extent earlier. It may also be helpful to observe parent–child interactions and use a coding system such as the Dyadic Parent–Child Interaction Coding System, Fourth Edition (DPICS-IV; Eyberg, Nelson, Ginn, Bhuiyan, & Boggs, 2013; see Appendix A).

Step 4: Further Assessment

Since child report of trauma may be more closely related to the child's functional impairment, especially for disasters (Furr et al., 2010), it is important to have the child complete screening measures for current symptoms and reactions to traumatic events. The Youth Self-Report (Achenbach, 2013; Achenbach & Rescorla, 2001b) for children ages 11–18 allows the child to report a range of problem behaviors the child may be experiencing. For reactions to traumatic events, the UCLA PTSD Reaction Index (Pynoos et al., 1998) has a child version for ages 7–12 years and adolescent version for youth over 13 years old. The CPSS (Foa et al., 2001) also has a child version for ages 8–18 years. In addition, it may be helpful to get a more subjective measure of the child's experience. Maladaptive responses and poor coping skills can be assessed in children ages 6 to 18 with the Roberts Apperception Test for Children (Roberts–2; Roberts & Gruber, 2005).

It may also be important to obtain information from the school about the child's academic progress and interactions with others. An interview with the teacher and/or school counselor may be helpful to determine whether the child is having academic difficulties and possibly exhibiting symptoms in the classroom or in other settings, such as the lunchroom and at recess. It would be particularly helpful if the teacher has seen changes in behavior since the trauma and is able to describe specifics of this change in the child. For example, in one case, an interview with the teacher of a 12-year-old helped to elucidate how the child's grades had gone down significantly over several months. However, the teacher did not realize that the change in grades was related to the child's reactions after witnessing domestic violence between her parents that resulted in her mother going to the emergency room with severe injuries. A description of peer interactions may also be helpful to ascertain whether the child plays primarily alone, is passive with peers, and/or is aggressive during interactions in different environments. The teacher could also complete the CBCL Teacher Report Form (Achenbach, 2013; Achenbach & Rescorla, 2001a, 2001b) to obtain information on a range of possible problem child behaviors. If possible, a school observation could enable the clinician to actually observe the child's behaviors across different academic settings and with different adults and peers.

Step 5: Collaboration with Other Health Care Professionals

Depending on the type of trauma the child has experienced, it may be important for the child to have a complete medical examination. If a medical examination has not already been done in the case of physical or sexual abuse or other traumas that

have caused physical harm to the child, it is important to make a referral to the most appropriate physician.

Step 6: Communication of Findings and Treatment Recommendations

Before the findings of the evaluation can be communicated to parents and other professionals, the data gathered during the assessment must be evaluated. Organizing the background information collected according to the risk factors shown in Table 15.1 is helpful in discussing difficulties the child may be experiencing, as well as treatment recommendations. In a case in which the family has many risk factors or if CPS is involved with the family, recommendations regarding treatment or continued monitoring by CPS may be indicated. Communication of recommendations is a very important part of the process. Parents should receive information about symptoms, diagnoses, and discussion of intervention recommendations. In addition, if families have particular needs, especially for families that have been displaced by disasters or experienced decreased financial resources due to changes in family circumstances (e.g., the offending parent leaves the household), possible case management and/or resources should be recommended. Parents should be given general information about the impact of trauma on children's development and children's typical reactions to trauma, so that they have some idea of what to expect. Ways of handling inappropriate behaviors, such as sexual acting out or increased irritability or fears, should also be discussed. It is often important to have a written report to share with outside entities, particularly if the assessment is court ordered. The report should contain information on particular symptoms and diagnoses, so that the reasons why specific recommendations were made are clear.

Specialty Assessment of Maltreatment

A referral to determine whether maltreatment has occurred is very different from the assessment of the effects of maltreatment on children. To do it adequately, the clinician must have knowledge of typical child development, be familiar with recent research on memory and suggestibility, and be able to apply this knowledge to individual cases. In addition, the clinician needs to have experience working with CPS, police investigations, and the court system. For further resources in this area, consult the American Psychological Association Guidelines for Psychological Evaluations in Child Protection Matters (American Psychological Association, 2013), comprehensive assessment of different types of maltreatment (Bernet, 1997; Giardino & Alexander, 2005), and psychological assessment of maltreatment competencies (Damashek, Balachova, & Bonner, 2011). More communities have developed Child Advocacy Centers (CACs), which are best practice settings for these evaluations and include: (1) a multidisciplinary team approach for investigations; (2) specially trained child forensic interviewers; (3) victim advocacy and court education; and (4) developmentally friendly and safe, child-friendly environments (Cronch, Viljoen, & Hansen, 2006; Jones, Cross, Walsh, & Simone, 2005; Lamb, La Rooy, Malloy, & Katz, 2011). These types of settings can assist in gathering the necessary information to address questions of maltreatment.

Table 15.3 summarizes the type of information gathered during these evaluations.

TABLE 15.3. Framework for Organizing Assessment Data and Evaluating Alternative Explanations for Abuse Allegations

Nature and context of the behavior

- What is the physical/sexual/neglectful behavior described?
- What were the conditions under which the behavior occurred?
- How long ago did the reported event(s) occur?
- What was the motivation or intent of the behavior?

Characteristics of the initial disclosure

- Under what conditions was the disclosure made?
- Was the initial report spontaneous or prompted?
- What motivated reporting to authorities?
- What was the response of the parent(s), especially the mother?
- To what extent have parents questioned the child?
- What factors might have influenced the child's report?

Subsequent interviews

- How many times was the child interviewed and by whom?
- Were the interviews recorded? If so, are transcripts available?
- What factors might have influenced the child's responses to these interviews?
- Did the interviewer(s) consider alternative explanations for the child's responses?

Characteristics of the child

- What is the child's age or developmental level (language and cognitive skills, sexual knowledge)?
- Are there preexisting emotional, behavioral, or developmental problems?
- Does the child show symptoms of distress or sexualized behavior?
- What are the child's life circumstances?

Characteristics of the alleged perpetrator

- Is there evidence of psychopathology?
- Is there a history of alcohol or drug abuse?
- Is there evidence of significant life stress?
- What skills are used to cope with stress?
- Is there an appropriate sexual outlet?
- Is there a history of antisocial behavior?

Characteristics of the family

- Are there divorce and/or custody issues?
- Is the nonabusing parent able to protect the child?
- Does the family have the necessary resources?
- Is the family socially isolated?
- Is there a history of inadequate parenting?
- What are the family's attitudes/values about sexuality/punishment?
- Is there significant stress or instability?

TREATMENT OF TRAUMATIC EVENTS

Because children who have experienced traumatic events are a heterogeneous group, no single treatment protocol is appropriate for all of them. A developmental approach is essential in treating such children, however. Developmental factors influence all aspects of treatment, including the effects of trauma and prognosis for treatment, treatment issues and approaches, possible placement and protection decisions, and expectations for a child as a witness in legal proceedings. Because children understand the world differently at different ages, their understanding of experiences is a function of their developmental level and will change as they gain new cognitive abilities. Thus, a child who has experienced trauma will probably "reprocess" this event as cognitive capacity increases. Furthermore, developmental issues interact with treatment issues. Trust, for example, is a critical developmental issue for preschoolers and is likely to be a focus of treatment for this age group, whereas issues involving interpersonal and intimate relationships are more important for adolescents.

Intervention Strategies Soon after Trauma

Most children have some type of reaction directly following a traumatic event. However, less research has been done about what may be the best intervention for children soon after the event. Generally, interventions for children should be brief and present-focused, and help to screen children with more severe reactions in order to prevent an increase in problematic symptoms (La Greca & Silverman, 2009). In addition, it is important for adult caregivers of the child (including parents, teachers, other health professionals) to be able to reassure and monitor children to identify any major symptom reactions. For example, following a natural disaster, clinicians should provide children with information about the disaster, listen to their reactions, and help caregivers set up a safe environment and structure the day so that children can get back to a more normal routine.

Some programs have been formed to intervene in the early weeks after a trauma. Psychological first aid (PFA) was developed as an immediate response service to children, adults, and families, after a disaster or terrorist event (Vernberg et al., 2008). It uses five basic principles that have received empirical support for adapting to a trauma: (1) promoting a sense of safety, (2) promoting calmness, (3) promoting a sense of self and community efficacy, (4) promoting connectedness, and (5) instilling hope. Each of the intervention strategies provides specific recommendations for working with children and families. This approach also helps clinicians identify children and families that are having more severe reactions to connect them with further treatment services. In addition, psychoeducational materials and factsheets have been shown to help normalize reactions posttrauma for children and their families (La Greca & Silverman, 2009). These materials have been developed and are readily accessible on the Internet through organizations such as the National Child Traumatic Stress Network (*www.nctsn.org*), American Psychological Association (*www.apa.org*), and the American Red Cross (*www.redcross.org*). Another program, critical incident stress debriefing (CISD), was devised as a group intervention often delivered in field settings to address trauma symptoms by providing ways for victims to express their feelings

and normalize responses in a supportive context (Chemtob, Tomas, Law, & Cremniter, 1997). However, this program does not have empirical support, and there have been reports of possible negative effects, such as retraumatizing children. In addition, due to negative effects of the debriefing, families did not seek additional services (La Greca & Silverman, 2009; McNally, Bryant, & Ehlers, 2003). One of the main differences between this approach and the others we have discussed is that it may not individualize the intervention to different reactions, and the structure within the group format may compel people to participate when they may not be ready, which may cause more problems for families.

Interventions after Symptoms Develop

Trauma-focused cognitive-behavioral therapy (TF-CBT) has been used effectively for a range of symptoms that children may evidence after a traumatic event (for a Web-based learning course, see *www.tfcbt.musc.edu*). TF-CBT combines aspects of CBT to build skills, so that children are then able to work on the main trauma component, the *trauma narrative*. Cohen and Mannarino (2008) outline the different components of TF-CBT that can be used flexibly with children and parents who have experienced trauma, depending on the different symptoms and difficulties shown: (1) psychoeducation about the treatment approach and the particular trauma; (2) parenting component for parents to learn skills on how to deal with difficult behavior; (3) relaxation skills; (4) affective expression and modulation skills; (5) cognitive coping skills; (6) the trauma narrative and cognitive processing of the trauma experience; (7) *in vivo* mastery of trauma reminders; (8) conjoint child–parent sessions; and (9) enhancement of future safety and development. The components are expressed in the acronym PRACTICE to remind the family to work on skills outside of treatment sessions. Although there is a format suggested by the program that builds coping skills to address traumatic symptoms, the therapist has flexibility regarding when each of the components is introduced and how long it may take to go through each one of them. For example, if a child is not showing disruptive behavior, the therapist may not need to go through the "parenting component."

TF-CBT has shown the strongest empirical evidence for treatment across different traumatic experiences, with many of the studies conducted in real-world or hospital settings (Silverman, Ortiz, et al., 2008). Although most studies have shown that TF-CBT lessens symptoms of PTSD in older children, it has also been shown to work with children ages 3–6 years (Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011). For younger children, ages 3–4 years, some changes may need to be made in the protocol, so that some of the verbal tasks are more feasible, with visual aids and drawing rather than writing (Sheeringa et al., 2011). Not only has TF-CBT lessened children's traumatic reactions, it has also been shown to decrease parent's levels of depression and distress related to abuse, as well as increase their support of their child and appropriate parenting practices (Cohen, Deblinger, Mannarino, & Steer, 2004). However, if the parents are experiencing significant symptoms of trauma, PTSD, or other psychiatric symptoms that impair their own functioning, it is important for them to seek their own therapy (Cohen, Mannarino, & Deblinger, 2017).

Intervention with the Child

In general, behavioral and cognitive-behavioral interventions have been found to be more effective than other approaches in treating children who have experienced trauma, across different types of traumatic experiences (Silverman, Ortiz, et al., 2008). The focus of these interventions is on alleviating specific trauma-related symptoms by monitoring and modifying problematic thought processes and/or behaviors, and by increasing such skills as assertion, socialization, anxiety management, anger control, problem solving, and communication. It is also stressed that abuse prevention training should be part of any treatment program for children who have been maltreated—not only to decrease revictimization but also to provide secondary benefits in other areas (e.g., increasing self-esteem and decreasing fears) (O'Donohue & Elliott, 1992).

Helping the child feel important and in control is a primary goal for the first treatment session, so the clinician should take considerable time to talk about the child's interests and activities, play games, draw, and have fun. Using reflective comments and praise, instead of asking many questions, is essential to making the child feel comfortable. One way of communicating to the child that he or she is an important, valued person is for the clinician to keep all contracts and appointments consistently and on time. For example, if the child is told that he or she can choose a prize out of the prize box at the end of the session, or that next time the clinician will remember to bring drawing material, the clinician must be sure to keep these promises. If the child wishes, the parent is invited to stay in the room, but the clinician must be careful not to let the focus be on the adult during the session. Before the child and parent leave, they should be told what to expect in the next session, and both should be given the clinician's business card in the event that either needs to call before the next session.

Feelings and Coping Skills

Children's knowledge of feelings and their ability to cope with them are dependent on their developmental status, so assessment of what they currently understand is essential prior to attempting to process feelings about a trauma. We often begin by making a "feelings book," in which various feelings are described and illustrated. Older children enjoy making lists of things that make them happy, sad, angry, and so on, as well as ways to cope with these feelings. Younger children can cut out pictures depicting various feelings and paste them on each page. They can then develop and be reinforced for more appropriate strategies to use when they feel different ways (e.g., angry, sad, or afraid). Children can also draw pictures of themselves with different feelings represented by different colors, then talk about situations that give them those feelings and ways to cope with the feelings. Various techniques are effective in helping a child deal with feelings about a perpetrator of trauma such as abuse. As an example, a 6-year-old girl who was not able to talk about her feelings was still able to act out her feelings each week in her play with dolls in the dollhouse.

In the case of abuse or other violence, an older child may find it helpful to dictate or write a letter to the perpetrator (which can be sent or remain unsent, depending on the circumstances). A child often wants to know, and should be told, what has

happened to the perpetrator. The clinician should not appear surprised to hear concern or affection expressed by the child for the perpetrator. Especially in a case of incest, the child should be supported in understanding that he or she can have both negative and positive feelings toward the perpetrator, but that the behavior of the perpetrator was wrong and not the child's fault.

The Trauma Narrative

The trauma narrative is a key aspect of TF-CBT that is used with children to lessen symptoms of trauma. The main goal of the trauma narrative is to lessen the negative emotions surrounding the event, and help the child to gain more control and efficacy and find ways to move forward in his or her life. This is achieved by exposing the child to aspects of the trauma, and over time, lessening his or her reactions to the stressor. Although the trauma narrative is essential, it is usually started after the child has built other coping strategies to support the difficult work of the narrative (Cohen & Mannarino, 2008; Cohen et al., 2017). A metaphor that has been used with children and families to introduce the trauma narrative is falling and skinning one's knee. It may be introduced to the child and parent this way: "When you skin your knee, you could just put a Band-Aid on it and hope it gets better. However, doing this may cause an infection in your knee. What works better is to clean the skinned knee and put medicine on it. Talking about the trauma is just that: cleaning out the wound so that it can heal." Trauma narratives can be used with multiple types of traumas the child has experienced.

If the child has difficulties talking about the trauma, it may help to read books about other children's experience of trauma in difference situations, particularly traumas that are similar to the one the child experienced (Cohen et al., 2017). Some clinicians may feel uncomfortable having children talk about their trauma and may feel this will retraumatize them. However, the child has been referred for treatment because the memories of the trauma are affecting emotional and/or behavioral functioning. Helping children discuss their traumatic experience assists in normalizing the experience and healing the emotional wounds (Cohen & Mannarino, 2008). Discussing these experiences can also be very difficult for clinicians, so it is recommended that the clinician practice appropriate self-care strategies and be ready to respond to different situations the child may report.

Personal Safety Skills

Teaching self-protection skills to children who have experienced trauma is essential to restoring a sense of personal control and power. Children should be provided with the opportunity to practice skills in role-play situations. Especially with maltreatment, the importance of the child telling someone if there are any further incidents should be recognized, and a list should be made of people the child would feel safe telling. Children should also be told that it is not their fault if they cannot get away or make someone stop hurting them. The important thing is to tell someone, so that person can intervene to protect them. Those children who have experienced natural disasters can have a role in setting up their families' First Aid and Emergency Preparedness kit, and help plan for safety if there is another fire/tornado/hurricane while they are at home or school.

Sexuality Education

The importance of sexuality education cannot be overemphasized. Children today are bombarded with sexual messages from films, advertising, television situation comedies and soap operas, the Internet, and even the nightly news report (Gil & Shaw, 2013). Education about sexuality can help to put it into proper perspective, assist children in making sense out of confusing messages, and increase the chances that they will behave responsibly with regard to their own sexuality. Contrary to some beliefs, provision of sexual information is actually associated with postponement of sexual activity by teenagers and more responsible sexual behavior when they do become sexually active (Coley & Chase-Lansdale, 1998).

By understanding normal sexual development, parents and clinicians can more easily determine what information is needed by children as they grow and develop, and understand how best to respond to children's sexual behavior. One must keep in mind that it is not sufficient to teach the facts about sex; attitudes and values should also be taught. Ryan (1997, 2000) suggests that all sexual behaviors exhibited by children, especially behaviors that appear deviant, require some adult response. Because children inevitably look to adults for guidance, failure to respond to sexual behaviors can easily be interpreted by the children as acceptance or approval. Ryan proposes that goals for sexuality education should include teaching children to (1) communicate openly about sex, (2) recognize and respond empathically to the needs of others, and (3) take responsibility for their own behavior. This can be done by nonjudgmentally describing behaviors as children engage in them, telling children how those behaviors make others feel, and encouraging children to manage their behavior in the future.

Giving children information about sexuality helps them to protect themselves and results in a sense of empowerment. We typically begin by assessing what a child already knows about normal sexuality (body parts and functions, private parts, sexual behaviors) and the terms the family uses for sexual parts and functions. We then provide the child with appropriate information, keeping in mind that children who have been abused have often had precocious sexual experiences and may need information that would ordinarily be more appropriate for older children. Reading a book about sexuality often elicits further questions and comments from a child, and allows the clinician to provide reassurance and information directly related to the child's experience of sexual abuse. Sharing the sexual material with a parent before the session is important, so that the clinician can clarify any concerns the adult may have about the information. It is equally important for the clinician and child to briefly review the material covered with the parent(s) at the end of the session. This confirms for the child that it is acceptable to talk about these topics. Any concerns that the parent(s) may have about the child's sexual behavior can be discussed at this time, and plans may be made to handle any inappropriate sexual behavior. It is also helpful to send the sexuality education materials home with the family.

Group Treatment

TF-CBT has been adapted to work in a group setting in schools with children exposed to community violence. Group cognitive-behavioral intervention for trauma in schools (CBITS) has shown to be effective for children by targeting particular

posttrauma, anxiety, and depression symptoms (Silverman et al., 2008; Stein et al., 2003). The group focuses on psychoeducation about the trauma, graded exposures with writing and/or drawing, cognitive and coping skills training, and social skills interventions. After a group intervention, it was found that not only did children's trauma symptoms decrease, but also depression, psychosocial dysfunction, and classroom behaviors, including reduced acting-out behaviors, shyness, and learning issues (Stein et al., 2003).

Intervention with the Parents

Time should be set aside at each session to talk with parents about the gains that have been made in session. It is most useful if the child can discuss or demonstrate to parents what he or she has learned in the session and ways to apply the skills at home. In addition, TF-CBT has a parenting component for the clinician's work with parents who are having difficulties managing their child's disruptive behavior. The parents are given instruction in parenting skills, such as increasing positive time with their child, giving clear instructions, and setting appropriate rewards and consequences. For younger children, parent–child interaction therapy (PCIT) has been shown to improve outcomes for children and families, particularly those for children who have been exposed to interparental violence (Timmer, Ware, Urquiza, & Zebell, 2010), and/or abused by their parents (Chaffin et al., 2004). A core aspect of PCIT that often makes its outcomes more effective for families is that the program not only teaches parents new skills but it also has parents and children practice and hone new skills in session. The clinician then directly coaches parents, either in person or through a "bug-in-the-ear technique," on how to improve skills they are practicing (see Chapter 10). This aspect of change and the resulting positive changes in the parent–child relationship has been shown to reduce behavior problems in families (Chaffin et al., 2004).

It is also important that parents are involved as children develop their trauma narrative. Parents need to support the skills the child has learned in developing his or her narrative. Working closely with parents on their own concerns about the trauma narrative technique and the outcome of the trauma will help prepare them to discuss these difficult situations with their child. Often families have dealt with the trauma by not discussing it, and hoping the fear and pain will go away. The trauma narrative helps the family to face the trauma and build resilience to its effects. Parents who are extremely upset, to the extent that they are temporarily unable to meet the child's needs, may need separate sessions to express and work through their feelings about the trauma and receive support. The parents may learn coping skills as the child is learning them so that they develop ways to handle the trauma and also support the child. If available, one-way mirrors allow parents to observe their child's sessions, which can also help them come to terms with the trauma and be able to talk more appropriately with their child about it. They can also model coping statements the clinician uses about the trauma. As treatment progresses, a main goal is for the child to be able to share the trauma narrative with parents as a part of the change process. This may be done in phases: (1) The child writes the trauma narrative down, (2) the therapist reads it aloud to the child, (3) the child reads it aloud to the therapist, (4) the therapist reads it aloud to the parent, and (5) the child reads it aloud to the parent.

Working with Children Who Have Been Sexually Abused

Sexual abuse is fundamentally a relationship problem. Thus, a major focus in treatment of sexual abuse involves correcting failed adult–child relationships and, in instances of incest, failed relationships that may span generations. Parent work in cases of incest is necessarily different from that in cases involving extrafamilial abuse, and we give a brief overview of the important issues to consider in planning treatment for these two types of cases.

In a case of incest, the nonabusing parent (usually the mother) is often either overtly or covertly blamed for collusion with the perpetrator. This view can set the stage for the clinician to take a negative attitude toward the mother and, consequently, to decrease her involvement in the therapeutic process. It is more helpful to the process for the clinician to take a neutral attitude toward mothers. A clinician should be willing to understand the abuse from the mother's perspective in order to help her cope with the situation. Factors that have been found to help mothers cope with stress include social support, access to financial resources, problem-solving skills, and a realistic nondistorted belief system.

TF-CBT has been shown to work effectively for children who have been sexually abused, exhibiting better outcomes than play therapy, nondirective supportive therapy, and supportive child-centered therapy, and to have results similar to those in CBT family therapy (Cohen, Mannarino, & Knudsen, 2005). In addition to parenting skills targeted in this program, work with parents should include helping them provide a safe, consistent, and predictable environment for their child. In instances in which a child has ongoing contact with a perpetrator as approved by CPS, a series of family meetings (including the perpetrator) should be held to set some ground rules for appropriate and inappropriate touching, to provide ongoing support for the child, and to monitor the situation over an extended period of time.

In a case of extrafamilial abuse, the clinician is still working with an adult–child relationship problem, but the parent or parents are not likely to be dealing with the stress of the disintegration of the family (and therefore are usually more available to support the child). Friedrich (1990) points out, however, that sexual abuse usually is not a random event; therefore, even in cases not involving incest, something sets the stage for the abuse to occur. It may be that the mother has also been abused, or that the parents were not involved enough in making child care arrangements or monitoring the child's safety and well-being. Parents may need help in dealing with their guilt regarding the child sexual abuse, particularly if they have been abused themselves or have inadvertently contributed to the abuse in some way.

In the hope of encouraging more clinicians to work with sexually abused children, we have developed a protocol to provide immediate and potentially time-limited treatment for children. The protocol is based on Finkelhor and Browne's (1986) model that uses four factors to help explain how children cognitively process the diverse features of sexual abuse and therefore show a range of emotional and behavioral responses. The four factors are *betrayal, stigmatization, traumatic sexualization,* and *powerlessness*. There is empirical support for this model (Mannarino & Cohen, 1996a, 1996b; Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012), and we have found it to be particularly helpful in understanding the child's perceptions of the abuse experience and the resulting symptoms.

The protocol covers many of the critical treatment issues and helps the clinician determine the need for long-term treatment. This approach is summarized in Table 15.4. Although we have found all the components to be essential, the order in which they are included in treatment (with the exception of the first two components) is not fixed. Furthermore, the number of treatment sessions may vary, depending on the needs of the individual child. It often takes six to eight sessions, but we have done it all in one marathon session when we had only one opportunity to see a child. It is important to note that this treatment format is recommended for children whose sexual abuse has been substantiated.

Intervention in the Environment

Intervention in a child's environment in a case of trauma can involve collaboration with social services professionals to ensure the child's safety and well-being. In addition, it can be very helpful for mental health professionals at the school to be aware of difficulties the child is experiencing so that a plan can be set up to address academic difficulties. Sometimes it is important for children who have experienced trauma to have a "safe place" they can go in the school or someone to talk to if they are feeling sad or upset, especially if the traumatic event occurred in the school setting. At times, children may need more formal services to be placed in smaller classrooms for one-on-one interactions in a calmer or therapeutic environment.

Intervention in Medical/Health Aspects/Medication

A physical examination by the pediatrician should indicate whether intervention is needed in this area. The child should receive treatment for any sexually transmitted diseases he or she may have contracted or for the effects of physical abuse. In an article in the *American Academy of Child and Adolescent Psychiatry*, Cohen et al. (2010) reported research findings regarding medications for trauma symptoms in children, stating that selective serotonin reuptake inhibitors (SSRIs) may be beneficial to reduce child PTSD symptoms; however, they recommend that the medication should not be used alone but after psychotherapy is started (e.g., TF-CBT) and only if the child's symptoms suggest a need for additional interventions. In addition, SSRI treatment may be helpful for comorbid conditions such as major depressive disorder, general anxiety disorder, and obsessive–compulsive disorder. There is also limited evidence to suggest possible treatment of children using alpha-and beta-adrenergic blocking agents, novel antipsychotic agents, non-SSRI antidepressants, mood-stabilizing agents, and opiates (Cohen et al., 2010).

Preparation for Court

Since traumatic experiences often involve threatened or actual violence to children, there is a higher likelihood of legal intervention and court involvement. Both adults and children need to know what to expect from a court appearance. Depending on the case and the resources in the community, this can be done by the legal team, a victim advocate, CAC, or other professionals with this specialty experience (Lamb et al., 2011). A visit to the courtroom should be arranged shortly before the start of a trial; the child should be told who will be there, where these people will sit, what

TABLE 15.4. Treatment Issues and Intervention Strategies for Sexually Abused Children

Age	Traumatic sexualization	Stigmatization	Betrayal of trust	Powerlessness
0–6 years	• Sexuality education • Limits on sexual acting out • Reinforcement of appropriate interaction • Role plays	• Reinforcement of positive characteristics • Group treatment	• Setting and keeping routines • Reinforcing independence • Providing a safe environment	• Treatment of nightmares and sleep problems • Prevention skills • "What if" exercises • Role plays • Identifying feelings
7–11 years	• Sexuality education • Cognitive-behavioral techniques for assertiveness training and gaining control • Reinforcement of age-appropriate sexual behavior • Social skills training	• Group treatment • Age-appropriate activities	• Making a book—"Whom Can I Trust?" • Cognitive restructuring for depression • Teaching problem-solving skills regarding trust issues	• Prevention skills • Assertiveness training • Letter to abuser • Channeling aggression • Support success in school activities
12–18 years	• Sexuality education • Cognitive-behavioral techniques for assertiveness training and gaining control • Role plays of relationship skills • Social skills training • Relaxation training	• Group treatment • Age-appropriate activities	• Cognitive restructuring for depression • Group trust exercises • Using problem-solving skills regarding trust issues • Listing of people who can be trusted and why	• Prevention skills • Assertiveness training • Letter to abuser • Role plays of relationship skills • Support success in school activities • Support independence

will happen and in what order, and what is expected of him or her. Children could also make "homemade" books with simple line drawings that are specific to a child's experience and understanding of going to court; it can also be individualized to the court system in the child's area. In addition, a person who is well known and liked by the child (a teacher, family friend, neighbor, social worker, or guardian ad litem) could be designated as a support person to sit in the front of the courtroom where the child can see him or her during the court process.

CASE EXAMPLE: SEXUAL ABUSE

Step 1: Initial Contact

Mrs. Comfort called to request treatment for her two grandsons, ages 9 and 5. A few months prior to this contact, the 9-year-old, John, had told Mrs. Comfort, his maternal grandmother, that his father had been sexually abusing him and his little brother, Jimmy. John described oral and anal sex, as well as mutual masturbation, and reported that his father had said he would kill him, his brother, and his grandmother if he told. This child had recently returned home from a 6-month inpatient stay for severe depression. During hospitalization, no one had asked him about the sexual abuse, nor did he tell anyone. He told his grandmother that he "got better" so he could come home to protect his little brother from his father. Mrs. Comfort took the child to CPS, and an investigation substantiated the abuse.

The two boys had been living with their father, who was a local magistrate, and their stepmother. The boys' mother had died 2 years previously. Given the father's position in the community and the lack of evidence for abuse of Jimmy, the younger boy remained in the home while John was placed in the custody of Mrs. Comfort. CPS asked that the 5-year-old be brought to the local CAC for a forensic evaluation. The stepmother brought Jimmy, who was found to have anal lacerations and venereal disease. During the course of this evaluation, the stepmother admitted that the father had indeed abused the children and had been doing so over a long period of time. Both children were then placed in the custody of Mrs. Comfort. The father was charged with sexual abuse, tried, found guilty, and sentenced to two consecutive life terms.

The purpose of the referral was to determine the emotional status of both children and provide the children and the grandmother treatment due to their current level of impairment.

Step 2: Initial Intake Interview

Parent Interview

Mrs. Comfort, the CPS worker, and both boys were present for the initial interview. The CPS worker, at Mrs. Comfort's request, related what had been done and what was known about the abuse. They also discussed the court preparation the boys had received from the CAC and also the stress they experienced during this process. The boys were given some toys to play with during the interview. As they were playing, they often added information to the CPS worker's report. Both boys expressed a great deal of anger at their father, but they were also quite fearful that he would come to the grandmother's house and kill all of them. Mrs. Comfort assured them that the

house was secure and that she was quite capable of protecting them, especially since their father was now in prison. She transported the children to and from school, and outside of school they rarely left her side. Because they were both having nightmares, she also allowed them to sleep with her. Mrs. Comfort presented as a warm, supportive person who had struggled, against the father's wishes, to keep contact with her grandchildren since the death of her daughter.

Child Interview

The boys were seen separately for their initial interviews. John was able to share difficult information easily. He described with great sadness the death of his mother, who had been rushed to the hospital in a diabetic coma. John felt she had protected him from his father. It was after her death that the father began to abuse him. Until he was hospitalized, John did not feel that his younger brother had been abused. He found it difficult to discuss the specifics of the abuse, and he was not pressured to do so. Although John was afraid of what his father might do, he said he felt safe both at school and when he was with his grandmother. He appeared relieved by having told about the abuse and was able to express his anger toward his father, despite his fear of him. Although he admitted it was "scary," John stated that he was glad he testified in court so that his father would never be able to do this again.

Assessment of John's knowledge of sexuality revealed that he used slang terms for sexual body parts and was very knowledgeable about adult sexual behavior. He also knew about private parts and was forceful in stating that he would tell his grandmother or teacher if anyone tried to touch his private parts.

Five-year-old Jimmy refused to separate from his grandmother; as a result, she was included in this session. Jimmy was active and easily distracted by any noise or sudden movement on the part of the clinician. He was reluctant to talk about his father but stated that he missed being at home and playing with his toys. In playing with the dollhouse, Jimmy carefully avoided including the father doll in his play. When the clinician introduced the father doll, he turned away and refused to continue his play. Attempts to get him to play with family dolls resulted in his hiding behind a chair and refusing to come out until the father doll was put away.

Assessment of knowledge of sexuality indicated that Jimmy had slang terms for sexual body parts and did not know about private parts or what to do if someone tried to touch them. He also did not have any knowledge of adult sexual behavior, pregnancy, or birth. It was significant that he became very quiet or left the table when he saw pictures of nude adult males or males engaging in child care activities (bathing, putting a child in bed, etc.).

Step 3: Observation of Behavior

This case included only observations during clinic sessions. The boys appeared to have positive and warm interactions with their grandmother.

Step 4: Further Assessment

Additional assessment of the children's present emotional status was part of the treatment process. Their teachers were asked to complete the CBCL. Both boys had

significantly high scores on the Internalizing scale of the CBCL, with significant fears and physical complaints. In addition, phone calls were also made to each of the boys' teachers to determine their academic and social functioning within the school setting. They were reported to be well liked by their peers and "no problem" to their teachers. However, the teachers indicated that the boys often came to school very tired, appeared sad, and on many days did not want to join in academic tasks or social activities. They had noticed a dramatic improvement in the boys' affect, alertness, and willingness to participate in activities in the short time since they had begun living with their grandmother.

Step 5: Collaboration with Other Health Care Professionals

The boys had already had a medical evaluation, and Jimmy was being treated for venereal disease.

Step 6: Communication of Findings and Treatment Recommendations

Prior to beginning treatment, the clinician met with Mrs. Comfort and the CPS worker to summarize the assessment findings. They were told that John appeared to be resilient and was using a lot of good skills to cope with a very difficult situation. He reported feeling well-loved and protected by his grandmother, and was clearly very attached to his brother. Jimmy, on the other hand, was seen as emotionally vulnerable, with few coping skills available with which to deal with the trauma. Unlike John, he needed a great deal of support from his grandmother. Mrs. Comfort was described as having a good grasp of the children's needs and interacted with them in a very appropriate manner. The boys obviously cared for her, were affectionate with her, and responded well to her requests and discipline.

Course of Treatment

John and Jimmy were seen together for treatment, and Mrs. Comfort participated in the last 15 minutes of each 1-hour session. The course of six sessions followed the sexual abuse treatment program outlined earlier in this chapter. The children made "feelings books" to identify and talk about feelings, and to learn appropriate ways to express their feelings. They also were engaged in a sexuality education program that taught them the correct names for body parts and functions, who may touch their private parts and when, and personal safety skills. During this time, both boys were able to talk more openly about the abuse and to give details of what had happened to them, how they felt, and what they would do in the future if anyone tried to abuse them.

Mrs. Comfort had a good support system in the community and was handling the situation well. She needed little help from the clinician. She was given books on sexuality education and abuse prevention, as well as the children's "feelings" exercises to take home, so that she could talk with the boys about them throughout the week. She was also given information on sexual abuse and its effects on children. The clinician supported her appropriate parenting skills. The children's problem behaviors steadily lessened over the weeks, and Mrs. Comfort reported they continued to discuss positive and negative emotions they were experiencing with her. In addition,

the school social worker checked in with them at least once a week to help them in using their new coping skills in the classroom. Mrs. Comfort and the clinician decided to discontinue treatment at this time due to the boys' improvement. However, the clinician discussed with her the need to continue to monitor their symptoms and if they had increased symptoms related to their mother's death, their sexual abuse, relationship with their father, or during developmental transitions (e.g. adolescence), to seek out treatment again.

RESOURCES FOR CLINICIANS

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). *Treating trauma and traumatic grief in children and adolescents* (2nd ed.). New York: Guilford Press.

National Child Traumatic Stress Network
www.nctsn.org

Trauma-Focused Cognitive-Behavioral Training
http://tfcbt.musc.edu

RESOURCES FOR PARENTS

Holmes, M. (2000). *A terrible thing happened: A story for children who have witnessed violence or trauma*. Washington, DC: Magination Press.

Koocher, G. P., & La Greca, A. M. (2011). *The parents' guide to psychological first aid: Helping children and adolescents cope with predictable life crises*. New York: Oxford University Press.

Mark, B. S., Layton, A., & Chesworth, M. (1997). *I'll know what to do: A kid's guide to natural disasters*. Washington, DC: American Psychological Association.

Straus, S. F. (2013). *Healing days: A guide for kids who have experienced trauma*. Washington, DC: Magination Press.

National Child Traumatic Stress Network: Resources for Parents and Caregivers
www.nctsn.org/resources/audiences/parents-caregivers#q8

Trauma-Focused Cognitive Behavioral Therapy app
Search for "TF-CBT Triangle of Life" in the Apple iTunes store or Google Playapp

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