HANDBOOK OF PTSD
Science and Practice
SECOND EDITION

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Rates of exposure to violence and traumatic events for children and adolescents are alarmingly high. According to the 2010 American Academy of Child and Adolescent Psychiatry practice parameters for assessment of posttraumatic stress disorder (PTSD) in youth, more than 25% of children and adolescents will experience a traumatic event before the age of 18. In the United States alone, this amounts to more than 18 million children, with a disproportionate number of those coming from lower socioeconomic status and ethnic/minority backgrounds (DeNavas-Walt, Proctor, & Smith, 2011). Estimates from nationally representative samples also suggest that many children experience repeated exposure to trauma or multiple types of traumatic events over their lifetime (Copeland, Keeler, Angold, & Costello, 2007; Finkelhor, Ormrod, & Turner, 2009). The range of potentially traumatic events runs the gamut from child maltreatment and domestic violence to natural disasters, community and school violence, and others.

A significant number of children and adolescents exposed to potentially traumatic events develop PTSD, posttraumatic stress (PTS) symptoms, and other common trauma-related sequelae, including depression, anxiety, and behavioral disorders. The growing empirical literature also suggests that exposure to trauma during childhood and adolescence may profoundly derail healthy development and result in myriad psychosocial, biological, behavioral, and cognitive consequences that persist well into adulthood (Anda et al., 2006; Briere, Kaltman, & Green, 2008; Felitti et al., 1998; Ford, Connor, & Hawke, 2009). Among these, PTSD has been identified as perhaps the most common response. For far too many children, these experiences go unrecognized and untreated, resulting in increased risk for PTSD and a more chronic and debilitating course.

Given the prevalence of trauma among children and adolescents, the potential for PTSD, and the developmental implications of leaving trauma untreated, increased
attention has been placed on the assessment and treatment of PTSD in youth (Hawkins & Radcliffe, 2006). Our purpose in this chapter is to provide a comprehensive overview of the assessment of PTSD in children, with a particular focus on some of the challenges associated with assessing PTSD, including relevant developmental considerations, as well as potential new directions for clinicians and researchers given the shifting landscape expected as a result of the implementation and adoption of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013).

Prevalence, Course, and Consequences of Trauma Exposure

PTSD is one of the more serious and debilitating mental disorders that may occur following trauma exposure. Estimates of PTSD among children and adolescents vary considerably, ranging from approximately 5 to 60% of youth meeting criteria for PTSD in the months following traumatic exposure (Levendosky, Huth-Bocks, Semel, & Shapiro, 2002; Scheeringa, Zeanah, Drell, & Larrieu, 1995). The exact rate depends largely on the particular type of trauma examined (e.g., sexual abuse vs. natural disaster); gender of participants (girls tend to have slightly higher rates); the study population of focus (e.g., clinical vs. community samples); the age of the youth assessed (preschoolers vs. adolescents); and the specific assessment instruments, methods, or developmentally sensitive criteria utilized.

Despite variations in prevalence rates, many clinicians and researchers generally agree that PTS symptoms are pretty common following trauma exposure. Although most individuals adapt and recover, it is estimated that approximately 30% of adults and children develop PTSD, and nearly 50% of these individuals have an impairing and unremitting course (Davidson & Fairbank, 1993; DeYoung, Kenardy, Cobham, & Kimble, 2012; Le Brocque, Hendrikz, & Kenardy, 2010; Scheeringa, Zeanah, Myers, & Putnam, 2005). These findings are particularly concerning given that trauma during this critical developmental period may result in myriad consequences that may persist well into adulthood—including risky health behaviors (e.g., substance use), physical health conditions (e.g., heart disease), structural and functional impairments in brain functioning, dysregulation of affect and behavior; and learning and cognitive difficulties (Anda et al., 2006; Briere et al., 2008; Felitti et al., 1998; Ford et al., 2009).

Youth with PTSD often experience other comorbid conditions, making it difficult for clinicians to distinguish between overlapping symptoms, particularly anxiety and depressive symptoms. High rates of comorbidity have been documented in youth exposed to a variety of traumas (Kilpatrick, Saunders, & Smith, 2003; Runyon, Faust, & Orvaschel, 2002). A survey of 1,433 youth revealed that victimization, during a 15-month follow-up period, was significantly related to PTS symptoms and depression, even after researchers controlled for the symptoms they initially observed (Boney-McCoy & Finkelhor, 1996). Other studies describe the potentiating effects of co-occurring symptoms. Runyon and colleagues (2002), for example, found that abused children with PTSD and major depressive disorder reported more intrusive PTSD symptoms than did children with PTSD alone. Although the wide range of symptoms displayed in children and adolescents can make diagnosis more difficult, accurate diagnosis of PTSD remains essential. Table 21.1 contains guidelines for assessing disorders that may be comorbid with PTSD.
### TABLE 21.1. PTSD Assessment and Comorbid Disorders: Examples of Suggested Additional Assessments If Comorbid Disorders Are Suspected

<table>
<thead>
<tr>
<th>Comorbid disorder</th>
<th>Recommended assessments</th>
</tr>
</thead>
</table>
| Attention-deficit/hyperactivity and disruptive behavior disorders | Child Behavior Checklist  
Conners ADHD Rating Scale  
K-SADS-PL |
| Substance use and related disorders           | NIDA Drug Use Screening Tool  
K-SADS-PL |
| Mood disorders/suicidality                   | Child Behavior Checklist  
Children's Depression Index  
Columbia Suicide Screen  
K-SADS-PL  
Suicidal Ideation Questionnaire |
| Other anxiety disorders                      | Child Behavior Checklist  
K-SADS-PL  
Multidimensional Anxiety Scale for Children |
| Sleep disorders                              | Children's Sleep Habits Questionnaire                |

**Developmental Considerations**

There are several developmental factors to consider before assessing for posttraumatic stress disorder in children and adolescents: The first, of course, is current age and developmental stage/age at which the event(s) occurred; the second is the type, severity, and duration of the traumatic event(s); and the third is the context in which the trauma occurred, with particular attention on the child’s immediate family and home environment. Other critical factors to be considered are parental support and level of parental distress because research suggests that these contribute significantly to either reduction or the development and maintenance of reactions and symptoms in children (Scheeringa & Zeanah, 2001). This may be particularly true for very young children who are dependent on caregivers for safety, guidance, love, and support. Equally important is to consider the cultural perceptions, norms, and mores that may affect the response of the child and family. Other considerations include legal and other systemic involvement, such as child welfare or law enforcement, and the uncertainty and change that may accompany their interventions (e.g., removal from the home, incarceration of the perpetrator, and other secondary adversities). Finally, researchers and practitioners must also consider whether the child has been exposed to previous traumatic events or secondary adversities, and what strengths and protective factors he or she might have used to cope effectively. Taken together, these factors can be used to guide selection of the type of assessment tool(s) that will be most appropriate for assessing and evaluating symptoms in children and adolescents; to identify potential respondents and domains to be assessed; and to provide relevant information to augment coping, reduce distress, and foster resilience and recovery.

**Diagnostic and Assessment Challenges**

Much of the extant literature on PTSD focuses on children and adolescents who have been exposed to an acute event or single incident of trauma (e.g., a school shooting,
a natural disaster). This approach, however, fails to capture the more common "day-to-day" or chronic traumatic exposures (e.g., maltreatment, community violence) that tend to occur among children and adolescents presenting with symptoms of PTSD (Carrion, Weems, Ray, & Reiss, 2002). The burgeoning research on chronic exposure to trauma has begun to delineate symptoms of PTSD, as well as a pattern of potential impairments across multiple domains (i.e., cognitive, physiological, social, emotional, and behavioral), which in turn have deleterious implications for a child's further growth and development (Anda et al., 2006; Anderson, 2005; Briere et al., 2008; Felitti et al., 1998; Ford et al., 2009; Nader, 2004).

Many of the refinements and modifications of PTSD diagnostic criteria in DSM-IV-TR (American Psychiatric Association, 2000) were an attempt to compensate for the differences in symptom presentation in children and adolescents given that the criteria were originally field-tested, developed, and based largely on the clinical presentations of adults. This is especially problematic in terms of accurately assessing symptoms and manifestations of PTSD in children. For example, reexperiencing symptoms (i.e., intrusive memories, flashbacks, trauma-specific nightmares) as noted in DSM-IV-TR, may be manifested in children as behavioral reenactment/repetitive play with trauma-related themes or as more generalized nightmares (e.g., dreams about monsters, dangerous or frightening situations) rather than trauma-specific content. The three symptom clusters (i.e., reexperiencing, avoidance/numbing, and hyperarousal) and related notes and comments in DSM-IV-TR, however, may have failed to capture the full array of symptoms that occur among children exposed to traumatic events (Carrion et al., 2002; Levendosky et al., 2002; Nader, 2011).

Some of the revisions in DSM-5 may lead to significant advances in the field because it divides the diagnostic criteria for children by age and also acknowledges the broader impact on child and adolescent functioning. Moreover, DSM-5 has specific designations for the developmental presentations of PTSD for children age 6 and younger. This important modification of the previous edition will enhance practitioners' ability to capture the full array of symptoms that occur in young children exposed to traumatic events that was often not captured in the "adult version" of the diagnostic criteria (Carrion et al., 2002; Levendosky et al., 2002). For example, it is common for children to behave more aggressively following trauma, which is largely not captured in the current PTSD diagnosis; it is therefore common to omit, misattribute, or disregard aggression when assessing children even though increased aggression can be a core presenting feature (Nader, 2011). However, these new criteria for children mean that many of the assessment tools used to diagnose PTSD in children in general, and in young children in particular, will need to be amended to capture both the modifications to the diagnostic criteria in general (e.g., inclusion of negative cognitions rather than hypervigilance) and the new designation for children aged 6 and younger. Further complicating the assessment process, these differences in symptom presentation vary by developmental epoch of the child and are particularly pronounced among young children, who have limited verbal capacities. These developmental factors in turn have considerable implications for accurate assessment and the selection of appropriate treatment. In addition to new complexities associated with DSM-5 in assessing childhood PTSD, many of the aforementioned factors related to the specific type, severity, timing, and duration of traumatic events that are most commonly experienced by children may contribute to variation in PTSD symptoms and behaviors (Allwood, Bell-Dolan, & Husain, 2002).
**PTSD Assessment of Children**

Any clinician working with children knows that they are difficult to assess because, on the one hand, they may still be acquiring cognitive, expressive language, and other developmental skills that may result in limited capacity to relate symptoms and experiences; on the other hand, at the same time, they are developing rapidly, and both their perceptions and the type of situations they experience are continually changing. The developing complexities associated with assessing psychopathology in general are especially true for PTSD. Children may lack the language to describe internal states, certain events, or experiences (e.g., feelings of shame associated with rape and other forms of sexual abuse), and their perception of and reaction to traumatic events may be drastically different from that of adults (e.g., increased oppositional behavior is commonly seen in children following sexual abuse). In addition, children’s reaction to and perception of traumatic events can change drastically as they develop and attain more complex and accurate language and knowledge relative to past traumatic events, which makes substantially delayed and varied reactions to trauma common in children. For example, it is common for children who were sexually abused early in childhood first to develop PTSD in early adolescence, when language and knowledge related to sexual behavior matures (Wondie, Zemene, Reschke, & Schröder, 2012). This is similarly true for neglect, which is often overlooked but substantially related to PTSD (Collin-Vézina, Coleman, Milne, Sell, & Daigneault, 2011).

Further complicating assessment, a child who is evaluated following trauma may not meet criteria for PTSD, but when assessed later in development may meet criteria for that same trauma because timing of the exposure and acquisition of new developmental skills can confer both new meaning and risks for the development of symptoms. Furthermore, the types of trauma associated with the disorder often make caregiver report, typically a hallmark of childhood assessment, less reliable in the case of PTSD due to the “behind closed doors” nature of a good deal of childhood trauma, particularly child abuse and neglect. Moreover, this is often complicated by the fact that some parents are themselves the perpetrators, which increases the likelihood that parents will either minimize or inaccurately report PTSD symptomatology based on their level of support, distress, and/or their ability to accurately identify children’s internal affective states (Collin-Vézina et al., 2011).

Despite the many challenges of assessing PTSD in children and adolescents, it is clear that some of the many youth exposed to myriad traumatic events will have severe and debilitating reactions secondary to traumatic exposure that also require treatment. Thus, practitioners and clinicians need to be able to recognize PTS reactions in youth, understand their unique developmental and cultural considerations, and offer an array of empirically supported treatments that foster recovery and promote resilience.

Central to expeditiously and effectively making these challenging clinical determinations are targeted assessments for the types of trauma and subsequent PTSD symptoms with which children typically present. Our goal for the remainder of this chapter is to cull extant measures of PTSD in childhood by providing a review of evidence-based instruments developed and validated for assessing PTSD in children and adolescents. In keeping with the structure put forth by the U.S. National Center for PTSD, three categories of assessments are presented: clinical interviews, youth self-report, and caregiver report. For each of these childhood PTSD assessment instruments, the
TABLE 21.2. Trauma and PTSD Measures for Children and Adolescents

<table>
<thead>
<tr>
<th>Measures</th>
<th>Target age group (yr)</th>
<th>No. of items</th>
<th>Time to administer (min)</th>
<th>Allows multiple traumas?</th>
<th>Corresponds to DSM-IV criteria?</th>
<th>Example studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical interviews</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child PTSD Reaction Index (CPTS-R1)</td>
<td>6-17</td>
<td>20</td>
<td>15-20</td>
<td>No</td>
<td>No</td>
<td>Agustini (2011); Bal (2008); Goenjian (2011); Landolt et al. (2003); Levine et al. (2008)</td>
</tr>
<tr>
<td>Childhood PTSD Interview</td>
<td>n.s.</td>
<td>93/1</td>
<td>15-20</td>
<td>Yes</td>
<td>Yes</td>
<td>De Bellis et al. (2010); Steinbuchel (2009)</td>
</tr>
<tr>
<td>Children’s Impact of Traumatic Events Scale-Revised (CITES-2)</td>
<td>6-18</td>
<td>78</td>
<td>30-45</td>
<td>Yes</td>
<td>Yes</td>
<td>Thabet et al. (2008); Wondie et al. (2012)</td>
</tr>
<tr>
<td>Children’s PTSD Inventory (CPTSDI)</td>
<td>7-18</td>
<td>43/1</td>
<td>15-20</td>
<td>Yes</td>
<td>Yes</td>
<td>Dow et al. (2012); Yasik et al. (2001)</td>
</tr>
<tr>
<td>Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA)</td>
<td>7-18</td>
<td>33/2</td>
<td>30-120</td>
<td>Yes</td>
<td>Yes</td>
<td>Kletter et al. (2009); Rosner et al. (2012); Weems et al. (2003)</td>
</tr>
<tr>
<td>Traumatic Events Screening Inventory (TESI)</td>
<td>4 and up</td>
<td>18/ varies</td>
<td>10-30</td>
<td>Yes</td>
<td>Yes</td>
<td>Schiff et al. (2012)</td>
</tr>
<tr>
<td>UCLA PTSD Index for DSM-IV</td>
<td>7-12 child, 13+ adolescent</td>
<td>48</td>
<td>15-20</td>
<td>Yes</td>
<td>Yes</td>
<td>Elbert et al. (2009); Ellis et al. (2006); Harder et al. (2012); Loeb et al. (2011); Wolmer et al. (2011); Wu et al. (2008)</td>
</tr>
<tr>
<td>Youth self-report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child PTSD Symptom Scale (CPSS)</td>
<td>8-18</td>
<td>26</td>
<td>10-15</td>
<td>Yes</td>
<td>Yes</td>
<td>Havens et al. (2012); Kataoka et al. (2009)</td>
</tr>
<tr>
<td>My Worst Experiences Survey</td>
<td>9-18</td>
<td>105</td>
<td>20-30</td>
<td>No</td>
<td>Yes</td>
<td>Hyman et al. (2003)</td>
</tr>
<tr>
<td>Trauma Symptom Checklist for Children (TSCC)</td>
<td>6-17</td>
<td>54/1</td>
<td>10-20</td>
<td>Yes</td>
<td>No</td>
<td>Collin-Vézina et al. (2011); Kugler et al. (2012); Milot et al. (2010); Mohammadkhani et al. (2007); Strawn et al. (2010)</td>
</tr>
</tbody>
</table>

(continued)
TABLE 21.2. (continued)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Target age group (yr)</th>
<th>No. of items</th>
<th>Time to administer (min)</th>
<th>Allows multiple traumas?</th>
<th>Corresponds to DSM-IV criteria?</th>
<th>Example studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Report of Child’s Reaction to Stress</td>
<td>n.s.</td>
<td>79</td>
<td>30-45</td>
<td>Yes</td>
<td>No</td>
<td>Berent et al. (2008); Cruso et al. (2010); DePrince et al. (2009); Dorsey et al. (2012); Goldin et al. (2003); Self-Brown et al. (2011)</td>
</tr>
<tr>
<td>Trauma Symptom Checklist for Young Children (TSCYC)</td>
<td>3-12</td>
<td>54/1</td>
<td>20-30</td>
<td>Yes</td>
<td>No</td>
<td>Briere et al. (2001); Lanktree et al. (2008); Milot et al. (2010)</td>
</tr>
</tbody>
</table>

age group, number of items, time for administration, inclusion of multiple traumas, and relationship to DSM-IV criteria are summarized in Table 21.2. The focus is on measures that are specifically intended to assess childhood PTSD and does not include general psychological assessments that include PTSD as part of a broad symptom-based or DSM-based assessment (e.g., Child Behavior Checklist, Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children). To illustrate the effective application of these assessments in evidence based research, we have also included in Table 21.2 examples of peer-reviewed studies that have employed these measures. The field of child PTSD research is continually growing and rapidly evolving, particularly as we await the impact of the DSM-5 and its recommended changes in assessment and diagnosis of PTSD; consequently, this list is not exhaustive.

Clinical Interviews

Child PTSD Reaction Index

The Child PTSD Reaction Index (CPTSD-RI; Frederick, Pynoos, & Nader, 1992) is commonly employed in childhood PTSD research to assess PTSD symptoms and to diagnose children and adolescents ages 6-17 years following a traumatic event. This 15- to 20-minute interview comprises 20 items that are each given a score of 0 to 4 points based on symptoms. An advantage of the CPTSD-RI is that the language for assessing PTSD symptoms is developmentally appropriate and available in a number of languages. It has been used widely in research with a range of traumas, from earthquakes to war. Furthermore, the psychometric properties of the CPTSD-RI are well established, and the measure possesses good reliability and validity. This measure is most appropriate for single-trauma events rather than multiple-trauma exposures, and it does not correspond directly to DSM-IV criteria for PTSD. It is best for assessing children following traumatic incidents such as natural disasters and emergency situations because it was designed for rapid, accurate use in these situations and there is substantial evidence-based literature to support the effectiveness of its use in this context.
Childhood PTSD Interview

The Childhood PTSD Interview (Fletcher, 1996a) is a semistructured, 93-item clinical interview that is intended to diagnose PTSD and related symptoms. The interview takes approximately 15–20 minutes to complete and may be administered by paraprofessionals. It allows for multiple traumas and yields a categorical score of PTSD diagnosis, as well as a dimensional rating of symptom severity. The age range is not specified; however, the interview is written at a third-grade reading level and has been used with younger children. A parent report is also available (Fletcher, 1996b).

Children's Impact of Traumatic Events Scale—Revised

The Children's Impact of Traumatic Events Scale—Revised (CITES-2; Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991), a 78-item, structured clinical interview for children ages 8–16 years, takes approximately 30–45 minutes to administer. The scale is designed to measure PTSD symptoms, as well as social reactions and abuse attributions, particularly related to sexual abuse. It allows for the inclusion of multiple traumas and corresponds to DSM-IV criteria for PTSD.

Children's PTSD Inventory

The Children's PTSD Inventory (CPTSDI; Saigh et al., 2000) is a 43-item, clinician-administered measure of PTSD for children ages 6–18 years. The CPTSDI yields both categorical and dimensional scores indicating PTSD diagnosis and severity. There are also five subscales that correspond to primary PTSD symptoms and related challenges: Avoidance and Numbing, Increased Arousal, Reexperiencing, Significant Impairment, and Situational Reactivity. It has been used in research and clinical settings and takes from 30 minutes to 2 hours to administer, depending on the number of traumas endorsed and the severity of PTSD symptoms.

Clinician-Administered PTSD Scale for Children and Adolescents

The Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA; Nader et al., 1996) is a clinician-administered interview intended to assess DSM-IV PTSD criteria and related symptoms in children and adolescents. It contains 36 items that query about the traumatic event the child rates as most distressing; however, it allows for the inclusion of multiple or repeated traumas. The CAPS-CA yields a current and lifetime PTSD diagnosis, chronicity and severity of symptoms, as well as behavioral functioning in a range of domains. Since the CAPS-CA is clinician-administered, clinical judgment plays a role in designating the impact of traumatic events on functioning.

Traumatic Events Screening Inventory for Children

The Traumatic Events Screening Inventory for Children (TESI-C; Ribbe, 1996) is an 18-item, structured, clinician-administered measure of PTSD for children age 4 years and up. The TESI-C takes approximately 10–30 minutes to administer and provides queries on a range of traumatic incidents, as well as PTSD symptoms. A parent report
Assessment of Childhood PTSD

(TESI-PRF-R) is also available, as well as a child-specific form (TESI-CRF-R) that queries additional trauma specific to young children (e.g., being hit by a parent or caregiver).

UCLA PTSD Index for DSM-IV

The UCLA PTSD Index for DSM-IV (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998) is a 48-item, semistructured interview that assesses for multiple traumas, as well as PTSD symptoms and severity. There is a child version for youth ages 7-12 years and an adolescent version for youth ages 13 and older; there is also a parent version of the measure. This instrument is intended to serve as a brief screening tool in research or clinical settings for traumatic exposure, as well as PTSD symptoms.

Youth Self-Report

Child PTSD Symptom Scale

The Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001) is a 26-item, self-report measure of DSM-IV-based PTSD symptoms. It allows for the inclusion of multiple traumas and assesses overall adaptive functioning (e.g., academic performance, social relationships) in addition to assessing PTSD symptoms. Cutoff scores for a diagnosis of PTSD are available for children ages 8-18 years.

My Worst Experiences Survey

The My Worst Experiences Survey (National Center for Study of Corporal Punishment and Alternatives in Schools, 1992) is a 105-item, self-report survey for youth ages 9-18 years. It queries children on 21 different potentially traumatic events (e.g., domestic violence, physical abuse, natural disasters). Children who can read at the third-grade level can complete it in 20-30 minutes. Children are asked to rate PTSD symptoms based on the event that they deem to be their “worst” traumatic event. Items are rated on a 5-point Likert scale, and scoring includes a PTSD score, as well as scores for related symptoms (e.g., depression, oppositional behavior, somatic symptoms).

Trauma Symptom Checklist for Children

The Trauma Symptom Checklist for Children (TSCC; Briere, 1996) is a self-report measure for children and adolescents ages 8-16 years. This 54-item measure assesses PTSD symptoms after single or chronic traumatic incidents and is often used to assess sequelae associated with childhood sexual abuse. TSCC scoring yields six clinical subscales: Anger, Anxiety, Depression, Posttraumatic Stress, Dissociation, and Sexual Concerns. The TSCC is also available in a shorter, 40- and 44-item format, omitting questions about sexual concerns following trauma.

Caregiver Report

Parent Report of Child’s Reaction to Stress

The Parent Report of Child’s Reaction to Stress (Fletcher, 1996b) is a 79-item caregiver report that takes approximately 30-45 minutes to complete. It yields both a categorical
PTSD diagnosis, as well as a dimensional severity scale for associated symptoms. There is not a specific age range for the measure.

**Trauma Symptom Checklist for Young Children**

The Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005) is a caregiver report of trauma and PTSD symptoms for children ages 3–12 years. This 90-item measure assesses trauma, particularly that occurring in the past month. The TSCYC has eight clinical scales, which include PTS total score, as well as scores for other psychopathology commonly associated with PTSD (e.g., anger/aggression, depression, dissociation, and sexual concerns). An advantage is that the TSCYC can be administered and scored with little training; however, it does not query about trauma-specific behaviors in which children may be engaging (e.g., regression in developmental milestones, repetitive play of traumatic events).

**Future Directions**

Although there are many reliable, empirically based tools for assessing PTSD in childhood, the publication of the DSM-5 undoubtedly requires revision of current assessment instruments, especially for children 6 years old and younger (see Friedman & Resick, Chapter 2, this volume). This represents an additional opportunity to ensure that these measures not only meet DSM-5 criteria for PTSD but also reflect our knowledge of the diverse experiences and reactions of children.

A central new direction in DSM-5 is the first inclusion of a preschool-specific subtype for PTSD, intended for children under age 6. As is widely known, particularly related to child maltreatment, infants and preschool children are especially vulnerable to trauma and its sequelae due to their nascent and malleable development (Levendosky et al., 2002; Milot, Éthier, St-Laurent, & Provost, 2010). Trauma symptoms can manifest differently in young children due to the types of trauma they tend to experience (e.g., being neglected, witnessing domestic violence) and their developmentally specific responses to trauma. As such, future work is needed not only to evaluate current assessments geared toward young children but also to develop new measures. This will be especially challenging for preschool children given that parents are both a central source of childhood trauma and a primary reporter of traumatic events and reactions in young children. Given the vital need to develop treatments that target the preschool-specific PTSD subtype, future work will need to target assessments to meet the diverse cultural and socioeconomic needs of young children presenting with PTSD in light of the often limited resources of those whose task is to assess young children at risk.

Furthermore, emerging research is demonstrating that neuroimaging shows promise for differentiating PTSD in youth (e.g., Carrion et al., 2002). Research with school-age children has revealed structural and functional brain changes associated with diagnosis from structured clinical interviews for PTSD (De Bellis, Hooper, Woolley, & Shenk, 2010; Richert, Carrion, Karchemskiy, & Reiss, 2006). Although this research is still in the preliminary stages, there is mounting evidence that neuroimaging may become a worthwhile assessment tool for clinicians, with the power to reveal biomarkers underlying PTSD symptoms, as well as critical responses to treatment.
WEB RESOURCES

The following websites (current at the time of this writing) can connect the reader to three valuable resources:

The first is the link to the Measures Review site of the National Child Traumatic Stress Network (NCTSN) (www.nctsn.org/resources/online-research/measures-review). Many of the measures mentioned in this chapter, as well as others, can be found here, with a full description of psychometric properties, citations, reading level, and so forth.

The second link is to the Assessment Tools website for the California Evidence-Based Clearinghouse for Child Welfare (www.cebc4cw.org/assessment-tools). It shares many of the characteristics of the NCTSN website.

Finally, the reader is encouraged to explore the Internet for many emerging core competency documents, standards, and guidelines developed by several professional organizations (e.g., Council on Social Work Education, American Psychological Association, Academy on Violence and Abuse, etc.) to ensure trauma-informed assessment and treatment are skills possessed by clinicians working in the field of traumatic stress (e.g., www.cswe.org/File.aspx?id=63842; www.avahelth.org).

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