CH 7

Child and Family Assessment

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On successful completion of this chapter you should be able to:

1) Identify the critical elements elicited in the assessment process for disaster-exposed children
2) Describe the use of child and parent/caregiver psychological interviews to provide multiple sources of information for assessing the trauma-exposed child
3) Identify the leading assessment instruments and rating scales

Key Concepts

- The assessment of the child and family is critical to determine the full extent of the child's psychological responses to life-threatening events.
- The assessment process must be sensitive to the child's level of cognitive and emotional development.
- Optimal assessment uses multiple sources of information to provide understanding of the psychological responses and post-disaster psychosocial functioning of the family.
- Assessment procedures may be used as part of a triage process to identify children at high risk and for in-depth analysis of the psychological functioning of a disaster-exposed child.

Introduction

Disasters and traumatic events confront children and adults with a variety of stressors during the impact phase and in the aftermath. The awareness that children encounter the same constellation of stressors as adults has increased the focus on evaluation of children exposed to traumatic events. Careful assessment of children's psychological reactions is essential for identifying children at elevated risk for disaster-related psychosocial consequences and those in need of therapeutic intervention as well as accurately diagnosing trauma-related symptoms.

Screening

Screening and evaluation of children and their families are conducted in a phase-specific manner over time. Informal assessment occurs on an ongoing basis as first-line responders, school personnel, and public health professionals interact with children and families who have been exposed to disaster. First responders begin the process of identifying children at high risk. As schools reopen, systematic screening procedures may be implemented in the school setting to help identify at-risk children and to intervene as necessary on behalf of these children and their families. This process is guided by school counselors and crisis intervention specialists (Cohen et al., 2006).

In some instances, it will be necessary to refer children and their families to a mental health professional for formal assessment. Referrals are warranted for symptoms and behaviors that are severe and hinder the child's ability to meet the demands of everyday life. For the younger child, indicators include excessive and persistent fearfulness, clinging and dependent behaviors, temper tantrums, agitation, hyperactivity, loss of bladder and bowel control and disturbing nightmares. For the older child or adolescent, symptoms of concern include hyperarousal, anxiety, panic, depressed mood and such maladaptive behaviors as belligerence, family and interpersonal conflicts and misuse of substances.

Clinical Assessment

The evaluation process is complex and multifaceted. It requires not only an interview with the child but also information from other informants such as parents, family members, teachers and other significant persons in the child's life. Since the family system may either hinder or facilitate the child's psychological adaptation and coping strategies, it is essential to evaluate the effects of the traumatic stressor on the various members of the family with particular focus on the parental response. Clinicians generally agree that family and parental support mitigates the risk for posttraumatic stress symptoms (Cohen et al., 1998).

Before engaging children and parents in a psychological interview, safeguards should be in place to ensure that the child and family members are safe and secure, that life sustaining provisions are assured and that measures have been taken to provide continuity of support systems.

The parent interview elicits objective information regarding the nature and severity of the trauma exposure, stressors encountered, psychological responses (including possible posttraumatic stress symptoms), behavior problems, mood and anxiety symptoms, multiple unexplained physical symptoms (MUPS) and concurrent psychological disorders (Table 7.1). The parent interview explores the child's developmental history; risk and protective factors; parent and family responses to the disaster; and the ethnic, religious and cultural context of the traumatic event.

Table 7.1
Critical Elements Elicited in the Assessment Process

History of the Traumatic Exposure

- Assess the traumatic event as an extreme stressor
  - What is the nature of the traumatic event?
- Does it qualify as an imagined or actual threat to bodily integrity or to life itself?
- What was the level of exposure?
  - Direct physical impact, visual or media exposure, interpersonal relatedness to victims
  - What was the intensity and duration of exposure?

Family History

- Were the parents and other family members exposed?
- What was the parental or family response to the traumatic event?
  - Parents' emotional and behavioral symptoms
  - Parents' psychopathology
  - Parents' reaction to the child's distress
  - Family mental health history
  - Stability and functionality of the family support system

Inventory of Stressors

- Bereavement
- Separation from loved ones
- Loss of home/shelter
- Loss of school or other routine activities
- Relationship to peer group
- Physical injury

Child's Developmental History

- Previous exposure to traumatic events
- Coping behaviors
- Psychosocial adjustment
- Psychological morbidity
- History of psychological treatments
- Medical history
- School and academic performance

Child Interview

- Obtain the child's report of what happened
- Explore the child's attributions (their understanding of why it happened, their role in it happening, their thoughts and feelings about how they have responded, and their understanding of how the traumatic event has affected their emotional and behavior well-being)
- Complete a symptom inventory
- Assess for acute stress disorder (ASD) and post-traumatic stress disorder (PTSD)
- Assess for psychiatric comorbidity
  - Mood disorder
  - Anxiety disorder
  - Adjustment disorders
  - Disruptive behaviors: attention deficit/ hyperactivity disorder (ADHD), conduct disorder(CD), oppositional defiant disorder (ODD)
  - Symptoms of hyperarousal
  - Substance abuse
  - Dissociative disorders
  - Physical symptoms
- Assess self-efficacy, coping and adaptive capacities
- Assess the child's capacities to seek and use help from adults

In a separate interview, children are provided an opportunity to describe their perceptions and understanding of what happened and their reactions to the traumatic experience. It is important to establish a sense of ease with the child, to slowly win the child's confidence through friendly interactions and to find the child's level of discourse. In most instances, children are able to tell their stories in words or use nonverbal means for relating what happened as expressed in play, story-telling, and drawings. School-age children are usually able to provide self-reports of their traumatic exposures. Direct questioning is often necessary to fill in the gaps but the questions should be sensitive to the child's comfort, emotional availability and cognitive development.

The Child Interview: Direct Questions to Consider

- Have you been hurt or injured?
- Have you seen anyone get hurt badly?
- Has anyone in your family been hurt?
- Have you seen anything really scary and frightening?
- Do you ever have any scary dreams or nightmares?
- How do you sleep at night?
- What was the most upsetting and scary part of the experience?
- Do you ever see or hear anything that reminds you of something really scary?
- Who makes you feel safe?

Source: Modified from Bostic & King (2007)

Child assessment requires collecting information regarding the child's perceptions and understanding, his or her theory of causality, self-attributions, resiliency and the child's repertoire of adaptive and coping mechanisms for regulating emotions and impulse control.

While gathering information through the parent and child interviews, the clinician should be aware of how the child's level of cognitive and emotional development influences the expression of posttraumatic stress symptoms. Because of their cognitive and emotional immaturity, children are often

unable to fully discuss their distress and impairment. Infants and toddlers are limited in their expressive language skills and capabilities for describing their subjective experiences. Preschool children are unable to verbalize symptoms of distress, describe intrusive thoughts or flashbacks or identify sources of physical complaints. For preschool children, internal emotional states are revealed through behaviors such as clinging dependency, temper tantrums, separation anxiety, fear of the dark and sleep and appetite disturbances (Scheeringa et al., 1995).

Piaget (1967) observed that younger children do not recognize the existence of chance happenings. The younger child assumes that everything that happens is related to something that he or she did or did not do. Before the age of seven years, children often attribute purpose or intention to events that others realize are chance happenings.

For school-age children, the focus shifts to assessment of behavioral expressions of inner turmoil. Psychological distress may manifest through play and behavioral symptoms rather than through verbal description. Hyperactivity, sleep and appetite disturbances, decrements in school performance, inability to concentrate, physical symptoms, irritability and sibling rivalry are common responses to the traumatic situation. In contrast, older children are often able to express unpleasant internal emotional states in words, discuss the subjective experience of the trauma exposure and ascribe meaning to the event.

PTSD Rating Scales/Instruments

In the field of disaster psychiatry, assessment has been strengthened by the development of instruments to define disaster-specific stressors and reactions (Saylor & Deroma, 2002). Standardized assessment instruments target specific dimensions of disaster or trauma exposure and identify stressors, emotional and behavioral reactions and attributions of causation. Optimal assessment requires adherence to the basic principles of scientific research and practice, including the use of multiple information sources and the selection of well-established, reliable and valid assessment measures (Finch & Daugherty, 1993).

In order to properly define the assessment approach, the clinician must clarify the goals and define the key questions for investigation. One primary distinction is to determine whether the assessment will be used for triage purposes or as a tool to evaluate the child's psychological responses to the traumatic event. For example, is the goal of assessment to identify children with clinical psychological disorders such as PTSD or depression, or to identify children with problematic behaviors (that do not qualify as disorders)?

Balaban (2006) identified five field-tested screening instruments designed for children and adolescents that are applicable for use in disaster and emergency settings. Each of the five employs a standardized, scientifically-validated questionnaire that can be administered by clinicians or non-clinicians in 60 minutes or less (Table 7.2). Among the five measures, Balaban concluded that the PTSD Reaction Index (UCLA PTSD-RI) is the most appropriate measure for evaluating children across a wide variety of disasters. This measure, now available in multiple languages, is inexpensive, simple, rapidly administered and scored and supported by sound scientific research (Balaban, 2006).

Table 7.2
Instruments for Assessing Post-Traumatic Symptoms and PTSD

Instrument	Purpose	Availability	Ages	Length/administration time
UCLA PTSD Reaction Index for DSM IV	To assess post-trauma symptoms and PTSD in children	No cost; rpynoos@mednet.ucla.edu	6–17	22 items 20–30 minutes
Impact of Events Scale- Revised (IES-R)	To measure symptoms of PTSD after a traumatic event	No cost; available on many websites, such as http://www.swin.edu.au/victims/resources/assessment/ptsd/ies-r.html A 13-item version of the IES-R (IES-13) developed for children affected by war is available at http://www.childrenandwar.org/CRIES-13.doc	Used with children as young as 7 (not designed for children)	22 items 10–15 minutes
Child PTSD Symptom Scale (CPSS)	To evaluate symptoms and functional impairment related to PTSD	No cost; foa@mail.med.upenn.edu	8–18	24 items 15 minutes
Posttraumatic Stress Symptoms in Children (PTSS-C)	To identify pediatric post-traumatic symptoms in chaotic disaster contexts	No cost; Abdulbaghi.Ahmad@bupinst.uu.se	6–18	30 items 30 minutes
Trauma Symptom Checklist for Children (TSCC)	To assess PTSD symptoms after trauma, particularly sexual abuse	Licensed through http://www.parinc.com	7–16	54 items 20 minutes

Source: Balaban, 2006

Instruments for Depression, Anxiety and Behavioral Problems

In addition to posttraumatic stress symptoms, mood and anxiety symptoms are also common responses to the life-threatening situations and multiple losses that characterize disasters. Standardized instruments for the broader range of psychological reactions are presented in Table 7.3.

Table 7.3
Instruments for Assessing Depression, Anxiety and Behavior

Instrument	Purpose	Availability	Ages	Length/administration time
INSTRUMENTS FOR ASSESSING DEPRESSION				
Children's Depression Inventory (CDI)	To measure depressive symptom severity in children	Licensed through http://www.mhs.com	7–17	27 items 5–10 minutes
Depression Self-Rating Scale (DSRS)	To measure symptoms of depression	No cost; contact author	6–13	18 items
INSTRUMENTS FOR ASSESSING ANXIETY				
Multidimensional Anxiety Scale for Children (MASC)	To assess anxiety symptoms in children	Licensed through http://www.mhs.com	8–19	39 items 15 minutes (10-item short form also available)
Revised Children's Manifest Anxiety Scale (RCMAS)	To evaluate anxiety symptoms in children	No cost; available on many websites, including http://www.swin.edu.au/victims/resources/assessment/affect/rcmas.html	6–19	37 items
INSTRUMENTS FOR ASSESSING BEHAVIOR				
Pediatric Emotional Distress Scale (PEDS)	To measure post-traumatic behavioral problems in children	No cost; Conway.saylor@citadel.edu	2–10	21 items 10–15 minutes
Revised Behavior Problem Checklist (RBPC)	To rate problem behavior in adolescents and young children	Licensed through http://www.parinc.com	5–18	89 items 20 minutes

Source: Balaban, 2006

Summary

The assessment of the child and family is critical to determine the full extent of the child's psychological responses to life-threatening events. Optimal assessment uses multiple sources of information to provide understanding of the psychological responses and post-disaster psychosocial functioning of the family. Assessment procedures may be used as part of a triage process to identify children at high risk or for in-depth analysis of the psychological functioning of a disaster-exposed child.

A careful assessment and clinical history is taken from the parents or caretakers. The child interview should focus on engagement strategies, friendly interaction, empathic listening and sensitivity to the child's emotional state and cognitive level. The use of nonverbal modalities such as play, story-telling or drawings as well as some direct questioning is necessary to elicit the child's perception, understanding and response to the traumatic situation. Standardized instruments for the assessment of posttraumatic stress symptoms and the broader range of psychological reactions are often useful.