ALLEN RUBIN & DAVID W. SPRINGER, Editors

Treatment of Traumatized Adults and Children

Clinician's Guide to Evidence-Based Practice

Praise for *Treatment of Traumatized Adults and Children*

A major stumbling block to adoption of evidence-based practice in the real world of clinical practice has been the absence of clinician-friendly guides suitable for learning specific empirically supported treatments. Such guides need to be understandable, free of technical research jargon, infused with clinical expertise, and rich with real-life examples. Rubin and Springer have hit a home run with the Clinician's Guide to Evidence-Based Practice series, which has all of these characteristics and more.

Edward J. Mullen
Willma & Albert Musher Chair and Professor, Columbia University

This timely book provides detailed, easy-to-follow procedures for the treatment of traumatized adults and children, based on a solid foundation of empirically based practice. *Treatment of Traumatized Adults and Children*, as well as others in the Clinician's Guide to Evidence-Based Practice series, is a must-read for clinicians who incorporate notions of evidence-based practice in their work.

Tony Tripodi
Professor Emeritus, Ohio State University

In *Treatment of Traumatized Adults and Children*, Rubin and Springer and their contributors boil down more than 20 years of published research and practice to provide the busy practitioner with practical guidance in helping the traumatized. It is an indispensable guide to responsibly bringing relief to those who seek it.

Charles R. Figley,
Tulane University; Editor of *Traumatology*

Rubin and Springer have assembled the practice wisdom of leading practitioners of evidence-based practice interventions, enhancing the likelihood that these practices will be adopted by helping professionals. Each chapter introduces readers to principles that undergird a specific intervention and detailed descriptions of assessment criteria, flow of treatment, and procedural steps. Written in the language of practitioners, this book represents an exemplar for dissemination of evidence-based practice information.

Joanne Yaffe
Associate Professor, University of Utah College of Social Work

Treatment of Traumatized Adults and Children is straightforward and practical, and the step-by-step guides allow even the novice to master the skills needed for effective work with trauma. Marvelous job by the editors and contributors.

Kevin Corcoran
Professor, Portland State University

Clinician's Guide to Evidence-Based Practice Series

Treatment of Traumatized Adults and Children
Allen Rubin and David W. Springer, Editors
Substance Abuse Treatment for Youth and Adults
David W. Springer and Allen Rubin, Editors

ALLEN RUBIN & DAVID W. SPRINGER, Editors

Treatment of Traumatized Adults and Children

Clinician's Guide to Evidence-Based Practice Series

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Series Introduction

One of the most daunting challenges to the evidence-based practice (EBP) movement is the fact that busy clinicians who learn of evidence-based interventions are often unable to implement them because they lack expertise in the intervention and lack the time and resources to obtain the needed expertise. Even if they want to read about the intervention as a way of gaining that expertise, they are likely to encounter materials that are either much too lengthy in light of their time constraints or much too focused on the research support for the intervention, with inadequate guidance to enable them to implement it with at least a minimally acceptable level of proficiency.

This is the first in a series of edited volumes that attempt to alleviate that problem and thus make learning how to provide evidence-based interventions more feasible for such clinicians. Each volume will be a how-to guide for practitioners, not a research focused review. Each will contain in-depth chapters detailing how to provide clinical interventions whose effectiveness is being supported by the best scientific evidence.

The chapters will differ from chapters in other reference volumes on empirically supported interventions in both length and focus. Rather than covering in depth the research support for each intervention and providing brief overviews of the practice aspects of the interventions, our chapters will be lengthier and more detailed practitioner-focused how-to guides for implementing the interventions. Instead of emphasizing the research support in the chapters, that support will be summarized in an appendix. Each chapter will focus on helping practitioners learn how to begin providing an evidence-based intervention that they are being urged by managed care companies (and others) to provide, but with which they may be inexperienced. Each chapter will be extensive and detailed enough to enable clinicians to begin providing the evidence-based intervention without being so lengthy and detailed that reading it would be too time consuming and overwhelming. The chapters will also identify resources for gaining more advanced expertise in the interventions.

We believe that this series will be unique in its focus on the needs of practitioners and in making empirically supported interventions more feasible for them to learn about and provide. We hope that you agree and that you find this volume and this series to be of value in guiding your practice and in maximizing your effectiveness as an evidence-based practitioner.

Allen Rubin, PhD
David W. Springer, PhD

Preface

If you have been treating traumatized clients—or just reading about their treatment, perhaps in anticipation of treating them—you probably have encountered many comments referring to empirically supported trauma-focused interventions that are considered to evidence based. Such interventions include trauma-focused cognitive behavioral therapy (TFCBT), prolonged exposure therapy, and eye movement desensitization and reprocessing (EMDR), which have the best empirical support for treating posttraumatic stress disorder (PTSD). You may also have encountered entire books on each of these interventions and wished you had more time to read them. Perhaps you've seen some research articles reporting outcome studies providing strong empirical support for one or more of these interventions and wished they provided more clinical guidance as to how you could to provide them to your clients. Likewise, you may have read some books that contain chapters on various empirically supported trauma-focused interventions, but have been disappointed with the brevity of specific practice guidelines in those chapters. That is because such books typically just provide very brief thumbnail sketches of the interventions, perhaps accompanied by rather lengthy reviews of the studies that supported each.

If you have had the above experiences and reactions, then this book is for you. Its very detailed, lengthy how-to chapters—with case examples sprinkled throughout—are geared to practitioners who want their practice in treating traumatized clients to be evidence based but who don't have the time to read each book on empirically supported interventions for trauma before feeling that they have enough knowledge to make decisions about which approach to adopt and enough guidance to begin providing the chosen intervention as they learn more about it.

This book is also geared to practitioners who may not have had the time to read research articles about empirically supported interventions for traumatized clients or who may be bewildered by the some of the complex research concepts in those articles or by the diversity of findings from study to study. By reading this book, you will learn what interventions have had the best research support and how to provide them. That's because this book has

been written in a user-friendly/practitioner-friendly manner for clinicians who want to learn such things without having to struggle with daunting research and statistical terms. For readers who do not want to accept our conclusions just based on our authority, however, this book provides an appendix that reviews the supporting research.

Another aspect of this book that makes it practitioner friendly and that may enhance its value to practitioners is that every intervention chapter has been authored or co-authored by practitioners who have had extensive experience in the intervention and are clinical experts in it. As you read this book, you may be gratified by the extent to which the chapter authors are communicating more as practitioners and not as ivory tower researchers who don't understand the needs of practitioners. Although the book's editors are housed in academia, we have insisted that our chapters be written in a style that maximizes their utility to practitioners. Moreover, we, too, have had extensive practice experience, and the lead editor has had advanced training in EMDR, has had clinical experience in providing it, and has been teaching a clinical course on the assessment and treatment of traumatized populations.

Although the lengthy how-to detail in this book's chapters will not be as extensive as what you will find in an entire book devoted exclusively to the intervention being described in any particular chapter, it should be enough to get you started in providing the intervention and perhaps helping you decide whether you want to pursue further reading and training in that intervention. Toward the latter end, each chapter will also identify recommended additional reading as well as training options.

As previously mentioned, this book's chapters detail how to provide clinical interventions whose effectiveness with traumatized clients is currently being supported by the best scientific evidence. Thus, the separate chapters cover trauma-focused prolonged exposure therapy, cognitive restructuring, TFCBT, and EMDR. Three chapters describe how to provide such interventions to adults, and two chapters cover providing them to children. In addition to the how-to's of the interventions, each chapter covers their indications and contraindications.

Preceding the five chapters on specific empirically supported interventions is an introduction chapter that identifies commonalities among those interventions. Key among those commonalities is the prerequisite that the interventions be provided in the context of a strong therapeutic alliance. The importance of the therapeutic alliance should not be underestimated—not only in light of the research supporting it as a necessary component of effective treatment with *any* specific intervention approach, but also in light of the widespread misconception that the guidelines for providing empirically supported interventions devalue the importance of the therapeutic alliance and the related misconception that evidence-based practice requires

practitioners to function in a mechanistic way following cookbook-like manuals that disregard their practice wisdom and relationship skills. Readers will *not* find such guidelines in *this* volume. Instead, each chapter will reflect our emphasis on the importance of both the need to provide interventions that have had their effectiveness supported by the best research evidence and the need to choose, adapt, and provide those interventions in light of their practice expertise, their knowledge of idiosyncratic client characteristics and circumstances, and their relationship skills.

This book is timely as practitioners are increasingly being urged to provide empirically supported interventions and as those interventions are increasingly being required by third-party payers. Although EBP has become part of the definition of ethical practice, various studies have shown that practitioners rarely engage in the EBP process. Various pragmatic factors have been cited regarding this concern—in particular, real-world time constraints and the difficulty practitioners have in obtaining the needed expertise to begin implementing the interventions with the best empirical support. This book aims to provide that beginning level of expertise in a manner that fits clinician time constraints.

ORGANIZATION

After an introduction chapter (in Part 1), Part 2 of this book provides three chapters on TFCBT. Chapter 2 emphasizes the prolonged exposure therapy component of TFCBT with adults. Chapter 3 emphasizes the cognitive restructuring component of TFCBT with adults. Chapter 4 covers the provision of TFCBT with traumatized children and their caregivers. Part 3 provides two chapters on EMDR, one that focuses on treating adults (Chapter 5) and one that focuses on providing EMDR to children (Chapter 6). The book concludes with a brief afterword, two appendixes, and a glossary. Appendix A reviews the research that provides the empirical support for the interventions covered in this volume. Appendix B describes in detail the evidence-based practice process for readers who would like more detail about that process than is covered in the introduction chapter.

Regardless of which specific approach you use in treating traumatized clients, we hope this book helps you get started in making your treatment of trauma more evidence based. In connection with becoming more evidence based, we hope it also spurs you to pursue further your reading, training, and search for evidence regarding any interventions you decide to adopt or continue using. We would appreciate any feedback you can provide regarding the ways you have found this book to be helpful or any suggestions you may have for improving it. You can e-mail such feedback to arubin@mail.utexas.edu or dwspringer@mail.utexas.edu.

Acknowledgments

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About the Editors

Allen Rubin, PhD, is the Bert Kruger Smith Centennial Professor in the School of Social Work at The University of Texas at Austin, where he has been a faculty member since 1979. While there, he has worked as a therapist in a child guidance center and developed and taught a course on the assessment and treatment of traumatized populations. Earlier in his career he worked in a community mental health program providing services to adolescents and their families. He is internationally known for his many publications pertaining to research and evidence-based practice. In 1997, he was a co-recipient of the Society for Social Work and Research Award for Outstanding Examples of Published Research for a study on the treatment of male batterers and their spouses. His most recent studies have been on the effectiveness of EMDR and on practitioners' views of evidence-based practice. Among his 12 books, his most recent is *Practitioner's Guide to Using Research for Evidence-Based Practice*. He has served as a consulting editor for seven professional journals. He was a founding member of the Society for Social Work and Research and served as its president from 1998 to 2000. In 1993, he received the University of Pittsburgh School of Social Work's Distinguished Alumnus Award. In 2007, he received the Council on Social Work Education's Significant Lifetime Achievement in Social Work Education Award.

David W. Springer, PhD, LCSW, is the Associate Dean for Academic Affairs and a University Distinguished Teaching Professor in the School of Social Work at The University of Texas at Austin, where he is also Investigator of the Inter-American Institute for Youth Justice and holds a joint appointment with the Department of Psychology. Dr. Springer's social work practice experience has included work as a clinical social worker with adolescents and their families in inpatient and outpatient settings and as a school social worker in an alternative learning center with youth recommended for expulsion for serious offenses. He currently serves on the editorial board of several professional journals and on the National Scientific and Policy Advisory Council of the Hogg Foundation for Mental Health. He has co-authored or co-edited several other books, including *Substance Abuse Treatment for Criminal Offenders: An Evidence-Based Guide for Practitioners* and *Handbook of Forensic Mental Health with Victims and Offenders*.

Dr. Springer recently served as Chair of a Blue Ribbon Task Force consisting of national and regional leaders, which was charged with making recommendations for reforming the juvenile justice system in Texas. In recognition of his work with the Blue Ribbon Task Force, the National Association of Social Workers (NASW), Texas Chapter/Austin Branch selected Dr. Springer as the 2008 Social Worker of the Year.

About the Contributors

Robbie Adler-Tapia, PhD is a licensed psychologist who has worked with traumatized children and their families for 23 years. She is certified in EMDR, an EMDRIA Approved Consultant, an EMDR Institute Facilitator, and an EMDR/HAP (Humanitarian Assistance Program) Trainer. With the EMDR HAPKIDS Program, she volunteers to assist with coordinating research, consultation, and training for therapists working with children internationally. She also provided specialty trainings on EMDR with children at the EMDRIA International Conference and at advanced weekend trainings. She co-authored the book *EMDR and the Art of Psychotherapy with Children* and accompanying treatment manual for clinicians.

Joanne L. Davis, PhD is an Associate Professor of Clinical Psychology, Director of Undergraduate Studies in Psychology, and Co-director of the Tulsa Institute of Trauma, Abuse, and Neglect at the University of Tulsa, Oklahoma. She received her doctorate from the University of Arkansas and completed a predoctoral internship at the Medical University of South Carolina and a two-year postdoctoral fellowship at the National Crime Victims Research and Treatment Center in Charleston, South Carolina. Her research interests include the assessment, treatment, and prevention of interpersonal violence and its effects. In recent years, she has focused on the assessment and treatment of chronic nightmares.

Philip W. Dodgson, PhD, is a Consultant Clinical Psychologist in the United Kingdom's National Health Service and in private practice. He holds degrees in psychology from the universities of Oxford, Surrey, and Sussex and is an EMDR Institute and EMDR Europe accredited trainer. Dr. Dodgson's clinical practice is in the treatment of trauma, including working with people who have been victimized by physical, emotional, and sexual abuse and by torture and organized violence. He has worked clinically in the United Kingdom and the Middle East, and taught in the Middle East, Europe, and the United States.

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Elana Newman, PhD, is McFarlin Chair of Psychology, University of Tulsa, Oklahoma; Research Director of the Dart Center for Journalism and Trauma; and a past president of the International Society of Traumatic Stress Studies. Dr. Newman's research in the field of traumatic stress has examined the physical and psychological effects of trauma exposure on adults and children (including meaning of such events), health care costs and trauma, journalism and trauma, occupational health and trauma, research ethics in studying trauma survivors, and substance abuse and trauma. Her recent clinical and supervision work has focused on disseminating best practice for trauma-related disorders, psychological first aid, and trauma-focused interventions for substance users.

Kristi E. Pruiksma received her MA at the University of Tulsa and is currently a PhD student in the Clinical Psychology program. She is research assistant to Dr. Joanne L. Davis and is the lab manager of the Trauma Research: Assessment, Prevention, & Treatment Center (TRAPT) in the Department of Psychology. As a scientist-practitioner, her clinical and research interests include identifying, understanding, and treating difficulties associated with traumatic events; particularly trauma-related nightmares and associated sleep disorders.

Carolyn Settle, MSW, LCSW, is an EMDR Institute Facilitator, an EMDRIA Approved Consultant, and EMDR Humanitarian Assistance Program (HAP) Trainer. Ms. Settle co-authored the book *EMDR and the Art of Psychotherapy with Children* and the associated manual, in addition to co-authoring two journal articles and a chapter in the book *EMDR Scripted Protocols*. She is a co-investigator on a research study focused on the efficacy of using EMDR with children two to ten years of age. Presently, Ms. Settle is an international speaker and provides advanced training workshops. Ms. Settle currently works in private practice in Scottsdale, Arizona.

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PART 1

INTRODUCTION

CHAPTER 1

Introduction: Evidence-Based Practice and Empirically Supported Interventions for Trauma

ALLEN RUBIN

More and more clinicians these days want to engage in evidence-based practice (EBP). You may be one of them, and, if so, perhaps that's one reason why you are reading this book. Another likely reason, of course, is your interest in treating people who have been traumatized. Each chapter in this book provides a detailed, practitioner-focused how-to guide for providing a specific intervention approach for trauma survivors—interventions whose effectiveness has been supported by a solid evidence base.

Before describing those chapters, however, this introduction will cover some generic principles about trauma and its treatment. It also will summarize the evidence-based practice process and distinguish the overarching concept of *evidence-based practice* from the provision of specific empirically supported interventions.

GENERAL PRINCIPLES ABOUT TRAUMA AND ITS TREATMENT

Defining Psychological Trauma

Psychological trauma is a subjective and relative phenomenon. Definitions of it vary, depending on whether the focus is on a *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) diagnosis of posttraumatic stress disorder (PTSD), adults versus children, and the context of the potentially traumatic event. For a DSM-IV diagnosis of PTSD, to be traumatic the individual must experience, witness, or be confronted by at least one event that causes or threatens death or serious injury, or that threatens the

individual's or someone else's physical integrity. The diagnosis also requires that the individual's response involve intense fear, helplessness, or horror. Traumatizing events that are viewed as sufficiently catastrophic to be commonly associated with PTSD include natural disasters, physical and sexual assault, fires, serious automobile accidents and other serious accidents, military combat, torture, and other forms of exposure to violence.

However, people of all ages can be traumatized without a physical threat or a PTSD diagnosis. In Chapter 5 of this book, Dodgson discusses Shapiro's (2001) concept of ''large 'T' traumas'' and ''small 't' traumas.'' Small t traumas can have a marked impact on a person's life without meeting DSM-IV diagnostic criteria for being considered a traumatic stressor. For example, small t traumas might include adult events such as partnership breakdown or childhood experiences of humiliation.

Consider, for instance, the devoted wife of a successful and admired politician whose secretive and illegal consorting with prostitutes suddenly becomes exposed in the news media. Children, especially, can be traumatized without a physical threat. Consider the teenage daughters of the aforementioned politician. Also, imagine the difference in the degree of psychological trauma between a middle-aged adult learning that his father did not really die in the war but was in an institution for the criminally insane versus an only child aged 12 finding that out for the first time and realizing that his mother has been lying to him.

Regardless of the nature of the trauma and its context, there is agreement that a psychologically traumatic event will demand extraordinary efforts to cope with a sense of helplessness, fear, horror, or disgust. It will shatter basic assumptions and lead to exaggerated appraisals regarding one's vulnerability and self-image and the trustworthiness of other people. It might also be associated with self-blame and notions that life is meaningless.

The meaning and impact of a traumatic event, however, will be affected by its nature and context. A natural disaster—such as a flood, hurricane, or tornado, for example—probably won't induce as much self-blame and lack of trust as would an intentional human act like child abuse, rape, or terrorism. Likewise, the degree to which a traffic accident is psychologically traumatic might depend on whether the survivor was driving and who else was seriously injured or killed. If the traumatic event was an intentional human act, another factor to be considered is the relationship of the perpetrator to the victim. Being sexually abused by a neighbor, albeit horrific, probably will not devastate a child's sense of trust and self-blame as much as being sexually abused by a parent or other close relative.

Also to be considered is whether the client experienced only one isolated traumatic event or multiple such events. Combat veterans with PTSD, for example, often have experienced multiple traumas and consequently are

likely to need a much longer treatment regimen than victims of one hurricane. Likewise, children who have been abused multiple times are more likely to have more serious disorders and need more treatment than those who have been abused only once.

Regardless of which evidence-based approach you choose to treat trauma, the foregoing considerations should influence how you intervene. Likewise, before you introduce one of the evidence-based interventions discussed in this volume—interventions aimed at restoring trust and a *realistic* sense of vulnerability—you should first make sure that the client is safe. It would be tragically harmful, for example, to induce an unrealistic sense of trust and safety if the client is still residing in an environment where he or she is vulnerable to ongoing abuse, such as by a parent, sibling, or violent spouse.

Assessment

Implicit in the preceding considerations is the importance of conducting a thorough assessment before selecting or embarking on one of the evidence-based interventions discussed in this volume. Thus, each intervention chapter in this volume includes attention to assessment processes and issues pertinent to the intervention focus of that chapter. This section, therefore, will focus on generic assessment concepts that apply regardless of the interventions provided to traumatized clients.

Many of the undesirable psychological impacts of trauma on survivors are normal and will not last more than several weeks (if that long). These include such emotions as anger, fear, grief, guilt or shame, numbness, shock, cognitive disorientation, difficulty concentrating, somatic symptoms, problems sleeping or in appetite, being easily startled, interpersonal difficulties, and so on. Most survivors of traumatic events will recover on their own, have their trauma symptoms disappear over time, and not develop PTSD (Friedman, 2006).

DSM-IV Criteria for a PTSD Diagnosis One prime objective of assessment is determining whether the client meets the DSM-IV criteria for a PTSD diagnosis and, if so, its duration and severity. However, that is not the only important assessment objective. As Keane, Weathers, and Foa (2000) point out, a comprehensive assessment would gather information about the client's ''family history, life context, symptoms, beliefs, strengths, weaknesses, support system and coping abilities . . . [and] needs to include indices of social and occupational functioning'' (p. 32).

As mentioned earlier, the criteria for a DSM-IV diagnosis of PTSD require both of the following: (1) experiencing, witnessing, or being confronted by at least one event that causes or threatens death or serious injury, or that threatens the individual's or someone else's physical integrity; and (2) intense

fear, helplessness, or horror in the individual's response. The criteria also include at least one persistent reexperiencing symptom, at least three persistent avoidance or numbing symptoms, at least two persistent hyperarousal symptoms, a duration of the above symptoms of more than 1 month, and clinically significant distress or impairment in important areas of functioning.

Trauma Symptoms Reexperiencing symptoms include intrusive distressing recollections and dreams of the traumatic event. The recollections can include feeling as if the event is actually occurring such as through flashbacks. Flashbacks are not just flashes of memory or intrusive images; instead, they are dissociative episodes. Persons experiencing a flashback will have an altered state of consciousness and be at least partially unaware of their current surroundings. Flashbacks typically last only a few moments, during which time the person has a sense of reliving (not merely recalling) the traumatic event. The flashbacks might involve hallucinations, ''such as hearing cries of the dying or seeing images of the dead'' (Taylor, 2006, p. 13). Reexperiencing symptoms might also include sensory experiences, ''such as seeing unwanted images of the trauma when victims close their eyes, or experiencing smells, tastes, sounds, or emotions experienced at the time of the trauma, such as horror, dread, or helplessness'' (Taylor, p. 12). The recollections can include nightmares that might involve waking with nocturnal panic attacks.

Avoidance symptoms involve avoiding stimuli that are associated with the trauma. The symptoms might involve avoiding a particular place where the trauma occurred as well as similar places that are associated with the trauma due to overgeneralization. Abused individuals might avoid people who remind them of the perpetrator of abuse. They might avoid other people in general so as not to be let down by them, and they may feel as if they can't trust anyone anymore. They may have a sense of a foreshortened future in a malevolent world in which they do not expect to have a normal life span or other formerly desired things like a career, a marriage, or children. No longer feeling safe in the world, they might avoid social situations in general. They might avoid feeling optimistic so they won't be disappointed. In turn, they may make no effort to form good relations with others or to further their own self-interest. Avoiding places or people that really are dangerous, however, is not a symptom of PTSD.

Numbing symptoms involve a restricted range of affect, such as being unable to feel love or happiness, the loss of a sense of humor, and a diminished interest in activities that were formerly enjoyable. With severe numbing, the traumatized person might feel dead inside. The numbness might alternate with periods of anger, sadness, anxiety, or other aversive emotions. It might also lead to substance abuse, either to numb the pain and keep the trauma memories away or perhaps as an antidote to the numbness.

Hyperarousal symptoms can come in various forms. Traumatized individuals might be hypervigilant, in a constant state of alert and looking out for danger. They might be easily startled or threatened and misinterpret neutral or ambiguous social cues as threats. For example, not really knowing why peers are laughing, they might misinterpret the laughter as being derisively in reference to them. Hyperarousal might also involve insomnia, although insomnia also could be attributable to reexperiencing or avoidance symptoms, such as repeated awakening from nightmares or staying awake out of a fear of having terrifying nightmares (Taylor, 2006).

Other Trauma Diagnoses If the client has fewer than the number of symptoms specified for the PTSD diagnosis, there is a ''partial PTSD'' diagnosis. In addition, the ''complex PTSD'' or ''disorders of extreme stress not otherwise specified (DESNOS)'' diagnosis has been proposed for individuals whose traumas have been extremely severe and prolonged—such as early childhood sexual or physical abuse, repeated abuse or battering, being taken hostage, or being incarcerated and tortured—and whose consequent symptoms go well beyond the classic PTSD symptoms (Meichenbaum, 2003). It is beyond the scope of this volume, however, to provide a thorough coverage of all the aspects of making a DSM diagnosis. For that, readers can examine the DSM-IV (American Psychiatric Association, 2000).

If less than 1 month has elapsed since the traumatic event, the individual might be given a diagnosis of acute stress disorder (ASD), the symptoms of which overlap with PTSD symptoms. It has been estimated that 80% of survivors with ASD will develop PTSD 6 months later and that 70% will still have PTSD 2 years after that (Bryant & Harvey, 2000).

Assessing Other Problems At the end of this introduction are some additional readings on assessing traumatized individuals. Those readings elaborate on the assessment concepts discussed above, as well as some others, such as neurophysical and biochemical symptoms, problems in attention and concentration, trauma-related guilt and shame, cultural considerations, age considerations, and common disorders that co-occur with PTSD, such as depression, substance abuse, anxiety disorders and family dysfunction. I have drawn on those readings in writing this section on assessment, especially those by Foa and Rothbaum (1998), Meichenbaum (2003), and Taylor (2006). One of the readings, by Keane et al. (2000), presents a helpful review of assessment instruments for diagnosing PTSD, including structured diagnostic interviews, self-report questionnaires, and psychophysiological measures. Another, by Turner and Lee (1998), offers a good collection of assessment resources, which can be copied by the clinician. The assessment measures are copyrighted, but the purchaser has permission to photocopy them.

Assessing whether PTSD is accompanied by co-occurring (comorbid) disorders is important. One reason for this importance is the prevalence of comorbidity with PTSD, which has been estimated to be as high as 80% for people in treatment for chronic PTSD (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Over 25% of people with PTSD are estimated to have comorbidity with alcohol or substance abuse (Friedman, 2006).

Assessment of Children As discussed in Chapters 4 and 6 of this book, the assessment protocol for children is different than with adults, and involves the use of special techniques and measures. It is likely to involve observing the child while using play therapy techniques (such as with a sand tray or puppets, or perhaps by drawing pictures). How parents or caretakers interact with the child should be observed. The parent or caretaker also should provide assessment information.

Assessment should also involve evaluating children for behavioral problems, learning disabilities, reading disorders, language disorders, and other developmental disorders. Conducting developmental assessments of children is important not only in treatment planning but also in helping parents understand the child's developmental level and to determine if the child is delayed in any areas. With young children, it also is helpful to assess for sensory integration issues.

Standardized assessment tools may be needed to assess the preceding concerns as well as to assess problems in parents or caretakers, such as their own trauma symptoms, depression, or parenting practices. Table 1.1 lists some useful assessment scales for children. These scales, additional scales, and other special features of assessment with children will be elaborated upon in Chapters 4 and 6. (Assessment tools for adult clients are listed in Chapters 2, 3 and 5.)

Table 1.1
Assessment Scales for Children

Trauma Symptoms

- Children's Impact of Traumatic Events Scale–Revised (CITES-R) by Wolfe, Gentile, Michienzi, and Sas (1991). The CITES-R is a scale used to assess the impact of abuse on children with questions focused on identifying symptoms consistent with post-traumatic stress disorder and can be found online at http://vinst.umdnj.edu/VAID/TestReport.asp?Code=CITESR.
- Children's Reactions to Traumatic Events Scale–Revised (CRTES-R) by Jones (2002) has been used to assess children for symptoms associated with experiencing a traumatic event. The CRTES-R is frequently used in research studies to assess for pre/posttest functioning in children in order to assess for treatment effectiveness.
- Kiddie Schedule for Affective Disorders and Schizophrenia–PTSD section (K-SADS PTSD) semistructured interview for both the child and caregiver regarding the child's exposure to traumatic events and PTSD symptoms (Chambers & Puig-Antich, Hirsch, M. et al. 1985).