

Available Instruments for Evidence-based Assessment

Assessment in behavioral health tends to take one of two approaches—(1) the medical model emphasizing diagnosis or (2) the empirical model which assesses the frequency or severity of specific symptoms along a continuum. The medical model drives insurance reimbursement and such a model makes sense in “traditional” medicine when a specific type of cancer can be identified and matched to a specific treatment. In medicine, you often either have the illness in question, or you do not. In behavioral health, children (and adults) may present with significant post-traumatic stress symptoms (which deserve treatment), but for which they do not meet the diagnostic criteria.

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

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

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

There also is a unidimensional measure of sexualized behavior, the Child Sexual Behavior Inventory (CSBI; 38 items, completed by caregivers for ages 2-12), which was developed by Dr. William Friedrich and also published by Psychological Assessment Resources, Inc. While the instrument is reliable, valid, and normed, it is a unidimensional measure and its norms have been criticized as not representing the U.S. demographic and being dated inasmuch as it was published before the widespread availability of the internet.

No assessment is perfect, and that includes the TSCC and TSCYC. As empirically derived measures, they do not purport to make a diagnosis, so clinicians should follow standardized administration with follow-up questions to assess for companion symptoms associated with particular diagnoses and to establish onset, duration, and frequency of symptoms. Also, the PTS scale of the TSCC is comprised primarily of re-experiencing symptoms and is under-represented by avoidant and hyperarousal symptoms.

Finally, abuse impacts individuals in a variety of ways, as does its investigation, the family's response and support or lack of support, and events which occur following the initial forensic interview (e.g., medical exams, placement outside the home, and arguments among family members). The timing of these events may impact the validity of the instruments. That is, avoidant symptoms, family conflict, and/or family secrets may result in under-reporting. Conversely clinical experience suggests that for some children, the disclosure of abuse at the time of the forensic interview and the support of a parent results in under-reporting by the child. Simultaneously, as the event of the forensic interview is potentially experienced as a relief for the child, it may represent the confirmation of every parent's worst nightmare—especially for parents with their own abuse history. For a segment of these parents, their own distress may be projected onto their ratings of the child and thus lead to over-reporting.

While the aforementioned measures are the only ones which are reliable, valid, and normed assess relevant, abuse- and trauma-related symptoms, other measures may be developed in the future. Competition might benefit pricing structures though the research and development costs associated with developing norms are considerable. While costs often are a major consideration among CACs, the proverbial adage, "You get what you pay for" is relevant in this situation. Note to clinicians and CAC Directors: You can find instruments in the public domain (i.e., free or close to it), but they do not exhibit the psychometric properties discussed. One final note: The Child and Adolescent Needs and Strengths (CANS) tool often receives attention at least in part because it includes strengths of the child and it is free. However, as an *information integration tool*, its summary information is only as good as the assessment or clinical interview which informs it. Therefore, if the CANS is utilized or required, using tools such as those described above to inform the completion of the CANS is a recommended strategy.