GIL INSTITUTE
for trauma recovery & education

GIL INSTITUTE SERVICE DESCRIPTION

TRAUMA ASSESSMENT & INTERVENTION FOR CHILDREN AND YOUTH (TAICY)

Statement of the Problem

Young children and youth may experience Type 1 or Type 2 traumas. Type 1 traumas are acute and can include external events such as natural catastrophes, accidents (e.g., car accidents, fires, natural disasters, and school shootings), single or isolated physical or sexual assaults, or other unexpected, short-term events. Type 2 traumas tend to be chronic, interpersonal, and repetitive and can include acute or chronic incidents of physical abuse, sexual assault, or neglect. Gil Institute clinicians provide assessment and treatment services for both types of trauma, as long as traumatic events have been documented and/or substantiated in an objective manner. Otherwise, we have other services that might be more suitable for children and youth whose childhood traumas, losses, and past experiences are not well known. In cases of known complex trauma, specific domains of impairment are explored. Our services will be modified and adjusted for children ages 2 to 17 years. The Trauma Assessment for Children and Youth (TACY) are most relevant for children whose trauma has been identified and as questions persist about how children are functioning post-trauma.

Service Description

Clinicians conduct a comprehensive assessment to include: interviews with referring agencies; meeting with current caregivers to obtain social/developmental history; review of collateral information from school, daycare, prior psychologists or mental health professionals, medical personnel, etc. Clinicians will meet with children and youth to engage them in a process of becoming increasingly comfortable with the setting and clinician. An integrated, trauma-focused approach is offered to

children and they are invited to participate in a wide range of directive and nondirective strategies which are designed to help clinicians understand children's perceptions of self and important others. In addition, attention will be focused on established target areas for childhood trauma through a combination of direct observation of children, data analysis of their expressive work, and opportunities to understand their functioning with peers, adult caretakers, and significant attachment figures. Depending on the age of the child, paper and pencil assessment instruments might be obtained from them directly, or from caretakers and school personnel.

Service Procedures

1. Clinicians will first meet with parents/caretakers or referring professionals to obtain historical psychosocial and developmental information, and to complete paperwork, including several standardized instruments. Clinicians will also collect relevant collateral information.

2. After clinicians meet with parents/caregivers to collect relevant information about the child's traumatic experience and disclosure or discovery, they meet individually with child clients. Efforts are made to make young children comfortable with the setting and the clinician. Parents or caregivers might need to encourage children and stay present for a period of time. However, the clinical goal is to assess children individually. Clinicians will also decide about observing children with others including siblings or caretakers.

3. The trauma assessment is conducted over a period of time, with a typical range of 8 to 12 sessions and children may be seen once- or twice-weekly. Clinicians will assess children and youth in specific trauma-related domains, interact with parents/caretakers and other involved professionals, and assess children's functioning across settings.

4. Specific trauma-related domains reflect consensus areas proposed by the National Center on Traumatic Stress Network and include attachment, biology, affective and behavioral dysregulation, dissociation, cognition, and self-concept.

Cognition: Children who experience traumatic events can have issues with attention, concentration, or memory. This results from having acute fear states that flood the brain with extra doses of cortisol and adrenalin. It's hard to know how many times after the event, traumatized children struggle with memories or reminders of acute or chronic trauma. Chronically traumatized children may belittle and abuse themselves with negative self-talk.

A Brief Intervention for Acute Trauma

Traumatized children are capable of compartmentalizing their difficult experiences, only to be triggered later in life, by developmental changes, cognitive maturation, and situations that trigger memories of unprocessed traumatic events. Children are capable of sophisticated defenses that include denial, dissociation, suppression, and repression and it's important to provide some direct and immediate attention to facilitate integration of Type 1 traumatic experiences.

Our clinicians will be using the Chapman Art Therapy Treatment Intervention (CATTI) designed to help children remember, express, and integrate their traumatic experience. There are four components of this intervention beginning with a kinesthetic scribble, followed by the child drawing a sequential description of the event and a discussion about each drawing that extends to the child's perception of how he will adjust when he is released from the hospital after an acute trauma. The child is then engaged in retelling the story while referring to his images. Clinicians may ask for clarification, will normalize physical and emotional reactions, and will respond to questions. When children are unable or unwilling to draw, they will be allowed to tell and retell their story with toys and their post-

trauma play will follow the same course as the CATTI. This brief intervention has been shown to cause observable reductions in children's symptoms.

Trauma-informed Treatment

Inevitably, traumatized children and youth need opportunities to address their traumas directly, sometimes in layers of depth, until the original traumas are dismantled and their impact is neutralized. GITRE clinicians will utilize a variety of evidence- and practice-informed, developmentally-sensitive approaches including the use of cognitive-behavioral and expressive therapies. In this way, children and youth can make healthy choices, strive and hope for positive outcomes, and engage in more fully rewarding relationships. Relational issues are often quite challenging to those who have experienced traumatic experiences in childhood.

Collateral Services for Parents of Traumatized Children

Caretakers or parents of traumatized children have experienced vicarious traumatization. Parents will need support in order to provide the children the very best opportunity for a healthy recovery. Our services will include attention to parent/caregiver responses and clinicians will equip parents/caregivers with the necessary tool to make helpful interventions regarding traumatic events. Parents will be asked to participate in a range of trauma-specific interventions (including the CATTI) as deemed appropriate in order to maximize and transfer positive treatment outcomes. Parents will be offered guidance, psychoeducation, or therapeutic support.

Assessment-Specific Instruments

Clinicians will use discretion to select trauma-specific instruments such as the UCLA PTSD Index, Child Behavior Checklist for Children (CBCL), or other relevant age-specific trauma instruments such as the Trauma Symptom Checklist for Children and Young Children, TSCC/TSCC-YC and the Child Sexual

Behavior Inventory (CSBI). The Posttraumatic Stress Disorder Reaction Index (PTSD-RI for children and adolescents) and the parent version of the PTSD-RI will be utilized. In addition, depending on the age of the child, instruments that gauge developmental functioning, such as the Greenspan Social-Emotional Growth Chart Questionnaire, may be included.

Service Fee

Clinicians conducting the TACY charge their hourly fees and these are agreed upon in the written treatment agreement at the time of intake. Assessment sessions may occur weekly or bi-weekly depending on the specific needs of the child or youth. The specific format, timeframe, and structure will be determined at the outset and may be adjusted if and when deemed clinically necessary. In addition, clinicians and clients will clarify expectations for verbal or written reports.