Trauma Assessment Report

Child's Name: A
Child's Date of Birth: (Age at time of assessment 15.9)
Parent's Name: Mom
Date Assessed: 11/24/14, including an interview on 11/25/14
Date of Report: 01/06/15
Referring person and agency: Probation Officer/Cass County Family Court
Assessed by: X Agencies
Reason for referral: To determine appropriate services for A due to her impulsive behaviors in and out of the home.

Overview of Assessment:

	Strengths	Within Age Expectations	Moderate Concern	Significant Concern
Developmental			**X**	
Cognitive/Academic				**X**
Social/Family			**X--------**	**--------X**
Emotional/Behavioral				**X**
Trauma Index			**X--------**	**--------X**

Social/Family History
Interview with A's Mother on 11/27/2014

A lives with her mother Mom, step-father Step-Dad, and younger half-siblings: sister (age 13), and 8 year old boy and girl twins. A is Multiracial, while every other member of the family is Caucasian. They also have a dog, Lucky. When asked to describe A's relationships with her family, Mom reports that with Step-Dad, "They don't get along. A doesn't like to be home with Step-Dad or by her self." She stated Step-Dad has been in A's life consistently since age two. She reports they got along well when A was young, up until her sister was about one. Prior to this, they, "Used to do everything together." She is unsure of what changed, but described an incident around that time where A smacked her sister in the face hard enough to leave a red mark that was still visible when the mom came home later in the day.

When asked about A's relationship with her sister, her mother described it a "Love-hate" relationship. She stated that A is very protective of her sister, and that "Her sister shows resentment that A gets in trouble and asks 'why does she put our family through this?" When asked about the twins, Mom stated, "She gets along better with her twin sister than with her twin brother. Her twin brother annoys her." Finally, when asked to describe her own relationship with A, Mom became very tearful and distraught. Amidst her tears, she stated. "It can be difficult. When she got into all this trouble, she would tell me, 'This is all your fault.' And then there will be days where she hugs and kisses me."

A has had no contact with her biological father since being 10 months old. Prior to that, she saw him 3-4 times. A's primary caregiver has been a grandfather who recently passed away and step-grandma. A and Mom lived with maternal grandmother the first two years of A's life, but throughout this time, step-grandma was identified as the primary caregiver. She has had some contact off and on with a half-brother and a half-sister (bio-father's children) who are in the 7th and 8th grade at her school.

Mom reports that she and the children were close with her father and stepmother. Step-grandmother was who A went and lived with briefly last school year. However mom states that, "for the past 5 years, we were pushed out of the family. Whenever we would call for the kids to go over, they wouldn't answer the phone and we would not be able to go over there." Mom blames her stepmother for this. Mom reports her father passed away 2.5 years ago due to his alcohol use, but also reports his death as unexpected. This was the primary trauma that Mom identified in A's life. She also reports A had an extremely tough break-up at the end of the past school year with a long-term boyfriend.

A is currently a student at X High School. She is currently taking 9th and 10th grade classes, and is classified as a sophomore. She is not currently involved in any extracurricular activities at this time, though A reports she has requested this. She was involved in band briefly. Mom reports her grades have been somewhat improved. "She's not flunking every class. She is putting forth the effort." Mom reports that A is most likely not to try if she doesn't like the teacher. She reports she has one teacher currently that she "can't stand," her English Teacher. She reports prior to this the only teacher A really did not like was her second grade teacher. It was in second grade when she first got in trouble at school. This was for stealing. She stated, "The next couple years wasn't bad except attitude. Things got really bad in 6th grade. She went into middle school and all hell broke loose: suspended numerous times for fighting with a boy, having a knife a school, stabbing a girl in the back with a pencil." Prior to this, she had been kicked out of daycare for stealing. At that time, she was put on probation. Mom reports numerous issues with A stealing with the primary target being Step-Dad's phone. Currently, the largest issue at school seems to be her language. The class that she has struggled in the most academically seems to be math. Mom reports that what A seems to like about school is that she is not at home and she can see friends. When asked about how A does with problem solving, Mom stated, "She doesn't face it, gets angry, then runs and hides. She doesn't problem solve at all. She avoids it. I always thought she didn't listen to me. When you talk with her, she just gets a blank stare."

Mom reports a normal pregnancy with A. She stated that delivery was unremarkable. She stated that A achieved developmental milestones on time as an infant and toddler. A started Head Start when she was 4 years old and by this time, she knew her colors and numbers 1-10. At first, she was quiet, but she became more talkative. She started reading in first grade, and mom reports that she did this more easily than any of her other siblings. Mom reports no concerns related to development through elementary school.

Mom stated that A, "has always been healthy." She is current and up to date on her immunizations. A started birth control 3 months ago. A has been sexually active and has been having unprotected sex. Mom reports she now believes this has been the past for the past 1.5 to 2 years. Mom reports that she has had her tested for STDs. (She has tested negative.)

Mom's primary concerns for A are with depression and anger. She stated, "She doesn't get too excited. She is happy when she goes to friends." She reports that the anger goes in a cycle and she will explode a few times a week, but anger always seems to be there under the surface. Mom reports two of her primary triggers seem to be "telling her to do something if she thinks someone else should have to or not getting what she wants." Mom reports that she "never" shows remorse or apologizes and stated that "pain doesn't bother her." Mom stated, "I think some of it's genetic, but I don't know. I think it's from her father." She reports she has been on Abilify and Adderall in the past. Presently, she is on Lamictal. She is currently on her fourth therapist. Her first outpatient therapy was when she was in the 6th grade. She was going every couple weeks and did this for 6 months to a year. Mom stated it "did no good." Her second exposure was May to November of last year at CMH. When asked about this experience, Mom stated "I don't believe it was helpful much because she wouldn't show her true self and the one time she did she brought out a big sheet of paper and it wasn't helpful." Her last two have been recently. She started again with CMH. Mom stated, "I really don't know that I have seen any part of counseling that's helpful. Haven't found the right target to help her be her without being angry."

Mom denies any history of abuse or neglect of any kind for A. She did state that CPS has been involved with the family three times in A's life. The first time was 1.5 years ago when A made allegations of physical abuse from her mom to the school. A has since recanted these allegations. Mom explained it this way, "She got mad at me for making her come home. She turned away from me and I put my hand on her shoulder. She went to school the next day and told them we got into a physical altercation." The other two incidents were when A went to X and refused to come home (leading to current probation charges) and the third event was shortly after this. Mom reported that a CPS report had also been made after Mom's husband would not let A sit at the dinner table and made her sit at another table due to having a lip ring that A refused to take out.

Additional reports & information (provided by referral source, therapist, etc.):

CMH Psycho-social Assessment 08/04/2014

Dx: Mood Disorder NOS, Oppositional Defiant Disorder, Borderline Personality Disorder. A has issues with her moods that are not otherwise explained by other diagnosis. She will verbally/physically fight with her family members, peers, and others in the community. A reported that she is not happy with where she is at emotionally. A threatens/intimidates others, initiates physical fights, has stolen items from friends and family members, and ran away from home twice in the past year. A has a pattern of unstable/intense relationships with others, unstable sense of self, impulsivity with peers, sex, substance abuse, past hx of cutting, intense mood swings, chronic feelings of emptiness and frequent displays of temper. A has been smoking marijuana and drinking since the age of 12. Her peer group consists of users.

Family Court Records

A had four Probation Violations after being placed on probation on 07/21/14, resulting in her being placed in secure juvenile detention from 10/09/14-10/12/14.

Additional Information

A was required to testify at a preliminary hearing in September, 2014 as a witness against a 25 year old man charged with Criminal Sexual Conduct 1st degree for having sex with A in May, 2014. A reported that she had been drinking at the time of the incident. A stated that her mother is the one who pressed charges, and she did not want charges pressed.

Neurodevelopmental Evaluation Measures

Kaufman Brief Intelligence Test, 2nd Edition (KBIT-2)

The *Kaufman Brief Intelligence Test, Second Edition (KBIT-2)* is a brief measure of the verbal and nonverbal intelligence of children, adolescents and adults, spanning the ages of 4-90 years. The Verbal score measures verbal, school-related skills by assessing a person's word knowledge, range of general information, verbal concept formation and reasoning ability. The Nonverbal score measures the ability to perceive relationships and complete visual analogies as well as think logically and solve problems in novel situations. Age-based standard scores have a mean of 100 and a standard deviation of 15; scores between 85 and 115 are within the average range.

	Standard Score	90% C.I.	Percentile	Descriptive Category
Verbal Subset	93	86-100	32	Average
Nonverbal Subset	81	74-90	10	Below Average
IQ Composite	85	79-92	16	Average

School Performance: A is currently taking both 9th and 10th grade classes in an effort to recover her 9th grade credits. A has had disciplinary action this school year for swearing and arguing with teachers.

Behavior Rating Inventory of Executive Function (BRIEF)

The *Behavior Rating Inventory of Executive Function (BRIEF)* is a family of assessment instruments designed to evaluate executive function of children and adolescents from multiple perspectives – the caregiver [*BRIEF-P*], an educator [*BRIEF-T*] (omitted), and the individual's self-report [*BRIEF-SR*]. The executive functions are a collection of processes that are responsible for guiding, directing, and managing cognitive, emotional, and behavioral functions, particularly during novel problem solving.

The *BRIEF* addresses eight clinical scales that measure different aspects of executive functioning, and also includes two sub scales (Behavioral Shift and Cognitive Shift) and two Validity scales. Raw scores are converted into a *T* score, percentile and confidence interval (CI). A *T* score of 65 represents 1.5 standard deviations above the mean, which is the recommended threshold for interpretation of a score as abnormally elevated and indicates potential for clinical significance (indicated with an "X" in the charts below). A *T* score of 60 to 64 indicate mildly elevated scores that may reflect areas of concern (indicated with a * in the charts below).

***BRIEF-P,* Completed by: Biological Mother**

Index/Scale	*T* Score	Percentile	90% C.I.	Significant
Inhibit	**78**	**98**	**72-84**	**X**
Shift	**63**	**92**	**56-70**	*****
Emotional control	**80**	**98**	**75-85**	**X**
Behavioral Regulation Index (BRI)	**78**	**99**	**74-82**	**X**
Initiate	**74**	**99**	**66-82**	**X**
Working Memory	**51**	**67**	**45-57**	
Plan/Organize	**74**	**98**	**69-79**	**X**
Organization of Materials	**71**	**99**	**65-77**	**X**
Monitor	**77**	**99**	**69-85**	**X**
Metacognition Index (MI)	**73**	**98**	**69-77**	**X**
Global Executive Composite (GEC) (BRI + MI)	**76**	**99**	**73-79**	**X**

Scale	Score	Cumulative Percentile	Protocol Classification
Negativity	**1**	**<90**	**Acceptable**
Inconsistency	**3**	**<98**	**Acceptable**

***BRIEF-SR,* Completed by: A**

Index/Scale	*T* Score	Percentile	90% C.I.	Significant
Inhibit	**68**	**95**	**65-71**	**X**
Shift	**52**	**57**	**50-54**	
Emotional control	**52**	**55**	**49-55**	
Monitor	**67**	**95**	**65-69**	**X**
Behavioral Regulation Index (BRI)	**61**	**87**	**56-66**	*****
Working Memory	**68**	**96**	**65-71**	**X**
Plan/Organize	**61**	**86**	**58-64**	*****
Organization of Materials	**65**	**93**	**63-67**	**X**
Task Completion	**62**	**87**	**59-65**	*****

Metacognition Index (MI)	**67**	**95**	**61-73**	**X**
Global Executive Composite (GEC) (BRI + MI)	**65**	**94**	**57-73**	**X**

Subscale	*T* Score	Percentile	90% C.I	Significant
Behavioral Shift	**41**	**23**	**39-43**	
Cognitive Shift	**63**	**89**	**61-65**	**X**

Scale	Score	Cumulative Percentile	Protocol Classification
Negativity	**1**	**0-98**	**Acceptable**
Inconsistency	**1**	**0-98**	**Acceptable**

Within these summary indicators, all but three of the individual scales are within the clinically significant or area of concern range, indicating that A has great difficulty accessing skills associated with executive function. Concerns are noted with her ability to inhibit impulsive responses (Inhibit *T* = 68; 95%), to monitor her own behavior and be aware of its impact on others (Monitor *T* = 67; 95%), to hold the information in mind to be able to complete a task or make the appropriate response (Working Memory *T* = 68; 96%), to anticipate future events or consequences/use goals or instructions to guide her behavior/plan and organize problem solving approaches (Plan/Organize *T* = 61; 86%), to be able to organize her environment—i.e. backpack and bedroom (Organization of Materials *T* = 65; 93%), to persist at a satisfactory pace on a task unto completion (Task Completion *T* = 62; 87%), and to initiate problem solving or activity (Initiate *T* = 74; 99%).

Although there is an apparent discrepancy in A's (Shift *T* = 52; 57%) and Mother's (Shift *T* = 63; 92%) scores in the Shift Scale potentially indicating concern with A ability to transition from one situation, activity or aspect of a problem to another as the situation demands and/or solve problems flexibly, A's Subscale Score (Cognitive Shift *T* = 63; 89%) is congruent and indicates that she may have difficulty solving problems flexibly. It is also notable that although A did not indicate concern with modulating her emotional responses appropriately to situational demand or context (Emotional Control *T* = 52; 55%) her Mother did (Emotional Control *T* = 80; 98%) and concern with this ability was noted during the assessment.

The overall index, the Global Executive Composite (GEC), was elevated (GEC *T* = 65, 94%), as was the Metacognition Index (MI) (MI *T* = 67; 95%), and the Behavioral Regulation Index (BRI) (BRI *T* = 61; 87%).

Pragmatic Protocol

The *Pragmatic Protocol* measures social communication skills, which are the ability to understand a social situation and then to respond appropriately for that social situation. These skills allow a child to successfully engage in conversations, initiate, as well as to develop and maintain positive social relationships. Additionally, social communication skills support the ability to understand the perspectives and intentions of others, which is instrumental in predicting others' motivations and can be useful in modifying one's own behavior. Social communication skills were examined through the assessment of three skills.

First, conversations were analyzed for the child's ability to participate as a full communication partner. Second, narratives or stories are important tools for determining the child's ability to relate connected events together (cohesion) and to provide essential elements of a past event (informativeness). The retelling task requires the child to retell the story of their favorite TV show or movie and retell the story with sufficient detail that a listener who does not know the story can follow along. The generation task is more difficult than the retelling task because the child is required to develop his own characters, their relationships to each other, story organization, and events. This task also provides some information about the child's ability to use executive functioning skills (organization and planning skills) and pro-social thinking. Third, the ability to demonstrate

awareness of others' points of view and intentions is an important skill because it helps to predict others behaviors, as well as to govern one's own behavior according to the needs of a particular context or interaction.

Skill	Age Appropriate	Emerging	Demonstrated Difficulty
Conversational Skills			**X**
Narrative (Story) Retelling		**X**	
Narrative (Story) Generation	**X**		
Understanding one person's perspective		**X**	
Understanding two people's perspectives		**X**	
Understanding other's intentions		**X**	

Social Communication Summary:

A demonstrated inconsistent conversational skills. She demonstrated difficulty with providing sufficient information and used vague language ("this, that, thing") making it difficult for others to be able to fully understand what she was trying to convey. Her relational skills were inconsistent. Although she did respond to most questions when asked and used a fitting language style for the situation, she had difficulty staying on topic and did not ask conversationally relevant questions. A did demonstrate strength in her conversational manner. She made minimal revisions while talking, took turns appropriately using an appropriate volume and tone. Difficulties with conversational skills may cause A's potential communication partners to lose the intended meaning of what she is trying to communicate. She also may be less sensitive to the linguistic needs of her listeners or have difficulty clarifying herself if the listener misunderstands her.

A demonstrated inconsistent ability to retell a story. She was able to retell a story with a beginning, middle and end in a way that was easily followed by the listener. She included most of the important elements in the story and related them back to the overall story theme. Where A demonstrated difficulty was in conveying the feelings, thoughts, and perceptions of the characters. Even when asked by the clinician how she thought the characters felt, A was unable to provide this information. In her story, A did not include efforts made by the characters to solve the problem, nor did she adequately describe the actions they took. These results suggest A may have difficulty recounting past events at a level of detail that allows others to understand what she is trying to convey. Also, she may have difficulty understanding the linguistic needs of others; that is she may have a limited understanding about how much information another person needs to have in order to understand what she is attempting to convey. Also, these difficulties suggest that A may not be fully able to infer what others might be feeling or thinking.

A was only intermittently able to see an event from one other person's point of view, although it is expected that she would be able to see an event from at least two other person's points of view. She did not demonstrate an age appropriate ability to separate her own knowledge about an event from what at least two other people might know about an event, suggesting that she may not be able to successfully recognize or identify emotions, beliefs, and/or the knowledge of others that differs from her own. This outcome could affect her performance in school, her reading and listening comprehension and may present difficulties informing and maintaining relationships with peers.

A demonstrated difficulty inferring when another's intention was joking/teasing. This difficulty suggests that she may not be able to always attribute appropriate motivations to others actions. This difficulty could affect her interactions in school, as these skills allow her to modify her own behaviors when involved in social interactions with others. A also may misinterpret intentions (e.g., jokes, sarcasm) or be

confused by them, which are frequently used in casual conversations, school classrooms, books and movies.

Adolescent/Adult Sensory Profile

The *Adolescent/Adult Sensory Profile* is a standard method of measuring sensory modulation abilities to profile the effect of sensory processing on functional performance in daily life. This is a self-questionnaire for children and adolescents ages 11-18. Each item asks the child/adolescent to rate the frequency of various sensory experiences/behaviors, indicating almost always, frequently, occasionally, seldom, or almost never.

Quadrant	Much Less Than Most People	Less Than Most People	Similar To Most People	More Than Most People	Much More Than Most People
	− −	−	=	+	+ +
Low Registration				X	
Sensation Seeking		X			
Sensory Sensitivity			X		
Sensation Avoiding			X		

Individuals with "More Than Most People" scores in the Low Registration quadrant notice things in their environment and are attentive to stimuli around them without being bothered by those stimuli. Noticing does not automatically mean seeking out additional stimuli, just that she is probably aware of her surroundings.

Individuals scoring "Less Than Most People" in the Sensation Seeking quadrant may not create additional sensory stimuli; however, a low score does not necessarily mean that A is not actively involved in intensifying the sensory environment. (Pearson, 2014)

Parent/Caregiver Rating Scales

***Children's Alexithymia Measure* (*CAM*)**

The *Children's Alexithymia Measure* (*CAM*) (Way, Applegate, Cai, Kimball-Frank, Black-Pond, Yelsma, Robers, Hyter, & Mulliett, 2010) has a unidimensional factor structure and measures difficulties expressing feelings. The concept of alexithymia has been defined various ways. Simply stated, it is a lack of words for feelings (Buchanan, Waterhouse, & West, 1980); more complexly stated, it is defined as having difficulty identifying and describing feelings, difficulty distinguishing between feelings and bodily sensations, a lack of imaginative ability, and a focus on the external world rather than internal feelings (Hendryx, Haviland, &Shaw, 1991).

Information provided by biological mother indicates a score of **27/42** which is consistent with children who may have difficulty identifying or expressing subtle feelings verbally or with expressing their emotions verbally when in crisis or under stress. In those occasions, they may complain of physical problems (e.g., headaches, stomach aches).

NICHQ Vanderbilt Assessment Scales

The NICHQ Vanderbilt Assessment Scales is a 55-question assessment tool. It reviews symptoms of ADHD according to the DSM-IV criteria. It also screens for co-existing conditions such as conduct disorder, oppositional-defiant disorder, anxiety and depression.

Items intended to screen for Oppositional Defiant Disorder and Conduct Disorder were endorsed. Items intended to screen for ADHD, Inattentive-type were in endorsed on the teacher scales, but not the parent scales.

Psychosocial Interview and Draw a Person

The interview began with discussing who A could trust. A stated there was "Nobody" she could trust. She placed her boyfriend (of two weeks) in the category of somewhat trustable and "Everybody" else was placed in the not trustable category.

A refused to draw a picture of her family, but allowed the interviewer to draw her family tree. Her family tree included her mother, step-dad, three half-siblings who live in the family home, her grandparents and step-grandparents (omitting her biological maternal grandmother), her biological father, his partners and six half-siblings from her father. A included the ages of all of the children.

A indicated that of her family she was closest to her step-grandma. According to A, she lived with her step-grandma for four months last year. A has not spoken to her step-grandmother since returning to the family home this past summer. A stated that she called her step-grandma once, but that step-grandma did not call her back.

A avoided talking about her step-father. She would make comments under her breath, change the subject or say, "I don't want to talk about it," when he was mentioned.

A asked if she was done after just a few minutes of the interview and a couple additional times during the interview. A exhibited difficulty regulating her emotions. She became dysregulated at various times throughout the interview, but she was able to regain her regulation on her own with time.

When posed with three wishes, A answered, "To be rich. If I was rich, I would not need three wishes." She stated she would buy a horse and a dog. When asked what would be different, A stated, "Nothing." A stated two of three wishes for her family that they would "not be irritating" and "be rich." The three things A reported she likes about her family are "We have Mike (step-dad's friend from work)" and "we have food." She would not elaborate.

While discussing some of her feelings, although previously stating that she could not trust anyone, A indicated that she felt safe with her Mom, herself and her twin siblings. She identified herself and the twins as happy, stating that she is "happy when I read a book." She also indicated that her Mom made her feel sad.

Throughout the interview, A expressed frustration with the court system and its involvement in her life by her refusal to answer questions and participate in the interview at times because the Assessment was court ordered. A expressed that her court-appointed counselor and probation officer made her feel mad and frustrated. She indicated that she felt out of control and there were things she felt she was not being told by the court system. She expressed her dislike for the people from the court. A stated she was both irritated and sad for having to participate in the Assessment.

Trauma Exposure & Symptom Measures

CTAC Trauma Screening Checklist (6-18)

The *CTAC Trauma Screening Checklist (6-18)* (Henry, Black-Pond & Richardson, 2010) was developed to help identify children at risk. Identified trauma exposure does not necessarily mean substantiation of the child's experience; it is for screening purposes only and reflects information received throughout the assessment about known or suspected trauma exposure; as well as behavioral, emotional and relational concerns often associated with trauma exposure.

Completed by: Probation Officer

Known or Suspected Trauma Exposure:			
Y	Physical abuse		Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy
	Neglectful home environment		Lengthy or multiple separations from parent
Y	Emotional abuse		Placement outside of the home (kinship care, foster care, residential)
	Exposure to domestic violence	**Y**	Loss of significant people, places, etc
	Exposure to other chronic violence		Frequent/multiple moves; homelessness
Y	Sexual abuse or exposure		Other:
	Parental substance abuse		
	Impaired parenting (mental illness)		
Y	Exposure to drug activity (aside from parental use)		

Behavioral Signs of Trauma:			
Y	Aggression towards self; self-harm	**Y**	Oppositional/defiant behavior
Y	Excessive aggression or violence towards others	**Y**	Sexual behaviors not typical for age
Y	Explosive behavior (going form 0-100 instantly)		Difficulty sleeping, eating, or toileting
	Hyperactivity, distractibility, inattention		Social/developmental delays in comparison to peers
	Excessively shy	**Y**	Other: Inconsistency in skills

Emotional Signs of Trauma:			
Y	Excessive mood swings	**Y**	Flat affect, very withdrawn, seems emotionally numb or "zoned out"
Y	Frequent, intense anger	**Y**	Other: No Emotion—could sleep forever
Y	Chronic sadness, doesn't seem to enjoy any activities, depressed mood		

Difficulties in School:			
Y	Low or failing grades	**Y**	Difficulty with authority/frequent behavior referrals
	Attention and/or memory problems	**Y**	Other: Fighting-suspensions;
	Sudden changes in performance	**Y**	Inadequate performance

Relational/Attachment Difficulties:			
	Lack of eye contact or avoids eye contact		Does not seek adult help when hurt of frightened
Y	Lack of appropriate boundaries in relationships		Other:

Adolescent Dissociative Experiences Scale-II (A-DES)

The *Adolescent Dissociative Experiences Scale-II (A-DES)* is a self-report measure completed by the adolescent developed by Judith Armstrong, Ph.D., Frank W. Putnam, M.D., and Eve Bernstein Carlson, Ph.D. English. The approximate age range for this version is 10-21 years. This instrument is in a preliminary stage of validation. Initial results show that a score of 4.8 is the mean for dissociative adolescents with a standard deviation of 1.1. The authors suggest a score above 3.7 would warrant further evaluation for a dissociative disorder diagnosis.

Information provided by A indicates a score of **1.9**.

Child Dissociative Checklist (CDC), Version 3

The *Child Dissociative Checklist (CDC), Version 3* is a 20 question observation measure completed by the parent developed by Frank W. Putnam, M.D. Behaviors which occur in the present and for the last 12 months are included. Generally, scores of 12 or more can be considered tentative indications of sustained pathological dissociation.

Information provided by A's mother indicates a score of **11**.

Trauma Symptom Checklist for Children (TSCC)

The *Trauma Symptom Checklist for Children (TSCC)* is a self-report measure of posttraumatic distress and related psychological symptoms in children. For all clinical scales *T* scores at or above 65 are considered clinically significant.

Validity Scales	***T* Score**	
Under-responsive	**47**	**Valid**
Hyper-responsive	**46**	**Valid**
Clinical Scales	***T* Score**	**Clinically Significant**
Anxiety	**52**	
Depression	**52**	
Anger	**51**	
PTS Symptoms	**47**	
Dissociation	**56**	
Dissociation - Overt	**57**	
Dissociation - Fantasy	**52**	

Resiliency Scales for Children & Adolescents

The *Resiliency Scales for Children & Adolescents* are self-report scales that measure the core characteristics of personal resiliency in children and adolescents (ages 9-18). Two of the three scales were used: the Sense of Mastery scale and the Sense of Relatedness scale; the Emotional Reactivity scale was omitted. Each scale is comprised of 2-24 questions.

T scores for resiliency scales between 46 and 55 are in the average range. Higher *T* scores on the Sense of Mastery and Sense of Relatedness scales indicate greater resiliency. The Resiliency Profile provides a picture of the youth's relative strengths and vulnerability at a given point in time.

Resiliency Scale/Subscale	***T* Score**	**Scaled Score**	**Descriptive Category**
Mastery	**35**		**Low**
Optimism	**13**	**6**	**Below Average**
Self-Efficacy	**13**	**3**	**Low**
Adaptability	**6**	**5**	**Below Average**

Relatedness	**33**		**Low**
Trust	**10**	**4**	**Low**
Support	**13**	**5**	**Below Average**
Comfort	**8**	**5**	**Below Average**
Tolerance	**12**	**4**	**Low**

Summary and Conclusion

A was referred for a comprehensive trauma assessment. Behavioral and emotional problems including incidences of running-away, disrespect/incorrigibility with her family, failing classes and regular disciplinary contact in school, smoking marijuana, drinking, multiple sexual partners beginning at an early age, engaging in unprotected sex, and incidences of cutting have been reported. A had a minor incident of trouble in second grade, but began to demonstrate significant issues in 6th grade when she was expelled from school for multiple incidences of violence and initially placed on probation for stealing.

Results of A's performance on the neurodevelopmental testing indicate concerning results. Although on the low end of normal, her IQ potential is within the average range (Composite; 85) which can be considered a relative strength. A's verbal skills tested higher (Verbal; 93) which indicates that A's verbal communication abilities may mislead those she is speaking with to believe that she understands more than she actually does. According to her mother's returned BRIEF, A has clinically significant scores involving all areas of executive functioning except one (Working Memory, which A indicated as a concern on her self-report). The results from the two BRIEFs suggest that A has difficulty regulating her behavior, inhibiting impulse, monitoring herself and making logical decisions especially at times of stress, in conflict or when confused. A's self-report indicated a higher self-perception of her ability to modulate her emotional responses appropriately than did her mother's BRIEF and than was observed during the Assessment. Contributing to A's self-perceived higher score on the emotional control measure may be her level of Alexithymia (27/42) which indicates her limited ability to identify and express language for her emotions. A's demonstrated inconsistency in her ability to see an event from another's point of view and her difficulty in separating her own knowledge about an event from that of at least two others also suggests that she may not consistently be able to successfully recognize or identify emotions, beliefs and knowledge of others that might differ from her own. Delays in executive functioning not only affect her social communication perspective taking and problem solving, but also affect her ability to think about the consequences of her actions. Therefore, threats of consequences are not meaningful for A. Additionally, A's ability to cooperate and/or verbally communicate an explanation of her behavior when under stress is also significantly limited.

Similarly, during the interview, A's avoidance of speaking about her relationship with her step-father, who she is reported to have a hostile relationship with, is representative of her attempt to avoid difficult emotions and experiences, which is consistent with A's Alexithymia and the findings above. A is reported to spend much of her time at home in isolation, choosing to remain in her room and read ("I am happy when I read a book."), rather than engaging with the family, often refusing to participate in family fun (i.e. boating, 4-wheeling). A reported to her counselor that her step-father makes derogatory racial comments. Although not specifically directed at her, because she is Multi-racial, these comments have a significant impact upon their already difficult relationship and A's self-concept, as he is the only father figure she has ever known. Being the only multi-racial member of the family and the lack of family support specifically in this area contributes to A having a lower self-concept; this, coupled with being the identified trouble-maker in the family leads A to often struggle with feeling singled out when she gets in trouble in a group setting. A tries to avoid attracting attention to her self in the home, isolating herself to do so. Unfortunately, her attention-seeking behavior outside the home is getting her into trouble. Understanding that A wants and needs connection with others is important, but recognizing her ability to feel safe in relationships is impaired, interfering with her ability to make and sustain

close relationships. The resulting lack of trust can appear to be defiance or oppositional behavior, but is better understood as an unconscious coping strategy meant to keep her safe, but ultimately, further isolates her from others.

The absence of a relationship with her biological father despite A's attempts to have one and the hostile relationship with her step-father have created a dynamic that reinforces A's belief that she is unlovable and unwanted, placing her at a higher risk of seeking out male attention. A's angry outbursts and alternating isolation reveal her challenges with executive functioning and self-regulation; and these resulting 'fight or flight' behaviors serve to protect her from the rejection, sadness and depression she feels. Equally, humiliating consequences or power struggles for control will further support her belief that she is unlovable, even if she cognitively states otherwise.

A's own evaluation of her resiliency factors, as reported on the *Resiliency Scales for Children & Adolescents* is currently low. Both her sense of mastery and relatedness are low. Her low sense of mastery indicates that she struggles to fully understand cause and effect, expect a good outcome, feel competent she can overcome obstacles, be receptive to constructive criticism and learn from her mistakes. A's results on the *Children's Hope Scale* reflecting her level of agency (i.e. goal directed energy) and pathways (i.e. planning to accomplish goals) are an additional indicator that she needs experiences which provide her with a sense of efficacy and mastery. Her low sense of relatedness indicates a lack of a sense of trust, difficulty perceiving that support is accessible, a lack of a sense of being comfortable when with others, and trouble feeling safe expressing her differences within relationships. A lacks a trusting relationship with one adult, which is necessary for children to be socially successful. A is emotionally isolated, does not feel emotionally safe in her home, and has limited healthy strategies for communicating feelings. She does not believe that her circumstances can or will improve. This hopelessness contributes to a level of disorganization and vacillation from hypo-arousal (flat affect, withdrawal, emotional numbing, etc.) to hyper-arousal (fight/flight). At each extreme, her behaviors are unconsciously intended to keep herself safe.
Overall, A feels alone and has not resolved her multiple losses and repeated exposure to instability and harm within the caregiving system including the abandonment from her biological father, the on-going rejection of her step-father, the death of her grandfather, the physical altercation with her mother (this past summer over a cell phone) and her perceived helplessness and lack of control when she had to testify against her desires against a 23 year old man that her mother reported for having sex with A last summer. These losses and instabilities result in A feeling as if nobody understands or 'gets her'; she lacks a sense of belonging. A sense of belonging is necessary to feel safe in relationship. Even though she rejects the attempts of others to help and guide her, she also needs their empathy and assistance in handling her stress reactions and deescalating power struggles before they happen. Threats and increased punishment will not build the skills needed to manage stress and/or frustration or create the sense of safety that A needs long term.

Ultimately, it is important for adults, along with A'S input, to identify and encourage the three principles of resiliency that can help her better manage stress, build self-esteem, and build self-efficacy. A needs a relationship with at least one adult who can provide consistency, predictability and patience along with non-shaming and non-judgmental ways to reframe her behavior (her mother may be able to do this with support). The second goal is to teach A affect regulation skills (Ford, 2007) to address not only her frustration and anger but also her sadness and unresolved grief from her losses. A would benefit from practicing these skills with her trusted adult's support to normalize her need to manage emotions and create new pathways in her brain. Thirdly, it is vital to help her find activities that she enjoys and does well. Finally, it is equally important that A's parents learn and be able to implement complex parenting strategies (using disciple and consequences which are concrete, fitting and previously discussed to minimize power struggles), anticipate stressful situations for her, help her through transitions, provide structure and consistent safety, and provide the patience and supervision to assist her in her development, especially in the most stressful times. This is important if A is to have a better attitude, engage in positive family interactions and be successful in society.

Diagnosis: Axis I

	313.81	Oppositional Defiant Disorder
	296.90	Mood Disorder, NOS
	305.20	Cannabis Abuse
R/O	309.81	Posttraumatic Stress Disorder

Axis II

R/O	301.83	Borderline Personality Disorder

Recommendations:

1. **Instruction in affect regulation to educate A about her brain, ways to regulate stress, and new coping strategies. TARGET (Ford, 2007) is a curriculum which has proven successful in aiding adolescents in the juvenile justice system to improve their regulation and coping skills.**
2. **Assistance by caregivers to help A to identify and distinguish emotional states when under emotional stress. It is important for adults to identify and reflect A's feelings back to her during these situations (Swiller, 1988). She will also benefit from role modeling by adults and peers who identify their own feelings.**
3. **Teaching alternative strategies to A's mother and step-father to respond to A differently. Parenting responses and/or discipline needs to be safe, concrete and preferably previously discussed. Shaming, teasing, and/or sarcasm will likely be experienced as rejecting and reinforce her sense of insecurity as well as triggering behaviors that serve to protect her. There will not be lasting change in A's behavior unless alternative relational patterns that do not threaten her perception of self can be established between A and her parents.**
4. **Provide education to parents on the impact of A being the only multi-racial member of her family and the importance of supporting her in safely developing her identity.**
5. **A may benefit from therapy which facilitates nonverbal expression of feelings (such as art therapy, sand tray therapy or play therapy, etc.) (Helman, Strnad, Weiland, & Wise, 1994).**
6. **A is currently participating in a supervised program at an Equestrian Center once a week caring for and interacting with horses. It is recommended that she continue with this program and it not be taken away as a consequence of negative behavior/choices.**
7. **Collaboration with the school to create a plan to allow for A to have additional time to regulate herself and make appropriate choices when facing stress or conflict.**
8. **Participation in extracurricular activities which promotes her sense of mastery/self-efficacy (and positive contribution) to achieve a more positive perception of herself and reality.**
9. **Trauma informed treatment which engages her parents and A in understanding the impact of her experiences on her emotional and cognitive functioning, that focuses on emotional and behavioral self-regulation, as well as trauma processing is important to enhancing appropriate parenting and attachment.**