Assessing Children and Adolescents Exposed to Trauma

Courtney L. McMickens, MD, MPH, MHS[a,b,*], Alexis French, PhD[a], Jenika Hardeman, PhD, MS[c], Michelle P. Durham, MD, MPH[b,d]

KEYWORDS

• Traumatic stress • Trauma-informed assessment • Mental health
• Social drivers of health • Cultural humility

KEY POINTS

- Over two-thirds of children experience at least one traumatic event by age of 16 years, affecting various aspects of their development, including brain function, emotional processing, social skills, physical health outcomes, and mental health.
- Trauma screening is a brief process by frontline providers to identify trauma exposure, while a trauma-informed assessment is a comprehensive evaluation by mental health professionals that explores trauma's impact on a child's functioning, with effective methods like semistructured posttraumatic stress disorder interviews to gather detailed information.
- Understanding the neurobiological, psychosocial, and cultural factors of traumatic stress, along with awareness of structural inequities, can build trust, improve symptom assessment, and inform treatment plans.

INTRODUCTION

Trauma exposure is common among youth, with more than two-thirds of children experiencing at least one traumatic event by age 16.[1] Trauma impacts children on many levels across developmental stages, influencing brain development, emotion regulation, social functioning, physical health, and mental health.[2–5] When assessing

[a] Division of Child/Family Mental Health & Community Psychiatry, Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, 2608 Erwin Road, Suite 300, Durham, NC 27705-4597, USA; [b] Lorio Forensics, 675 Seminole Avenue Northeast, Unit T-03, Atlanta, GA 30307, USA; [c] Department of Psychiatry and Behavioral Sciences, Morehouse School of Medicine, 720 Westview Drive Southwest, Atlanta, GA 30310, USA; [d] Department of Clinical Sciences, University of Houston Tilman J. Fertitta Family College of Medicine, PO Box 130432, Houston, TX 77219, USA
* Corresponding author. Division of Child/Family Mental Health & Community Psychiatry, Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, 2608 Erwin Road, Suite 300, Durham, NC 27705-4597.
E-mail address: courtney.l.mcmickens@gmail.com

Child Adolesc Psychiatric Clin N Am 35 (2026) 203–222
https://doi.org/10.1016/j.chc.2025.11.002 **childpsych.theclinics.com**

Abbreviations	
ACE	adverse childhood experience
ASD	acute stress disorder
CANS	Child and Adolescent Needs and Strengths
CAP-CA-5	Clinician-Administered PTSD Scale for DSM-5 Child and Adolescent Version
CPSS-5	Child PTSD Symptom Scale for DSM-5
CSDC	Child Stress Disorders Checklist
DIPA-L	Diagnostic Infant Preschool Assessment - Likert version
DSM	Diagnostic and Statistical Manual of Mental Disorders
PTSD	posttraumatic stress disorder
PTSD-PAC	PTSD in Preschool-Aged Children
TSCC	Trauma Symptom Checklist for Children
TSCYC	Trauma Symptom Checklist for Children (TSCC) and Young Children
UCLA-RI-5	UCLA PTSD Reaction Index for DSM-5

exposure to and effects of traumatic experiences, it is imperative to understand the complexity of trauma and its effects on neuropsychological development. Trauma is defined as an event or experience(s) resulting in significant distress that overwhelms one's psychological and physiologic functioning, impairing the ability to function and cope. Traumatic experiences include abuse (physical, sexual, or emotional), neglect, exposure to violence (within the home or community), accidents, and medical trauma. Traumatic stress may also result from experiencing chronic deprivation, neighborhood violence, natural disasters, collective violence (historical trauma), discrimination (racial trauma), and family or parental stress.

CLINICAL MANIFESTATION OF TRAUMA

Trauma response is an alteration of the brain and body's stress response system, which comprises multiple neurobiological connections, notably the hypothalamic-pituitary-adrenal (HPA) axis and the catecholamine system.[6,7] This alteration can influence emotional reactivity and social processing, which may present differently based on several characteristics. It is established that trauma is associated with threat sensitivity and misperception of threat cues and can lead to hypervigilance and selective attention as well as emotional dysregulation.[8] Acutely, trauma response can result in sleep changes, increased muscle tension, lower startle threshold, and preoccupation with potential threats in one's surroundings. During a traumatic event, there may be a loss of time (dissociation), making it difficult to recall every detail of the experience or event.[9] Intrusive memories or flashbacks may also occur following a traumatic experience, immediately or in the months or sometimes years following the experience. Behaviorally, traumatic experiences may be associated with efforts to distract or self-soothe in a variety of ways.[9,10] These strategies may be adaptive, such as seeking social connection from supportive peers and adults, or they may be maladaptive, such as the use of substances to mitigate sleep difficulties or intrusive thoughts. Emotional and cognitive responses can be associated with behavioral dysregulation, compulsive behaviors (such as overeating), and impulsive behaviors (such as aggression or elopement in response to perceived threat). Experiences of abuse and physical neglect have also been associated with an increased risk of suicide attempts.[11]

Trauma, especially when experienced early in life, can impair executive functioning—such as memory, cognitive flexibility, inhibition, and reasoning—which disrupts capacity for emotional regulation and coping. Complex trauma, involving repeated or prolonged exposure, can derail biological, emotional, social, and cognitive development, increasing

the risk of adult psychopathology.[12,13] Children who have experienced trauma in early childhood may not have the cognitive and language abilities to understand and express what has happened to them, which causes functional dysregulation and interferes with healthy development, attachment, and sense of identity.[14,15] While individuals who experience complex trauma can present with symptoms of posttraumatic stress disorder (PTSD), they may also display difficulties with social communication, emotional blunting, emotional dysregulation, and derailment of their developmental milestones. Repeated exposure to situations that are unsafe and harmful may cause a child to minimize or not acknowledge their traumatic experiences, inhibiting disclosures to others (in both clinical and nonclinical settings), as well as on self-reported screening measures.[16,17] Though children may experience repeated traumatic events of the same type (eg, neglect, abuse, exposure to violence), each child may process each event differently. These differences in responses to traumatic events are mediated by protective factors, risk factors, developmental stage, biological predisposition, and pre-existing psychopathology.[7,8,12,18]

Trauma in the Context of Familial Caregiver Relationship

Trauma is often viewed as a singular event or experience; however, many children experience persistent traumatic stress related to a singular point in time, multiple traumatic events throughout their lives, and/or trauma that is compounded by chronic stress associated with historical and intergenerational factors.[19] At the foundation of childhood trauma is often a violation of social responsibility and boundaries. Given that children are typically dependent on the adults and the systems that surround them, a traumatic event and the response to that event can be closely linked to failures of these systems, including family and child-serving systems. Exposure to trauma within a family context, perpetuated by a caregiver, sibling, or other adult, has been associated with inconsistent or harsh parenting, housing instability, parental conflict, and family adversity.[20]

Trauma can affect the functioning of family systems across generations. Intergenerational trauma occurs when the effects of trauma exposure that occurred in a previous generation impact subsequent generations. Stated differently, maladaptive responses to trauma are often passed down from one generation to the next. Research has shown that parents who have experienced trauma are more likely to struggle to provide emotional stability and empathy to their children due to how their trauma has negatively influenced their own perception of safety, trust, the world, and self.[21–23] Intergenerational trauma can be transmitted through several pathways, including direct observation, modeling, epigenetic changes, and social factors.[24] When children observe violent behavior or the disregard of appropriate boundaries, they may engage in similar behaviors under coercion or as a normative form of coping. There is also evidence that links traumatic experiences in one generation to genetic changes in the next. These are known as epigenetic changes, and they can affect how certain genes are expressed.[24] The role of these changes in risk for traumatic stress and the manifestation of specific symptoms is still under investigation. Social factors and the multifactorial underpinnings of traumatic stress also play a role in intergenerational trauma.[25,26] As first investigated by the developers of the term, the offspring of Holocaust survivors experienced several mental health symptoms at high rates, including behavioral disturbances, hypervigilance, and worry about family safety in children and grandchildren.[24] Other historical events that may have intergenerational effects include natural disasters, public health crises, and political unrest. Findings have also been linked to other events and populations, such as Vietnam veterans, descendants of slavery in the United States, and American Indian and other indigenous

populations that experienced colonization.[25–27] These experiences link intergenerational trauma, historical trauma, and structural factors.

Historical and Structural Trauma

Structural trauma is experienced by a group of people due to systemic deprivation of resources, exposure to violence, or restriction of opportunity. It is often linked to policies and socioeconomic factors and usually has a related historical event or origin. Disparities across social drivers of health are inextricably health inequities, which are driven by policies that have historically harmed racially and ethnically minoritized groups.[28] Structural traumas are associated with the alienation of marginalized groups and play a role in the exposure to and recovery from a traumatic experience. Individuals from marginalized groups are at greater risk of experiencing traumatic stress and socioeconomic difficulties.[29] Children develop within multiple intersecting, interacting layers of context that include not only the individual but also their family, neighborhood, society, structural, and systemic aspects of their environment.[30] These layers of context interact with and impact child development and outcomes.

Neighborhood factors, such as income, community resources, and social networks, influence child development and well-being.[31–33] Neighborhood income disadvantage has been identified as a marker of exposure to heightened levels of trauma and subsequent symptoms because of the link to higher rates of crime, income-related barriers to accessing mental health care, and poorer environmental conditions.[34,35] Children from low-income families in urban environments report elevated rates of child maltreatment.[36] Black and Latinx children are at increased risk for exposure to higher rates of trauma, and therefore, heightened risk for developing mental health problems, compared to White children.[33,37,38] Even independent of neighborhood income disadvantage, racial and ethnic minoritized identity is associated with higher rates of polyvictimization and higher levels of maladaptive grief, findings which suggest belonging to a minoritized group independently influences this relationship.[39]

Racial trauma and the developmental impact of discrimination, interpersonal racism, and systemic racism also result in symptoms of traumatic stress.[40] Racial trauma may include physical violence, threats, race-based insults, or witnessing race-based violence.[41] It is estimated that over half of individuals who identify as Black, Hispanic, or Asian in the United States have experienced racial discrimination of some form.[42] Experiences of racially minoritized populations in Canada are similar.[40] Traumatic stress from racial trauma is similar to the effects of exposure to chronic trauma.[41] It is associated with internalizing symptoms, such as anxiety and depressed mood, as well as externalizing symptoms, including behavioral problems.[25,27] Response to racial trauma may be difficult to identify within the framework of PTSD because experiences can be subtle and go underrecognized, even by the individuals exposed to them.[40,41] However, studies show that young children who have been exposed to racial trauma may begin to develop a negative self-concept and an undermining of their sense of safety within their environment. At different developmental stages, their racial trauma responses may include avoidance of school or peers due to race-based interactions, academic underperformance, and shame, which can be associated with anxiety and depression.[40,41,43]

DIAGNOSTIC CONSIDERATIONS

Trauma- and stressor-related disorders are a category of mental health conditions that arise following exposure to a traumatic or stressful event. This category includes disorders such as PTSD, acute stress disorder (ASD), adjustment disorders, reactive

attachment disorder, and disinhibited social engagement disorder. The diagnostic category includes PTSD (symptoms lasting over a month), ASD (lasting 2 days to 4 weeks post-trauma, with a high risk of progressing to PTSD), adjustment disorder (emotional/behavioral responses to identifiable stressors, typically resolving within 6 months), as well as "Other Specified" and "Unspecified" trauma-related disorders used when symptoms do not meet full criteria or information is lacking.[44] Accurate diagnosis is essential for guiding evidence-based treatment, yet diagnostic errors are common, often due to clinician biases or incompatible heuristics, which can result in mismatched care and missed opportunities for early intervention. Common features across these disorders include emotional and behavioral symptoms such as anxiety, depressed mood, anger, or dissociation that are directly linked to a specific stressor. The severity, type of symptoms, and duration vary by disorder, but all are marked by an identifiable stressor as the triggering factor. Diagnosis depends on the nature of the stressor, symptom patterns, and the impact on daily functioning.

Despite the high prevalence of trauma exposure, only 16% of children meet diagnostic criteria for PTSD.[45] This does not mean that only 16% have significant impairment and distress stemming from traumatic experiences. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is a categorical system despite mental health symptoms being experienced on a continuum and across conditions.[46] According to the DSM-5, PTSD is characterized as experiencing, witnessing, or learning about at least one life-threatening or other traumatic event and reported symptoms of reexperiencing of the event, avoidance of trauma reminders, hyperarousal, and negative alterations in cognitions and/or mood that have been present for at least 1 month and cause significant impairment.[44] The DSM-5's binary system and the symptom overlap of several mental illnesses contribute to the underdiagnosis and misdiagnosis of PTSD. Additionally, the DSM-5 requires significant perceived distress or impairment as part of the diagnostic criteria.[44] However, if the child is minimizing or denying what has occurred to them, they may not endorse this criterion. Awareness of these pitfalls and limitations is important when assessing for and diagnosing trauma-related disorders and comorbidities in children.[15]

FRAMEWORK FOR TRAUMA SCREENING AND ASSESSMENT

Trauma-informed assessment and screening are often used interchangeably but they each serve a unique purpose and are completed at different time points and often by different providers. Trauma screenings are usually administered by frontline providers such as a pediatrician, social worker, or school-based provider to identify traumatic exposures. In contrast, a trauma-informed assessment is a more in-depth process that helps identify details about the child's trauma history including type(s), severity, and frequency of event(s), how trauma has affected the child's functioning, and any mental health symptoms they may be experiencing due to the trauma.[47,48] This type of assessment is typically completed by a mental health provider and aims to obtain information across various domains of functioning from different perspectives.

The ongoing relationship that pediatric primary care providers have with children and their families makes the medical home an ideal setting for screening, assessing, and intervening on behalf of both the child and family who have experienced trauma. A crucial first step in intervention is helping the family identify trauma and understand its effects. Assisting the family in articulating the child's symptoms and challenges, and providing context for these experiences, can be incredibly valuable. Given the high rates of adversity in the lives of children and families, trauma-informed care should be a universal precaution[49] Just as care should be provided with the sensitivity that

each person has dealt with adversity in their lives, in parallel, everyone can be approached in a way that promotes their strengths, resilience, and positive relationships. Child-serving systems, such as primary care and schools, can promote health and adaptive responses to adversity through support that fosters the development of healthy coping skills while also mitigating risk factors for toxic stress.[50]

For primary pediatric care, specifically, an essential aspect is screening for trauma exposure during visits with children and families. Each visit presents an opportunity to evaluate risk, intervene early, and deliver effective treatment. There are brief, evidence-based screening tools for childhood trauma and adolescent PTSD that are readily accessible and easy to implement in a primary care setting. Although adverse childhood experiences (ACE) screening can help understand population health, there is no single checklist that captures every experience that places children at risk for traumatic stress.[51]

This wide spectrum of adversity underscores the fact that ACE scores and other epidemiologically derived risk factors at the population level are not valid or reliable predictors at the individual level.[48] Furthermore, approaches that only measure adversity will miss out on opportunities to build on the strengths of the family. Using a screening instrument to elicit the presence of symptoms related to traumatic experiences can open the dialogue between the child, parent, and pediatrician for psychoeducation, ensuring safety, and appropriate school and home interventions.

Other child-serving systems, such as schools, juvenile justice, and child welfare, engage children and families that may benefit from trauma screening with appropriate education, psychotherapeutic support, safety planning, and resources for trauma-informed treatment and interventions. There are no universal guidelines for screening in child welfare or justice settings; however, trauma-informed system-level changes have been promoted. Within juvenile justice, trauma screening may involve the use of a validated screening or be incorporated into a risk assessment, which is completed by a court officer, as opposed to a mental health clinician.[52] Similarly, within child welfare trauma screening is increasingly used as a part of the investigation or intake phase for child protective services or foster care. Child welfare professionals may have varying levels of comfort responding to the symptoms or experiences endorsed.[53] In both settings, in the event a screen identifies traumatic exposures, it is also helpful to have a comprehensive assessment with trauma-informed considerations regarding how the information obtained may be used. In settings with limited understanding of trauma, a youth's experience may carry a higher perceived rate of risk for safety concerns and poor prognosis in treatment.[54,55] With rates of trauma exposure for justice-involved youth and children in foster care above 80%, trauma-related responses can influence the length of surveillance, stability of the home environment, school performance, and social support.[47,56–58]

Once the child and or family trauma exposure has been established, a conversation about the traumatic experience and response should begin. A supportive provider can help the child feel more comfortable. The age of the child will influence how the questions are asked. Compared to screening, a trauma-informed assessment is a more in-depth process that helps identify details about the child's trauma history including type(s), severity, and frequency of event(s), how trauma has affected the child's functioning, and any mental health symptoms they may be experiencing due to the trauma.[59] This type of assessment obtains information across various domains of functioning from different perspectives, identifies and addresses the needs of the child and family, consolidates and summarizes the information in a way that can be effectively communicated to family members and other providers, and guides treatment recommendations.

Comprehensive Trauma Assessment

Considering the nuances and challenges with the clinical presentation of trauma, a comprehensive clinical interview is needed to ensure trauma symptoms are not overlooked or misdiagnosed. Although there are best practices and resources for identifying trauma exposure and symptoms in children, trauma may be missed by clinical providers without a systematic process for completing a comprehensive trauma-informed assessment. Additionally, providers are often operating without incomplete information about the child's history. To address these barriers, trauma-informed assessments should be completed over multiple sessions and include a clinical interview, as well as a validated measure of symptoms and function related to trauma exposure.

Clinical interview

Gathering information from multiple sources, including the child, caregivers, teachers, and neighborhood, is important given the possible discrepancies in reports and contextual insights as well as potential impacts of bias and accuracy.[60,61] A study by Grasso and colleagues, 2009 found that parents and children did not report 50% of documented incidents of physical and sexual abuse. Without collateral information from child welfare, no trauma history would have been known to the evaluator.[62] Further, there were significant differences between parent and child reports regarding sleep, nightmares, concentration, and irritability, supporting the need for multiple informants when assessing PTSD.[62] Thus, obtaining information from various perspectives can help improve diagnostic clarity and case conceptualization.

Children and caregivers may not report any trauma symptoms at all, or they may underreport symptoms, which can make it challenging for clinical providers to recognize the presence—and the associated symptoms—of trauma exposure. Even when directly asked or evaluated for trauma exposure and symptoms, some children may not accurately report their experiences for several reasons, including a lack of awareness about what constitutes trauma and/or fear of retaliation for disclosure. Several interpersonal and intrapersonal factors may influence a child disclosure, such as emotional regulation (ie, avoidance of unpleasant emotions like shame, guilt, sadness, or anxiety that may be aroused by screening), social desirability, stigma (eg, associated with victimhood), relationships (eg, with caregivers or providers), and or continued contact with the abuser.[63] Moreover, even in high-risk situations, children may be too developmentally immature to recognize the long-term benefits of disclosing trauma.[64] Even if children deny exposure to trauma, providers must recognize that the likelihood of trauma exposure may still be high, especially when there are known risk factors.

Trauma is shaped by cultural, historical, and social contexts, and as such, comprehensive assessments should also consider the child's history, neighborhood context, familial relationships, and patterns of behavior that may suggest undisclosed symptoms of trauma. A child's responses to trauma and their willingness to disclose are influenced by their cultural backgrounds. In some cultures, discussing personal trauma or family issues may be seen as shameful or inappropriate. Thus, understanding the child's cultural perspective on trauma is essential to understanding a child's experience. Cultural humility is a transformative approach in health care that acknowledges that cultural understanding is an ongoing, multifaceted process.[65] The facets include continuous learning, self-reflection, and genuine recognition of the intricacies and diversities within each culture, including power dynamics.[66]

On one end, cultural humility involves adopting a modest and open-minded attitude toward efforts to comprehend individuals' distinctive cultural backgrounds, beliefs, experiences, and values.[65] At the same time, this process acknowledges and critically

examines power dynamics and institutional biases that may perpetuate health care inequities and foster distrust.[65,66] The interplay of the mental health care and child welfare systems provides one example. Providers need to acknowledge that due to entrenched structural racism marginalized families experience inequities in family separation when involved in child welfare.[67] Research has shown that racially minoritized populations are less likely to disclose trauma, with fear of child welfare involvement and family separation as a possible driver. Youth and families' disclosures may be influenced by the clinical interview, including what questions are asked by the clinician and how, the level of transparency and informed consent (eg, right to refuse to answer), and clinician's response following the disclosure.[67,68] It is necessary to also assess whether trauma is ongoing or the child remains at future risk of trauma exposure. Additionally, the clinician should examine how the caregiver has responded or will respond to the traumatic event and its disclosure as these are prognostic factors.[19] Such a comprehensive strategy is necessary to not only effectively address issues related to disclosure but also highlights the need for systematic development and implementation of culturally humble and structurally informed practices in health care. This approach coupled with a shared decision-making model can assist in obtaining an accurate trauma history and symptoms from the child, caregiver, and other collateral sources of information (**Fig. 1**).

Measures

Trauma measures are an essential part of comprehensive trauma assessment, as these provide details about both the types of traumatic events that a child has been exposed to and the symptoms associated with the traumatic event(s). Given the amount of time required to administer and score these measures (up to 30 minutes), these measures are often administered in specialty mental health settings and/or by mental health clinicians as part of a clinical intake or diagnostic evaluation. Although there are several standardized trauma measures, only a few of these have been updated for the DSM-5. These updated measures include the UCLA PTSD Reaction Index for DSM-5 (UCLA-RI-5), Clinician-Administered PTSD Scale for DSM-5 Child

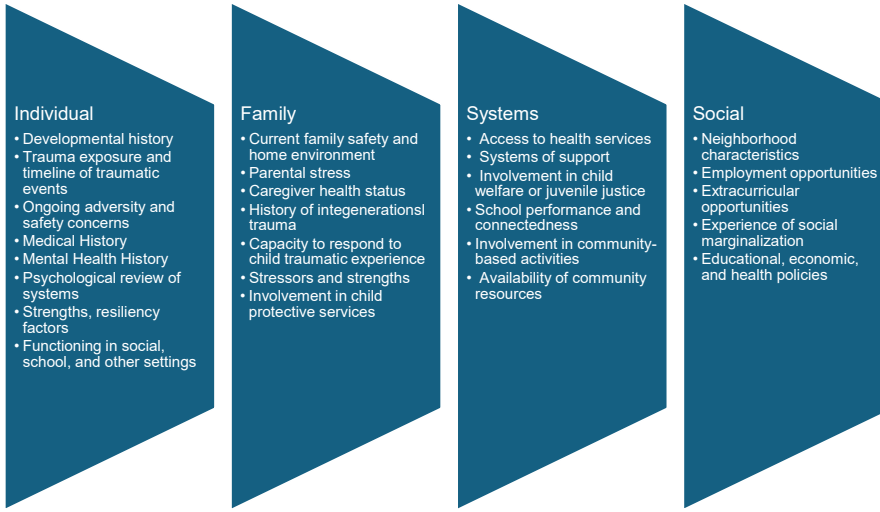

Fig. 1. Assessment domains. (*From* Refs.[89,112,113])

and Adolescent Version (CAP-CA-5), Child PTSD Symptom Scale for DSM-5 (CPSS-5), and Diagnostic Infant Preschool Assessment - Likert version (DIPA-L).[69–71]

The UCLA-RI-5 is one of the most widely used and validated trauma measures for school-age children and adolescents. This measure, which requires a fee to use, provides an expansive list of possible traumatic events and assesses the child's age and duration of trauma exposure for each type of trauma. The UCLA-RI-5 also assesses DSM-5 PTSD symptoms associated with the most bothersome traumatic event identified by the child or the caregiver. There are 2 versions of the UCLA-RI-5, a child and adolescent self-report and a parent/caregiver report.[72] The parent/caregiver report can be used to assess trauma symptoms for children of any age. The UCLA-RI-5 has been validated for diverse populations within the United States and internationally, including populations in Europe, Africa, and Asia.[69,73–76]

The CAPS-CA-5 and CPSS-5 are publicly available measures and are similar to the UCLA-RI-5 regarding the assessment of DSM-5 trauma symptoms associated with the most distressing traumatic event identified by the child. However, the CAPS-CA-5 does not provide a list of potential traumatic events and rather uses an open-ended question to ask the child to identify the worst traumatic event.[77–79] The CPSS-5 includes 14 possible trauma types. As a result, the CAPS-CA-5 and CPSS-5 may not provide an accurate clinical picture for children who have experienced complex trauma, especially those involved in the child welfare and or juvenile justice systems. The CAPS-CA-5 has been validated for international populations in Amsterdam, Japan, Portugal, and Tunisia, as well as Latino, African American, and white populations in the United States.[77–81] CPSS-5 has been normed across these populations in the United States, as well as populations in Australia, Portugal, and the United Kingdom.[82–84] The DIPA-L, which is also a publicly available measure, assesses trauma symptoms in very young children, is a broader measure that includes a PTSD module as well as 5 other modules (ADHD, ODD, DMDD, GAD, and SAD).[85,86] All 4 measures should be administered by a clinician, typically one specializing in mental health.

Other measures that may be used as part of a comprehensive trauma assessment include the Child and Adolescent Needs and Strengths (CANS) - Trauma Comprehensive, Child Stress Disorders Checklist (CSDC), PTSD in Preschool-Aged Children (PTSD-PAC), and the Trauma Symptom Checklist for Children (TSCC) and Young Children (TSCYC).[71,72,85–90] The CANS assessment tool, which is publicly available, measures the type of trauma exposure, traumatic stress symptoms, strengths, and other clinical factors that may impact treatment and outcomes. It can be utilized as a treatment planning tool or as a guide for assessing the child's history and presenting concerns. Similar to some of the other measures, the CSDC is a publicly available measure that assesses exposure to seven different types of possible traumatic events and PTSD symptoms. The PTSD-PAC, which is also publicly available, was originally developed to assess trauma symptoms among very young children exposed to domestic violence, only assesses trauma-related symptoms. The TSCC and TSCYC require a few to use and assess trauma symptoms and include 2 validity scales to identify whether the child and or caregiver may be under reporting or overreporting symptoms. It has been normed across diverse populations in the United States.[88,91,92] However, these measures do not inquire about specific traumatic events that the child may have experienced. The Trauma & Adverse Childhood Experiences Survey (TRACES) assesses trauma endorsed by expanding upon prior measures and including trauma and ACEs identified by Filetti and colleagues[93] The CAPC-5 is an updated version of a validated and internationally used measures of PTSD that reflects changes in the DSM-5. The CAPC-5 assesses for Complex PTSD, including emotional

dysregulation, outbursts, interpersonal difficulties, and negative self-concept and providing the option for simultaneous score of multiple posttraumatic stress-related syndromes.[93] The time needed to complete the measure, available language, and the populations the measure was normed are important factors to consider when selecting which measure to use as part of the assessment (**Table 1**).

CHALLENGES WITH ASSESSING TRAUMA

Even when information is available on trauma history and associated symptoms, diagnosis can be difficult due to the current DSM-5 diagnostic criteria, particularly for younger children, as it may not fully capture the developmental variations of symptom expression. Although DSM-5 attempted to improve the developmental sensitivity of the diagnostic criteria for PTSD, such as combining avoidance and negative cognitions into one category, only requiring one symptom from this category, and not requiring intrusive thoughts to appear distressing, limitations remain.[94] Younger children who have experienced trauma may display regressive behaviors, have difficulty separating from caregivers, and have somatic complaints, none of which are explicitly included in DSM-5 diagnostic criteria. Younger children exhibiting emotion dysregulation may be misdiagnosed with ADHD or ODD, as the symptoms associated with these problems are more observable than some of the PTSD symptoms that are more internal (eg, intrusive thoughts).[95]

Children with PTSD frequently present with symptoms that overlap with other mental health conditions, which can make diagnosis challenging.[96–101] Even when PTSD is not present, symptoms of depression, anxiety, and other psychiatric disorders can be associated with trauma.[4,8,98,102] A recent study found that among children with PTSD symptoms, 73% had elevated anxiety symptoms and 50% had elevated depressive symptoms.[103] Anxiety and depressive symptoms are common reactions to trauma, given the lack of control, uncertainty, physiologic changes, and negative cognitive distortions about self, others, and the world associated with a traumatic event. However, the presence of an anxiety disorder is based on worry or fear about a situation, object, or outcome unrelated to the traumatic event, while PTSD-related anxiety is focused on fear of the traumatic event occurring again. Additionally, symptoms of anxiety disorders are likely present before trauma exposure and may be exacerbated by the experience. Symptoms of a depressive disorder, such hopelessness, low energy, little interest in engaging in pleasurable activities, feelings of worthlessness, and changes in sleep and appetite, may appear following a traumatic event, but symptoms of major depressive disorder tend to be more chronic and pervasive, cause significant impairment (eg, difficulties completing daily activities of living), and involve suicidal or self-injurious behaviors compared to trauma-related depressive symptoms.[6,98]

Research has suggested that for some psychiatric disorders, such as ADHD and ASD, the relationship between these disorders and trauma may be bidirectional.[99,100] More specifically, these disorders may increase one's risk of experiencing trauma, or once PTSD appears, it exacerbates certain symptoms of these disorders. Exposure to a greater number of traumatic events has also been found to increase the likelihood of engaging in high-risk or rule-breaking behaviors and aggression, which are associated with externalizing disorders (eg, conduct disorder).[102–106] Children who experience trauma and have a psychiatric comorbidity, regardless of a PTSD diagnosis, are vulnerable to re-experiencing trauma and substance use in the future.[107,108] These adaptations to the trauma may lead to several negative outcomes (eg, hospitalizations, school issues, and juvenile justice involvement).[109–111] As a result of the difficulties

Table 1
Selected and recommended child and adolescent trauma-focused assessment tools[a]

Measure	Domains	Items	Ages	Reporter Format	Language(s)	Source
Child & Adolescent Needs & Strengths (CANS)–Trauma Comprehensive	TE, PTSD, CTR, FI, INT, EXT	110	0–18	Clinician	English	Kisiel et al,[87] 2018
Diagnostic Infant & Preschool Assessment (DIPA)	TE, PTSD, INT, EXT, ATT	517	0–6	Caregiver	English	Scheeringa & Haslett,[83] 2010
PTSD in Preschool Aged Children (PTSD-PAC)	PTSD	18	2–5	Caregiver	English	Levendosky et al,[88] 2002
Child PTSD Symptom Scale for DSM-5 (CPSS-5)	TE, PTSD, FI	27	8–18	Clinician Youth	English, Hebrew, Portuguese, Slovenian, Spanish, and Swedish	Foa et al,[70] 2018
Trauma Symptom Checklist for Children (TSCC)[b]	PTSD, CTR, INT CSA, DIS	54	8–16	Youth	English, Chinese, Dutch, French, Japanese, Latvian, Slovenian, Spanish, Swedish.	Briere,[85] 1996
Trauma Symptom Checklist for Young Children (TSCYC)[b]	PTSD, CTR, INT	90	3–12	Caregiver	English, Spanish	Briere,[86] 2005
UCLA Child/Adolescent PTSD Reaction Index for DSM-5	TE, PTSD DIS	22	6–18	Youth	English, Arabic, Armenian, Farsi/Persian, Filipino/ Tagalog, French, German, Greek, Hebrew, Japanese, Norwegian, Russian, Spanish, Visayan, Nyanja	Pynoos et al,[71] 2014

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Table 1
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Measure	Domains	Items	Ages	Reporter Format	Language(s)	Source
Clinician Administered PTSD Scale for DSM-5 Child and Adolescent Version (CAPS-CA-5)	PTSD, FI, STR, DIS, CS	30	7–18	Youth	English	Pynoos et al,[69] 2015

Abbreviations: ATT, attachment/relationships; CSA, child sexual abuse; CTR, complex trauma response; DIS, postdisaster; EXT, externalizing; FI, functional impairment; INT, internalizing; PTSD, PTSD symptoms and/or diagnosis; SB, sexual behaviors; STR, strengths; TE, trauma exposure.

[a] Many of these tools are included in the NCTSN Measures Review Database (www.nctsn.org/resources/online-research/measures-review). For additional measures specific to complex trauma, see www.nctsn.org/trauma-types/complex-trauma/assessment.

[b] Fee associated.

Adapted from Kisiel C, Conradi L, Fehrenbach T, et al. Assessing the effects of trauma in children and adolescents in practice settings. Child Adolesc Psychiatr Clin N Am 2014;23(2):223–42.

with social processing (eg, over-identification of threat), emotional regulation and awareness, and accelerated developmental and biological aging associated with trauma, children are at increased risk for developing various mental health disorders.[102,105] Therefore, assessment is critical given the risks associated with untreated trauma and the role trauma plays in the development of other psychopathology.

SUMMARY

Assessing trauma is the first step in addressing symptoms related to traumatic stress, especially in children and adolescents. Given trauma's complex effects on mental health, a comprehensive evaluation is essential to understand the diverse reactions children may have after a traumatic event. Clinicians must consider the child's community, family, and societal context, including historical and intergenerational trauma. Child-serving professionals play a key role in identifying trauma exposures through screening. A thorough assessment, built on trust and safety, helps reveal the full impact of trauma. However, challenges like limited awareness, mistrust, and lack of disclosure can hinder effective trauma assessment.

CLINICS CARE POINTS

- Clinical presentation of trauma-related symptoms vary based on child specific characteristics, such as developmental stage and age, and trauma-specific characteristics such as chronicity of exposure and type of traumatic experience.
- Trauma reactions can present with symptoms across diagnostic categories; therefore, screening for traumatic experiences and possible symptoms is an important initial step for all mental health evaluations.
- Cultural awareness and an understanding of the clinical population is central to selecting the appropriate assessment tools, as well as assessing strengths and vulnerabilities across diverse populations.
- A comprehensive trauma assessment often includes multiple sessions with the use of a screening tool, a trauma assessment tool, and a thorough clinical interview of a child, caregiver, and other informants as needed, such as school staff or child welfare staff.

DISCLOSURE

There are no commercial or financial conflicts of interest.

During the preparation of this work, the authors used Gen AI. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

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