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Measuring and Implementing Protective Factors with Traumatized Youths

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Traumatic and violent experiences in childhood can create negative health, behavioral and mental health outcomes. However, these results can be offset by resilience, a perspective that must be included when aiding children and adolescents in their path toward recovery following traumatic experiences (Ginsberg & Jablow, 2011). We observe resilience in children when they are immersed in positive influences across their ecological systems.

Clusters of protective factors that help youths overcome the negative effects of trauma and adverse experiences range from individual skills and processes of the child to influences across the child's environment that are empirically shown to help children combat the negative outcomes related to trauma. These protective factors include: Self Value, Self-Regulation, Hopeful Future Goal Setting, Problem Solving, Supportive Belief Structures, Positive Family Influences, Supportive Friendships, Supported Academic Achievement, Activities/Positive Diversions, and Supportive Community Connections. These factors are indicators of strengths in ten domain clusters as associated with resilience in over 200 empirical articles and this author's qualitative work with both children and adults (Madsen Thompson, 2010; Madsen Thompson & Klika, 2015). However, in order to further understand the presence, impact, and outcomes in both clinical and research settings, we must be able to measure and assess the progression of these protective factors.

The Trauma Resilience Scale for Children (TRSC) is a youth self-report measure that is the result of extensive research including pilot studies with youths in group homes, meta-analyses, and quantitative investigations, as well as ongoing qualitative research involving several hundred youths (Madsen Thompson, 2010). The TRSC is most useful when applied in the full ten-factor model. However, each of the ten subscales may be calculated and interpreted individually as well. In an original sample of 208 children in foster group homes, outpatient clinical, and general populations, the scale demonstrated strong psychometric properties across reliability ($\alpha^{\text{stratified}} = .96$), external and internal convergent and discriminant validity, and distinct factor structure modeling. Therefore, it can be used with confidence for research, clinical, and general population samples.

In the validation sample, a little over half the children self-identified as Americans of African, Asian and/or Hispanic ethnic minority groups and half identified with each gender. The scale may be used with confidence across these diverse groups as Item Response Theory (IRT) based differential item functioning calculations showed no ethnic or gender bias (Madsen Thompson, 2010). Since this time, the measure has demonstrated applicability in research and clinical settings. The measure is a unique tool addressing trauma and resilience in youths that is now being utilized with youths from diverse backgrounds across North America and in European, Asian, and Latin American countries.

Among both adolescent females and males who were known to have committed sexual offenses, protective factors were correlated with less criminal recidivism (van der Put & Asscher, 2015 & van der Put, 2015). However, measures used in these and other studies do not break down all ten protective factors in the TRSC into aspects individually measured with the youth. Many studies and scales cluster factors such as Self-Value, Self-Regulation, Problem-solving, Goal Setting, into general categories and leave out known protective factors such as Supportive Belief Structures and supportive Community Connections. In research settings, this can still be useful. However, the TRSC can assess and allow practitioners to delve into each protective factor as expressed and assessed by the youth's own perceptions. In conjunction with their therapist, family, school, and community, young clients can examine and set specific goals towards attaining progress in the areas in which she or he can directly improve.

Specific examples of the TRSC being applied with youths include a youth who had been sexually abused who set goals to maintain positive connections with healthy friends and to increase involvement with her school resources and activities. Another youth who had reacted aggressively, after several traumatic events including witnessing the violent death of a friend, achieved goals to reduce his fighting by connecting more with a loving grandparent, expressing himself through music, and praying for strength. As youths set goals such as these, real changes can be observed in their scores of resilience allowing the positive progress to be observed directly by an interventionist and the youth.

Further research is being conducted on specifically applying protective factor work in clinical interventions using the TRSC. Preliminary observations are showing that the TRSC is effectively used in conjunction with traditional measures of emotional, cognitive, and behavioral symptoms such as the Child Behavior Checklist (ASEBA, 2017). Treatment goals and evidence-based interventions are implemented related to both reducing problematic behaviors and increasing protective behaviors and support systems for youths who have experienced trauma. With this dual focus, motivation and progress appear to be increased. The TRSC is a solid tool for both research and direct intervention with youths who have experienced trauma and acting out behaviors helping them to improve specific aspects of protective factors ranging from their own internal processes to their relationships and wider community-based levels of interventions.

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