

# CenterinG

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## Trauma Assessments

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**P**ychological assessment for persons with a history of trauma is an important and expanding area of specialization in the mental health field (Briere, 1997; Carlson, 1997; Dutton, 1992; Wilson & Keane, 1997). This article explores the rationale for and essential domains of trauma assessment. Trauma assessments are useful for a variety of important reasons (Carlson, 1997). They aid the development of an appropriate treatment plan, help the clinician target treatment effectively and efficiently, and, quite importantly, distinguish trauma from other conditions that may produce trauma-like symptoms and may, therefore, be misunderstood or misdiagnosed.

### Domains of Assessment

Trauma assessments include attention to assessment in several key domains of information not usually covered in more generic evaluations: (1) the nature of traumatic experience, (2) the impact of traumatic experience on the individual, (3) coping strategies and their outcomes (both currently and at the time of the trauma), and (4) the ecological context of the individual's life (both currently and at the time of the trauma).

### The Nature of Traumatic Experience(s)

In most clinical settings, obtaining information about a person's history of traumatic experience is important since these experiences are relevant to many mental and physical health conditions and symptoms. Failing to identify a trauma history can result in inadequate clinical formulations, misdiagnoses, and ineffective treatment efforts. Historically, misunderstanding or misinterpretation of trauma symptoms has been an all too

common experience for trauma survivors who seek mental health assistance.

An understanding of the impact of trauma begins with an assessment of the nature of traumatic experiences to which the individual has been exposed. In some cases, the situation that triggered the demand for assessment is defined by acute symptoms (e.g., difficulty sleeping, flashbacks and reexperiencing phenomena, nightmares) related to the occurrence of a recent traumatic event (e.g., physical or sexual assault). Traumatic experiences that occurred in the past (e.g., childhood abuse) are also relevant for understanding current psychological functioning and planning for treatment. Sometimes, the client's traumatic experience is known to the clinician. At other times, there is no prior information concerning the presence of a trauma history, one of the reasons that all assessments should include questions about traumatic experiences. Notably, even when a particular traumatic experience (e.g., childhood sexual abuse) is known, the presence of other types of traumatization (e.g., spouse abuse, prior sexual assault, combat trauma, exposure to community violence) is important to identify and assess. Effects can be compounded by additional traumatic experiences.

Several measures exist for screening and assessing traumatic experiences. Reviews of these measures can be found in Carlson (1977), Stamm (1996), and (Meichenbaum, 1994). Most such measures include screening for exposure to a variety of traumatic experiences over the lifetime, such as physical and sexual assault, other criminal violence, combat, disasters, and major accidents. It is important to remember that witnessing traumatic events such as violence can qualify as a traumatic stressor and should

be assessed as a form of traumatic exposure in addition to those events that involve more direct experiencing. Follow-up probes to screening questions typically include such information as: frequency of occurrence, severity of both the actions and the injuries received, and duration of experience for events that occurred over time; types of behaviors involved; features of the experience, including suddenness of onset, intentionality, and controllability; the presence of others in the event as bystanders, participants, or cohorts; and response to the traumatic experience from others and from the traumatized person at the time and later.

It is important to assess traumatic experiences over the course of the lifetime, but assessment of specific traumatic events or of specific time periods may also be useful for particular purposes. For example, risk of revictimization is a serious clinical issue for persons previously victimized (Messman & Long, 1996). Thus, identifying recent (i.e., within the last year) exposure to violence and presence of high risk behaviors may signal an increased risk for recurrent victimization that can be addressed within the treatment plan. Using the Risk Assessment Protocol (Dutton, Goldstein, Courtois, & Turkus, 1996), adapted from the Conflict Tactics Scale (Straus, 1979) and the Danger Assessment scale (Campbell, 1995), THE CENTER inpatient treatment team routinely screens and assesses for exposure to violence from both intimate partners and others and for the subjective experience of fear during the past year. In addition, the Protocol assesses patients' subjective appraisal of current danger from others. Together, this objective and subjective information is important for the identification, assessment, and

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intervention of persons at high risk of revictimization by others.

### **The Impact of Traumatic Experience**

The negative impact of traumatic experience can be pervasive - resulting in *psychological symptoms* (e.g., depression, suicidality, anxiety, intrusive symptoms, dissociation, anger), *physical problems* (e.g., chronic pain, headaches, back aches, gastro-intestinal symptoms), *decreased ability to function* (e.g., interference with ability to engage in job or parenting responsibilities), *negative cognitive schema* (e.g., view of self as damaged or undeserving, generalized mistrust of others, generalized view of the world as unsafe), *negative social and inter-personal outcomes* (e.g., social isolation, rejection, loss of children, dissolution of intimate relationships), and *negative economic consequences* (e.g., job loss, loss of property). Understanding the impact of traumatic experience across these areas is necessary in order for effective intervention. No single assessment measure taps all of these domains, so it is typically necessary to utilize a battery of measures most suited to the clinical setting for assessing a range of types of sequelae to trauma. Many resources exist to assist the clinician in identifying useful approaches to assessing the impact of trauma (Briere, 1997; Carlson, 1997; Dutton, 1992; Meichenbaum, 1994; Stamm, 1996; Wilson & Keane, 1997).

Trauma survivors may exhibit symptoms that meet criteria for one or more trauma-related Axis I diagnoses found in DSM-IV: Posttraumatic Stress Disorder (PTSD), Acute Stress Disorder (ASD), or one of the Dissociative Disorders (DD). Persons exposed to trauma may also exhibit symptoms that fit criteria for specific Axis I disorders reflecting associated symptoms of posttraumatic conditions: Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Social Phobia, Major Depressive Disorder, Somatization Disorder, and Substance-Related Disorders. Finally, the effects of chronic trauma also may be demonstrated through patterns of behavior that meet criteria for several Axis II disorders: Borderline, Dependent, Avoidant, and Antisocial Personality Disorder.

At THE CENTER, assessment of the negative impact of traumatic experience relies on clinical assessment interviews

and a variety of standardized measures which currently include the Trauma Symptom Inventory (Briere, 1995), the Suicide Behavior Questionnaire adapted from the work of Marcia Linehan, and the Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993). We have also assessed a sub-sample of patients for symptoms of PTSD using the Clinician-Administered PTSD Scale (CAPS) (Blake et al., 1995) and complex PTSD or Disorders of Extreme Stress Not Otherwise Specified (DESNOS) using the Interview for Disorders of Extreme Stress (SIDES) (Pelcovitz et al., 1997).

### **Coping Responses**

Understanding the traumatized person's ability to cope with the resulting impact of trauma is an essential component of the overall trauma assessment. Coping can be understood as a process, rather than trait-like styles (Lazarus & Folkman, 1984). This perspective emphasizes the changing cognitive and behavioral efforts to manage both specific external and/or internal demands that are appraised as exceeding the resources of the person (Lazarus & Folkman, 1984, p. 141). In some cases, responses used to cope with traumatic experience and the subsequent effects of that experience may also be identified as psychological symptoms (e.g., dissociation).

Information about both coping responses focused on managing or altering a problem (i.e., problem-focused coping) as well as dealing with regulating the emotional response to the problem (i.e., emotion-focused coping) are important. In particular settings, information about coping with specific aspects of the trauma sequelae may be especially relevant, such as an individual's response to depressive/suicidal thoughts or self-harm impulses, addictive impulses or aggressive impulses. In addition to knowing what coping behaviors the traumatized person has employed, information about the utility of these strategies is also important. The latter provides some information about the likelihood that the individual may continue to employ a given strategy.

At The Center, an example of assessment of coping strategies using a standardized measure is the Reasons for Living (RFL), a measure of cognitive coping responses and resources that are hypothesized to counterbalance suicidal

urges. The RFL provides information about six cognitive responses for coping with suicidal thoughts or urges: (1) beliefs about one's ability or desire to survive, (2) responsibility to family, (3) child-related concerns, (4) fear of suicide, (5) fear of social disapproval for engaging in suicidal behaviors, and (6) moral objections to suicide. Knowing which, if any, of these cognitive coping strategies are currently employed by a suicidal patient provides some information about ways in which to connect with a patient in treatment.

### **Social Ecology: The Contexts of Traumatic Experience and of Recovery**

Trauma is best understood in the context of an individual's life, both the one in which the traumatic experience occurred and that which defines the recovery environment. Thus, these social ecologies are another important domain of assessment in addition to those described above.

A model of social ecology relevant to trauma assessment, originally adapted from (Bronfenbrenner, 1977; Bronfenbrenner, 1979), has been discussed previously in relation to victims of domestic violence (Dutton, 1996). This model is applicable to persons exposed to other forms of traumatic events as well.

**Economic and tangible resources.** The availability of economic and tangible resources, both at the time of traumatic experience and during the period of recovery, influence access to needed help for dealing directly with the traumatic experience as well as the subsequent effects of it. For example, a child or a battered woman abused in the midst of poverty suffers not only from the abuse per se, but also from other forms of material deprivation. The unavailability of adequate medical care, for example, may increase the risk of undetected abuse.

Continued lack of economic and other tangible resources during the period of recovery from trauma can create greater hardship. For example, lack of health insurance benefits make more difficult access to available treatment options. Further, priorities of obtaining housing, food, and other scarce resources interfere with the opportunity to focus on recovery from trauma. Finally, lack of economic and tangible resources can contribute to an increased risk of continued trauma

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through exposure to high-risk situations (e.g., assault related to living in quarters with inadequate security).

Access to means provides a different type of social ecology relevant for the assessment of trauma. Stereotypes about wealthy persons may contribute to erroneous assumptions about the possibility of traumatic experience, its impact, or the person's ability to cope with it. Higher levels of social and economic status may create unique obstacles for the traumatized individual who may feel additional shame and embarrassment about the presence of trauma in their lives.

**Individual history.** Events in the individual's life other than the traumatic experience(s) create a unique fabric that forms the backdrop for understanding the impact of trauma and the individual's response to it at the time, and the later capacity to engage in the recovery process. In addition to the constellation of traumatic events, it is important to recognize the role of other significant life events, including developmental stages. Assessment of these issues provides information about the individual's strengths and vulnerabilities. It is important to examine both the facilitating and interfering function of significant life events, rather than to assume their role in the traumatized person's life. For example, the additional burden of a chronic illness can suggest an increased vulnerability at the time of a traumatic experience. Alternatively, the illness may have provided greater access to supportive resources for responding to the traumatic experience. The birth of a child, typically a joyous event, may trigger unresolved feelings of childhood abuse.

**Social networks (microsystem).** Social support has been theorized to serve a "buffering" role in dealing with stressful life events, including trauma (Cohen & Willis, 1985; Hobfoll, 1988; Mitchell & Hodson, 1983). Conversely, social obstruction (Gurley, 1990), including such acts as isolation, stigmatization, disconfirmation, deceit, betrayal, confusion, retribution, and humiliation are consistent with recognized traumatogenic dynamics of abuse (Finkelhor & Browne, 1986) and can interfere with an individual's ability to recover from the effects of trauma.

Knowledge about the traumatized person's social networks at the time of the traumatic experience and current-both in terms of support and obstruction-is a cornerstone for understanding the availability of resources for recovery (e.g., the individual's opportunity for emotional attachment).

**Institutional response (exosystem).** The occurrence of trauma, especially violence and abuse, often triggers involvement of community institutions such as police, hospitals and other health-care providers, child protective services, the courts, and religious institutions. Understanding the nature of this response, at the time of the traumatic experience and subsequent to it, provides an important component of the social ecology. For example, knowing about a pattern of foster care placements - and the child's experience within them - may be important for understanding the adult survivor's response to abuse toward her own children by her abusive partner. Having experienced many instances of mis-diagnosis and previously ineffective treatment may lead a person diagnosed with Posttraumatic Stress Disorder or Dissociative Identity Disorder to understandably mistrust the treatment process as a new admission to a trauma treatment program. Abuse by a member of the clergy may contribute to a traumatized person's mistrust of persons in institutional positions of authority or in organized religion.

**Cultural "blueprint" (macrosystem).** We all live within a cultural context that dictates norms for behavior and attitudes. Whether the culture is (Continued from page 3) defined in terms of race, gender, ethnicity, sexual preference, age, or social class, these cultural mandates mediate the experience of trauma, the definition of self, the expression of symptoms, and the help-seeking behaviors of the traumatized person (see *Centering*, March/April 1998, *Cultural Issues in Trauma Treatment*).

**Historical antecedents (chronosystem).** The historical context of an individual's life provides yet another component of the social ecology. A pattern of intrafamily abuse - repeated over generations - establishes a context within which intervention with family members may be handled differently from when there exists no such pattern. Historical traditions of racism experienced by

families of color compound the traumatic experience of one of its members.

### **Interpretation of Psychological Testing**

A key component of trauma assessment is the interpretation of assessment results in the context of the individual's life situation, in particular the experience of trauma. Many psycho-logical symptoms and behaviors are understood in a different light when interpreted through the lens of the traumatic experience (Rosewater, 1987; Wilson, 1990). For example, items included on the paranoia scale (Sc 6) of the MMPI-2 may reflect the mistrust commonly resulting from having been the victim of interpersonal violence (Janoff-Bulman, 1992; McCann & Pearlman, 1990). Elevations on the schizophrenia scale (Sc 8) or the Bizarre Sensory Experiences scale of the Harris-Lingoes subscales may reflect intrusive symptoms characteristic of posttraumatic reactions (Wilson, 1990). In another example, clinical elevations on the Schzoid Scale of the MCMI-III may be best interpreted in light of the social isolation and disrupted social networks that often accompany traumatic experience. Without attention to the specific impact of traumatic experience, interpretation of psychological assessment can miss the etiological connection to trauma and over - pathologize the patient's psychological condition.

### **Conclusion**

Effective trauma assessment requires an understanding of the dynamics of traumatic experience including: an appreciation of the phenomenon of traumatic events, recognition of the broad range of possible sequelae to trauma, the wide spectrum of coping responses employed by trauma victims and the coping function of many psychological "problems," and the necessity of locating the traumatic experience within the ecology of the individual's life situation. Trauma assessment from this perspective provides an avenue for effectively facilitating the healing process.

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