Chapter 2 outlined the various symptoms and psychological disorders that can arise from trauma exposure. The current chapter describes the various ways in which these posttraumatic outcomes—and the events that produced them—can be assessed. Although we strongly support the use of empirically validated assessment instruments and structured diagnostic interviews, it is also true that most “real-world” clinical assessments occur in the context of less formal, relatively unstructured interchanges between the client and clinician during an intake session. Although more subjective, and thus more prone to interpretative error, observation of client responses can yield important information that has direct implications for subsequent treatment. For this reason, we begin with the clinical interview, and then move on to the application of more standardized methodologies.

Assessment in the Clinical Interview

Immediate Concerns

Most of this chapter addresses assessment approaches that allow the clinician to evaluate specific trauma-related symptoms or dysfunction. Such assessment is necessary to ensure that whatever interventions occur are best suited to the client’s specific needs. However, the evaluation of the client’s
immediate level of safety, psychological stability, and readiness for further
assessment and treatment is even more critical.

Life Threat

Most obviously, the first focus of assessment in any trauma-related situa-
tion is whether the client is in imminent danger of loss of life or bodily
integrity, or is at risk for hurting others. This includes—in the case of imme-
diate accident, disaster, or physical attack—assessment of whether the client
is medically stable. In cases of ongoing interpersonal violence, it is also very
important to determine whether the client is in danger of victimization from
others in the near future. Most generally, the hierarchy of assessment is as
follows:

1. Is there danger of imminent death (for example, by bleeding, internal injuries,
toxic or infectious agents), or immediate danger of loss of limb or other major
physical functioning?

2. Is the client incapacitated (for example, through intoxication, brain injury or
delirium, severe psychosis) to the extent that he or she cannot attend to his or
her own safety (for example, wandering into streets, or unable to access avail-
able food or shelter)?

3. Is the client acutely suicidal?

4. Is the client a danger to others (for example, homicidal, or making credible
threats to harm someone), especially when means are available (for example,
a gun)?

[Note: #3 and #4 are of equal importance.]

5. Is the client’s immediate psychosocial environment unsafe (for example, is he
or she immediately vulnerable to maltreatment or exploitation by others)?

The first goal of trauma intervention, when any of these issues are present,
is to ensure the physical safety of the client or others, often through referral
or triage to emergency medical or psychiatric services, law enforcement, or
social service resources. It is also important, whenever possible, to involve
supportive and less-affected family members, friends, or others who can assist
the client in this process.

Psychological Stability and Stress Tolerance

Psychological stability is also very important. A common clinical error is
to immediately assess for psychological symptoms or disorders in a trauma
survivor without first determining his or her overall level of psychological homeostasis. Individuals who have recently experienced a traumatic event, such as a rape or mass disaster, may still be in a state of crisis at the time of assessment—in some cases psychologically disorganized to the extent that they are unable to fully comprehend their current situation, let alone respond to a clinician's inquiries or interventions. In such instances, as is true with some cases of debilitating longer-term trauma impacts, psychological assessment may not only further challenge the survivor's fragile equilibrium, but may also lead to compromised assessment results. For this reason, the first step in the mental health evaluation of trauma victims should be to determine the individual's relative level of psychological stability. When it appears that the client is overwhelmed or cognitively disorganized, stabilizing interventions (for example, reassurance, psychological support, or reduction in the level of environmental stimuli) should be provided before more detailed evaluation is pursued.

In some cases, however, although the trauma survivor may appear superficially stable following a traumatic event, he or she may suddenly display extreme distress, high anxiety, intrusive posttraumatic symptoms, or sudden outbursts of anger when faced with even superficial inquiry about the event. As described later in this chapter, these reactions are referred to as *activation responses*—intense, often intrusive, trauma-specific psychological states that are triggered by reminders of the traumatic event. Although some level of activation is normal—even desirable—during treatment, and most survivors in research studies do not report negative effects of trauma evaluation, per se (Carlson, Newman, Daniels, Armstrong, Roth, & Lowenstein, 2003; Walker et al., 1997), assessment-related activation may be psychologically destabilizing if the individual does not have sufficient capacities to internally regulate his or her distress. As a result, it is important to determine the extent to which trauma issues can be discussed with a given survivor without unduly “retraumatizing” him or her. When excessive activation is likely, it is usually preferable to at least temporarily defer significant questions about or discussion of traumatic material (Najavits, 2002). The decision to avoid significant discussion of trauma with a trauma survivor should be made carefully, however, given the often helpful effects of talking about traumatic memories (see Chapter 4) and the sometimes immediate need for assessment.

At the risk of repetition, the usual components of assessment should be initiated only after the traumatized person's immediate safety, psychological stability, and capacity to discuss traumatic material have been verified. Failure to adequately evaluate these preconditions may result in unwanted outcomes, ranging from unnecessary client distress to, in extreme cases, emotional harm.
Assessing Trauma Exposure

Once the clinician has determined that the client is safe and reasonably stable, the specifics of trauma exposure and response can be investigated. In many cases, the clinician begins by asking about the traumatic event or events, including the nature of the trauma and its characteristics (for example, severity, duration, frequency, level of life threat). Because it is logical to start with events and then move on to outcomes, assessment of trauma exposure is presented here before the assessment of trauma effects. In some cases, however, the client’s emergent psychological state is obviously of greater initial concern than how he or she got that way. For example, except in some forensic situations, the evaluation of an acute rape victim often will focus more immediately on her or his emotional functioning and psychological symptoms than on the specifics of the rape itself. In other cases, however, especially when the trauma is farther in the past and the client is not currently acutely distressed, it is reasonable to begin with a trauma history.

Although one might assume that traumatized individuals easily disclose the events that bring them to therapy, this is not always the case. In fact, several studies indicate that many trauma survivors are reluctant to volunteer detailed (or any) information in this area unless directly asked, due to embarrassment, a desire to avoid reactivating traumatic memories, or the clinician’s own avoidance of such information (Read & Fraser, 1998). For example, Briere and Zaidi (1989) surveyed the admission charts of a randomly selected group of women presenting to a psychiatric emergency room (PER), and found that only 6 percent documented a history of childhood sexual abuse. In a second phase of the study, PER clinicians were requested to routinely ask female patients about any history of childhood sexual victimization. When charts from this phase were examined, documentation of a sexual abuse history increased more than tenfold. Further, sexual abuse history assessed in Phase 2 was associated with a wide variety of presenting problems, including suicidality, substance abuse, multiple Axis I diagnoses, and an increased rate of borderline personality disorder.

We recommend that each client, whatever the presenting complaint, be assessed for trauma history as part of a complete mental health evaluation. When this occurs will vary according to the clinical situation. Often, as described previously, traumatized clients present with a chief complaint, such as depression, suicidality, generalized anxiety, or unexplained panic attacks, that does not obviously include the trauma. In such cases, it is advisable to explore with the individual the symptoms that bring him or her in for treatment before delving into the possibility of trauma exposure. This allows the client to develop an initial sense of trust and rapport with the evaluator,
before answering what may be perceived as intrusive (if not irrelevant) questions about traumatic experiences.

Many individuals, especially those who have never before been evaluated by a mental health professional, respond to questions about trauma history, particularly child abuse and other forms of interpersonal victimization, with embarrassment and/or guardedness. It is not uncommon for clients to ask, “Why do you need to know that?” upon being queried about specifics of their trauma history. Victims of interpersonal violence who have been repeatedly hurt and betrayed by others may be especially reluctant to share intimate details with an evaluator whom they have just met.

Even those clients whose chief complaints are related to a particular acute or past traumatic event may balk at being asked questions about their past. The victim of an earthquake who complains of acute anxiety, for example, may not want to answer questions about child abuse, feeling that such details are not relevant to his or her current situation. Likewise, the recent rape victim may interpret questions about other sexual assaults and childhood sexual abuse as implicit criticism from the evaluator, or as a subtle message that he or she in some way “asks” to be victimized.

In light of such concerns, general guidelines for assessment of trauma exposure include the following:

- Establish an initial level of trust and rapport before assessing trauma.
- Spend some time at the beginning of the assessment interview exploring the client’s overt reason for presenting for clinical services, whatever it may be.
- Ask questions in an empathic and nonjudgmental manner.
- Become comfortable talking about details of sexual abuse and violence experiences with clients; victims of interpersonal traumas may be especially sensitive to nuances in the clinician’s voice and body language. For example, certain clients may avoid reporting disturbing experiences if they believe that the clinician will be too upset by such material or will make negative judgments.
- Use behavioral definitions. For example, a woman who was sexually assaulted and forced to perform oral sex on a man but was not vaginally penetrated may not believe that she was in fact raped. It is rarely sufficient to ask, “Were you ever raped?” Instead, a better question might be, “Did anyone ever do something sexual to you that you didn’t want, or make you do something sexual to them?”
- Remember that trauma is deeply personal and that the client may fear being stigmatized. In the course of a trauma-focused interview, clients may disclose information that they have never told anyone before. The clinician should keep this possibility in mind, and respond to such disclosures with visible support.
- Be aware that disclosure of trauma history may bring up intense feelings, including shame, embarrassment, and anger. Clients may respond in a variety of
ways—some may cry, others may become agitated and anxious, and some may withdraw. Still others may become irritable and even hostile toward the interviewer. In such contexts, gentle support and validation of the client’s feelings and reactions may be especially important.

- Repeat assessments as necessary—some clients may not disclose certain trauma-related information at the initial evaluation, but may do so later, when they feel more comfortable with the clinician and the treatment process.

Some evaluators find it helpful to preface questions about trauma exposure with an opening that frames assessment in a supportive and nonjudgmental context. Examples of such opening statements might include:

- “If it is okay with you, I’d like to ask you some questions about your past. These are questions that I ask every client I see, so I can get a better sense of what [he or she] has been through.”
- “I’d like to ask you some questions about experiences you may have had in the past. If you feel uncomfortable at any time, please let me know. Okay?”
- “Sometimes people have experienced things in their pasts that affect how they are feeling now. If it is okay, I’d like to ask you some questions about things that may have happened to you.”

Other clinicians prefer to integrate assessment of trauma history into the flow of the initial interview. What follows are two examples of how this might be accomplished with different clients. These examples are not intended to provide an exhaustive list of potential trauma exposures; rather, they illustrate ways of approaching traumatic material in a nonthreatening and organic way in the context of a mental health evaluation.

- For those clients who appear reluctant to discuss interpersonal information, a trauma history can be gathered at the same time as medical history is assessed. This formalizes the questioning and places it in the context of other, more routine, questions that are generally experienced as both necessary and nonthreatening. The flow of questions in such a scenario might follow a pattern such as:
  
  - “Do you have any medical problems?”
  - “Are you in any physical discomfort right now?”
  - “What medications are you currently taking?”
  - “Do you have any allergies to medications?”
  - “Have you ever had any surgeries?”
  - “Have you ever been in a car accident? Were you injured? Did you receive medical attention?”
  - “Have you ever been in a disaster such as a fire, earthquake, or flood? Were you injured? Did you receive medical attention?”
  - “Have you ever had a head injury? Did you lose consciousness? Did you receive medical attention?”
“Have you ever witnessed a violent event, such as a shooting?”
“Have you ever been assaulted by anyone? How old were you? Were you injured? Did you receive any medical attention afterward?”
“Has anyone ever forced you to do something sexual against your will? Has anyone ever touched you sexually in a way that made you feel uncomfortable? Did you receive medical attention for this?”

[Follow with childhood trauma exposure questions.]

- For those patients who are willing to discuss their family and relationships, an alternative scenario for questioning might follow a different pattern:
  - “Where did you grow up?”
  - “What was your childhood like?”
  - “Who did you grow up with?”
  - “When you were a child what was home like?”
  - “Were both parents at home?”
  - “Did you witness any violence at home when you were a child?”
  - “How were you punished when you were a child?”
  - “When you were a child was anyone abusive to you in any way?” (In some cases, this question alone will prompt the client to report all of their childhood abuse experiences.)
  - “Did anyone ever do anything sexual to you when you were a child, or make you do something sexual to them?”

[Follow with more detailed childhood trauma questions.]

- “Have you ever been in a car accident? Were you injured? Did you receive any medical attention afterward?”
- “As an adult, were you ever attacked by anyone? How old were you? Were you injured? Did you receive any medical attention afterward?”

[Follow with other adult trauma questions.]

Given potential client reluctance in this area, and the likelihood that some traumas will be overlooked in an informal assessment interview, trauma assessment is probably best accomplished when the clinician refers to a pre-defined list of potential traumas during the evaluation interview. This structured approach ensures not only that trauma exposure will be formally assessed, but also that all relevant types of trauma will be explored. Included in Appendix 1 of this book is an instrument that can be used to evaluate the client’s life history of traumatic events, the Initial Trauma Review-3 (ITR-3). This is a behaviorally anchored, semi-structured interview that allows the clinician to assess most major forms of trauma exposure. It also inquires about subjective distress in response to these traumas, as required by the
DSM-IV A2 criterion for PTSD and ASD. The clinician should feel free to paraphrase the items of the ITR-3 in such a way that the process is supportive and nonstigmatizing, and to add any additional traumas that he or she thinks are relevant to the client’s situation. There are also a number of other instruments available in the psychological literature (for example, the Stressful Life Events Screening Questionnaire, developed by Goodman, Corcoran, Turner, Yuan, and Green, 1998; and the Traumatic Events Scale, developed by Elliott, 1992) that the clinician may use to review a client’s trauma history. In addition, some psychological tests of traumatic stress include traumatic event reviews, as described later in this chapter.

In the Psychological Trauma Program at Los Angeles County + University of Southern California Medical Center, trainees often initially assess trauma history in a relatively unstructured manner, asking questions as appropriate in the context of the dynamics of the interview and the client’s presenting complaints. In the second session, they more formally assess trauma exposure using the ITR-3. Asking about trauma on both occasions often yields a more thorough and complete history.

**Evaluating the Effects of Trauma**

For the purposes of this book, the effects of trauma can be divided into two categories: *process* responses, involving impacts of traumatization that are readily determined during the interview, and *symptom* responses, involving the more classic markers or forms of psychological disturbance.

**Process Responses**

Considerable information may be gained by observing the traumatized client’s behavior during the clinical interview or therapy session. Because this form of assessment is based on the clinician’s perceptions, and thus is influenced both by clinical experience and personal subjectivity, data gathered in this manner are not always as valid as the results of standardized testing. On the other hand, the alert and perceptive evaluator often can discern things that are rarely, if ever, tapped by psychometric tests. Such information can be divided into four areas: activation responses, avoidance responses, affect dysregulation, and relational difficulties.

**Activation Responses.** As described in greater detail in Chapter 8, activation responses are the sudden emergence of posttraumatic emotions, memories, and/or cognitions in response to some sort of triggering stimulus. Some of these responses may be sensory reexperiencing of the traumatic event; in other
cases the response is less extreme, involving sudden emotional distress or anxiety. Although extreme activation is generally to be avoided, in most cases lower levels of such responses can provide information regarding both severity of the client’s current posttraumatic stress and the degree to which his or her trauma memories can be readily activated by the external environment.

Typically, the clinician’s intent is not to trigger activation, but rather to be alert to its emergence during the interview or during therapy. For example, the clinician interviewing a burn patient in his hospital room a week after a fire may watch carefully for changes in facial expression, tone of voice, verbal content, or even respirations when the patient is gently asked about his or her trauma experience. Or, a child sexual abuse survivor may be observed for changes in emotion, body position, eye movement, or verbal syntax while he or she discusses a childhood molestation experience.

When the trauma is relatively recent, a moderate level of activation is often a good sign, indicating that the client is not in a highly avoidant or numbed state and that his or her traumatic material is available for internal processing. Especially easily triggered and intensely experienced activation, however, may suggest more severe posttraumatic stress and may indicate that unwanted intrusive symptoms can be triggered by a wide variety of stimuli in the environment. In a similar vein, easily triggered activation in chronic traumatic states (for example, tearfulness and distress in a combat veteran when discussing war experiences that occurred 30 years prior to the interview) may indicate inadequate processing, since, in the uncomplicated case, posttraumatic stress would be expected to resolve—or at least decrease—naturally over that time period.

The attuned examiner or therapist may find that consistent attention to an individual’s emotional, verbal, and motor reactivity to trauma cues provides continuous information regarding (1) the level of posttraumatic stress the person is experiencing, and (2) the extent to which traumatic reexperiencing is being blocked through dissociation or other avoidance responses. Information regarding the client’s level of posttraumatic activation can assist not only in diagnosis and assessment, but may also indicate his or her level and type of response to the exposure component of trauma therapy (see Chapter 8).

Avoidance Responses. Observational assessment of avoidance in trauma survivors generally involves attention to both inferred underactivation—the relative absence of expected activation—and the visible presence of avoidance activities. In the former case, avoidance can be hypothesized when activation would be expected (for example, in a recent sexual assault victim) but where
little or no significant emotional reactivity is observed (for example, describing
the event in an especially detached or overly matter-of-fact manner). In the lat-
ter, the clinician is able to detect direct evidence of dissociation or substance
use, or the client informs the clinician of effortful avoidance (for example, no
longer driving a car after a motor vehicle accident).

Underactivation can occur as a result of a number of different defensive
mechanisms that are not, by themselves, visible, although their effects may be
inferred. They include:

- **Emotional numbing.** The client displays reduced emotional reactivity to trauma
  triggers as a result of severe posttraumatic stress (see Chapter 2).
- **Dissociative disengagement.** The client engages in subtle cognitive-emotional
  separation or disengagement from potentially upsetting stimuli, but does so
  without exhibiting overt signs of dissociation, per se.
- **Thought suppression.** The client cognitively blocks or suppresses emotionally
  upsetting thoughts or memories.
- **Denial.** The client acknowledges the traumatic event, but develops a theory or
  perspective that reduces the perceived threat or seriousness associated with the
  trauma.
- **Anxiolysis without obvious intoxication.** The client uses a psychoactive sub-
  stance (for example, alcohol or a benzodiazepine) prior to the session that is not
  evident during treatment or evaluation but that blocks anxious responses to
  trauma triggers.

Underactivation is often both difficult to identify and hard to pin down in
terms of the specific mechanism involved. For example, when a trauma sur-
vivor presents as less upset than the circumstances might warrant (for exam-
ple, a calm and nontraumatized demeanor one day after involvement in a
major automobile accident with multiple fatalities), potential mechanisms
include those listed as well as the possibility that the client is not engaging in
avoidance at all, but, instead, is especially resilient to stress. Despite this uncer-
tainty, the experienced trauma clinician often learns to discriminate various
types of defensive avoidance strategies from psychological health, whether
through increased sensitivity to subtle avoidance mechanisms or through a
growing sense of when a posttraumatic response would logically occur.

Explicit signs of avoidance, on the other hand, usually involve the use of
mechanisms that are visible to the clinician or are expressed directly. Most
typically, these include:

- **Visible dissociative symptoms.** The client “spaces out,” demonstrates obvious
  fixity of gaze (for example, the “thousand-mile stare”), moves in a disconnected
  manner, or seems to enter a different identity state.
• **Self-reported dissociation.** The client describes symptoms such as depersonalization (for example, out-of-body experiences) or derealization (for example, feeling like he or she is in a dream).

• **Intoxication.** The client comes to the session visibly intoxicated on drugs or alcohol.

• **Effortful avoidance.** The client describes behaviors consistent with the effortful avoidance cluster of PTSD symptoms, such as avoiding people, places, or situations that might trigger posttraumatic intrusions or distress. Effortful avoidance is also evidenced in the session by visible attempts to avoid discussing traumatic material. Missed sessions also may reflect effortful avoidance.

The excessive presence of emotional avoidance in the evaluation or treatment session typically signals a greater likelihood of posttraumatic stress (Plumb, Orsillo, Luterek, 2004), an increased chance of chronicity (Lawrence, Fauerbach, & Munster, 1996), and potentially greater difficulties dealing with the exposure component of therapy (Jaycox, Foa, & Morral, 1998). In addition, client reports of effortful avoidance may indicate specific areas in which the client is having especially intrusive experiences (for example, avoidance of sexual activity because it triggers flashbacks to a rape). Such information may allow the clinician to explore Cluster B (reliving) PTSD symptoms that otherwise might not be identified or disclosed. It is important to note, however, that avoidance is typically a coping response that the survivor uses to maintain psychological stability in the face of potentially destabilizing trauma memories. As a result, although such responses typically indicate traumatic stress, they are not necessarily maladaptive at the moment they occur—especially early in the recovery process.

**Affect Dysregulation.** Some trauma survivors are prone to visible difficulties with affect regulation. Affect regulation refers to the individual’s relative capacity to tolerate painful internal states (affect tolerance) and to internally reduce such distress without resorting to dissociation or other avoidance techniques (affect modulation). Affect regulation problems appear to arise from, among other phenomena, extreme and/or early trauma exposure (Pynoos, Steinberg, & Piacentini, 1999; Schore, 2003), and, as noted earlier, are associated with subsequent distress-avoidance symptoms such as substance abuse, impulsivity, self-injurious behavior, and other seemingly “personality disorder”-level responses (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Individuals with reduced affect regulation capacities may be less able to process traumatic memories in therapy without becoming overwhelmed by the associated painful emotions. The risk of overwhelming trauma survivors with too much therapeutic exposure is of sufficient concern that some
clinicians (for example, Briere, 2002a; Cloitre, Koenen, Cohen, & Han, 2002; Linehan, 1993a) consider affect dysregulation to be a central issue for those with more complex traumas. In other cases, typically when the trauma is less severe and occurs later in life, affect regulation difficulties may be less relevant. In any case, however, a complete assessment of the trauma victim should include such issues so that the treating clinician can either address them in therapy (see Chapter 6) or be satisfied that otherwise effective therapy is unlikely to retraumatize the client.

Problems with affect regulation may be identified in the assessment or therapy session by any of the following signs:

- Mood swings that are not attributable to a bipolar or cyclothymic disorder
- Very short (for example, measured in hours), yet symptomatically intense depressive episodes that seem to resolve spontaneously
- Sudden, extreme, emotional distress during the session, with apparent difficulty calming down or shifting to a more positive emotional state thereafter
- A tendency to act out, self-mutilate, become aggressive, make suicide attempts or gestures, or otherwise engage in sudden tension reduction behaviors when upset or distressed
- Sudden dissociative responses in the context of strong emotionality

When such signs suggest affect regulation difficulties, the clinician should evaluate the possibility that (1) the client has a history of severe or early child abuse and neglect, and/or (2) he or she has a personality disorder characterized by affective instability (although see Chapter 2 for cautions about over-generalizing from the borderline personality disorder diagnosis). In such cases, as noted in Chapter 8, therapeutic intervention (especially exposure activities) often must be carefully titrated to the client’s existing capacity to regulate painful feelings.

**Relational Disturbance.** Relational information is obtained in the interview by observing the client’s responses to the clinician and to the therapy environment. Such information can also be extracted from the content of client disclosures regarding important others in his or her life. In general, these responses signal underlying cognitive schemas, assumptions, and beliefs (as well as their associated affects) that the individual carries regarding important interpersonal figures and relationships.

Central relational issues (and their associated intra-interview signs) are discussed following.

**Alertness to Interpersonal Danger.** Because many trauma survivors have been hurt, betrayed, or otherwise maltreated in interpersonal relationships,
they may respond to evaluation or treatment with hypervigilance to physical or emotional danger (Courtois, 1988; Herman, 1992a). In extreme cases, this response may take on nearly paranoid proportions: the recent victim of torture or rape may covertly examine the clinical setting for possible weapons, hidden spyholes, or hiding places for other people; the refugee from a totalitarian state may scrutinize the clinical process for evidence of governmental collusion; the stalking or battering victim may voice fears that he or she was followed to the session or that the clinician is in communication with his or her perpetrator; and the Vietnam veteran may position himself for ready access to the nearest doorway.

Although such responses are not always part of the clinical presentation of trauma survivors, even those less severely affected may display signs of hyperalertness to potential aggression, boundary violation, unfair criticism, or other potential dangers. The client may question the evaluator or therapist regarding his or her intentions, the appropriateness or relevance of various assessment questions, and the intended use of the information gathered from the session. Sexual trauma victims may evidence special distrust of male interviewers, and those with highly punitive parents may be hypersensitive to the possibility of negative evaluation by the clinician.

The presence of such preoccupations may indicate a specific sensitivity to evaluation and interactions with authority figures. More typically, however, the fact that danger schemas are easily triggered in the survivor signals a generalized expectation of potential injury in interpersonal situations, and is, most basically, a reflection of posttraumatic stress.

ABANDONMENT ISSUES. Individuals with histories of childhood neglect or rejection may signal abandonment concerns during assessment and treatment—both by their description of significant others in their lives and by their responses to the clinician. There may be a preoccupation with themes of needing people or relationships (sometimes regardless of the valence or health of those connections), fears or expectations of abandonment or loss in relationships, or historical renditions that seem excessively characterized by being left or rejected. In the session, clients with abandonment concerns may become especially attached to the clinician, even over a very short period of time; they may be reluctant to allow termination of the interview, and may seem especially “clingy” or dependent. On occasion, they may express anger or despair regarding the examiner’s perceived insufficient caring or support and the brevity of the evaluation or therapy session, or concern that the clinician is not sufficiently attuned to their emotional experience. Also common is the tendency for clinician unavailability (for example, while on vacation or during personal emergencies) to trigger abandonment schemas and produce anger or despondency.
As might be expected, it is not always easy to detect abandonment fears in the evaluation interview or the first sessions of treatment—it may only be later in psychotherapy that the client’s underlying preoccupation with relationships and avoiding abandonment becomes clear. As noted in Chapter 9, however, such issues are highly relevant in work with those who were neglected or maltreated early in life. Not only do they represent potential sources of distress and conflict as the client encounters the constraints of the treatment process, but the underlying dysfunctional schemas they reflect are important targets for psychological intervention.

**Need for Self-Protection Through Interpersonal Control.** The experience of helplessness that arises from interpersonal victimization may lead to a later need for personal control in relation to others. Often, this manifests as an insistence on autonomy, a tendency to micromanage one’s interactions with others so that one’s own safety and self-determination are intact, and negative responses to control, perceived manipulation, or influence by other people. This interpersonal style may also manifest as difficulty with authority figures who, by definition, have some degree of implicit control over the trauma survivor.

Those individuals with a high need for control may engage in behaviors that seek to maximize their own autonomy during interpersonal interactions—including those that take place in the evaluation or treatment session. For example, the trauma survivor may attempt to control the session by speaking in a continuous manner, thereby keeping the clinician from exerting verbal influence over the assessment or treatment process. In such instances, interruptions by the clinician may be ignored or may prompt irritation or anger. Similarly, the client may resist interview questions that lead away from whatever topic he or she is discussing, viewing the clinician’s desire to gain historical or psychological information as an attempt to overtake the client’s agenda or autonomy. Such behaviors arise from a fear of being revictimized by others, and often reflect underlying relational anxiety—a posttraumatic state that leads to interpersonal rigidity and sometimes an almost compulsive self-protectiveness.

Signs of a need for interpersonal control should be viewed as potential evidence of a history of (1) highly controlling, intrusive, or abusive caretakers earlier in life, (2) early emotional neglect associated with a chaotic childhood environment, and/or (3) later trauma experiences that were especially characterized by extended helplessness, such as torture or forced confinement.

The immediate implications of this interpersonal style are for the assessment process itself: it may be quite difficult to steer the control-focused survivor into domains that the clinician (but not the client) feels are important to evaluate and treat, including current symptomatology, prior history, and level of interpersonal functioning. Clinical experience suggests that the clinician will be most effective in this regard to the extent that he or she does not overly
challenge the client’s need for interpersonal control, but rather works to reassure him or her—both verbally and nonverbally—of the benign intent of the clinical process. In some cases, this will require considerable patience on the part of the clinician.

Capacity to Enter into and Sustain a Clinical Relationship. Psychological assessment and treatment typically requires that the client enter into a working relationship with the clinician. Unfortunately, victims of interpersonal traumas such as child abuse, rape, torture, or partner violence may experience any sort of intimate connection to an authority figure as potentially dangerous—no matter how “safe” that figure is deemed by others (McCann & Pearlman, 1990). For example, in the normal process of therapy, the clinician may inadvertently activate victimization-related flashbacks, threat-related cognitions, or conditioned fears in the client that disrupt what otherwise might be a good working alliance. For this reason, one of the goals of assessment is to determine both the client’s most obvious relational triggers and his or her overall capacity to form an ongoing relationship with the clinician. In cases where the relational capacities of the client are impaired, the therapist should be especially alert to potential difficulties with trust, boundaries, and safety—phenomena that may need to be addressed (or at least taken into account) before much overt trauma-related material can be processed.

To varying degrees, trauma survivors (especially those who were repeatedly victimized in childhood) may show evidence of some or all of the relational issues described here. On a practical level, such disturbances may result in responses and behaviors that are often labeled as “difficult,” “manipulative,” “demanding,” or “disordered.” Reframing such responses as the probable effects of trauma rather than as necessarily evidence of an underlying personality disorder may allow the clinician to approach the client in a more accepting, nonjudgmental, and therapeutically constructive manner.

The relational dynamics listed may also intrude upon the assessment process itself. The same trauma-related activations that discourage an effective therapeutic relationship may cause the client to produce test or interview responses that are compromised by extensive avoidance, fear, anger, or restimulated trauma memories. Although victimization-related hypervigilance, distrust, and traumatic reexperiencing are not easily addressed in the immediate context of psychological assessment, the clinician should do whatever he or she can to promote and communicate respect, safety, and freedom from judgment. Typically, this will involve:

- A positive, nonintrusive demeanor
- Acknowledgement of the client’s distress and immediate situation
A clear explanation of the assessment process (including the goals of the evaluation and its intended use)

Explicit boundaries regarding confidentiality and the limits of the assessment inquiry

In addition, it may be helpful to avoid excessively direct or intrusive questions that might feel demeaning or interrogating, and, instead, work to facilitate the client’s self-disclosure at his or her own pace and level of specificity. When assessment communicates respect and appreciation for the victim’s situation, he or she is more likely to be forthcoming about potentially upsetting, humiliating, or anxiety-producing traumas and symptoms.

**Symptom Responses**

Above and beyond the process signs of trauma response presented thus far, an obvious goal of trauma assessment is to determine the victim’s current mental status and level of psychological functioning, and to inquire about the major symptoms known to be associated with trauma exposure. During a full work-up, whether trauma-focused or otherwise, the client should ideally be evaluated for the following forms of disturbance:

- Altered consciousness or mental functioning (for example, dementia, confusion, delirium, cognitive impairment, or other organic disturbance)
- Psychotic symptoms (for example, hallucinations, delusions, thought disorder, disorganized behavior, “negative” signs)
- Evidence of self-injurious or suicidal thoughts and behaviors
- Potential danger to others
- Mood disturbance (for example, depression, anxiety, anger)
- Substance abuse or addiction
- Personality dysfunction
- Reduced ability to care for self

In combination with other information (for example, from the client, significant others, and outside agencies or caregivers), these interview data provide the basis for diagnosis and an intervention plan in most clinical environments. However, when the presenting issue potentially includes posttraumatic disturbance, the classic mental status and symptom review is likely to miss important information. Individuals with significant trauma exposure—perhaps especially victims of violence—do not always disclose the full extent of their trauma history or their posttraumatic symptomatology unless directly asked, and thus require specific, concrete investigation in these areas.
When there is a possibility of trauma-related disturbance, the assessment interview should address as many (if not all) of the following additional components as is possible, many of which were outlined in the previous chapter:

- Symptoms of posttraumatic stress
  - Intrusive/reliving experiences such as flashbacks, nightmares, intrusive thoughts and memories
  - Avoidance symptoms such as behavioral or cognitive attempts to avoid trauma-reminiscent stimuli, as well as emotional numbing
  - Hyperarousal symptoms such as decreased or restless sleep, muscle tension, irritability, jumpiness, or attention/concentration difficulties
- Dissociative responses
  - Depersonalization or derealization experiences
  - Fugue states
  - “Spacing out” or cognitive-emotional disengagement
  - Amnesia or missing time
  - Identity alteration or confusion
- Substance abuse
- Somatic disturbance
  - Conversion reactions (for example, paralysis, anesthesia, blindness, deafness)
  - Somatization (excessive preoccupation with bodily dysfunction)
  - Psychogenic pain (for example, pelvic pain or chronic pain that cannot be explained medically)
- Sexual disturbance (especially in survivors of sexual abuse or assault)
  - Sexual distress (including sexual dysfunction and/or pain)
  - Sexual fears and conflicts
- Trauma-related cognitive disturbance
  - Low self-esteem
  - Helplessness
  - Hopelessness
  - Excessive or inappropriate guilt
  - Shame
  - Overvalued ideas regarding the level of danger in the environment
  - Idealization of the perpetrator or inaccurate rationalization or justification of the perpetrator’s behavior
- Tension reduction activities
  - Self-mutilation
  - Bingeing/purging
  - Excessive or inappropriate sexual behavior
  - Compulsive stealing
  - Impulsive aggression
- Transient posttraumatic psychotic reactions
  - Trauma-induced cognitive slippage or loosened associations
Trauma-induced hallucinations (often trauma congruent)
- Trauma-induced delusions (often trauma congruent, especially paranoia)
- Culture-specific trauma responses (for example, attaques de nervios), if relevant, when assessing individuals from other countries or cultures

This list may be more comprehensive than is relevant for certain posttraumatic presentations (for example, the survivor of a motor vehicle accident), although most of the components may be appropriate for chronic traumas (for example, extended child abuse or political torture). Some review of these symptoms is usually indicated in a comprehensive evaluation, even if it is followed by a more structured diagnostic interview.

The assessment of the reexperiencing and dissociative symptoms associated with posttraumatic stress can be challenging, especially if the client has not described his or her symptoms to anyone before, and views them as bizarre, or even, perhaps, psychotic. Both reexperiencing and dissociation involve a change in level of consciousness and awareness of one’s surroundings, which can be difficult to put into words. Suggested interview approaches and questions in this area are presented next.

- **Posttraumatic nightmares.** Some clients may not report nightmares that they only indirectly associate with the trauma in question—as a result, asking simply if they have nightmares about the event may not be sufficient. For example, a rape victim may not dream about the rape, but may have nightmares about being chased down a dark alley, or about being attacked by animals or evil spirits. Clarifying questions may include:
  - “Do you have bad or frightening dreams?”
  - “What are your dreams about?”
  - “Do you ever dream about bad things that have happened to you?”

- **Flashbacks.** Many clients will not know the meaning of the word flashback, and may need a more descriptive explanation. More detailed questions include:
  - “Do you ever have visions of [the trauma] that flash into your mind?”
  - “Do you ever feel like the [trauma] is still happening to you?”
  - “Do you ever feel like you are reliving the [trauma]?”
  - “Do you ever hear the voice of the person who hurt you?”
  - “Do you ever hear the sound of the [gunshot/accident/other trauma-relevant sound]?”

- **Intrusive thoughts.** Some clients report intrusive or ego-dystonic thoughts that intrude “out of nowhere” and/or that are a major source of ongoing preoccupation. Questions that may assist in the exploration of such cognitive symptoms include:
  - “Do you think about the [trauma] a lot? All the time?”
  - “Do you find that you can’t get the thought of the [trauma] out of your mind?”
Assessing Trauma and Posttraumatic Outcomes

- "Does thinking about the [trauma] make it hard for you to concentrate on other things?"
- [For those with associated insomnia] "When you can’t sleep at night, are there thoughts that keep you awake?"

- **Dissociation.** Because dissociation is an internal process that may be difficult for the client to express to others, the clinician often can assist the client by asking questions specific to the dissociative experience. Broken down by symptom type, these include:

  **Depersonalization**
  - "Do you ever feel like you are outside of your body?"
  - "Do you ever feel that you can’t recognize parts of your body, or that they change size or shape?"
  - "Do you ever feel like you are watching things that happen to you from outside of yourself?"

  **Derealization**
  - "Do you ever feel like you are living in a dream?"
  - "Do you ever feel like people and things around you are not real?"

  **Fugue states**
  - "Have you ever found yourself somewhere far away and wondered how you got there?"
  - "Have you ever traveled a significant distance from home without realizing it?"

  **Cognitive-emotional disengagement**
  - "Do you find out that you ‘space out’ while at work or at home and lose track of what you are doing?"
  - "Do other people tell you that you sometimes seem ‘a million miles away’ or ‘out of it'?"

  **Amnesia or missing time**
  - "Are there important things in your life that you can’t remember very well or at all?"
  - "Do you ever have experiences where you ‘zone out’ for a few minutes and then find out that a much longer amount of time has passed?"

  **Identity alteration**
  - "Do you ever forget your own name or think you have a different name?"
  - "Do you ever feel like there are different people inside you?"
Psychosis in the Context of Posttraumatic Response

Because dissociation and posttraumatic stress can sometimes involve reduced contact with—and altered perceptions of—the external environment, discriminating such responses from the symptoms of psychosis is not always easy. At times, the boundaries between posttraumatic reexperiencing and hallucinations; between reasonable posttraumatic fears, overvalued ideas and paranoid delusions; and between anxiety-related cognitive fragmentation and frank thought disorganization may become blurred. In addition, severe trauma-related dissociation may appear indistinguishable from withdrawn, internally preoccupied psychotic states. As mentioned earlier, there is a relationship between trauma and psychosis: psychotic depression and PTSD are frequently comorbid, and severe trauma can lead to brief psychotic reactions. As well, those with underlying psychotic processes may be at increased risk for victimization due to decreased levels of vigilance or self-care. However, it is important to exercise caution before jumping to the conclusion that a trauma survivor is psychotic—not the least because treatments for psychotic disorders are not typically effective for posttraumatic stress. In some instances, the clinical presentation may be so ambiguous as to make a definitive determination impossible; in such cases, clients should be carefully followed in treatment with frequent reassessments.

In differentiating psychosis from posttraumatic stress, the following, if present, may suggest a posttraumatic rather than psychotic process:

- **Reexperiencing, as opposed to hallucinations**
  - The content of the perceptions is trauma-related (for example, hearing the voice of the perpetrator or another sound associated with the trauma). Note, however, that a prior trauma history can affect the content of psychotic hallucinations and delusions, as well (Ross, Anderson, & Clark, 1994).
  - The perceptions occur in the context of a triggering experience or trauma-related anxiety.
  - The perceptions are not interactive: they do not, for example, “talk back” to the survivor.
  - The perceptions are not bizarre.

- **Posttraumatic expectations as opposed to delusions**
  - The content of the ideas or fears is related to the traumatic event.
  - The client is able to express an understanding that such ideas or fears are not reasonable (for example, a woman who was raped may fear all men and may not want to be alone with men due to fears of being further victimized, although she may be able to cognitively express that not every man is a rapist).

- **Trauma-induced fragmentation as opposed to loosened associations**
  - The fragmentation or disorganization occurs only when the client is talking about upsetting or trauma-related subjects, and not throughout the client’s discourse.
  - The level of disorganization decreases as the client becomes less anxious.
Conversely, the following, if present, may suggest a psychotic rather than posttraumatic process:

- **Hallucinations as opposed to reexperiencing**
  - At least some of the content of the perceptions is not trauma-related (for example, hearing the voices of others not involved in the trauma).
  - The perception is interactive, and/or the client is observed by others to be talking or laughing to himself or herself.
- **Delusions as opposed to posttraumatic expectations**
  - The content of the ideas/fears is not simply related to the traumatic event, but extends to other areas (for example, a woman who was raped states that not only will all men potentially hurt her, but believes that the CIA is wiretapping her home).
- **Loosened associations as opposed to trauma-induced fragmentation**
  - The cognitive slippage occurs throughout the client’s discourse, whether the client is anxious or not, and irrespective of the topic of conversation.

### The Structured Interview

Although an informal mental status examination and symptom review can reveal many forms of posttraumatic disturbance, the unstructured nature of such approaches often means that certain symptoms or syndromes may be overlooked or inadequately assessed. In fact, it is estimated that up to half of actual cases of PTSD are missed during unstructured clinical interviews (Zimmerman & Mattia, 1999). For this reason, some clinicians and most researchers use structured clinical measures when evaluating posttraumatic stress, especially PTSD. The most commonly used of these structured interviews are discussed next.

### The Clinician-Administered PTSD Scale (CAPS)

The CAPS (Blake et al., 1995) is considered the “gold standard” of structured interviews for posttraumatic stress disorder. The CAPS has several helpful features, including standard prompt questions and explicit, behaviorally anchored rating scales, and assesses both frequency and intensity of symptoms. It generates both dichotomous and continuous scores for current (1 month) and lifetime (“worst ever”) PTSD. In addition to the standard 17 PTSD items, the CAPS also contains items tapping posttraumatic impacts on social and occupational functioning, improvement in PTSD symptoms since a previous CAPS assessment, overall response validity, and overall PTSD severity, as well as items addressing guilt and dissociation.
Unfortunately, the CAPS may require an hour or longer for complete administration, may sometimes provide more information than actually is needed clinically, and focuses only on PTSD.

The Acute Stress Disorder Interview (ASDI)

When the diagnostic issue is ASD, as opposed to PTSD, the clinician may find the ASDI (Bryant, Harvey, Dang, & Sackville, 1998) useful. This interview consists of 19 items that evaluate dissociative, reexperiencing, effortful avoidance, and arousal symptoms. Although relatively new, the ASDI has good reliability and validity and can be administered in a relatively short period of time (Bryant et al., 1998).

The Structured Interview for Disorders of Extreme Stress (SIDES)

The SIDES (Pelcovitz et al., 1997) was developed as a companion to existing interview-based rating scales for PTSD. The 45 items of the SIDES measure the current and lifetime presence of DESNOS and each of six symptom clusters: Affect Dysregulation, Somatization, Alterations in Attention or Consciousness, Self-Perception, Relationships with Others, and Systems of Meaning. Item descriptors contain concrete behavioral anchors in order to facilitate clinician ratings. The SIDES interview has good interrater reliability and internal consistency (Pelcovitz et al., 1997).

The Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (SCID-D)

The SCID-D (Steinberg, 1994) evaluates the existence and severity of five dissociative symptoms: amnesia, depersonalization, derealization, identity confusion, and identity alteration. This interview provides diagnoses for the five major DSM-IV dissociative disorders (presented in Chapter 2), along with acute stress disorder (although we recommend the ASDI for the latter). Also evaluated by the SCID-D are “intra-interview dissociative cues,” such as alterations in demeanor, spontaneous age regression, and trancelike appearance, which are coded in a postinterview section.

The Brief Interview for Posttraumatic Disorders (BIPD)

Although the preceding (and other) diagnostic interviews are clearly helpful tools, we have included the BIPD (Briere, 1998) in Appendix 2 for those who
desire a broader band, somewhat less structured interview. This measure, which can be photocopied or otherwise reproduce for general clinical use, is relatively easily and quickly administered. It reviews all those symptoms associated with PTSD, acute stress disorder, and brief psychotic disorder with marked stressors. On the other hand, the semi-structured format of the BIPD means that it is somewhat less objective than the CAPS or ASDI, and it does not provide as many detailed definitions regarding specific symptom criteria.

Psychological Tests

In contrast to clinical interviews, structured or otherwise, most psychological tests are self-administered, in the sense that the client completes a paper inventory using a pencil or pen. Standardized psychological tests have been normed on demographically representative samples of the general population, so that a specific score on such measures can be compared to what would be a “normal” value for that scale or test. We strongly recommend the use of such tests, since they provide objective, comparative data on psychological functioning (both trauma-specific and general) in trauma survivors. A number of testing instruments are briefly described below. Not discussed are projective tests, although one (the Rorschach Ink Blot Test; Rorschach, 1981/1921) also can be helpful in the assessment of posttraumatic states (Luxenberg & Levin, 2004; Armstrong & Kaser-Boyd, 2003). The interested reader should consult the Suggested Reading list at the end of this chapter for books and articles that address in greater detail the psychometric evaluation of traumatized individuals.

Generic Tests

A variety of psychological measures can be used to assess generic (that is, non-trauma-specific) psychological symptoms in adolescent and adult trauma survivors. Several of these assess anxiety, depression, somatization, psychosis, and other symptoms relevant to Axis I of DSM-IV. Because posttraumatic distress often includes such symptoms, a good psychological test battery should include at least one generic measure in addition to more trauma-specific tests.

Examples of generic tests include:

- Minnesota Multiphasic Personality Inventory, 2nd edition (MMPI-2: Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989)
- Minnesota Multiphasic Personality Inventory for Adolescents (MMPI-A: Butcher, Williams, Graham, Archer, Tellegen, Ben-Porath, & Kaemmer, 1992)
Psychological Assessment Inventory (PAI: Morey, 1991)
Millon Clinical Multiaxial Inventory, 3rd edition (MCMI-III: Millon, Davis, & Millon, 1997), and
Symptom Checklist-90-Revised (SCL-90-R: Derogatis, 1983)

Each of these tests (especially the PAI and MCMI-III) also provides some information on the personality-level (that is, Axis II) difficulties associated with the complex posttraumatic outcomes described in Chapter 2. In addition, three (the MMPI-2, PAI, and MCMI-III) include PTSD scales—although these scales are typically only moderately effective in identifying actual cases (and non-cases) of posttraumatic stress disorder (Briere, 2004; Carlson, 1997). Most major generic instruments also include validity scales, used to detect client under- or overreporting of symptoms. Such scales can be helpful in identifying denial, exaggeration, and some cases of malingering. However, traumatized individuals—by virtue of the unusual quality of some posttraumatic symptoms—tend to score higher than others on negative impression (overreporting) scales, even when not attempting to malinger or otherwise distort their responses (for example, Jordan, Nunley, & Cook, 1992).

Trauma-Specific Tests

Although generic tests can detect many of the more nonspecific symptoms associated with trauma, as well as other comorbid disorders that might be present, psychologists often use more specific tests when assessing posttraumatic stress, dissociation, and trauma-related self-capacity disturbance (Carlson, 1997). The most common of these instruments are presented below.

For Posttraumatic Stress and Associated Symptoms

- **Posttraumatic Stress Diagnostic Scale (PDS).** The PDS (Foa, 1995) evaluates exposure to potentially traumatic events, characteristics of the most traumatic event, 17 symptoms corresponding to DSM-IV PTSD criteria, and the extent of symptom interference in the individual’s daily life. The PDS has high internal consistency (\(\alpha = .92\) for the 17 symptom items) and good sensitivity and specificity with respect to a PTSD diagnosis (.82 and .77, respectively). This measure has not been normed on the general population and thus does not yield standardized T-scores. Instead, PTSD symptom severity estimates are based on extrapolation from a clinical sample of 248 women with trauma histories.

- **Davidson Trauma Scale (DTS).** The DTS (Davidson et al., 1997) is a 17-item scale measuring each DSM-IV symptom of PTSD on five-point frequency and severity scales. This measure yields a total score, as well as Intrusion, Avoidance/Numbing, and Hyperarousal scale scores, although there are no
norms available for interpreting symptom severity on these scales. The DTS has good test-retest reliability and internal consistency, as well as concurrent validity. Criterion validity has been assessed vis-à-vis the SCID, where the DTS was found to have a sensitivity of .69 and a specificity of .95 in detecting PTSD.

- **Detailed Assessment of Posttraumatic Stress (DAPS).** The DAPS (Briere, 2001) yields DSM-IV diagnoses for PTSD and ASD, as well as measuring a number of associated features of posttraumatic stress. Normed on general population individuals with a history of trauma exposure, the DAPS has validity scales (Positive Bias and Negative Bias) and clinical scales that evaluate lifetime exposure to traumatic events (Trauma Specification and Relative Trauma Exposure), immediate responses to a specified trauma (Peritraumatic Distress and Peritraumatic Dissociation), PTSD symptom clusters (Reexperiencing, Avoidance, and Hyperarousal), and three associated features of posttraumatic stress: Trauma-specific Dissociation, Suicidality, and Substance Abuse. This measure has good sensitivity (.88) and specificity (.86) with respect to a CAPS diagnosis of PTSD.

- **Trauma Symptom Inventory (TSI).** The TSI (Briere, 1995) is a 100-item instrument that evaluates the overall-level posttraumatic symptomatology experienced by an individual over the prior six months. It has been normed on the general population and has been shown to have good reliability and validity. The TSI has three validity scales (Response Level, Atypical Response, and Inconsistent Response) and 10 clinical scales (Anxious Arousal, Depression, Anger/Irritability, Intrusive Experiences, Defensive Avoidance, Dissociation, Sexual Concerns, Dysfunctional Sexual Behavior, Impaired Self-Reference, and Tension Reduction Behavior). It is often used to index more complex or wide-ranging posttraumatic outcomes.

- **Trauma Symptom Checklist for Children (TSCC).** Although often used to evaluate the trauma-related symptomatology in children, the TSCC (Briere, 1996) is also used to assess adolescents up to age 17. This measure is normed on more than 3,000 individuals under age 18, and consists of two validity scales (Underresponse and Hyperresponse) and six clinical scales (Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, and Sexual Concerns).

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**For Affect Regulation, Interpersonal Relatedness, and Identity Problems**

- **Trauma and Attachment Belief Scale (TABS).** The TABS (Pearlman, 2003; formerly the Traumatic Stress Institute Belief Scale) is a normed instrument that measures disrupted cognitive schemas and need states associated with complex trauma exposure. It evaluates disturbance in five areas: Safety, Trust, Esteem, Intimacy, and Control. There are reliable subscales for each of these domains, rated both for “self” and “other.” In contrast to more symptom-based tests, the TABS evaluates the self-reported needs and expectations of trauma survivors as they describe self in relation to others. For this reason, the TABS is helpful in understanding important assumptions that the client carries regarding his or her relationships to others, including the therapist.
Inventory of Altered Self Capacities (IASC). The IASC (Briere, 2000a) is a standardized test of difficulties in the areas of relatedness, identity, and affect regulation. The scales of the IASC assess the following domains: Interpersonal Conflicts, Idealization-Disillusionment, Abandonment Concerns, Identity Impairment, Susceptibility to Influence, Affect Dysregulation, and Tension Reduction Activities. Scores on the IASC have been shown to predict childhood trauma history, adult attachment style, interpersonal problems, suicidality, and substance abuse history in various samples. The Idealization-Disillusionment, Susceptibility to Influence, and Abandonment Concerns scales are useful in warning of potentially therapy-disrupting issues or dynamics that emerge in work with some survivors of more complex and severe trauma.

For Dissociation

- **Dissociative Experiences Scale (DES).** The DES (Bernstein & Putnam, 1986) is the most often used of the dissociation measures, although it is not normed on the general population. The DES taps “disturbance in identity, memory, awareness, and cognitions and feelings of derealization or depersonalization or associated phenomena such as deja vu and absorption” (Bernstein & Putnam, 1986, p. 729). A score of 30 or higher on the DES correctly identified 74 percent of those with DID and 80 percent of those without DID in a large sample of psychiatric outpatients (Carlson et al., 1993).

- **Multiscale Dissociation Inventory (MDI).** Based on data suggesting that dissociation is a multidimensional phenomenon, the MDI (Briere, 2002b) is a normed clinical test that consists of six scales (Disengagement, Depersonalization, Derealization, Memory Disturbance, Emotional Constriction, and Identity Dissociation). Together, these scores form an overall dissociation profile. The MDI is reliable and correlates as expected with child abuse history, adult trauma exposure, PTSD, and other measures of dissociation, including the DES. The Identity Dissociation scale had a specificity of .92 and a sensitivity of .93 with respect to a diagnosis of dissociative identity disorder (Briere, 2002b).

Assessment of Physical Health

A trauma evaluation is not complete without an assessment regarding the client’s self-reported physical health status. At some point in the interview, the clinician (whether a medical or nonmedical practitioner) should ask if the client has any active medical conditions, whether he or she is in any current physical distress, and whether he or she takes any medications (including over-the-counter medications, vitamins, and herbal supplements). This part of the interview is especially relevant for traumatized individuals, because, as described in Chapter 2, those with PTSD are at increased risk for physical health problems. In addition, some medical conditions (such as endocrine
problems, neurological disorders, and traumatic brain injury) can mimic the symptoms of PTSD (Kudler & Davidson, 1995).

Given this complexity, and the fact that somatization is more common in traumatized individuals, the determination of which symptoms are due to actual medical illness (and require medical intervention) often can be quite challenging. In health care settings that provide services to indigent, uninsured, or undocumented clients, or where, for various other reasons, clients have difficulty obtaining medical care, concerns about medical complications may be especially relevant. In such instances, the mental health clinician may be the client’s primary point of contact with the health care system. We therefore recommend that therapists refer traumatized clients for full medical examinations and regular medical follow-ups.

**Suggested Reading**


