Chapter 2 outlined the various symptoms, difficulties, and disorders that can arise from trauma exposure. The current chapter describes a number of ways in which these posttraumatic outcomes—and the events that produced them—can be assessed. We strongly encourage the use of empirically validated assessment instruments and structured diagnostic interviews. However, 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 potentially more prone to interpretative error, observation of client responses can yield important, sometimes unique, 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 describes 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

The first focus of assessment in any trauma-related situation is whether the client is in imminent danger of loss of life or bodily integrity, or is at risk for hurting others (Briere & Lanktree, 2011). This includes—in the case of immediate 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 available 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: No. 3 and No. 4 are of equal importance.]

5. Is the client’s immediate psychosocial environment unsafe (for example, is he or she 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 services. 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 it 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, 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 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 significant negative effects of trauma evaluation, per se (E. B. Carlson et al., 1993; Griffin et al., 2003), assessment-related activation may be psychologically challenging 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 more extreme cases, temporary emotional destabilization.

### 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 further 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 trauma survivors are often 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 (Agar & Read, 2002). For example, Briere and Zaidi (1989) surveyed the admission charts of a randomly selected group of nonpsychotic 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 the second phase 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 who 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 other 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 these:

• “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/patient 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 nontaxing 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 nontaxing. The flow of questions in such a scenario might follow a pattern such as this:
  - “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?”
  - “Did anyone ever do anything sexual to you when you were a child, or make you do something sexual to them?”
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[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, & Green, 1998) 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.

Evaluating the Effects of Trauma

For the purposes of this book, the effects of trauma can be divided into two categories: process responses, involving trauma effects 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 by both 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 trauma reexperiencing is being blocked through dissociation or other avoidance responses. Information regarding the client’s level of posttraumatic activation not only can assist in diagnosis and assessment, but it 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 latter, 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 responses that are not, by themselves, visible, although their effects may be inferred. They include the following:

- **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 (for example, by not understanding obvious questions at times or seeming somewhat distant interpersonally), but does so without exhibiting major signs of dissociation, per se.
- **Thought suppression.** The client cognitively blocks or suppresses emotionally upsetting thoughts or memories, often visible as sudden lapses in discourse or reports of inadequate memory.
- **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 substance (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 survivor presents as less upset than the circumstances might warrant (for example, a calm and nontraumatized demeanor one day after involvement in a major automobile accident with 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 uncertainty, the experienced trauma clinician often learns to discriminate various types of defensive avoidance strategies from resilience, 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 the following:

- **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 or elsewhere, typically signals a greater likelihood of posttraumatic stress (Pietrzak, Harpaz-Rotem, & Southwick, 2011; Plumb, Orsillo, Luterek, 2004), an increased chance of chronicity (Lawrence, Fauerbach, & Munster, 1996; Marshall et al., 2006), and potentially greater difficulties dealing with the exposure component of therapy (Jaycox, Foa, & Morral, 1998; Zoellner et al., 2011). 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 in 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 (Briere & Rickards, 2007; Pynoos, Steinberg, & Piacentini, 1999; Schore, 2003) and, as noted earlier, are associated with subsequent distress-avoidance symptoms such as substance abuse, impulsivity, suicidality, self-injurious behavior, and other seemingly “personality disorder”–level responses (Briere et al., 2011; van der Kolk et al., 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 & Lanktree, 2011; 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
- Reports of long-term substance abuse or dependence
- 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 overgeneralizing from the borderline personality disorder diagnosis). In such cases, as noted in Chapter 8, therapeutic intervention (especially exposure activities) should 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 next.

**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, 2004; Herman, 1992b). 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, spy holes, 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 veteran of the war in Iraq may position himself or herself 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 and trafficking 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.

Although the presence of such preoccupations may indicate a specific sensitivity to evaluation and interactions with authority figures (Briere & Lanktree, 2011), the fact that danger schemas are easily triggered in the survivor may signal 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 or sensitivity to rejection 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 issues 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 or rejection 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 therapist 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, often 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.
Psychological assessment and treatment typically require 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 (Briere & Lanktree, 2011; I. L. McCann & Pearlman, 1990). For example, during 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 “attention seeking.” 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.

These relational dynamics 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 (Briere, 2004). 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 (Newman, Briere, & Kirlic, in press). Typically, this will involve the following:

- A positive, nonintrusive demeanor
- Good rapport
- Acknowledgment 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

It also 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 detail. When
the assessment process communicates respect and appreciation for the vic-
tim’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 psychological work-up, whether trauma focused or otherwise, the cli-
ent 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 symptomatol-
ogy 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, intru-
sive 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, ataques de nervios), when assessing individuals from other countries or cultures

This list may be more comprehensive than necessary for certain posttraumatic presentations (for example, that of a motor vehicle accident survivor), although most of the components may be appropriate for chronic traumas (for example, extended child abuse or 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 these:
  - “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 these:
  - “Do you ever have visions of the [trauma] that flash into your mind?”
  - “Do you ever see things in your mind that have happened to you?”
  - “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/war/other trauma]?”

- **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 these:
  - “Do you think about the [trauma] a lot? All the time?”
  - “Do you have times when you can’t get the thought of the [trauma] out of your mind?”
  - “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 clients by asking questions specific to the dissociative experience. Broken down by symptom type, these include the following:
• 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 or a movie?”
  – “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 people ever say that sometimes you act like a different person or use 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 nearly indistinguishable from withdrawn, internally preoccupied psychotic states. As reviewed in Chapter 2, there is a relationship between trauma and psychosis: Psychotic depression and PTSD are frequently comorbid, severe trauma can lead to brief psychotic
reactions, and childhood trauma has been implicated in some instances of chronic psychosis. 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 some 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 (Hardy et al., 2005; C. A. Ross, Anderson, & Clark, 1994; A. Thompson et al., 2010).
  - 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 (for example, of God’s face or demons).

- **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 not only states that all men will 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. As DSM-V approaches, the CAPS authors have developed a new version that takes all criteria changes into account (F. W. Weathers, personal communication, May 22, 2012).
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. The ASDI has good reliability and validity and can be administered in a relatively short period of time (Bryant et al., 1998; Orsillo, 2001).

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, 2004) 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 include the BIPD (Briere, 1998) in Appendix 2 (and at http://johnbriere.com) for those who desire a broader band, somewhat less structured interview. This measure, which can be photocopied or otherwise reproduced for general clinical use, is relatively easily and quickly administered. It reviews all those symptoms associated with a diagnosis of DSM-IV PTSD,
ASD, 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, 1921/1981) also can be helpful in the assessment of posttraumatic states (Armstrong & Kaser-Boyd, 2003; Luxenberg & Levin, 2004). 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 standardized 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 often-used generic tests include the following:

- Minnesota Multiphasic Personality Inventory, 2nd edition (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989)
- Minnesota Multiphasic Personality Inventory for Adolescents (MMPI-A; Butcher et al., 1992)
- Psychological Assessment Inventory (PAI; Morey, 1991)
- Millon Clinical Multiaxial Inventory, 3rd edition (MCMI-III; Millon, Davis, & Millon, 1997)
- 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 noncases) of posttraumatic stress disorder (Briere, 2004; E. B. 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, R. G. 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 (E. B. Carlson, 1997). The most common of these instruments are presented below. Non-normed/nonstandardized tests are listed only briefly, since measures without normative data cannot be easily interpreted relative to “normal”/less symptomatic individuals (see a brief discussion later in this chapter).

**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 (a .92 for the 17 symptom items) and good sensitivity and specificity with respect to a PTSD diagnosis (.82 and .77, respectively). PTSD symptom severity is estimated, based on extrapolation from a clinical sample of 248 women with trauma histories.
- **Davidson Trauma Scale (DTS).** The DTS (J. R. T. 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 and standardized 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-2 (TSI-2).** The TSI-2 (Briere, 2011), a recent revision of the Trauma Symptom Inventory (TSI; Briere, 1995), is a 136-item standardized instrument that evaluates the overall level of posttraumatic symptomatology experienced over the previous 6 months. It has been normed on the general population and has been shown to have good reliability and validity. The TSI-2 has two validity scales (Response Level and Atypical Response), 12 clinical scales (Anxious Arousal, Depression, Anger, Intrusive Experiences, Defensive Avoidance, Dissociation, Sexual Disturbance, Impaired Self-Reference, Tension Reduction Behavior, Somatic Preoccupation, Suicidality, and Attachment Insecurity), and four summary scales (Posttraumatic Stress, Self-Disturbance, Externalization, and Somatization), determined by multiple groups confirmatory factor analysis.

**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 and standardized 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, 2000b) is a normed and 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.

- **Bell Object Relations and Reality Testing Inventory (BORRTI).** The only standardized test of what is generally referred to as object relations, the BORRTI (Bell, 1995) has scales that yield data on four constructs: Alienation, Insecure Attachment, Egocentricity, and Social Incompetence. These scales have been shown by the test author to predict and potentially explain relational dysfunction in individuals thought to have some form of personality disorder. Because the scales are linked to object relations theory, the results of this measure will be most directly applicable to clinicians who endorse that perspective.

### For Dissociation

- **Dissociative Experiences Scale (DES).** The DES (E. M. 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 déjà vu and absorption” (E. M. Bernstein & Putnam, 1986, p. 729). A score of 30 or higher on the DES correctly identified 74 percent of those with dissociative identity disorder (DID) and 80 percent of those without DID in a large sample of psychiatric outpatients (E. B. Carlson et al., 1993). Despite its nonstandardized/nonnormed psychometric status, it is included in this section because of its extremely wide use, and thus “quasi-normative” data.

- **Multiscale Dissociation Inventory (MDI).** Based on data suggesting that dissociation is a multidimensional phenomenon, the MDI (Briere, 2002a) is a normed clinical test that consists of six scales (Disengagement, Depersonalization, Derealization, Memory Disturbance, Emotional Constriction, and Identity Dissociation), which, together, define 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. In one study, the Identity Dissociation scale had a specificity of .92 and a sensitivity of .93 with respect to a diagnosis of dissociative identity disorder (Briere, 2002a). At the time of this writing, the MDI is available without cost to qualified individuals (those licensed to perform psychological testing) at http://johnbriere.com.
**Nonstandardized Tests**

Because clinicians needed to evaluate posttraumatic disturbance well before there were standardized or validated tests available to them, a number of instruments were developed in research contexts that, as yet, have not been fully standardized and normed. The most common and potentially most useful of these, in addition to the DES, are the *Intrusive Experiences Scale* (IES; M. Horowitz, Wilner, & Alvarez, 1979), *Multidimensional Inventory of Dissociation* (MID; Dell, 2006), *Posttraumatic Cognitions Inventory* (Foia, Ehlers, Clark, Tolin, & Orsillo, 1999), *PTSD Checklist* (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993), and the *Trauma Symptom Checklist-40* (TSC-40; Briere & Runtz, 1989; Elliott & Briere, 1992).

Some of these tests have been used in applied settings for years, and clinicians have developed cut-off scores for some in order to define normal versus clinical levels of distress (for example, the PCL). When deciding which of these measures to apply in a given clinical situation, we recommend that the clinician also consider any fully standardized and validated test that might be better (or additionally) employed, and consider any limitations of these tests that might constrain clinical interpretation. In general, psychometrically valid test interpretation (and modern psychological testing standards) requires that self-report clinical instruments demonstrate good internal consistency, convergent and discriminative validity, and statistical determination of symptom severity based on the relationship of a given score to the total distribution of scores in the general population (Anastasi & Urbina, 1997).

**Health Status**

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, pain, neurological disorders, and traumatic brain injury) can mimic or overlap with the symptoms of PTSD (Asmundson & Taylor, 2006; Kudler & Davidson, 1995; McAllister & Stein, 2010).

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.

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**Suggested Reading**


Once the client’s trauma history and posttraumatic symptoms have been determined, trauma therapy can be initiated. We begin the treatment part of this book by outlining general issues relevant to trauma therapy; the more technical aspects of treatment follow.

We refer throughout these chapters to the integration of cognitive-behavioral, psychodynamic, mindfulness, and eclectic approaches in the treatment of trauma effects. It is our position that the various components of these methods can be combined into a single, broad therapeutic approach—one that can be adapted to the potentially wide range of symptoms and needs of each client. Nevertheless, these models are superficially quite different from one another, and some of their originators may disagree with the idea of combining their techniques with those of other clinicians. In our experience, however, effective therapy almost always consists of a variety of interventions and theoretical models—whether acknowledged by the clinician or not. For example, many good cognitive-behavioral therapists use relational techniques in their work with clients, and many psychodynamic interventions are, at their base, translatable into cognitive-behavioral principles.

A review of the existing literature on the treatment of posttraumatic states, in combination with clinical experience, suggests that effective therapy—irrespective of underlying theory—can usually be broken down into a number of broad components, the exact combination of which varies according to the client’s specific clinical needs (Briere & Lanktree, 2011). These minimally consist of the following:

- An overall approach that is respectful, positive, and compassionate, and that provides support and validation in the context of an empathically attuned therapeutic relationship
- Psychoeducation on trauma and trauma symptoms
• Some form of stress reduction or affect regulation training
• Cognitive interventions that address harmful or debilitating trauma-related beliefs, assumptions, and perceptions
• Opportunities to develop a coherent narrative about the traumatic event
• Memory processing, usually involving guided self-exposure to trauma memories
• Processing of relational issues in the context of a positive therapeutic relationship
• Activities that increase self-awareness and self-acceptance, including opportunities to reflect on one’s internal experience and change one’s relationship to the effects of one’s history

Many of these interventions may occur within the same therapy session and may be hard to distinguish from one another during the treatment process. Nevertheless, they represent, to some extent, separate processes and goals. For this reason, each receives detailed attention in the following chapters. We also include in Part II chapters on the treatment of more acute trauma presentations and the psychopharmacology of posttraumatic states.
Central Issues in Trauma Treatment

A Basic Philosophy of Trauma, Recovery, and Growth

Although much of this book is devoted to the technical aspects of treatment, we start this chapter with philosophical and, to some extent, theoretical issues associated with trauma therapy. This is because the way in which the clinician views trauma and trauma-related outcomes, and what he or she believes to be the overbridging goals and functions of treatment, have significant effects on the process and outcome of therapy.

Intrinsic Processing

Perspectives on trauma and its treatment vary among clinicians, and a variety of clinical models can inform effective psychotherapy. The approach that we advocate in this book emphasizes the probably innate tendency for humans to process trauma-related memories and, when possible, to move toward more adaptive psychological functioning. As discussed in more detail in Chapter 8, many of the “reexperiencing” symptoms of posttraumatic stress disorder can be conceptualized as recovery algorithms that humans have evolved over time as a response to trauma exposure (Briere, 1996, 2002b; see also a related perspective by M. J. Horowitz, 1978). The intrinsic function of these reliving experiences appears to be, at least in part, a way to process, desensitize, and integrate upsetting material. This implies that individuals who present with intrusive trauma-related symptoms are, in a sense, attempting to metabolize or internally resolve distressing thoughts, feelings, and memories. This perspective reframes many posttraumatic symptoms as, to some extent, adaptive and recovery-focused rather than as inherently pathological. It also suggests that therapeutic exposure (see Chapter 8) and other approaches to processing traumatic memories may work by optimizing those activities in which the client is already engaged, as opposed to imposing entirely new or alien techniques. Seen in this light, traumatized individuals are not collections of symptoms, but rather people who, at some level, are
attempting to recover—albeit not always successfully. This view allows the therapist to more clearly understand expressed emotional pain as “just” emotional pain—not as intrinsically negative, nor as a trigger for countertransference, but rather as a process wherein the client can process her or his history and ultimately experience reduced emotional suffering.

A second, related notion offered here is that trauma can result in growth. Like many other therapists who work in this area, we have found that adversity and distress—beyond their capacity to disrupt and injure—often help people to develop in positive ways. As documented by various studies, this may involve new levels of psychological resilience, additional survival skills, greater self-knowledge and self-acceptance, a greater sense (and appreciation) of being alive, increased empathy, and a more broad and complex view of life in general (A. Brown, 2009; Joseph & Linley, 2008; V. E. O’Leary, 1998; K. Siegel & Schrimshaw, 2000; Updegraff & Taylor, 2000). The recently widowed person may learn new independence, the survivor of a heart attack may develop a more healthy perspective on life’s priorities, and the person exposed to a catastrophic event may learn important things about his or her resilience in the face of tragedy. The implication is not that someone is lucky when bad things happen, but, rather, that not all outcomes associated with adversity are inevitably negative, and that the process of surmounting obstacles may lead to increased capacities, and perhaps even greater wisdom. The message is not that one should “look on the bright side,” which can easily be seen as dismissive and unempathic, and may support avoidance. Instead, we suggest that the survivor’s life, although perhaps irrevocably changed, is not over, and that future good things are possible.

Of course, some traumatic events are so overwhelming that they make growth extremely difficult; they may involve so much loss that it seems impossible (if not disrespectful) to suggest any eventual positive outcomes to the client. Survivors of traumas such as severe childhood abuse, torture, or disfiguring fire may feel that they have been permanently injured, if not ruined for life. In other cases, life experiences may have pushed some survivors so far into withdrawal and defense that they cannot easily see beyond the immediate goals of pain avoidance and psychological survival. Even in these instances, however, treatment should not be limited to symptom reduction; it may also include the possibility of new awareness, insights, and skills. In less tragic circumstances, it may even be possible to suggest that adversity can make the survivor more, as opposed to less.

This philosophy may appear to be a distraction from the technical job of trauma treatment. Clearly, an injured person first needs attention to immediate safety and life support, and help with painful symptoms; it is often only later that the more complicated and subtle aspects of recovery and growth become salient. Yet, ultimately, some of the best interventions in posttraumatic psychological injury are implicitly existential and hopeful. This perspective can also be beneficial for the therapist—the possibility that the client not only can recover, but also may grow from traumatic experience, brings tremendous richness and optimism to the job of helping hurt people.
Respect, Positive Regard, and Compassion

One of the implications of this philosophy is that the traumatized client should be seen as someone who, despite being confronted with potentially overwhelming psychic pain and disability, is struggling to come to terms with his or her history—and, perhaps, to develop beyond it. It is often hard to be in therapy, especially when (as is outlined in the next few chapters) such treatment requires one to feel things that one would rather not feel and think about things that one would rather not consider. The easy choice, in many cases, is to block awareness of the pain and avoid the thought—to “let sleeping dogs lie.” It is a harder choice, when the option is available, to directly engage one’s memories and their attendant psychological distress and attempt to integrate them into the fabric of one’s life. As noted at various points in this book, it may be that—in order to survive pain—the client must engage in some level of avoidance in order to deal with otherwise overwhelmed memories, thoughts, and/or feelings during treatment. These responses are logical, even helpful, and should be understood as such by the clinician. Although sometimes problematic, such “resistance” does not contradict the fact that the client deserves considerable respect for being willing to revisit painful events and to choose some level of awareness over the apparent (although typically false) benefits of complete denial and avoidance.

Continuous appreciation of the client’s bravery is a central task for the trauma-specialized clinician—acknowledging the courage associated with the client’s mere physical presence during the therapy hour, and taking note of the strength that is required to confront painful memories when avoidance is so obviously the less challenging option. When the therapist can accomplish a respectful and positive attitude, imbued with the notion that the client is doing the best he or she can with the circumstances that confront him or her, the therapy process almost always benefits. Although the client may not completely believe the therapist’s nonjudgmental, positive appraisal of him or her (in C. R. Rogers’s [1957] lexicon, his or her unconditional positive regard), visible therapist respect and appreciation assists greatly in establishing a therapeutic rapport, increasing the likelihood that the client will make himself or herself psychologically available to the therapeutic process.

Related to positive regard, but extending beyond it, is the notion of compassion. Considered at various points in this book, compassion can be defined as nonjudgmental, nonegocentric awareness and appreciation of the predicament and suffering of another (in this case, the client), with the directly experienced desire to relieve that person’s distress and to increase his or her well-being. Compassion involves a positive emotional state in the clinician—unconditional caring that is directed to the client regardless of his or her actual or presumed good or bad qualities (see Briere, 2012a; Germer, 2009; as well as Chapter 10, for discussions of compassion and its various definitions).

Importantly, compassion is not equivalent to pity, which implies a power imbalance and clinician sympathy regarding the diminished state or status of
the client. Rather, it reflects the clinician’s awareness that he or she and the client share a common human predicament—the impermanence and fragility of life and well-being—and the fact that all humans, including the clinician, will suffer at various points in their lives. It also involves the natural caring feelings that tend to arise when we see, without distortion, the struggle and vulnerability of others.

From this perspective, the clinician communicates nonjudgmental caring in a way that is not clinically detached, pathologizing, or superior. In the presence of such valuation, the traumatized client may be more able to fully inhabit, accept, and process his or her distress, while incorporating a sense of loving acceptance in relationship to another. As we note in Chapters 8 and 9, this positive state may activate attachment-related neurobiological phenomena that, in turn, serve to countercondition the client’s negative emotional responses associated with past relational traumas.

Compassion is probably a normal human state, but it can be further developed in the clinician in various ways. These include clinical training and supervision that emphasizes nonegocentric attention and mindfulness, specific didactic and experiential exercises that teach compassion (Gilbert, 2009), and, for those interested in this path, contemplative activities such as metta and mindfulness meditation (for example, Salzberg, 1995).

Hope

Hope is critically important to effective trauma treatment. Repeated experience of painful things (including symptoms) may cause the client to expect continuing despair as an inevitable part of the future. In this light, part of the task of therapy is to reframe trauma as challenge, pain as (at least in part) awareness and growth, and the future as opportunity. This in no way means that the clinician should be Pollyanna-ish about the client’s experiences and current distress; it is very important that the client’s perceptions be acknowledged and understood. However, it is rarely a good idea for the therapist to accept and therefore inadvertently reinforce the helplessness, hopelessness, and demoralization that the client may infer from life experiences; to do so is, to some extent, to share in the client’s injury. Instead, the challenge is to acknowledge the sometimes incredible hurt that the client has experienced, while, at the same time, gently suggesting that his or her presence in treatment signals implicit strength, adaptive capacity, and hopefulness for the future.

Instilling hope does not mean that the therapist promises anything. For a variety of reasons (for example, genetic or biological influences, the possibility of premature termination, treatment interference through substance abuse, especially complex and severe symptomatology, new traumas, and so on), not every client experiences complete symptom remission. Because we cannot predict the future, we cannot guarantee that things will go well for any given person. Yet an overall positive view of the client and his or her
future is often justified and helpful. Even when not treated, many of those individuals exposed to major trauma will experience significant symptom reduction over time (Freedman & Shalev, 2000), probably as a function of the intrinsic self-healing processes described earlier in this chapter and in Chapter 3. Even more important, having completed trauma-focused treatment is associated with greater symptom reduction than not having done so (see Foa, Keane, Friedman, & Cohen, 2008, for a review of most current therapies and their effectiveness for trauma). For such reasons, it is generally appropriate to communicate guarded optimism regarding the client’s future clinical course and to note signs of improvement whenever they occur.

Ultimately, hope is a powerful antidote to the helplessness and despair associated with many major traumas and losses. Although not typically described as a therapeutic goal, the instillation of hope is a powerful therapeutic action (Meichenbaum, 1994; Najavits, 2002). It takes advantage of the ascribed power and knowledge of the clinician to communicate, with some credibility, that things are likely to get better. The impact of this message for many trauma survivors should not be underestimated.

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The Pain Paradox

Implicit in various aspects of this discussion is something we can call the **pain paradox**. It is referred to as a paradox because traumatized or otherwise suffering people sometimes inadvertently engage in pain-enhancing or sustaining behaviors while trying to reduce painful or upsetting states. In an effort to remediate distress and suffering, survivors may do things that specifically increase, not decrease, posttraumatic distress, and that often make them more chronic.

The paradox lies in how we are socialized to address emotional pain and discomfort. It is not uncommon to receive advice from friends or others to “just get over it,” “put your past behind you,” or “snap out of it.” Similarly, media advertising campaigns counsel the viewer or listener to take pills for all varieties of discomfort, buy things to feel better, and address self-perceived inadequacies with purportedly ego-boosting products, ranging from make-up to automobiles. The message is often that pain, distress, and dissatisfaction are bad things. Because they are bad, they should be removed, medicated, distracted from, or otherwise avoided. Once a person is no longer in pain, or his or her pain has been numbed, once he or she is not aware of bad feelings, then he or she will feel good and will experience happiness. In this context, in fact, feeling good often arises when one has done things to stop from feeling bad.

However, although a common approach to distress in our culture is to do whatever possible to end it, modern psychology (and, as it turns out, philosophies such as Buddhism) suggests that avoiding unwanted thoughts, feelings, and memories actually increases or sustains pain, symptoms, and distress—whereas directly experiencing and engaging pain ultimately reduces it. For
example, numerous studies indicate that those who use drugs or alcohol, dissociate, avoid discussing what has happened to them, and/or engage in other avoidance behaviors such as denial or thought suppression are more likely to develop intrusive and chronic posttraumatic problems and syndromes (Briere, Scott, & Weathers, 2003; Cioffi & Holloway, 1993; D. M. Clark, Ball, & Pape, 1991; Gold & Wegner, 1995; Morina, 2007; Pietrzak, Harpaz-Rotem, & Southwick, 2011). In contrast, those who are able to more directly experience distress, or engage in psychotherapy, mindfulness training, therapeutic exposure, or other ways of accessing traumatic memory, are likely to have improved and less chronic outcomes (Foa, Huppert, & Cahill, 2006; Hayes, Strosahl, & Wilson, 2011; Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010; Palm & Follette, 2011; B. L. Thompson & Waltz, 2010). As Bobrow (2011) notes, “what we cannot hold, we cannot process. What we cannot process, we cannot transform. What we cannot transform haunts us” (para. 5; also see Bobrow, 2007).

The pain paradox thus suggests that people who have been hurt do best if—to the extent possible—they can stay present in their pain, avoid less, and experience more. From this perspective, pain is not “bad,” nor are anxiety or sadness “bad” feelings; in fact, the experience of pain, distress, or even flashbacks may be “good”: It represents access to experiences that can be cognitively and emotionally processed and, once addressed, may then lessen or fall away.

Of course, it is easy to say that people in pain should try not to block, suppress, or deny. As noted at various points in this book, trauma-related problems in affect regulation and tolerance, especially in the context of overwhelming memories, and/or a lack of sufficient social support, may mean that the survivor essentially has no choice but to avoid, in order to maintain some degree of internal homeostasis. Asking a homeless war veteran, hospitalized burn victim, or torture survivor to “stay with the pain” can be a harsh, perhaps impossible, request. Yet even the very beleaguered person may have moments when he or she could tolerate more direct access to internal distress, painful memories, or potentially difficult realization. Further, the titrated exposure activities described in Chapter 8 are designed to provide the otherwise avoidant survivor with the opportunity to experience and process small increments of nonoverwhelming traumatic memory. Thus, the suggestion to allow emotional pain rather than avoid it is a general one—not a demand that the overwhelmed trauma survivor open the floodgates of previously suppressed trauma, but rather an invitation to engage when it is safe and appropriate to do so, and only to the extent possible.

The implications of the pain paradox for trauma therapy are significant. They suggest that approaches that encourage awareness of one’s ongoing experience, that allow access to nonoverwhelming amounts of painful memory, and that encourage deeper insight into the basis for ongoing suffering, will be helpful—whereas medications that only numb or mask unwanted
emotional states, or therapies that distract, focus merely on support, or even teach avoidance, may be less efficacious.

In general, concepts such as the pain paradox and intrinsic processing are depathologizing: Painful posttraumatic states such as flashbacks, grief, anxiety, or depression are not necessarily evidence of a disorder, per se. In many cases, they represent a healthy condition: access to immediate awareness, even if that awareness carries with it things that cause distress, make one sad, or bring one fear. As the client is more able to hold, tolerate, and process these states and their etiologies, without unnecessary interference through avoidance, the emotional mechanisms described in Chapter 8 will more easily take place and recovery will be more likely.

**Central Treatment Principles**

Beyond a philosophy of trauma and recovery, there are a number of basic principles of effective trauma-focused treatment. Although these principles apply most directly to psychotherapy, some are also relevant to other treatment methodologies, including trauma psychopharmacology.

**Provide and Ensure Safety**

Because trauma is about vulnerability to danger, safety is a critical issue for trauma survivors (Cook et al., 2005; Herman, 1992b; Najavits, 2002). It is often only in perceived safe environments that those who have been exposed to danger can let down their guard and experience the relative luxury of introspection and connection. In therapy, safety involves, at a minimum, the absence of physical danger, psychological maltreatment, exploitation, or rejection. Physical safety means that the survivor perceives, and comes to expect, that there is little likelihood of physical or sexual assault at the hands of the clinician or others, and that the building is not likely to collapse or burn during the session. Psychological safety, which is sometimes more difficult to provide, means that the client will not be criticized, humiliated, rejected, dramatically misunderstood, needlessly interrupted, or laughed at during the treatment process, and that psychological boundaries and therapist-client confidentiality will not be violated. It is often only when such conditions are reliably met that the client can begin to reduce his or her defenses and more openly process the thoughts, feelings, and memories associated with traumatic events. In fact, as discussed in Chapter 8, it is critical that the client experience safety while remembering danger; only under this circumstance will the fear and distress associated with trauma in the past lose its capacity to be evoked by the present.

Unfortunately, in order to feel safe, not only must there be safety; the client must be able to perceive it. This is often a problem because, as noted
earlier, trauma exposure can result in hypervigilance; many traumatized people come to expect danger, devote considerable resources to detecting impending harm, and have a tendency to misperceive even safe environments and interactions as potentially dangerous (Janoff-Bulman, 1992; Pearlman & Courtois, 2005). As a result, even a safe therapeutic environment may appear unsafe to some clients. For this reason, among others, treatment may take considerably longer—and call more on the clinician’s patience and sustained capacity for caring—than is allowed for by shorter-term therapies. Some multiply traumatized individuals—former child abuse victims, torture survivors, victims of sustained political oppression, adolescent gang members, “street kids,” or battered women, for example—may need to attend therapy sessions for relatively long periods of time before they can fully perceive and accept the fact that they will not be hurt if they become vulnerable in treatment. For such people, interventions such as therapeutic exposure or psychodynamic interpretation may not be appropriate until therapy has been in place for a long enough time to allow an expectation of safety and stability (Courtois, 2010). Given these concerns, it is obviously important that the therapist be able to determine the client’s relative experience of therapeutic safety, since many clinical interventions involve the activation and processing of upsetting memory material. To the extent that such memories trigger fear and pain, those who are not aware that they are safe may become more distressed by such activations.

As noted earlier in this chapter, providing safety also means working to ensure that the client will be relatively free of danger outside of the therapeutic setting. Highly fearful or endangered survivors are unlikely to have sufficient psychological resources to participate in psychotherapy without being emotionally overwhelmed and/or especially avoidant. The battered woman should be as safe as possible from further battery, and the sexual abuse victim must be out of danger from his or her perpetrator, before psychological processing of symptoms is attempted. Otherwise, the client’s life and physical integrity may be risked in the service of symptom relief. Although this may seem an obvious fact, many therapists fall into the trap of attempting to process traumatic memories with acutely traumatized individuals who continue to live in obviously dangerous circumstances.

This does not mean that all psychological interventions are ruled out in work with the still-at-risk—only those having as their exclusive focus the direct processing of traumatic memories and feelings, or those that prize insight over safety. For example, the acutely battered woman may easily gain from psychoeducational activities or cognitive interventions that provide information on increasing personal safety or that support the often daunting task of leaving an abusive partner (C. E. Jordan, Nietzel, Walker, & Logan, 2004). On the other hand, she may be placed at continued risk if the immediate focus of therapy is to emotionally process her last battery experience or to analyze what childhood issues are involved in her attraction to authoritarian men in the first place. Of course, some chronic life-endangering phenomena,
such as unsafe sexual practices or intravenous substance abuse, are not threats that can be easily terminated—the individual may need some level of symptom reduction, increased coping, or psychoeducation before these behaviors can be significantly reduced or terminated. Nevertheless, when the danger is acute and potentially avoidable, the clinician’s first focus must be on ensuring immediate safety.

Provide and Ensure Stability

*Stability* refers to an ongoing psychological and physical state whereby one is not overwhelmed by disruptive internal or external stimuli. It also implies some degree of capacity to resist the effects of such stimuli in the near future. Stability concerns are highly relevant to work with trauma survivors, since adverse events are often destabilizing and can produce conditions (for example, chaotic interpersonal or physical environments, posttraumatic stress, depression) that further increase susceptibility to stress. In addition, some trauma-related responses (for example, substance abuse, problematic personality traits, or reactive psychosis) can contribute to unstable lifestyles, such as homelessness, recurrent involvement in chaotic and intense relationships, or chronic self-destructiveness.

**Life Stability**

*Life stability* refers to generally stable living conditions. For example, those living in extreme poverty, chaotic environments, or chronically risky occupations (for example, prostitution) may have difficulty tolerating the additional distress sometimes activated by trauma therapy. Such conditions may involve hunger, fear, racial or sexual oppression, and the insecurity associated with inadequate or absent housing—none of which support emotional resilience in the face of activated distress. In fact, without sufficient security, food, and shelter, avoidance of traumatic material (for example, through numbing or substance abuse) may appear more useful to the trauma survivor than the seemingly counterintuitive notion of reliving painful memories. Trauma therapy is most helpful to those who have the social and physical resources necessary to experience safety and the option of trust. As a result, the first intervention with traumatized people who have few resources is often social casework: arranging adequate and reliable food, shelter, and physical safety.

**Emotional Stability**

In addition to physical stability, trauma survivors should have some level of psychological homeostasis before certain aspects of trauma therapy can be initiated (Cloitre et al., 2010; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Herman, 1992a). In general, this means that those with
acute psychotic symptoms, high suicidality, extremely high levels of posttraumatic stress, or debilitating anxiety or depression may require other interventions before exposure-based aspects of trauma therapy can be initiated. These include the appropriate use of medication (see Chapter 12), crisis intervention, development of affect tolerance and regulation skills, and, in some cases, simple supportive psychotherapy. In the absence of such pretreatment, activation of trauma-related material not only may result in an exacerbation of existing symptoms (for example, renewed psychosis or posttraumatic stress) but also may overwhelm the survivor’s existing capacity to regulate his or her emotional state, producing new distress and dysfunction (Briere, 2002b). Exacerbated or newly activated symptoms, in turn, may result in increased avoidance behaviors, such as substance abuse or suicidality, as well as increasing the likelihood that the client will drop out of therapy.

It is not always easy to determine when symptoms are too intense to warrant immediate trauma-specific interventions, as opposed to being worthy targets of treatment. For example, when is posttraumatic stress or anxiety too severe to support therapeutic exposure to traumatic memory, and when are these symptoms in the range that would be appropriate for such treatment? Specific assessment approaches that may shed some light on these issues were presented in Chapter 3. Most generally, the issue is whether the symptoms in question have significantly reduced the client’s capacity to “handle” or regulate the almost inevitable upsurge of emotion that follows therapeutic exposure to unresolved trauma memories. If the increased activation is not overwhelming, classic trauma treatment is usually indicated. If the response to treatment would be to become flooded with negative affects, more grounding, skills-development, and/or supportive psychotherapy will be required until greater psychological stability is present.

Interestingly, some forms of disorder traditionally assumed to be synonymous with psychological instability may not always be contraindications for therapeutic exposure. For example, some traumatized individuals with “borderline personality disorder” or low-level chronic psychosis may be sufficiently stable to tolerate trauma treatment, whereas others with less diagnostic severity may not. Clinicians often have appropriate concerns when working with psychotic, or Axis II, disorders because such disturbance is frequently associated with affect regulation problems and more extreme dysphoria. However, the critical issue is less the type of disorder, per se, than the client’s relative capacity to tolerate the emotions associated with exposure to traumatic memories.

**Maintain a Positive and Consistent Therapeutic Relationship**

One of the most important components of successful trauma therapy appears to be a good working relationship between client and therapist.
Chapter 4  Central Issues in Trauma Treatment

(Courtois & Ford, in press; Kudler, Krupnick, Blank, Herman, & Horowitz, 2009; Pearlman & Courtois, 2005). In fact, a number of studies indicate that therapeutic outcome is best predicted by the quality of the treatment relationship, as opposed to the specific techniques used (M. J. Lambert & Barley, 2001; Martin et al., 2000; Orlinski, Grawe, & Parks, 1994). Although some therapeutic approaches stress relationship dynamics more than others, it is probably true that all forms of trauma therapy work better if the clinician is compassionate and attuned, and the client feels accepted, liked, and taken seriously. Even in short-term, highly structured treatment approaches (for example, some forms of cognitive-behavioral therapy), clients with good relationships with their helpers are more likely to persevere in treatment, adhere to whatever regimen is in place, and, as a result, experience a more positive clinical outcome (Rau & Goldfried, 1994). Longer-term and more interpersonal treatment approaches, in which relational issues are more prominent, are even more likely to benefit from a strong therapeutic relationship.

Because trauma therapy often involves revisiting and processing painful memories, as well as potentially reactivating feelings of danger and vulnerability, successful treatment is especially contingent on therapeutic support and connection. Distant, uninvolved, or emotionally disconnected client-therapist relationships are, in our experience, quite often associated with less positive therapeutic outcomes (see Dalenberg, 2000, for an empirically based discussion of this issue). At a minimum, a positive therapeutic relationship provides a variety of benefits. These potentially include decreased treatment dropout and more reliable session attendance, less avoidance and greater disclosure of personal material, greater treatment adherence and medication compliance, greater openness to—and acceptance of—therapist suggestions and support, and more capacity to tolerate painful thoughts and feelings during therapeutic exposure to trauma memories (American Psychiatric Association, 2001; Cloitre et al., 2002; Farber & Hall, 2002; A. F. Frank & Gunderson, 1990; Horvath, 2007; McGregor, Thomas, & Read, 2006; Rau & Goldfried, 1994).

In addition to supporting effective treatment, the therapeutic relationship is more likely to be helpful to the extent that it both (1) gently triggers memories and schemas associated with prior relational traumas and (2) provides the opportunity to process these activations in the context of therapeutic caring, safety, and support (Briere, 2002b). As is described in more detail in Chapter 9, even the most benign client-therapist relationship may trigger at least some rejection or abandonment fears, misperception of danger, or authority issues in survivors of extended or severe trauma. When these intrusions occur at the same time that the client is feeling respect, compassion, and empathy from the therapist, they may gradually lose their generalizability to current relationships and become counterconditioned by positive relational feelings. In this sense, a good therapeutic relationship is not only supportive of effective treatment, but it is virtually integral to the resolution of major relational traumas.
Tailor the Therapy to the Client

Although a review of some currently available treatment manuals might suggest that clinical interventions are applied more or less equally to all mental health clients with similar complaints, this is almost never the case in actual clinical practice. In fact, the highly structured, sometimes manualized nature of some empirically validated therapies more directly reflects the requirements of treatment outcome research (that is, the need for treatment to be highly similar and equally applied for each client in a given study) than any clinically based intent to provide equivalent interventions for all presenting clients (Westen et al., 2004). In the real world of clinical practice, clients vary significantly with regard to their presenting issues, comorbid symptoms, and the extent to which they can utilize and tolerate psychological interventions. For this reason, therapy is likely to be most effective when it is tailored to the specific characteristics and concerns of the individual person (Briere & Lanktree, 2011; Cloitre et al., 2002). We next describe several of the more important individual variables that should be taken into account when providing mental health interventions, including trauma therapy.

Affect Regulation and Memory Intensity Issues

As noted previously, affect regulation refers to an individual’s relative capacity to tolerate and internally reduce painful emotional states. People with limited affect regulation abilities are more likely to be overwhelmed and destabilized by negative emotional experiences—both those associated with current negative events and those triggered by painful memories. Since trauma therapy often involves activating and processing traumatic memories, individuals with less ability to internally regulate painful states are more likely to become highly distressed, if not emotionally overwhelmed, during treatment (Cloitre et al., 2002; Cloitre et al., 2010; Courtois, 2010).

The affect regulation construct can be oversimplified, however. For example, some people are better at tolerating or regulating one type of feeling (for example, anxiety) than another (for example, anger), despite the common implication that any given person has a generalized capacity to regulate emotions. As well, some people’s emotional responses may be more intense than others’, as a function of having been exposed to more painful experiences. In this regard, it may take more affect regulation capacity to down-regulate emotions associated with some very painful memories (for example, of prolonged torture) than those associated with less intense memories (for example, of an automobile accident). It is rarely enough to decide that someone has “affect regulation difficulties” without also determining the affective load that requires regulating.

Variability in affect regulation capacity—and the severity of the memory-triggered affect to be regulated—has significant clinical implications. Most generally, individuals with impaired affect regulation—especially in the context
of easily triggered, highly painful memories—are more likely to experience overwhelming emotionality when exposed to upsetting memories during treatment and to respond with increased avoidance, including “resistance” and/or dissociation. Such responses, in turn, reduce the client’s exposure to traumatic material and to the healing aspects of the therapeutic relationship. As described in Chapter 8, treatment of those with impaired affect regulation capacities and/or a heavy trauma load should proceed especially carefully, such that traumatic memories are activated and processed in smaller increments than otherwise might be necessary. Often described as “titrated exposure” or “working within the therapeutic window” (Briere, 1996, 2002b), this usually involves adjusting treatment so that trauma processing that occurs within a given session does not exceed the capacities of the survivor to tolerate that level of distress—while, at the same time, providing as much processing as can reasonably occur (see Chapter 8). In individuals with substantially reduced affect regulation capacities (and/or especially distressing memories), this level of exposure and processing may be quite limited at any given moment. Nevertheless, over time, even seemingly small amounts of trauma processing tend to add up, ultimately leading to potentially significant symptom relief and greater emotional capacity without the negative side effect of overwhelming affect.

**Preponderant Schemas**

As noted in Chapter 2, trauma exposure often has effects on cognition. Depending on the type of trauma and when in development it occurred, this may include easily triggered perceptions of oneself as inadequate, bad, or helpless; expectations of others as dangerous, rejecting, or unloving; and a view of the future as hopeless. Such distortions inevitably affect the client’s perception of the therapist and of therapy. For example, the survivor may expect the therapist to be critical, unloving, or even hostile or abusive. Early child abuse and neglect may result in latent gestalts of preverbal negative cognitions (Baldwin, Fehr, Keedian, Seidel, & Thompson, 1993; DePrince, Combs, & Shanahan, 2009; Dutra, Callahan, Forman, Mendelsohn, & Herman, 2008) and feelings that are easily evoked by reminiscent stimuli in the immediate interpersonal environment. These relational schemas, when triggered, may result in sudden, intense thoughts and feelings that were initially encoded during childhood maltreatment and that are hard for the survivor to discriminate from current, real-time perceptions. As a result, the adult abuse survivor may experience sudden feelings of abandonment, rejection, or betrayal during psychotherapy and attribute them to the therapist. Because the cognitive effects of trauma vary from client to client, as a function of the individual’s specific history, therapy must be adjusted to take into account each client’s preponderant schemas of self and others (Pearlman & Courtois, 2005). In general, this means that the clinician should do as much as possible to (1) respond in ways that specifically do not reinforce the
client’s negative expectations and (2) avoid (to the extent possible) triggering underlying cognitive-emotional gestalts related to broader themes such as interpersonal danger or rejection. The individual with a tendency to view important interpersonal figures with distrust, for example, may require a therapist who is especially supportive and validating and who is careful not to trigger too many relational memories of maltreatment. This does not simply involve statements to the client that he or she is safe or positively valued—more important, the therapist should act and respond in such a manner that safety and caring is demonstrated and can be inferred. Because the distrustful client will be predisposed to miss such signs, and perhaps even actively misinterpret them, therapeutic interventions must be even more explicit and obvious in these areas than is the case for those without (or with less of) this cognitive set.

It is important to note here that tailoring one’s treatment approach to a given person’s major cognitive issues does not mean that these distortions or disruptive schemas are no longer evoked in therapy. As noted in Chapter 9, no matter how hard the clinician tries, the survivor who has been substantially maltreated in the past is likely to view some of the therapist’s behaviors as punitive, critical, or abusive, and thus issues in this area almost unavoidably become a topic of discussion during therapy. However, because the therapist is working hard to minimize the extent of these misattributions and triggered schemas, whatever emerges over time in therapy is likely to be less intense and more easily demonstrable as contextually inaccurate. The repetitive experience of fearing that one’s therapist is cold and rejecting, for example, and yet finding, over time, that these perceptions are manifestly untrue, often can be extremely helpful.

Significantly, although the clinician works hard to communicate an absence of criticism or rejection, this does not mean that he or she discourages the client’s discussion and processing of these perceptions and feelings as they relate to subtle client-therapist dynamics or to others in the client’s environment. Ultimately, the goal is to make treatment possible for those who are especially sensitive and suspicious of the vulnerability, connection, and intimacy that are part of the normal operating conditions of treatment. Knowledge that client X has “abandonment issues,” client Y tends to perceive caring as intrusive or sexual in nature, or that client Z responds to authority figures with expectations of hostility or domination can allow the therapist to adjust his or her approach so that it does not unnecessarily trigger these issues and thereby unduly interfere with the process of treatment.

**Take Gender Issues Into Account**

Although there is little doubt that men and women undergo many of the same traumatic events and suffer in many of the same ways, it is also clear that (1) some traumas are more common in one sex than the other and (2) sex role
socialization often affects how such injuries are experienced and expressed. These differences, in turn, have significant impacts on the content and process of trauma-focused therapy.

As noted in Chapter 1, women are more at risk for victimization in close relationships than are men, and both girls and women are especially more likely to be sexually victimized than their male counterparts. In contrast, boys are at greater risk than girls of childhood physical abuse, and boys and men are more likely to experience nonintimate physical assaults than girls and women. In addition to trauma exposure differences, men and women tend to experience, communicate, and process the distress associated with traumatic events in different ways. Although there is major variation among people within each sex, and across cultures and sexual orientations, women are generally socialized to express more directly certain feelings, such as fear or sadness, but are taught to dampen or avoid others, such as anger, whereas men are often more permitted the expression of anger, but may be socially discouraged from communicating “softer” feelings, such as sadness or fear (Cochrane, 2005; Krause, DeRosa, & Roth, 2002; Levant & Pollack, 1995; Renzetti & Curran, 2002). Men and women may also differ in how they act upon feelings and needs. Men are to some extent taught to externalize or cognitively suppress unpleasant feelings, and to act on the environment in order to reduce pain or distress, whereas women are generally socialized to express their distress to trusted others, and are, overall, less prone to externalizing their pain through acting on the environment (Bem, 1976; Briere, 1996; Feuer, Jefferson, & Resick, 2002; Renzetti & Curran, 2002). These sex-role-related differences in symptom expression and behavioral response often manifest themselves during trauma-focused psychotherapy. All things being equal, for example, male trauma survivors in treatment may be more prone to expressions of anger—or to denying posttraumatic distress entirely—than female survivors, whereas traumatized women may be more open to emotional expression, especially of feelings of sadness, fear, or helplessness.

Given these sociocultural influences, the therapist should be alert to ways in which trauma survivors express or inhibit their emotional reactions based on sex-role-based expectations. Often, this will involve supporting the client to express the full range of feelings and thoughts associated with a traumatic event, as opposed to only those considered socially appropriate to his or her gender. In fact, to the extent that (as described in Chapter 8) feelings and thoughts are more easily processed when fully expressed during treatment, unaddressed sex role constraints are likely to inhibit full psychological recovery.

The therapist also should be aware of sex differences in how trauma is cognitively processed. Because boys and men are often socialized to present themselves as strong and able to defend themselves, victimization may be more of a sex role violation for them than it is for girls and women (Mendelsohn & Sewell, 2004). Such social expectations can result in different responses to trauma. Victimized men, for example, may struggle with feelings of inadequacy, shame, and low self-esteem associated with the social
implication that an inability to fight off maltreatment reflects lesser masculinity or competence (Mendel, 1995). In addition, many sexually assaulted or abused males have sexual orientation concerns related to their trauma. In the case of childhood sexual abuse, for example, heterosexual boys and men may fear that molestation by another male has caused them to be (or be seen as) latently homosexual (Alaggia, 2005)—a response that, in a homophobic culture, may result in compensatory hypermasculinity or overinvolvement in heterosexual activity (Briere, 1996). Conversely, homosexual or bisexual men who were sexually abused by males as children may incorrectly believe that their sexual orientation somehow caused them to be abused by men, or that their abuse caused them to be paradoxically attracted to men, conclusions that, in many cultures, may lead to feelings of guilt, shame, and self-hatred (Briere, 1996).

Sex role expectations also affect, to some extent, how traumatized women view their victimization. Women who have been sexually assaulted may believe that they in some way enticed their perpetrators into raping them—a concern that reflects the traditional stereotype of females as sexual objects who are intentionally or unintentionally seductive (Baugher, Elhai, Monroe, & Gray, 2010; M. R. Burt, 1980). Similarly, women battered or otherwise abused by their partners may believe that their supposed lack of subservience or failure to perform as an adequate mate means that they deserved to be maltreated (Barnett, 2001; L. E. Walker, 1984).

Given these gender-specific influences on trauma-related cognitions, the clinician is likely to be more helpful if he or she closely attends to concerns about unacceptability, self-blame, low self-esteem, shame, and sexual orientation as they are expressed in survivors’ cognitive reactions to trauma. Traumatized men may require additional reassurance that they are not less masculine (regardless of sexual orientation) by virtue of having been victimized, and may gain from interventions that support the full range of emotional and cognitive expression without fear of stigmatization. Especially relevant, in this regard, is the need for many victimized men to process feelings of shame associated with viewing themselves as deviant and socially unacceptable. Women survivors, on the other hand, may gain especially from interventions that support self-determination and that help them to reject feelings of responsibility for their abuse, including the unwarranted notion that they somehow sought out or otherwise deserved maltreatment.

Be Aware of—and Sensitive to—Sociocultural Issues

**Social Maltreatment**

One of the more overlooked issues in the treatment of trauma survivors is that people with lesser social status are more likely than others to be victimized (Bassuk et al., 2001; Breslau, Wilcox, Storr, Lucia, & Anthony, 2004; Carter, 2007). Traumas common among those with lower socioeconomic
status, in addition to child abuse, neglect, and exposure to domestic violence (Bergner, Delgado, & Graybill, 1994; Finkelhor, Ormrod, Turner, & Hambray, 2005; Kyriacou et al., 1999; Sedlak & Broadhurst, 1996), are sexual and physical assaults by peers, community violence, shootings, robbery, sexual exploitation through prostitution, trauma associated with refugee status, and loss associated with the murder of a family member or friend (for example, Berthold, 2000; Breslau, Davis, Andreski & Peterson, 1991; Farley, 2003; Giaconia, Reinerz, Silverman, & Pakiz, 1995; Schwab-Stone et al., 1995; Singer et al., 1995).

Social, sexual, and racial discrimination also have direct negative psychological effects that are, in a sense, posttraumatic (Berg, 2006; Carter & Forsyth, 2010; Loo et al., 2001; Root, 1996) and typically are associated with environmental conditions in which further trauma is common (Breslau et al., 1998; North, Smith, & Spitznager, 1994; Sells, Rowe, Fisk, & Davidson, 2003). Some groups in North America suffer from multigenerational trauma, including African Americans, whose ancestors were held in slavery (Mattis, Bell, Jagers, & Jenkins, 1999), and American Indians, who, as a group, have experienced extended maltreatment and cultural near-annihilation (Duran & Duran, 1995; Manson et al., 1996). Social marginalization also means that many traumatized people have reduced access to appropriate mental health services (for example, McKay, Lynn, & Bannon, 2005; Perez & Fortuna, 2005; Rayburn et al., 2005). Combined with the discrimination often experienced by other racial/ethnic minority groups, and the relatively dangerous living environments in which many are forced to live, social inequality provides a vast depot of trauma and trauma impacts in North America.

**Refugees**

Beyond North America, individuals from certain regions of the world are especially likely to be maltreated. When these people immigrate to North America or other places, they often carry with them the trauma experienced in their countries of origin. Mental health centers specializing in refugee or immigrant issues regularly deal with the effects of holocausts or mass murder (for example, “ethnic cleansing”), political imprisonment, war, extended torture, trafficking, “honor” killings, sexual violence, and extreme ethnic or gender discrimination (Allden, Poole, Chantavanich, & Ohmar, 1996; Basoglu, 1992; Marsella, Bornemann, Ekblad, & Orley, 1994; K. E. Miller & Rasco, 2004; Steel et al., 2009). The effects of such experiences tend to be especially long-lasting; in one sample of 80 Vietnamese refugees resettled to Norway, the majority still had very high symptom scores on a standardized measure 23 years later (Vaage et al., 2010). The concatenation of social adversity and ethnic variation means that cultural and historical issues are often highly relevant to the process and content of trauma-focused psychotherapy and should not be overlooked (Marsella et al., 1996; Nickerson, Bryant, Silove, & Steel, 2011).
Cultural Variation

Partially because ethnic and racial minorities are more likely to be traumatized, and partially due to the general multicultural mix present in many modern societies, individuals presenting for trauma services are likely to reflect a wide range of cultures and ethnic groups. Such cultural differences are not merely a function of race: People of low socioeconomic status often have different worldviews and experiences than those of the same race or ethnicity who have more economic and social opportunities. Similarly, merely knowing that someone is, for example, “African American,” “Hispanic,” “Asian,” or “American Indian” says little about his or her cultural context. An individual from Vietnam, for example, may be quite different in perspective, language, and emotional style from a person raised in Japan. The Surgeon General’s (2001) last report on the cultural aspects of mental health services noted:

Asian Americans and Pacific Islanders . . . include 43 ethnic groups speaking over 100 languages and dialects. For American Indians and Alaska Natives, the Bureau of Indian Affairs currently recognizes 561 tribes. African Americans are also becoming more diverse, especially with the influx of refugees and immigrants from many countries of Africa and the Caribbean.

These wide cultural differences often translate into different trauma presentations and idioms of distress, as described in Chapter 2. In addition, above and beyond their social status in North America, people from the various cultures and subcultures of the world have widely different expectations of how clinical intervention should occur, and of the ways in which clinicians and clients should interact (Marsella et al., 1996; Nader, Dubrow, & Stamm, 1999; Van der Veer, 1995). In one culture, for example, eye contact between clinician and client is a sign of respect; in another, it may be the complete opposite. Similarly, in some cultures, certain topics (for example, sexual issues, visible loss of dignity) are considered to be more embarrassing or shameful than in others, and thus should be raised only when relevant to treatment, and then with great sensitivity.

Although the focus of this book precludes a detailed discussion of this issue, a central point must be made: Cultural awareness and sensitivity are an important part of any psychotherapeutic process—including trauma therapy. Clinicians who find themselves, for example, regularly working with Cambodian refugees, Hmong clients, or Mexican immigrants have a responsibility to learn the primary rules of clinical engagement with people from these cultures, as well as, if possible, something of their culture, history, and language.

Monitor and Control Counteractivation

An additional important concept in trauma-focused therapy is what is commonly referred to as countertransference (described as counteractivation...
in self-trauma theory [Briere, 2006]; see Chapter 8). Although this phenomenon has many different definitions, we use it here to refer to occasions when the therapist responds to the client with cognitive-emotional processes (for example, expectations, beliefs, or emotions) that are strongly influenced by prior personal experiences. In many of these cases, these experiences involve childhood maltreatment, adult traumas, or other upsetting events. Of course, all behavior is influenced by past experience, and not all counteractivation responses are negative (Dalenberg, 2000; Pearlman & Saakvitne, 1995). Even positive countertransference, however, must be monitored by the therapist, since it may produce unhelpful responses such as idealization of the client, the need to normalize what are actually problematic client behaviors or symptoms, or even sexual or romantic feelings. Ultimately, the concern is that counteractivation can interfere with treatment by leading to either (1) a detrimental clinical experience for the client or (2) processes that disrupt the treatment process.

For example:

- Therapist A was raised by a critical, psychologically punitive parent. She now finds that she tends to experience angry or guilty feelings when her client complains about any aspect of the therapy.
- Clinician B experienced a traumatic miscarriage a month ago. Upon hearing her client’s excitement about a new pregnancy, she experiences unexpected anger and distress.
- Therapist C, who is dealing with a recent traumatic death of a loved one, finds that he is prone to feelings of extreme sadness and emptiness while treating a client whose son was killed in a fire.
- Clinician D grew up in a violent, chaotic family atmosphere, where safety and predictability were rarely in evidence; her supervisor notices that she has a strong need to control the process of therapy and tends to see certain clients as especially manipulative, malingering, or engaging in therapeutic “resistance.”
- As a child, Clinician E was often protected by a supportive aunt when his mother would go into angry, abusive tirades. He is now treating an older, kindly woman whom he has a difficult time seeing as psychologically disabled, despite her obvious symptomatology.

An additional form of counteractivation involves therapist denial or cognitive avoidance of certain subjects or themes during the treatment process. A clinician who tends to avoid thinking about unresolved traumatic material in his or her own life may unconsciously work to prevent the client from exploring his or her own trauma-related memories and feelings. In such instances, the clinician may even become resentful of the client for restimulating his or her own avoided memories or feelings, or may reinterpret appropriate client attempts to confront the past as hysteria, self-indulgence, or attention seeking.

The primary manifestations of an unconscious desire to distance oneself from the client’s distress are attempts to avoid discussion of the client’s trauma
history and generally decreased emotional attunement to the client. In each instance, the underlying strategy is the same: reduced therapeutic contact as a way to reduce the likelihood of triggered emotional pain. When this response is especially powerful, the clinician may slow or neutralize therapy by decreasing the client’s exposure to traumatic material to such a point that it is not processed. At the same time, therapist distance or lack of attunement may activate client abandonment issues, further impeding treatment.

**Reducing the Negative Effects of Therapist Counteractivation**

As noted earlier, not all counteractivation is necessarily problematic, and, in fact, all therapists experience some level of counteractivation in their work. When it interferes with treatment, however, steps must be taken to reduce its influence.

One of the best preventive measures against countertransference problems is regular consultation with a seasoned clinician who is familiar with trauma issues and, hopefully, the therapist (Briere, 2006; Pearlman & Courtois, 2005). Another option is to form a consultation group with one’s peers. However structured, such meetings should allow the clinician to share the burden of his or her daily exposure to others’ pain as well as to explore ways in which his or her own issues can negatively affect therapeutic outcome. In many instances, inappropriate identification or misattribution can be prevented or remedied by the consistent availability of an objective consultant who is alert to countertransference issues in general, and the clinician’s vulnerabilities in specific.

An additional intervention, for clinicians who acknowledge the impacts of trauma in their own lives, is psychotherapy. It is an ironic fact that, at least in some environments, clinicians endorse the power of psychological treatment for others yet eschew it for themselves as somehow shameful or unlikely to help. This double standard is unfortunate, since having experienced psychotherapy is usually a good thing for therapists. Therapy is not only likely to reduce the clinician’s trauma-related difficulties; it can also increase the richness of his or her appreciation for human complexity and can dramatically decrease the intrusion of his or her issues into the therapeutic process.

**Practice Ethically and Within the Standard of Care**

A final topic in this chapter is that of ethical and professional practice. Because the trauma client is often in a vulnerable state, and psychotherapy generally involves a power imbalance between client and therapist, it is very important that the clinician attend to any issues or dynamics that might even remotely result in maltreatment, exploitation, or inadequate care.

In many cases, ethical and risk-reducing activities correspond to what would be good therapeutic practice in any event. For example, honoring the client’s boundaries, refraining from any form of exploitation or maltreatment, reporting and (when appropriate) intervening in potential danger to the client
and others, and guarding the client’s confidentiality all reflect activities that increase safety (Chapter 4), support identity development and functioning (Chapter 9), and/or encourage a positive therapeutic relationship (Chapter 4). Similarly, the therapist should take care to not overdisclose his or her personal history, relationships, preferences, or ideas about things unrelated to the client, as well as constraining the extent to which the client and therapist interact outside of the treatment. This not only allows him or her to manage the client’s trauma activations, but it also addresses professional and ethical issues around dual relationships, clinical boundaries, and professional standards of care. Finally, professional requirements regarding documentation and charting allow the clinician to monitor the client’s progress in therapy, such that treatment interventions correctly address the client’s current needs, as well as to provide relevant information to other professionals when warranted.

As noted earlier in this chapter, because the form of treatment outlined in this book emphasizes relational connection with—and positive regard toward—the trauma survivor, issues associated with counteractivation are especially salient. For example, although compassion—requiring nonegocentric caring and the need for the therapist to be interpersonally “present”—is an important part of trauma-focused psychotherapy, these issues occasionally can be challenging for the clinician. For example, when are one’s caring feelings for the client based on compassion and appreciation of his or her suffering, and when do they potentially represent the clinician’s own needs for intimacy or connection, or unprocessed sexual or romantic issues? Similarly, how is the therapist to discriminate understandable anger at the client’s trauma perpetrator, or sadness at his or her irrevocable losses, from counteractivation of the clinician’s own childhood memories? What is the exact boundary point that must be reinforced when the client requests additional attention, caring, or self-disclosure from the therapist? In some cases, responsiveness and slightly increased connection or attunement can be helpful, if it is appropriate to the situation and monitored for counteractivational distortions. In other cases, the therapist’s over-response to such demands or requests may reflect co-transferential dynamics and produce problems.

Although this is obviously a complex topic, we offer several suggestions:

• Therapy boundary violations, including voyeurism, emotional gratification, exploitation, dual relationships (inside or outside of the therapy environment), romanticization, or any sexual behavior are unethical and potentially very harmful to the client. If the clinician is concerned that any of these phenomena are occurring, he or she should proceed under the assumption that the concern is valid. Under such circumstances, outside help, consultation, or (in the case of actual and significant behavior) intervention should be sought.

• Authoritarian or overly directive treatment can have negative impacts. A corollary of this is that the therapist should not be definitive when, in fact, the issues are complex; the client is, in some ways, unknowable to the therapist; and absolute truth is hard to find. Interventions that involve lecturing
or heavy-handed declarations of fact are likely to go awry, and may be bad practice. Examples include

- Telling the client that he or she has or has not been abused, despite his or her protestations to the contrary or a lack of evidence one way or the other;
- Making definitive interpretations about the meaning or etiology of the client’s current behavior when, in fact, such hypotheses are largely speculative;
- Validating or supporting unfair or prejudicial social messages about sex, race, age, ethnicity, sexual orientation, gender identity, or socio-economic status;
- Reinforcing dependency or acquiescence in someone who needs to become more entitled, self-referenced, and independent; and
- Making value judgments about things that are best seen nonjudgmentally, such as many forms of “bad” or “immoral” behavior.

- Duty to report trumps confidentiality. If the therapist becomes aware—or has reasonable suspicion—of child, elder, or dependent adult abuse, or of the client’s danger to himself or herself or others, the clinician must do whatever is required by law and professional ethics to ensure safety. This may involve the child welfare system, law enforcement, or involuntary hospitalization. Issues in this area are sometimes hard for clinicians to confront, especially when the correct action goes against the wishes of the client. There are no easy answers to the breach of trust that the client may feel in such circumstances. We suggest, however, that clients be informed at the onset of therapy about what the law or professional ethics require the therapist to report or intervene in, so that such actions at a later date are less surprising (see Briere and Lanktree, 2011, for a more detailed discussion of this topic).

- Clinician counteractivational responses are, in our experience, typically triggered ones. If the therapist notes a significant change in his or her internal state or perspective, or intrusive phenomena similar to those outlined for trigger identification in Chapters 6 and 7, he or she should entertain a strong hypothesis that such responses are at least partially a function of his or her own history, as opposed to solely client-level stimuli. Although this is not always true—sometimes sudden affective or cognitive shifts reflect insight or compassion—we generally recommend the psychoanalytic dictum that if the therapist suddenly wants to make an exception to the relational rules in therapy, the best advice is not to do so and to reflect on the impetus.

- As a correlate to the above, be wary of very strong feelings or reactions during therapy, even if they seem to be about social justice, the client’s entitlements, or things that have been done to him or her. It is entirely appropriate to be on the client’s “side,” even to be his or her advocate, when necessary and therapeutically appropriate. And social injustice should be confronted whenever possible. However, if the therapist detects strong anger, outrage,
overidentification with the client, or an intrusive need to protect or parent, it is at least possible that he or she is being triggered and is responding to his or her own needs rather than those of the client. Such instances violate a significant principle of relational treatment: The central unit of analysis in psychotherapy is the client, not the therapist. All of this is difficult to parse in some instances, and we do not mean that the therapist should be distant or uninvolved. Rather, we suggest that the attuned and helpful clinician is someone who carefully scrutinizes his or her therapeutic behaviors to make as sure as possible that they are dedicated to the client’s safety and well-being, as opposed to reflecting his or her own history, needs, or inappropriate expectations.

- This work is sometimes very difficult, albeit important and meaningful. As noted earlier, we strongly recommend that the trauma-focused clinician (as well as other helpers) access resources that can provide the support necessary to sustain this process—whether in consultation, supervision, or one’s own psychotherapy. The clinician’s willingness to hear painful things, connect with people who may have difficulty with interpersonal connections, and do this work rather than something else, is a tremendous gift to the traumatized client. But such work should not be done alone.

The reader is referred to the following sources for more detailed information on ethical practice, counteractivation/countertransference issues, and professional standards of care related to trauma treatment: Cloitre et al., (2011); Courtois and Ford (in press); Courtois, Ford, and Cloitre (2009); Dalenberg (2000); Kinsler, Courtois, and Frankel (2009); and Pearlman and Saakvitne (1995).

Suggested Reading


