

# CenterinG

Newsletter of THE CENTER: Posttraumatic Disorders Program

VOLUME 3, NO. 3, MAY/JUNE 1998

## Issues and Challenges in Assessing Trauma

Christine A. Courtois, Ph.D.

*Successful psychological assessment of posttraumatic states, whether by diagnostic interview or formal psychological testing, typically includes the following characteristics: a neutral or positive, nonintrusive evaluation environment, inquiry that extends beyond the detection of trauma symptoms alone, awareness that clients may underreport or overreport traumatic events and symptoms, and an understanding of potential constraints on the interpretation of trauma-relevant psychological assessment data (Briere, 1997, p. 57).*

**A**s this quote implies, there are a number of issues and challenges inherent in the assessment of both trauma history and trauma symptoms. The clinician must maintain a delicate balance between the general stance and approach to the client and the neutrality of questions asked. Traumatized individuals can be difficult to engage due to many factors, some of which have to do with their posttraumatic history, reactions, and symptoms. Some victims are closed and suspicious of the assessment and may resist offering any information that is a painful reminder of things they would rather not focus on. Others may find direct questions overwhelming and may destabilize during the course of an assessment that is mispaced or too focused on details. Their responses may, in turn, affect the assessor and cause countertransference responses that must be carefully monitored and managed, lest they interfere with or influence the assessment data. On the other hand, it should also be noted that some traumatized individuals are immediately and obviously relieved to be asked about their trauma history and experience. The assessment may be the

first time anyone has indicated interest in their experience and they may find the interview or testing (especially when conducted with sensitivity and attention to pacing and reactions) to be immediately cathartic and therapeutic.

### **Interview Atmosphere and Evaluator Demeanor**

In general, it is best if the practitioner approaches the assessment (whether a clinical interview or a testing session using structured instruments) from a position of supportive neutrality and equipped with a grasp of common reactions to traumatization. Neutrality is especially important given the current charges that biased therapists suggest and implant false memories of trauma (generally abuse) in their clients or are overzealous in finding and diagnosing victims. Supportive neutrality is recommended because the traumatized individual may be unable to disclose the trauma or its effects unless a supportive and encouraging stance is maintained by the clinician. It is necessary for the evaluator to be carefully attuned to the client and his/her clinical status during and after the process. The evaluator should strive to maintain a very calm and respectful demeanor and be prepared to be regarded with suspicion, if not outright mistrust or even hostility, by some clients. By definition, trauma victims (especially those who have suffered severe and/or repeated interpersonal victimization) have experienced danger and intrusion at the hands of others. Where the traumatization has been recent and severe, the evaluation may seem to some victims as an unwarranted intrusion and, therefore, as another experience of victimization or an example of "adding insult to injury".

It is also useful for the practitioner to understand that the assessment process itself is quite stressful for some trauma victims, no matter how gently or sensitively it is conducted. It is, therefore, essential to create assessment conditions and a testing environment that are as safe as possible and to develop a reasonable amount of rapport with the individual. This sometimes requires additional time at the outset of the session, time that is well-spent if it allows the assessment to proceed. Clients should also be encouraged to maintain as much control as possible and to engage in a collaborative assessment effort. They should be informed ahead of time that the assessment might be stressful in order for them to give informed consent or informed refusal regarding their participation. They should also be advised, however, that the testing circumstance is not inherently hurtful but that focusing on the trauma might understandably cause discomfort. The request to describe traumatic events in some detail (whether verbally by interview or in written form via structured testing) can restimulate unsettling and painful material, producing additional distress in someone who is already quite distressed.

The attentive evaluator takes this potential response into consideration right from the start and closely monitors the client's reactions. At times, it will prove necessary to change the pacing or to suspend the assessment because it is overly unsettling and also because the client's level of distress has the possibility of influencing or even contaminating the results. Shifting the pace and/or extending the testing time may be in the interest of both the client and the attainment of a valid and accurate assessment of the client's status. When

(continued)

the client becomes destabilized (evidenced by flashbacks, regressive behaviors, numbing/dissociation, anger, anxiety, etc., in the session or in its aftermath) despite the evaluator's best efforts, the primary task is to restabilize the individual. In some cases, the testing can resume (with continued monitoring) after the client has restabilized; in other cases, the better course of action is to stop the inquiry altogether.

### **Inquiry Beyond Trauma Symptoms**

The assessment should be comprehensive and not focused only on trauma symptoms. In some cases, the assessment is necessarily oriented towards a determination of whether the traumatic experience is likely the proximate cause of posttraumatic reactions and symptoms, as well as the client's diagnoses and clinical status. This is especially the case when the assessment is conducted for forensic purposes (e.g., civil litigation for psychological damages; a criminal proceeding for an assault) and requires that the evaluator carefully document the temporal emergence and sequence of reactions following the trauma and the nature and severity of the symptoms. The evaluator should take particular care in describing the specific content of intrusive symptoms such as flashbacks, memories, images, and sounds associated with the traumatic event(s) and should monitor the sequence and precipitant(s) of numbing/denial) symptoms as well.

It is usually difficult to definitively link the client's clinical picture to prior trauma. This difficulty often arises in conditions of chronic or delayed PTSD and dissociative or personality-related symptoms where the etiological circumstance(s) may have occurred much earlier in the individual's life and been influenced by a range of more recent events and issues.

In this case, the evaluator can assess the general validity of the client's trauma history and can only speculate about its relation to the client's patterns of symptoms and diagnosis.

A comprehensive assessment should include attention to the client's entire symptom and diagnostic picture, not only the posttraumatic spectrum. Individuals with PTSD/DD often have a number of other coexisting or comorbid Axis I disorders including depression, anxiety disorders (panic, agoraphobia, social phobia), substance abuse, eating

disorders, and obsessive-compulsive conditions, as well as Axis II disorders such as avoidant, dependent, borderline, antisocial, and mixed personality (many of the latter group can be broadly conceptualized as posttraumatic and are often associated with childhood victimization/traumatization, family dysfunction and parental disturbance). Furthermore, as noted in the previous article, traumatized clients have been found to be at greater risk for suicidality, self-harm, and revictimization and to have relational difficulties and coping deficits that, alone or together, can greatly complicate their clinical status. These often require ongoing clinical assessment and monitoring.

### **Reporting Accuracy**

Traumatized clients may underreport or overreport their histories and symptoms, a circumstance that must also be anticipated. Adults' retrospective reports of trauma are subject to error from several sources. Clients may not report or may underreport past abuse or traumatic life experiences if questions about these experiences are imprecise, missing, or misunderstood. For example, when asked if she has had "a traumatic experience" or an "experience outside the range of usual human experience," a client might respond "No" if what happened is not understood as either traumatic or unusual. For this reason, it is necessary that questions be asked in behavioral and precise terms, in open-ended form, yet as neutrally and calmly as possible (e.g., Did you, as a child, ever have a sexual experience with an adult? with a family member? with another child? Have you ever been exposed to violence between members of your family? Have you ever been pressured into unwanted sexual contact of any sort?). Clients might also underreport in an attempt to hide the shameful and/or painful material from the evaluator, especially if s/he shows reactions indicative of aversion, judgment, or personal distress at hearing the client's story. Self-monitoring (and possibly personal debriefing after an assessment) on the part of the evaluator is warranted, as noted above.

Under-reporting might also result from poor encoding, storage, or retrieval of traumatic memories (due to such factors as young age when the trauma occurred, no social support system to help label, validate, or consolidate such experiences, or physiological and emotional

overarousal that interfere with neurologic encoding); avoidance and forgetting (clients might actively avoid thinking about the events in order to manage their painful and distressing feelings; in some cases, a lack of rehearsal might lead to temporary or more permanent forgetting); vasillating or ongoing amnesia or lack of recall (whether total or partial); or dissociation or the splitting off of aspects of the experience, including memory of its occurrence.

Although overreports or erroneous reports of past trauma are counter-intuitive, they do occur for a number of reasons, including: the desire for secondary gain (including sympathy, attention, compensation and financial gain, retribution/vindictiveness, an explanation for life's problems – labeled the "abuse excuse" by some critics); delusions due to psychosis or other severe personality disturbance; memory errors and misperceptions; and personal traits of suggestibility or fantasy proneness that would increase the likelihood of compliance with suggestions from an authority figure. With the recent concern over false memories of some types of childhood trauma (especially sexual abuse and incest), the accuracy and validity of adults' retrospective report of abuse has been questioned. Some clinicians have reacted to these issues by no longer asking about abuse or trauma. Instead, it is recommended that clinicians follow guidelines for general trauma assessments supplementes with attention to issues of delayed memory (see *Centering*, January/February 1998, *Guidelines for Treatment*).

At present, it is unknown how often past trauma is overreported or reported in error or how often it is underreported or denied. The implication is that the practitioner must conduct the assessment with care and attention to possible exaggeration or under-reporting.

### **Assessment Accuracy**

Assessments of both traumatic experiences and trauma-related symptoms will be more accurate if the evaluator uses instruments that have been constructed by experts in human traumatization, that are psychometrically sound in terms of reliability and validity, and that are neutrality on the part of the evaluator and of the measurements items and questions also helps to reduce confusion and misunderstanding about

(continued)

what is being asked. The reader is referred to the reference list for resources on specific instruments and strategies for comprehensive assessment. To further maximize the accuracy of assessment results whenever possible a client's assessment and treatment should be conducted by different professionals so that bias can be minimized.

### Summary

The assessment of trauma is an emerging area in the treatment of traumatized individuals. This article has reviewed issues and challenges that arise in the

evaluation of traumatized individuals and provided suggestions for sensitively conducting trauma assessment.

### References

Courtois, C.A. (1997). Guidelines for the treatment of adults abused or possibly abused as children. *American Journal of Psychotherapy*, 51, 497-510, Fall 1997. Reprinted with permission in *Centering*, January/February 1998.

Courtois, C.A., (1995). Assessment and diagnosis. In C. Classen & I.D. Yalom (Eds.). *Treating women molested in childhood*. (pp. 1-34) San Francisco:

Jossey-Bass.

Stamm, B.H. (1996). *Measurement of stress, trauma, and adaptation*. Lutherville, MD: Sidran Press.

van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (Eds.). (1996). *Traumatic Stress: The effects of overwhelming experience on mind, body and society*. New York: Guilford Press.

Wilson, J.P., & Keane, T.M. (1997). *Assessing psychological trauma and PTSD*. New York: Guilford.