Contemporary Issues and Innovations in the Assessment of Adult Survivors of Traumatic Abuse

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Childhood abuse experiences can have many different negative effects on children. Some abuse events are distinctive, however, in that they cause a child to experience overwhelming fear and put a child at risk for traumatization (Carlson, Furby, Armstrong & Shlaes, 1997). Such traumatic abuse experiences can result in posttraumatic responses like those seen following other, non-abuse traumas. Since the effects of unresolved traumatic abuse can extend into adulthood, it is important for clinicians who see adults to assess both experiences of traumatic abuse and posttraumatic symptoms

Fortunately, new resources on planning and conducting effective trauma assessments have recently become available and are readily accessible. This article begins with a discussion of how more attention to trauma assessment can lead to more effective treatment. It follows with a brief review of some of the obstacles to understanding traumatic experiences and their impact and some of the challenges involved in assessing past abuse experiences and current symptoms in adult survivors of traumatic abuse. Next, some practical aspects of choosing and administering measures of traumatic experiences and trauma responses are discussed. Finally, the types of measures now available for trauma assessment and recently published resources for locating, selecting, administering, and interpreting the results of these measures are presented.

Why Focus on Traumatic Experiences or Conduct Trauma Assessments?

Increased understanding of a client's traumatic experiences and careful assessment of responses and symptoms can help clinicians plan and implement more effective treatment. To begin with, a better understanding of the impact of traumatic experiences, including core, secondary, and associated symptoms, allows the clinician to conduct a more thorough assessment and to be alert to the possibility that the client has a trauma history, even if undisclosed at intake. Knowing the most likely symptoms also insures that the clinician assesses all of these symptoms as well as the psychosocial variables and experiences that may moderate or exacerbate the effects of traumatic experiences.

Detailed trauma assessment and an understanding of trauma effects leads to improved treatment because the clinician can better distinguish between abuse experiences that were traumatic and those that were not. Such a distinction is important because these two types of abuse and their respective set of responses and symptoms may call for different treatment strategies and methods. Trauma theories can also help with an understanding of the psychological significance of a particular client's symptoms so that treatment can focus on the most critical issues. For example, a different therapeutic approach would be used to address anger that is part of trauma-related affective reexperiencing than would be used with a client's anger at unjust treatment by parents.

Careful assessment can improve treatment in a number of other ways. Obtaining a complete trauma history is valuable because it helps identify whether the client experienced single or discrete traumatic events versus multiple or chronic ones. On average, the individual's responses to chronic events are likely to be more complicated or compounded. A detailed trauma history can also reveal connections between experiences and current symptoms that relate to treatment planning. For example, knowing the details of early traumatic experiences may help clarify what elements of a client's current environment or behavior might be serving as reminders or reenactments of aspects of past trauma. An understanding that a particular symptom is a manifestation of reexperiencing or avoidance will help the therapist determine an appropriate and effective therapeutic approach. Finally, thorough assessment of trauma response facilitates a more rapid identification of symptoms, allowing the clinician to more rapidly focus on the most pressing presenting problems.

In a time when clinicians are expected to accomplish more in less time, many question the value of conducting specialized assessments of traumatic experiences and responses. I would argue that such assessments save time and effort in the long run and are necessary because the sources of information clinicians typically rely upon can be misleading when the client has been previously traumatized. Studies have shown that standard intake interviews very frequently fail to uncover traumatic experiences or trauma-related symptoms. Standard intake interviews typically do not include the necessary questions or do not ask the questions in a way that yields valid results. Standardized psychological tests (such as IQ tests, symptom inventories, and personality inventories) may produce misleading results because most do not assess trauma responses and standard interpretations of their results do not take into account the unique patterns of responses common to trauma survivors. For example, elevated F scale scores on the Minnesota Multiphasic Personality Inventory (MMPI) are usually interpreted as indicating malingering, but F scale scores are commonly elevated in persons with known traumatic experiences.

Finally, presenting symptoms of trauma victims often overlap considerably with those of clients with other psychological disorders. This difficulty with differential diagnosis in traumatized persons along with frequent comorbid disorders and symptoms that are secondary to trauma disorders create a symptom picture that can be quite confusing. Specialized assessment of trauma experiences and responses can

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greatly clarify the diagnostic picture for many clients and need not require added expense or clinician time.

Obstacles to Understanding Trauma Responses

The effects of traumatic experiences can be difficult to understand because of the complex relationships among aspects of the traumatic stressor, factors that mitigate or exacerbate responses, and outcomes. Great individual differences in response to trauma are found due to the influence of such factors as biological predisposition, developmental level at the time of trauma, trauma characteristics, social context, and prior and subsequent life events. Though reexperiencing and avoidance symptoms (in affective, cognitive, behavioral, and physiological modes) tend to comprise the initial core response to trauma, other symptoms may come to predominate over time. For example, symptoms that are secondary to core trauma symptoms (such as depression or guilt) or symptoms that are associated with aspects of the trauma context (such as low self-esteem) may become more prominent than initial reexperiencing and avoidance symptoms. Recently published resources that include theoretical discussions of the effects of traumatic experiences include Briere (1997), Carlson (1997), and van der Kolk, McFarlane, & Weisaeth (1996).

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Challenges to Assessing Traumatic Experiences and Responses to Trauma

Most therapists are aware of the clinical manifestations of trauma-related symptoms and disorders, but few have had any specific training in assessing trauma and trauma responses. Those who specialize in the assessment and treatment of survivors of traumatic abuse have felt a growing need for such specialized resources and training, especially as the accuracy of client reports of childhood abuse has been increasingly questioned. In light of research findings that highlight the inaccuracies of normal memory processes, some critics question reports of early abuse when corroboration is unavailable from official records or witnesses or when family members deny that abuse occurred. Concern has also been expressed that clients may overreport their abuse experiences (or even fabricate an abuse history) due to secondary gain motivations or because they were influenced by overzealous therapists "looking for" abuse victims. At the present time, the client reports that are most controversial are reports of sexual (and especially incestuous) abuse, reports of extreme or seemingly improbable abuse experiences, and reports of abuse that was not remembered for some period of time but was later recalled on the basis of delayed or recovered memories.

Indeed, adults' retrospective abuse reports and reports of current symptoms are subject to error from several sources. Clients may not report or may underreport past abuse or traumatic life experiences because they are not directly asked or because questions about them are imprecise or are misunderstood. For example, when asked if she has ever had "a traumatic experience" or an "experience outside the range of usual human experience," a survivor of traumatic abuse might well say "No" if she has not identified what happened to her as either traumatic or unusual. Underreporting might also result from poor encoding of trauma memories (due to such factors as young age when the trauma occurred, no social context in which to identify or consolidate such experiences, or physiological and emotional overarousal at the time of trauma); forgetting (survivors may avoid thinking about these events so that a lack of rehearsal leads to forgetting); motivated forgetting and ongoing amnesia (some may not remember traumatic events because to do so is psychologically distressing); dissociation or the splitting off of aspects of the experience including memory of its occurrence; or avoidance of thinking or talking about past upsetting events.

Overreports and erroneous reports of past traumatic abuse can also occur. These are most often the result of delusions; compliance with therapist suggestions or statements about the likelihood that the client was abused or the client's perceptions about therapist's wishes; desire for secondary gain (including sympathy, attention, financial gain, or retribution); memory errors; and reports of misperceptions at the time of the events. At present, it is unknown how often past abuse is overreported or reported in error. Some research has found that underreports of real traumatic abuse experiences occur commonly. The implication is that the therapist must assess carefully with an understanding that abuse might be either over- or underreported.

Addressing Challenges to Assessing Trauma and Trauma Responses

Given the potential for error in reports of trauma and trauma responses, it is important to use a systematic approach to assessment. When assessing past traumatic experiences, it is advisable to avoid becoming focused on determining the veracity of abuse memories. This is because, first, the therapist is unlikely to be able to confirm or disconfirm particular memories and is not in an investigative or confirmatory role, and second, because preoccupation with the veracity of memories can hinder effective treatment. Some clients may think that knowing "the truth" will lead to relief, but this alone is not likely to ameliorate the effects of traumatic abuse. For some clients, "the

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truth" will never be known and their therapeutic work involves struggling with and learning to tolerate uncertainty about what might have happened to them It is also important for the therapist to keep in mind that overreporting or reports of improbable or impossible events does not necessarily mean that a client experienced no traumatic events In fact, a recent research study found that fantastic elements may be more commonly reported by children in the context of corroborated versus uncorroborated abuse cases (Dalenberg, 1996) It is also possible that some adults exaggerate and report improbable forms of abuse as a screen memory or to protect themselves from facing the effects of more likely forms of abuse (especially incest and/or abuse that involves significant betrayal by someone close to the child).

Self-report and interview measures for adults and children are also available to measure PTSD and dissociative symptoms, generally considered the most distinctive post-traumatic responses.

Assessments of both traumatic experiences and trauma-related symptoms will be more accurate if the therapist uses measures that have been carefully developed by experts in human traumatization, that are neutral and precise in their tone and in the type of questions asked, and that are psychometrically sound in terms of reliability and validity. Neutrality of the interviewer and in the measurement items helps minimize the effects of interviewer and client bias and expectations Precision in the wording of measure items and interview questions can also add clarity and reduce confusion and misunderstanding about what is being asked To further maximize the accuracy of assessment results, those conducting assessments should: be alert to signs of misunderstanding, underreporting, exaggeration, and secondary gain motivations; avoid making overt or inadvertent suggestions about a client's past experiences or symptoms; and avoid assessment methods that may influence memories (hypnosis, amytal interviews, age regression exercises and the like). Additionally, whenever possible, a client's assessment and treatment should be conducted by different professionals so that bias can be minimized.

Choosing Which Domains to Assess and Which Measures to Use

Trauma assessments should include measures of traumatic experiences and prominent posttraumatic symptoms. Self-report and interview measures of past trauma that can be administered fairly quickly are now available for both adults and children. Self-report and interview measures for adults and children are also available to measure PTSD and dissociative symptoms, generally considered the most distinctive posttraumatic responses A few instruments are available that also assess a range of other symptoms common in adult survivors of childhood abuse such as depression, guilt, self-destructive behavior, dysfunctional sexual behavior, difficulty regulating affect, somatization, damaged self-perceptions, and difficulties in relationships These measures include: the Trauma Symptom Inventory (Briere, 1996b) , the Clinician-Administered PTSD Scale (Blake, Weathers, Nagy, Kaloupek, Gusman, Charney & Keane, 1995) , and the Structured Interview for Disorders of Extreme Stress (Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997) .

Recently, more measures have become available that are suitable for clients who may have experienced multiple traumatic events. Such measures eliminate the problems encountered when asking a client to report only symptoms related to a single traumatic stressor and include the Trauma Symptom Inventory (Briere, 1996b), the Modified PTSD Symptom Scale (Falsetti, Resnick, Resick, & Kilpatrick, 1993), the Screen for Posttraumatic Stress Symptoms (see Carlson, 1997), and the Penn Inventory (Hammarberg, 1992). The Clinician-Administered PTSD Scale also now allows reporting of up to three traumatic events. Descriptions of these measures can be found in the assessment resources listed below.

Within each category of measures, numerous instruments are available that may be more appropriate for some clients than for others. When choosing measures, the therapist should consider the following questions: What is the best measure format for this client (self-report or interview)? Are the measure's length and complexity right for this client? Is the language used in the measure appropriate to this client's level of comprehension? Is the measure's content appropriate to this client's age, experiences, level of insight, and cultural background? Has the measure been developed by an expert in traumatic stress and have the reliability and validity of the measure been studied and established?

Detailed information on the measures mentioned above and many other instruments to assess traumatic experiences and responses can be found in Briere (1996a; 1997) , Carlson (1997) , Stamm (1996), and Wilson and Keane (1996). Particular guidance on selecting, administering, and interpreting the results of trauma assessments can be found in Briere (1997) and Carlson (1997) and specialized information on the psychological assessment of adult survivors of child abuse can be found in Briere (1996a, b). With this wealth of newly available information and advice on the assessment of traumatic experiences and posttraumatic responses, it is much easier for clinicians to find the tools to conduct careful, relatively

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rapid, and inexpensive assessments of adult survivors of childhood abuse

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Children Who Molest Children

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prevent those that are within a reasonable range of probability. It is also reassuring for professionals to know that they are only expected to act reasonably to protect children in their care. If a child with a documented history of sexually inappropriate behavior is closely supervised, if staff are aware of the potential danger, and if, in spite of precautions taken, the child succeeds in outwitting the safeguards and injures another child, the courts will simply hold the institution to the standard of care of a similarly situated institution or professional under the same or similar circumstances. The measures suggested in this article should provide guidance to professionals regarding current standards of care for the supervision of children who molest children.

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