Chapter 1

The Importance of Understanding Responses to Trauma

Every new client presents something of a mystery. You and the client need to "solve the mystery" in order to develop an appropriate treatment plan or referral. Solving the mystery involves assessing the client's current symptoms and coming to an understanding of his or her psychological problems. For a number of reasons, it can be especially difficult for mental health professionals who have no special training in traumatic stress disorders to assess and understand the symptoms of a traumatized person. At the same time, studies of the prevalence of potentially traumatic events and of trauma-related psychological disorders such as posttraumatic stress disorder (PTSD), dissociative disorders, and acute stress disorder (ASD) have shown that traumatic events and related disorders are far from rare.

A review of studies of the prevalence of potentially traumatic events in the United States shows that rates of exposure vary from moderate to quite high, depending on the population sampled and the methods used to define and ask about the experiences (Green, 1994). For example, when a random sample of young adults from an urban area of the Midwest were asked whether they had experienced an event outside the range of normal human experience, about 40% of them said they had (Breslau, Davis, Andreski, & Peterson, 1991). When a random sample of women in South Carolina were interviewed, 34% of them reported at

least one experience of sexual abuse before the age of 18 (Saunders, Villeponteaux, Lipovsky, Kilpatrick, & Veronen, 1992). A study of a women enrolled in colleges and universities across the United States found that 27% of them reported that they had been sexually assaulted or raped at least once since the age of 14 (Koss, Gidycz, & Wisniewski, 1987). Norris (1992) studied a community sample of men and women and asked them about their experience of a wide range of potentially traumatic events. She found that 69% of the subjects reported having been exposed to at least one potentially traumatic event. In another study of a community sample, lifetime exposure to potentially traumatic events was also found to be 69% (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993).

Rates of exposure to potentially traumatic events are also very high among people who seek treatment for psychological problems. When a sample of psychiatric outpatients was asked whether they had experienced an event outside the range of normal human experience, 81% of them reported having had one or more of these experiences (Davidson & Smith, 1990). Two studies of psychiatric outpatients found that between 64–68% of those sampled reported childhood experiences of physical or sexual assault when they were asked directly (Jacobson, 1989; Surrey, Swett, Michaels, & Levin, 1990). Similar studies of reported childhood physical or sexual assault in samples of psychiatric inpatients have found rates that vary from 63% to 81% (Bryer, Nelson, Miller, & Krol, 1987; Chu & Dill, 1990; Craine, Henson, Colliver, & MacLean, 1988; Jacobson & Richardson, 1987). It is clear, then, that a substantial proportion of people who come to mental health professionals for treatment have had an experience that may have been traumatizing.

Reviews of research on rates of traumatic stress responses have estimated that 25–30% of those exposed to extreme stressors develop PTSD (Green, 1994; Tomb, 1994). Research has not yet clearly established what proportion of those who experience a stressor develop other trauma-related disorders such as dissociative disorders or ASD. If rates of exposure to trauma are in the 60–80% range in psychiatric treatment settings, and 25–30% of those exposed develop PTSD, then clinicians can expect at least 15% of their clients to have current or past trauma-related symptoms. Although assessing trauma responses can be tricky, the task is one faced by virtually every clinician.

The difficulties of accurately assessing trauma responses have been exacerbated in the 1990s by increasing pressure on mental health professionals to assess and treat clients quickly and cost-effectively. In many clinical settings, it is no longer possible to conduct or order a full psychological evaluation or a complete battery of psychological tests on every client because the time and resources for this simply are not avail-

able. Similarly, most clinicians do not have the luxury of seeing a client five or six times before making a treatment or referral recommendation. The reality faced by many (perhaps most) mental health professionals today is that they must make a treatment plan or a referral decision after only one or two sessions and without using expensive assessment tools. In these circumstances, making sense of responses to trauma has become even more challenging, and the obstacles to understanding and assessing trauma responses have become more and more salient.

OBSTACLES TO UNDERSTANDING TRAUMA RESPONSES

One obstacle to understanding responses to traumatic experiences is the rich complexity of relationships among traumatic experiences, the moderating variables that influence the response to a traumatic experience, and the outcomes that the clinician observes in the form of symptoms. This is partly because the traumatic experiences a person might have can vary greatly in terms of their intensity, duration, frequency, meaning, and other factors. But even for a particular stressor, there is no clear and simple cause-and-effect relationship between a traumatic experience and subsequent psychological symptoms. Two people can have the same traumatic experience yet show very different responses. For example, suppose two people are in a convenience store when there is an armed robbery. Each of them might respond very differently to that event, depending on individual variables such as previous history of trauma, age, sex, cultural background, biological vulnerability (or resilience) to stress, perceptions about how much danger they were in, and the amount of social support they get following the experience. One person might largely have "gotten over" the experience a month later, whereas the other might have severe PTSD. In Chapter 4, I discuss the factors that influence responses to traumatic experiences in more detail.

Another obstacle to understanding traumatic stress responses is that most mental health professionals do not receive much (if any) training or experience with these disorders during their graduate training. Even though it may seem nonsensical that trauma-related disorders were not covered in courses or practicums taken by today's practicing therapists along with other psychological disorders, this situation probably results from the fact that this is a fairly new area of study in psychology and psychiatry. Traumatic stress reactions were described in rudimentary forms in the first and second editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association, but PTSD was not recognized as a distinct diagnostic category un-

til 1980 when the third edition of the DSM was published (Wilson, 1994a). Similarly, dissociative disorders, which research has linked to traumatic experiences (Classen, Koopman, & Spiegel, 1993), first appeared as a diagnostic category in DSM-III (American Psychiatric Association, 1987). Since diagnostic criteria (and measures of the relevant symptoms) are necessary for empirical research on a disorder, research on traumatic stress reactions did not begin in earnest until the 1980s. Trauma researchers and clinicians have had relatively little time to understand how traumatic events affect people, and the knowledge that the "first generation" of trauma researchers has acquired is just beginning to be incorporated into the curricula of graduate training programs. In short, most clinicians practicing today did not get training relating to trauma because most of their graduate faculty and clinical supervisors were not knowledgeable about trauma.

OBSTACLES TO ACCURATELY ASSESSING TRAUMA RESPONSES

There are several obstacles that make it especially difficult for clinicians to accurately assess traumatic stress responses and trauma-related disorders. One of these obstacles involves the more practical and technical aspects of assessment, while others result from the nature and complexities of the trauma responses themselves.

Using Psychological Tests to Assess Trauma Responses

In practical terms, in order to assess responses to traumatic experiences, it is necessary to ask about the relevant symptoms. Although I discuss the prominent responses to trauma in more detail later, it is safe to say here that measuring PTSD symptoms and dissociative symptoms is crucial to a good assessment of trauma response. Unfortunately, the most widely used psychological tests are not useful for assessing PTSD or dissociative symptoms. Worse yet, some of the results from these measures can be misleading for traumatized people.

Three of the most popular self-report symptom measures that are frequently given to people who seek treatment include the Minnesota Multiphasic Personality Inventory (current version is the MMPI-2), the Millon Clinical Multiaxial Inventory (current version is the MCMI-III), and the Symptom Checklist 90—Revised (SCL-90-R). Often, one of these global symptom measures is part of a routine intake assessment at outpatient clinics and psychiatric hospitals. All of these three measures yield subscale scores for various symptoms and characteristics, but two

have no subscale for PTSD symptoms, and none of them has a subscale for dissociative symptoms. The MCMI-III has a PTSD subscale, but it has not been established as a valid measure of PTSD. Two of these inventories do have subscales for anxiety, which may be somewhat helpful in assessing trauma responses, but they will not help you with making a differential diagnosis between PTSD and another anxiety disorder.

For the MMPI, subscales have been developed to measure PTSD symptoms, but they may not be adequate clinical measures of these symptoms. For example, the Keane PTSD Scale (also known as the PK subscale) uses 46 MMPI-2 items to measure PTSD symptoms (Lyons & Keane, 1992). Unfortunately, since the items are drawn from MMPI-2 items, they do not fully represent the symptoms of PTSD. For example, there are no items about symptoms of intrusive images or emotional numbing that are commonly associated with posttraumatic responses. Also, studies of the subscale's ability to correctly identify those with PTSD have shown mixed results (Solomon, Keane, Kaloupek, & Newman, 1996). In some studies, the subscale did not do a very good job of picking out those with a PTSD diagnosis. Also, since norms are not yet available for various traumatized groups for the updated PK subscale that corresponds to the MMPI-2, it is difficult to make clinical interpretations of these scores. The PK subscale may be useful if you have access to MMPI results and no other options for measuring PTSD, but it is not optimal for that purpose.

Some results from general symptom inventories may even be misleading for those with trauma-related disorders. For example, the MMPI F scale is often elevated in those with posttraumatic or dissociative disorders (Carlson & Armstrong, 1994; Orr et al., 1990). The F scale was designed to be a validity scale to indicate carelessness in responding, gross eccentricity, or malingering (or "faking bad"), and it was originally made up of items that were thought to be rare psychiatric symptoms (Anastasi, 1988). It now appears that some of those symptoms are common to many with posttraumatic or dissociative disorders, particularly war veterans. For example, F-scale items include "I have nightmares every few nights" and "I believe my sins are unpardonable." Using the MMPI to assess a traumatized person might lead to the mistaken conclusion that the person is exaggerating his symptoms, when he is actually accurately reporting them. The danger of misinterpretation of an elevated F-scale score is very likely present in the MMPI-2 as well as the MMPI, as 60 of the 64 items that load onto the F scale were retained in the MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). It is possible that similar problems with other symptom measures might lead to misdiagnosis or misinterpretation of results, but too little research has been done on MCMI-III and SCL-90-R results in trauma-

tized people to determine whether they might be misleading. Clearly, though, none of these major symptom inventories is optimal for assessing traumatic symptoms because these inventories do not directly assess the core symptoms of PTSD and dissociation.

In a standard psychological testing battery, other tests such as intelligence tests and projective tests are often used to gather clinical information. For example, those who use intelligence tests are familiar with the subscales known as the "anxiety triad" that indicates impairment of intellectual functioning due to anxiety. Theoretically, it might be possible to identify a similar "trauma triad" as a marker of impairment of intellectual functioning due to PTSD and/or dissociative symptoms, but to date, such a marker has not been identified.

Among projective tests, the Rorschach inkblot test is widely used in clinical assessments. In recent years, there has been increased interest in identifying Rorschach markers for trauma (Levin & Reis, 1996). Some very promising work has been done to develop a Traumatic Content Index (Armstrong & Loewenstein, 1990) that may provide information about how a person is responding to a known trauma. This index may one day be part of a Rorschach scoring system, but until then, a standard scoring and interpretation of the Rorschach will not be of much help in assessing trauma responses. Results from other projective tests such as the Thematic Apperception Test (TAT) or projective drawing tests (like the Draw-A-Person) may provide some interesting and useful clinical hypotheses, but since results from these tests tend to have questionable validity and are usually not objectively scored, they cannot provide clear and objective information about PTSD or dissociative symptoms. All in all, then, results from a standard psychological test battery are unlikely to yield the information you need for a systematic assessment of trauma responses.

Using Standard Intake Interviews to Assess Trauma History and Trauma Responses

Most clinicians use some type of assessment or intake interview to assess new patients and make initial treatment or referral plans. Most of us have some standard set of questions that we like to ask to find out about a client's life history and current problems. And most of the time, this standard interview provides us with enough information to give us confidence that we do know the important life events and that we understand the client's problems well enough to plan treatment. But there may be ways in which our standard intake interview may fail us without our realizing it. In particular, most intake interviews are likely to miss important traumatic experiences and to miss some of the symptoms most relevant to traumatic experiences.

For example, studies have found that routine assessments in psychiatric hospitals often fail to uncover potentially traumatic experiences of childhood abuse. This happens largely because most routine assessments simply do not ask people about these kinds of experiences. In one study, psychiatric inpatients were given detailed interviews about their experiences of physical or sexual assault as children and as adults. The researchers then checked the records of those who had had such experiences and found that 91% of the assaults reported in the interviews had not been noted in their records (Jacobson, Koehler, & Jones-Brown, 1987). Inadequate assessment of trauma and trauma responses may be especially prevalent in specialized treatment facilities where assessment and treatment are focused on a particular disorder. For example, clinicians working in a pain treatment center who do not systematically assess trauma and trauma responses may miss important information in those who have experienced traumatic injuries. Similarly, clinicians treating people with drug and alcohol dependency problems may miss important diagnostic information when drug and alcohol problems are comorbid with trauma symptoms.

It is worth noting that the lack of attention to trauma history (including childhood abuse experiences) predated the concern over the possibility of "false memories" that has troubled mental health professionals in the 1990s. I discuss the difficulties of asking about abuse in more detail in Chapter 6. For now, suffice it to say that epidemiological research on child abuse has unequivocally established that millions of children are abused every year in the United States (Panel on Research on Child Abuse and Neglect, 1993). Since it seems reasonable to expect that those experiences would have an impact on a person's psychological functioning, clinicians should ask about them.

Another problem that makes it hard to get an accurate assessment of a person's trauma history is that many people have partial or complete amnesia for traumatic events that occur to them (Loewenstein, 1996). Several studies have found that a substantial proportion of those who are physically or sexually assaulted as children have partial or complete amnesia for the experiences for some period after. In one particularly compelling study, a group of women, who had been examined and treated in a hospital emergency room after sexual assaults when they were children, were interviewed as adults (Williams, 1994). As adults, 17 years after their assaults, the women were asked if they could be interviewed for a study of women who had received hospital care as children. Despite detailed questions about past experiences of sexual assault, 38% of the women did not report the incident for which they had been treated at the hospital. Of those who did recall the incident, 16% reported that they had had amnesia for the event for some time following it (Williams, 1994).

Similar results were found in a study of a nationally representative random sample of adults. Of those who reported that they had experiences of sexual assault during childhood, 42% said that they had had some level of amnesia for the experience, and 20% said that they had had complete amnesia for the experience for some time in the years following the event (Elliott & Briere, 1995). Another study found even higher rates of amnesia in a clinical sample of subjects. In a sample of people in outpatient treatment, 59% reported some level of past amnesia for childhood sexual assault experiences (Briere & Conte, 1993). I have found similar rates of amnesia in my own study of psychiatric inpatients (Carlson, Armstrong, Loewenstein, & Roth, 1997). Of those who reported sexual assault experiences in childhood, 61% reported having at some time experienced some level of amnesia, and 42% reported total amnesia for the event. A higher rate of amnesia for psychiatric patients compared to people who were not seeking treatment can probably be explained by the finding (from both studies) that people with more severe symptoms and more severe trauma are more likely to have amnesia for traumatic experiences (Carlson, Armstrong, Loewenstein, & Roth, 1997; Elliott & Briere, 1995).

Limited memory for traumatic events is also a problem for those who have traumatic experiences as adults. For example, in my own research on Cambodian refugees who experienced traumatic events as adults, 90% of the subjects reported having amnesia for important aspects of the events (Carlson & Rosser-Hogan, 1991). Partial or total amnesia has also been found in survivors of traumatic experiences such as combat, concentration camp incarceration, torture, and natural disasters (Loewenstein, 1996; van der Kolk, 1996d). In fact, lack of memory for important aspects of traumatic experiences is so common among traumatized persons that it constitutes one of the diagnostic criteria for PTSD.

It seems then that a substantial proportion of those who have traumatic experiences in childhood or adulthood will not remember part or all of their experiences later on. This means that it is likely that some people who come for treatment will not give complete reports of their trauma histories even when they are specifically asked about such experiences.

Another pitfall of intake interviews is that peoples' reports about their symptoms can be incomplete. Setting aside the possibility of intentional misreporting that may occur in a small minority of cases, many traumatized persons may unintentionally misreport their symptoms. In some cases, this might be because the client is not aware of what symptoms are relevant to her evaluation and treatment. At a time when a lot of therapists are not sure about the relationships between traumatic experiences and particular symptoms, we surely cannot expect the average person to have such knowledge. In some cases, a person might be reluc-

tant to report symptoms that seem very unusual or "weird" to her. New clients might be especially unwilling to tell an unfamiliar therapist about "strange" phenomena such as flashbacks, intrusive images, or distorted perceptions of themselves or their surroundings—all common posttraumatic symptoms.

In still other cases, a client might not report an important symptom because she does not perceive it as a symptom. This might happen, for example, to a woman who has experienced chronic, severe, and traumatizing abuse as a child that resulted in the lifelong symptom of emotional numbing in the form of a restricted range of affect. This woman might not report "feeling numb" when she seeks treatment if she does not ever remember feeling differently. In other words, she may not perceive the restricted affect as a symptom of disorder because it is "normal" for her.

To summarize, a standard intake interview may sometimes fail to provide you with all of the information you need about a person's trauma history and symptoms. This can happen when an interview does not include specific questions about possible traumatic experiences, when a person has amnesia for part or all of his traumatic experience(s), or when a person's reports about his symptoms are incomplete.

Presenting Symptoms May Be Misleading

Another major obstacle to accurate assessment of trauma responses is the fact that presenting symptoms of traumatized people can be very misleading. Although assessing and diagnosing a new client is often a challenge, assessment of traumatized people can be especially perplexing and enigmatic because of the great overlap between trauma-related symptoms and symptoms of other disorders. There are many disorders that have symptoms in common with other disorders, but symptoms of trauma-related disorders such as PTSD, dissociative disorders, and ASD overlap or are similar to symptoms of dozens of DSM-IV disorders. This problem is compounded by the fact that many clinicians have little or no formal training in assessing and conceptualizing trauma-related disorders.

Because trauma-related disorders have a number of symptoms in common with other disorders, a therapist might interpret a posttraumatic symptom as part of some other, more familiar disorder and miss its significance as a response to trauma. The most common examples of this are trauma symptoms such as problems with sleep and concentration that may be mistaken for symptoms of other anxiety disorders or depression. Another example of a shared symptom is difficulty with reality testing. Although this may appear to indicate a psychotic disorder or borderline personality disorder, it may, in a traumatized per-

son, simply be a temporary difficulty related to reexperiencing symptoms. Particular constellations of symptoms may also be mistakenly interpreted to indicate symptoms of other conditions. As mentioned earlier, although the constellation of symptoms measured by the F scale on the MMPI is usually interpreted to indicate malingering, this would be an inappropriate interpretation for a traumatized person.

Another reason why presenting symptoms of traumatized people are sometimes misleading is that trauma-related symptoms often occur simultaneously with other psychiatric disorders. Such comorbidity occurs frequently among trauma survivors, possibly because those with psychiatric disorders are more at risk for being traumatized. When a comorbid condition is present, symptoms of another disorder may confuse the presenting diagnostic picture. For example, a dramatic style of interpersonal interaction that is indicative of histrionic personality disorder may lead a clinician to believe that reports of trauma-related anxiety symptoms are exaggerated. This issue of comorbidity in the context of making a diagnosis is discussed in more detail in Chapter 9.

A third reason why presenting symptoms of traumatized people can be misleading is that symptoms may be present that are secondary to the trauma disorder. Here, new symptoms have developed as a result of symptoms related to the traumatic event. For example, trauma symptoms of loss of control over intrusive memories and emotions may lead to depression. In this case, a clinician might mistakenly believe that the client has an affective disorder rather than a trauma disorder.

Since, trauma-related disorders have symptoms in common with so many other disorders, it is not possible to go into detail regarding all of the commonalties. Here I limit the discussion to listing some disorders that seem particularly easy to confuse with trauma-related disorders and to giving some clinical examples to illustrate how such confusion might occur. There might be other disorders as well that can be added to this list. After reading Chapters 3 and 5, a reader with little familiarity with trauma-related disorders might find it useful to go through the list and identify the symptoms for each disorder that might be similar to those of PTSD, ASD, or dissociative disorders.

Below I have listed DSM-IV (American Psychiatric Association, 1994) categories of disorders and the names of any specific disorders within categories that might be particularly difficult to distinguish from a trauma-related disorder. Disorders seen in adults or children are listed separately from those usually first seen in children.

- Anxiety disorders
  - Panic disorder (with or without agoraphobia)
  - Agoraphobia without panic disorder
  - Generalized anxiety disorder
- Mood disorders
  - Major depressive disorder
  - Dysthymic disorder
  - Bipolar disorder (type I or II)
  - Cyclothymic disorder
- Somatoform disorders
  - Somatization disorder
- Eating disorders
  - Anorexia nervosa
  - Bulimia nervosa
- Sleep disorders
  - Primary insomnia
  - Nightmare disorder
  - Sleep terror disorder
- Impulse control disorders
  - Intermittent explosive disorder
- Adjustment disorders
- Amnestic disorders
- Substance-related disorders
- Schizophrenia and other psychotic disorders
  - Schizophrenia
  - Schizophreniform disorder
  - Schizoaffective disorder
  - Brief psychotic disorder
- Personality disorders
  - Antisocial personality disorder
  - Borderline personality disorder
  - Histrionic personality disorder
  - Avoidant personality disorder
  - Dependent personality disorder

- Disorders usually first seen in infancy, childhood, or adolescence
  - Attention-deficit and disruptive behavior disorders
    - Attention-deficit/hyperactivity disorder
    - Conduct disorder
    - Oppositional defiant disorder
  - Other disorders of infancy, childhood, or adolescence
    - Separation anxiety disorder
    - Reactive attachment disorder

Diagnostic Dilemma Cases

The diagnostic dilemmas presented below show how a trauma-related disorder might easily be mistaken for another disorder. Although a person may have more than one psychological disorder at a time, most mental health professionals do tend to make a primary diagnosis (or interpretation) and to focus on treating the client for that problem first. Similarly, although there may be more than one accurate interpretation of a person's symptoms, most therapists would agree that some interpretations (or diagnostic labels) are more accurate than others, and therapists try to make the most accurate interpretation they possibly can. As you read each case, consider what the consequences would be for the client if you went down the "wrong" diagnostic path.

Diagnostic Dilemma Case 1

Joan is a 42-year-old, divorced accountant with two teenaged children who comes to you for help with panic episodes that have been bothering her for about 6 months. She tells you that on five occasions over the past 6 months, she was suddenly seized with feelings of complete panic. Her heart would race, it became difficult for her to breathe, she began to sweat profusely, and her thoughts became confused and agitated. One of these panic attacks occurred when she was stopped at a traffic light while driving to work, one when she was at a PTA meeting, one when she was grocery shopping, and two when she was shopping at a mall. She reports no previous history of panic or anxiety. The panic attacks disturbed her greatly, and she was embarrassed about the attacks she had in public. Lately, she has found herself worrying more and more about the possibility of having another attack.

With this much information, you might naturally focus on the prominent symptoms of panic disorder and begin thinking about whether or not there is also agoraphobia. But suppose you assessed trauma-related symptoms and found that Joan is also hypervigilant, has been having nightmares about being attacked or in danger, has had trouble sleeping, and has been unusually irritable. Since Joan has so many posttraumatic symptoms, you might begin to wonder whether her panic attacks are related to some traumatic experience. You then assess for specific traumatic experiences and find that Joan was mugged by a man with a knife about 7 months before. Upon further discussion, you discover that Joan was terrified during the incident and feared for her life. She has been trying to "put the whole thing behind her" ever since by avoiding thinking about the incident. After further discussion and exploration of Joan's memo-

ries of the mugging, she suddenly realizes that just before each panic attack occurred, she saw a man resembling the mugger. The panic attacks turn out to be reexperiencing symptoms in the form of psychological distress and physiological reactivity in response to cues that remind Joan of a traumatic event.

Diagnostic Dilemma Case 2

Jim is a 38-year-old single man who works as an officer in an urban police department. He comes to you for help because he has been "feeling down" for the past 2 months. Jim says he feels sad and lonely, has trouble sleeping, and has not felt like going out with friends. His feelings have been affecting his work, and he is thinking of asking for a leave of absence so he can "get himself together," but he is not sure that he can afford to do that. He also tells you that Amy, his girlfriend of 5 years, moved out of their apartment 2 months ago. Amy isn't sure they should continue their relationship. When you ask Jim about problems in their relationship, he tells you that they fought a lot and he would lose his temper, which frightened Amy. Jim tells you that Amy complained that Jim's job had changed him and that he "was not the same gentle and kind man she had met 5 years ago." He does not know whether they will get back together, but he cannot stand being so miserable. He says that the only time he ever felt worse than this was when his mother died 12 years ago.

At this point in your assessment, it seems that Jim's major problem is depression over the loss of his relationship with Amy. You also wonder whether his current situation is bringing up feelings of loss relating to the death of his mother. When you give Jim a screening measure for PTSD symptoms, he reports sleeplessness, nightmares, and intrusive images. You then give him a trauma questionnaire, and he reports having witnessed a shooting 6 months ago. It turns out that during an arrest, Jim's partner had been shot and almost died. After some prodding, he tells you that he has been having intrusive thoughts and images and nightmares about the shooting. In the nightmares, sometimes his partner dies, and sometimes it is Jim who has gotten shot. He is also hypervigilant when on duty. Jim reports being somewhat ashamed of these feelings and has not mentioned them to anyone because "After all, I'm not the one who got shot, so why should I be a wimp about it."

Upon further exploration, you find that Jim's angry outbursts toward Amy all occurred in the evening on days when he had been in particularly threatening situations. He would lash out at Amy

when she would ask him about what had happened that day or would suggest that his job was "too dangerous." It seems, then, that Jim's relationship problems and depression may have been secondary to his response to a traumatic event.

These case examples illustrate just a few of the ways that therapists can be misled by the complex presenting symptoms of traumatized persons. Such perplexing presentations make a formidable obstacle to accurate diagnosis and assessment. Since a standard psychological test battery and a standard intake are not likely to provide you with enough information about traumatic experiences or trauma-related symptoms to "solve" the diagnostic "mystery," you need additional clinical tools to make your best assessment.

HOW A BETTER UNDERSTANDING WILL IMPROVE YOUR ASSESSMENTS

Although it is not hard to see how better assessment tools would help you evaluate traumatized people more effectively, it is less obvious how a better theoretical understanding of traumatic responses will enable you to make more accurate assessments and make them more rapidly. But a good working knowledge of the interconnections among aspects of traumatic experiences, individual characteristics, and responses to trauma will allow you to quickly choose your assessment tools and to make the most of the information they supply.

For instance, if you are knowledgeable about the core responses to traumatic stressors, and you know that a person has experienced a traumatic event, you can be alert to potential trauma-related symptoms. Such attentiveness can often help you to avoid focusing on comorbid symptoms to the exclusion of trauma-related symptoms. In other words, if you are knowledgeable about characteristic trauma responses, you are less likely to get distracted and waylaid by other symptoms that are present. You can see how such theoretical knowledge would be advantageous in the first diagnostic dilemma case. Suppose, at the beginning of your assessment, you gave Joan a brief self-report inventory of traumatic stressors and found that she had been in an armed robbery 6 months before. If you knew that the experience of that event was associated with a particular constellation of symptoms, and you knew that one of the prominent symptom groups was reexperiencing, then you would be more likely to understand her episodes of panic as reexperiencing symptoms and less likely to see them as "classic panic attacks." In this case,

understanding the relationship between trauma and reexperiencing would improve your ability to assess Joan.

In the same way, awareness of the theoretical relationships between moderating factors and symptoms might lead to a more effective evaluation of a person's trauma response. Again, to use Joan's case as an example, if you were trying to understand why Joan's traumatic response to the mugging was persisting for so long, you might consider factors that are theoretically proposed to exacerbate or ameliorate a trauma response. For instance, if you were knowledgeable about the relationship between social support and severity of response to trauma, you might ask Joan some questions about how her family and friends have responded to the mugging. Since Joan was trying to forget about the experience, you might find that she minimized the event and gave people the impression that she did not need any help coping with her experience. Unintentionally, then, Joan cut off the social support that might have helped her recover. Here, again, in your effort to understand Joan's responses, a good conceptual appreciation of the trauma process could serve you well.

In other cases, if you were familiar with the theoretical relationships between aspects of traumatic experiences and later symptoms, particular presenting symptoms might cue you to ask about particular kinds of traumatic events and moderating factors. For example, suppose a new client reported long-standing problems with a wide range of posttraumatic stress and dissociative symptoms, including experiences of dissociated identity and amnesia for long periods of childhood. If you knew that this pattern of symptoms is thought to be related to early, severe, and chronic trauma, you could begin to investigate that possibility by choosing structured interviews for early experiences of abuse and neglect. The bottom line is that theoretical knowledge about trauma responses will help you to assess traumatized people more quickly and accurately.

HOW A BETTER UNDERSTANDING AND ASSESSMENT WILL LEAD TO BETTER TREATMENT

The ultimate goal of your efforts to understand and assess clients' psychological problems is to offer them treatment that is as effective and efficient as possible. There are countless ways in which understanding and assessing trauma and trauma responses well will help you to treat traumatized clients effectively and efficiently. A few of the most important benefits of understanding and assessing trauma and trauma responses are discussed here.

Familiarity with trauma theory is very valuable in the treatment planning process. Understanding the defining characteristics of traumatic events enables you to distinguish between events that have the potential to cause trauma responses and those that are simply distressing. Making this distinction allows you to choose the most appropriate treatment interventions for your client because different treatments would be optimal for a traumatic response and a distressing experience.

Familiarity with trauma theory can also foster your treatment efforts because understanding the psychological reasons for particular symptoms will help you decide how to address them. This is because the meaning of a symptom for a person in relation to his trauma is important to the process of resolution of the traumatic response. For example, in Diagnostic Dilemma Case 2, Jim's angry outbursts toward his girlfriend may have a very specific meaning and relation to his traumatic experience. For a person like Jim, his anger is really meant for the person who shot his partner and made him feel so helpless and fearful. Another man's outbursts might reflect a basic hostility toward women, an inability to control his angry impulses, or any number of other things. For Jim, understanding his anger as expression of his fear would lead to the most effective way to address that particular symptom.

Treatment can also be improved in a number of ways by a thorough assessment of trauma. A systematic assessment of trauma history will provide valuable information about early or multiple traumatic events in a client's life. As discussed in detail in Chapter 5, early childhood traumas and multiple traumas may call for different therapeutic approaches than single traumatic events in an adult.

Careful assessment of a client's trauma history will also provide valuable information about the role of traumatic experiences in a client's condition. The connection between current symptoms and past traumas often has important implications for treatment. For example, a client's chronic pain following a traumatic injury may be maintained or exacerbated by unresolved emotions relating to the trauma. In such a case, attention to resolving feelings relating to the trauma may be necessary before the pain symptoms can be addressed effectively. Another client's alcohol abuse problems might be a function of efforts at avoidance of intrusive trauma-related thoughts and feelings. Successful treatment of this client's alcohol problem may not be possible until intrusion symptoms are under control.

Detailed trauma history assessments can also help clarify connections between traumatic events and current problems by supplying important details that will aid prediction and control of symptoms and in implementing treatment interventions. For example, details about trauma history can help you identify cues that trigger traumatic reac-

tions for a particular client. A woman who experienced traumatic abuse at the hands of her aggressive, dark-haired, Italian father might become anxious around her boss who is also an aggressive, dark-haired, Italian man. Although such a connection may seem obvious to the therapist, the link may be outside of the client's conscious awareness. In this way, identification of traumatic cues through knowledge of trauma history allows for greater prediction and control of trauma-related reactions. Identifying traumatic cues can also promote the implementation of treatment interventions. For example, trauma cues can provide content for developing anxiety hierarchies as part of behavioral techniques such as systematic desensitization.

Systematic assessment of trauma responses are also important to effective treatment. First, a good assessment of trauma responses enables you to identify traumatic stress responses rapidly and begin an appropriate treatment. Every therapist has had the experience of noticing and treating symptoms that seem prominent at first, only to realize later that the problem she has been working on is not really the most pressing problem. In Jim's case, if you had not investigated PTSD symptoms, it would have been very easy to become mired in a long, involved exploration of his loss of an important relationship and possible earlier emotional losses. The important issue for Jim, as is true for most clients, is what his most pressing psychological problem is. While work on emotional losses may be of benefit to Jim, it may not help relieve him of PTSD symptoms that interfere with his day-to-day activities. Addressing the trauma response might be all he needs to return to his previous high level of social and emotional functioning. If he chooses to continue treatment to work on emotional losses, he is likely to be more successful if he is comfortable at work.

In addition, careful assessment of trauma-related symptoms can help you identify the symptoms that are the most distressing and disabling for a particular client. Since different symptoms often require different treatment strategies, identification of the most pressing trauma symptoms is very important in your treatment planning.

SUMMARY

Traumatic experiences and trauma-related psychological symptoms are common enough among persons seeking help for psychological problems to warrant routine assessment, but understanding and assessing trauma symptoms can be especially difficult. It is hard to make sense of trauma responses because of the complex relationships among traumatic experiences, moderating variables that influence the response to a trau-

matic experience, and later symptoms. Most clinicians receive little if any formal training in the theory and assessment of trauma responses. Impediments to assessment of trauma responses include the inadequacy of standard intake interviews and global psychological measures for assessing posttraumatic and dissociative symptoms and trauma histories and the ambiguous presentation of many trauma-related symptoms. A good conceptual framework for trauma responses can improve your evaluations by allowing you to assess traumatized people more quickly and accurately and by affording you a better appreciation of the meaning of trauma-related symptoms. Effective assessments of trauma and trauma responses can save you and your client valuable time and energy as you pursue solutions to presenting problems.

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