

# 3

## Assessment

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**A**s outlined in the last chapter, abused or otherwise traumatized adolescents and young adults may experience a wide range of symptoms and problematic behaviors. The type and extent of these difficulties often vary as a function of the types of trauma the youth has experienced, when in the developmental process they occurred, and their frequency and duration, as well as other biological, psychological, and social variables that might intensify or otherwise moderate the clinical presentation (Briere & Spinazzola, 2005). For this reason, it will rarely be true that any given adolescent or young adult presents with exactly the same clinical picture as any other one. This variability means that the treatment of complex posttraumatic disturbance can only occur after some form of psychological assessment is performed.

In ITCT-A, assessment typically involves collecting information from a number of sources, including the client's self-report, caretaker reports of his or her functioning, collateral reports from caregivers, teachers, and other providers, and psychometric testing. The primary focus of assessment is the adolescent's trauma exposure history and his or her current psychological symptoms or problems. Other types of information may also be collected, however, as needed. This may include the youth's developmental history, primary attachment relationships, child protective services involvement and placement history, current school functioning, history of losses, medical status, coping skills, and environmental stressors such as community violence. It may also be important to assess the psychological functioning of caretakers and other family members.

## Evaluation of Current Safety

Most obviously, the first focus of assessment is whether the client is in imminent danger or at risk of hurting others. 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 immediate future. Most generally, the hierarchy of assessment is as follows:

- Is there danger of imminent injury or death?
- Is the client incapacitated (e.g., through intoxication, illness, brain injury, or psychosis) to the extent that he or she cannot attend to his or her own safety (e.g., wandering into streets or unable to access available food or shelter)?
- Is the client acutely suicidal or a danger to others (e.g., homicidal or making credible threats to harm someone)?
- Is the client's immediate psychosocial environment unsafe (e.g., is he or she immediately vulnerable to maltreatment or exploitation by others)?

The first goal of trauma intervention, when any of these issues is 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, child protection, 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.

At a less acute level, questions include the following:

- Does the client have a place to stay tonight?
- When did he or she last eat?
- When did he or she last get a medical examination?
- Does he or she have a serious or life-threatening medical condition? If so, is he or she reliably taking any required medication?
- Is he or she engaged in unsafe sex, IV drug abuse, or other risky behaviors?
- Does he or she report self-injurious behavior (e.g., self-cutting, self-burning)?
- Is there evidence of a severe eating disorder?
- Is he or she being exploited sexually or otherwise by another person? Is he or she engaged in prostitution?
- Is he or she involved in a gang? If so, how dangerous is the situation, both to the client and to others?

## Evaluation of Trauma Exposure History

After evaluating immediate safety risks, typically next considered is the client's trauma history. Common types of trauma are the following:

- Child abuse (physical, sexual, and psychological)
- Emotional neglect and/or abandonment
- Assaults by peers (both physical and sexual)
- Community violence
- Events associated with homelessness and/or prostitution
- Witnessing violence done to others
- Traumatic loss
- Exposure to serious accidents (e.g., motor vehicle accidents) and disasters
- Serious medical illness or injury

Assessment typically involves determining not only the nature of these various traumas, but also their number, type, and time of onset.

The adolescent or young adult may not report all significant trauma exposures during the initial assessment session or early in treatment. In some cases, important historical events may be disclosed only later in therapy, as the client engages more fully with the clinician and experiences a greater sense of trust and safety. The manner in which adolescents, as well as caretakers, are directly questioned regarding trauma exposures may also determine the extent to which a complete account is provided (Lanktree & Briere, 2008a).

The environmental context in which the assessment is conducted also can affect the extent of trauma information that is disclosed by the adolescent and/or family, whether by interview or on psychological tests. For example, in school settings, the youth may not feel as free to divulge information due to concerns about confidentiality, including fear that his or her trauma history or symptoms will be shared with school personnel or other students. In hospital settings, where an adolescent may be assessed for psychological trauma following serious medical illness or condition (e.g., HIV infection, cancer, surgeries) or traumatic injury (e.g., the results of an assault or accident), the client and family's need to cope with urgent or chronic medical issues may lead them to overlook or suppress information regarding prior (or even current) abuse or violence. In forensic contexts, such as a child abuse investigation, the adolescent may be reticent to disclose information that could lead to separation from the family or incarceration of an alleged perpetrator.

## **Initial Trauma Review for Adolescents (ITR-A)**

Because clients may interpret trauma labels in different ways, evaluation of trauma exposure is often more effective when it employs behavioral descriptions of the event(s), as opposed to merely asking about “rape” or “abuse.” This is often best accomplished by using some sort of structured measure or interview that assesses exposure to the major types of traumatic events in a

standardized way. The reader will find in Appendix I of this book a version of the Initial Trauma Review (Briere, 2004)—hereafter referred to as the ITR-A—adapted for adolescent and young adult clients. We recommend that this trauma exposure measure be used in ITCT-A, since it covers most of the major traumatic experiences likely to be encountered by adolescents and young adults.

## Information From Caretakers

Discussions with caretakers can reveal significant information on the adolescent's developmental, family, mental health, trauma, and substance abuse history, as well as ongoing psychological and social functioning that might not otherwise be available from the client, treating professionals, child protection, or the schools. Assessment is also crucial in determining background family factors, the readiness of family members for therapy, current caretaker and family functioning, intergenerational abuse and other traumatic exposures, and losses, separation, or abandonment by caretakers. Finally, family stressors such as poverty, homelessness, and caretaker unemployment must be taken into account.

Some of this information can be garnered in parent interviews, during the process of caretaker or family therapy, or through the administration of relevant psychological tests. On the other hand, such information may be biased or compromised by caretaker issues, including their own psychological problems, trauma histories, level of investment in the youth, and emotional responses to the adolescent's difficulties, both positive and negative (Friedrich, 2002; Gil, 1996; Pearce & Pezzot-Pearce, 2007).

Because complex trauma often includes insecure attachment associated with inconsistent or emotionally neglectful parenting (Blaustein & Kinniburgh, 2010; Cook et al., 2005), the caretaker may provide a sketchy or incomplete developmental history for the adolescent. The caretaker may also have difficulty disclosing background information on themselves or the family. There also may be limited developmental information from the current caretaker because the youth had multiple caretakers, was in foster care, or early parenting was provided by a person who is no longer available and had minimal communication with the current caretaker.

As a result, we advise the clinician to gather information and test data from a variety of sources, including, but not limited to, caretakers and to “triangulate” these data to come to a more accurate set of conclusions about the youth and his or her social, familial, and psychological matrix (Lanktree et al., 2008; Nader, 2007).

## Evaluation of Trauma-Relevant Symptoms

An optimal assessment of traumatized adolescents and young adults generally includes a detailed estimation of current psychological functioning in all pertinent areas. The results of such assessment, in turn, determine whether an immediate clinical response is indicated, as well as what specific treatment modalities (e.g., cognitive interventions, therapeutic exposure, family therapy, psychiatric medication) might be most helpful. Further, when the same tests are administered on multiple occasions (e.g., every three months), the ongoing effects of clinical intervention can be evaluated, allowing the clinician to make midcourse corrections in strategy or focus when specific symptoms are seen to decrease or exacerbate (Briere, 2001).

For some clients, abuse, neglect, family and community violence, major losses, and injuries or illnesses may have occurred more-or-less concomitantly, resulting in a more complex clinical picture. In addition, gender-related, developmental, and cultural factors may affect how any given symptom or psychosocial problem manifests. For this reason, when possible, it is preferable to administer multiple psychological tests, tapping a variety of different symptoms, or to make sure that interview-based assessment covers the full range of complex posttraumatic outcomes. Further, whether interview-based or psychometric, such assessment should take mediating demographic, social, and cultural issues into account.

### Interview-Based Assessment

When formal psychological testing is unavailable or inappropriate, the clinician may have to assess various potential trauma impacts during the course of the interview, ideally touching on all the potential outcomes described earlier. Although interview-based symptom reviews can be quite helpful, they are by nature relatively subjective, and it is quite easy for the assessor to overlook certain symptoms or problems and/or to be unclear about whether the level of symptomatology or difficulties disclosed by the individual reaches clinically meaningful levels. On the other hand, assessment questions that are integrated within the clinical interview may be less disruptive and more acceptable to those traumatized youth who find psychological testing intimidating or not relevant to their experience. As noted later, ITCT-A provides a specific symptom assessment template, the Assessment-Treatment Flowchart, that guides the interview process, whether or not it is augmented with psychological testing.

## Psychological Testing

Trauma symptom assessment using psychological tests has several advantages. It is more objective and structured, in that it does not rely on the clinician to articulate the full range of possible trauma outcomes and accurately interpret the client's responses to questions. Further, when tests are standardized and normed (a basic requirement of modern psychometric instruments), the youth's self-report of symptomatology can be compared to a reference group of other youths in the general population, so that his or her symptomatology can be evaluated for its severity relative to "normal" respondents. As well, in some cases traumatized youth will respond more honestly and with less avoidance when they are endorsing symptoms on a pencil-and-paper measure, as opposed to a face-to-face inquiry by the therapist. Finally, some young clients find it validating that an independent, standardized test inquires about specific experiences and symptoms they have undergone, with the implication that such issues are relatively commonplace and not necessarily "about them," *per se*.

*Rapport and safety.* As noted in the trauma assessment literature, psychological testing is best conducted in the context of safety and good clinical rapport (Briere & Spinazzola, 2005; Lanktree & Briere, 2008a). Especially for very traumatized or alienated youth, this may require that the clinician specifically demonstrate by his or her behaviors, demeanor, and words the fact that

- (a) the assessment will be helpful to the client, in terms of allowing the clinician to understand the client and his or her difficulties, and thus provide better, more targeted, treatment;
- (b) the assessor and the testing environment are not dangerous to the client, either physically (e.g., through physical assaults, sexual exploitation, or punishment) or psychologically (e.g., through criticism, judgment, or rejection); and
- (c) the client has the right to discontinue testing at any point.

Also discussed should be the possibility of some (typically small and temporary) exacerbation of distress when traumas or symptoms are being evaluated, and any possible uses of the test data in legal contexts, if relevant.

It is our clinical experience that traumatized youth are much more forthcoming and less defensive in their test responses if they feel safe and supported, are allowed to ask questions and, to some extent, control their participation in the testing process, and if they believe that the testing has an actual helpful purpose, as opposed to just being an institutional requirement.

*Immediate information.* Unlike other contexts in which psychological testing may occur, there is sometimes a need to determine the client's emergent psychological status immediately after psychological testing. Most typically, this occurs when the client discloses a danger to himself or herself, a danger to other people, or severe psychological disturbance that requires immediate attention. Much of this potential danger can also be assessed during the clinical interview. However, some clients will deny danger to self or others in an interview, yet endorse it in psychological testing. For this reason, we recommend that—whenever possible—test data be scored as soon as possible after it is collected and that the clinician review specific test items before the client leaves the session. It might be important that the therapist knows, for example, that items # 20 and 52 on the Trauma Symptom Checklist for Children (Briere, 1996b) ask about suicidality, and that other items, e.g., # 21 and 50, inquire about potential for aggression and fear of being killed, so that he or she can rapidly examine these specific items before the client is no longer immediately accessible.

*Choice of tests.* Standardized trauma assessment measures are almost always preferable to those without norms or validation studies. Such tests may involve either caretaker reports of the adolescent's symptoms and behaviors or self-reports of their own distress and/or behavioral disturbance. In addition, such measures may be either generic or trauma-specific; we recommend that at least one test of each type be included in the assessment battery.

The choice of whether to use self- or caretaker-reports of adolescent symptoms can be difficult, since each approach has its own potential benefits and weaknesses. Self-report measures allow the client to directly disclose his or her internal experience or problems, as opposed to the clinician relying on “secondhand” reports of a parent or caretaker. However, the youth's self-report may be affected by his or her fears of disclosure or denial of emotional distress (Elliott & Briere, 1994). Similarly, a caretaker report of the youth's symptomatology has the potential benefit of providing a more objective report of the client's symptoms and behaviors, yet may be compromised by parental denial, guilt, trauma history, or reactivity to the adolescent's trauma (Friedrich, 2002). Caretakers also may have difficulties accurately assessing the adolescent's internal experience, especially if the adolescent, for whatever reason, avoids describing those experiences to the caretaker (Lanktree et al., 2008). For these reasons, and assuming the caretaker has ongoing contact with the child,<sup>1</sup> it is recommended that the assessment of traumatized adolescents uses *both* self- and caretaker-report measures whenever possible, so that the advantages of each methodology can be

maximized, and the child's actual clinical status can be triangulated by virtue of multiple sources of information (Lanktree et al., 2008; Nader, 2007). Caretaker-report will not be appropriate, of course, when the client is an emancipated youth or when the caretakers are abusive, neglectful, or unavailable.

## Specific Psychological Tests

*Generic (non-trauma-specific) measures.* Perhaps the most commonly used generic test in the assessment of traumatized youth is the Child Behavior Checklist (CBCL; Achenbach, 2002), which has separate Parent Report, Teacher Report, and Youth or Young Adult Self-Report versions. Other good indices of general functioning for adolescents are the Behavioral Assessment System for Children (BASC-2; Reynolds & Kamphaus, 2006), adolescent versions of the Psychological Assessment Inventory (PAI-A; Morey, 2008), and the Minnesota Multiphasic Personality Inventory (MMPI-A; Butcher et al., 1992). Standardized tests for specific symptoms or disorders include the Child Depression Inventory (CDI; Kovacs, 1992), Suicidal Ideation Questionnaire (SIQ; Reynolds, 1988), and Tennessee Self-Concept Scale (TSCS; Roid & Fitts, 1994). Projective tests like the Rorschach (Exner, 1974) and Robert's Apperception Test (RATC; McArthur & Roberts, 1982) also may be helpful in some instances (Briere & Spinazzola, 2009). Although these various instruments often do not enquire about posttraumatic symptoms (e.g., flashbacks, dissociation, hyperarousal) in particular, they do examine other issues that are very relevant to the traumatized client, such as depression, anxiety, suicidality, externalization, and low self-esteem. For this reason, we recommend that at least one generic test be administered in addition to one or more trauma-specific tests. In the MCAVIC-USC project, for example, the CBCL and CDI were administered to almost all clients.

*Trauma-specific tests.* Standardized, trauma-specific self-report measures for adolescents can be divided into those for youth ages 12–17, those for adolescents aged 18–21, and those for all adolescents (aged 12–21). Some of these trauma-specific measures are briefly described here.

*Trauma Symptom Checklist for Children* (Briere, 1996b). Normed on over 3,000 children and adolescents across a range of sociodemographic strata, the 54-item TSCC evaluates self-reported trauma symptoms in children ages 8–16, with minor normative adjustments for 17-year-olds. It has two validity scales and six clinical scales: *Anxiety, Depression, Anger, Posttraumatic Stress, Sexual Concerns* (containing two subscales: *Distress* and *Preoccupation*), and

*Dissociation* (containing two subscales: *Overt* and *Fantasy*). There is an alternate form (the TSCC-A) that does not include any sexual items.

*UCLA PTSD Index for DSM-IV* (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998). An updated version of what was formerly described as the Reaction Index, the UPID is a 48-item interview that can be administered to children and adolescents aged 7–18 years. It evaluates exposure to a variety of traumatic events and provides a PTSD diagnosis, as well as containing additional items that assess associated features such as guilt, aggression, and dissociation.

*Trauma Symptom Inventory* (Briere, 1995) and *Trauma Symptom Inventory-2* (Briere, 2011). The TSI taps the overall level of posttraumatic symptomatology experienced by an individual in the prior six months and can be used in the current context with older adolescents and young adults, ages 18 to 21. It has three validity scales and 10 clinical scales (*Anxious Arousal*, *Depression*, *Anger/Irritability*, *Intrusive Experiences*, *Defensive Avoidance*, *Dissociation*, *Sexual Concerns*, *Dysfunctional Sexual Behavior*, *Impaired Self-Reference*, and *Tension Reduction Behavior*). The new TSI-2 evaluates all of these areas but additionally includes *Attachment Insecurity*, *Suicidality*, and *Somatization* scales, the first of which may be especially helpful in assessing complex trauma issues.

*Inventory of Altered Self-Capacities* (Briere, 2000). The IASC is a standardized test of difficulties in the areas of relatedness, identity, and affect regulation. As such, it is especially relevant to the concerns and presentations of older adolescents (i.e., those aged 18 to 21) presenting with more complex posttraumatic outcomes. IASC scales are *Interpersonal Conflicts*, *Idealization-Disillusionment*, *Abandonment Concerns*, *Identity Impairment*, *Susceptibility to Influence*, *Affect Dysregulation*, and *Tension Reduction Activities*.

*Trauma Symptom Scales for Adolescents* (TSSA: Briere, *in progress*). An adaption and extension of the unpublished *Trauma Symptom Review for Adolescents* (TSRA: Briere, 2007), the TSSA was developed specifically to tap the major issues of traumatized adolescents aged 12 to 21. It has scales measuring, among other constructs, posttraumatic stress, attachment issues, dissociation, dysfunctional sexual behavior, social isolation, tension-reduction (acting-out) behaviors, and substance abuse. It is currently undergoing standardization trials and is expected to be published in 2013. Prior to that point, scores on the TSSA cannot be used to determine norm-referenced levels of clinical disturbance.

## Assessing the Caretaker

Of course, it is not only the youth who should be assessed. Also important are factors impinging on the caretaker's capacity to parent their child. These include his or her

- own attachment history, especially the extent to which he or she felt support and emotional attunement from his or her primary caretaker(s);
- cultural background, as well those of his or her children (they may not be the same);
- history of trauma and loss;
- issues and symptoms that may be associated with trauma, such as depression, anxiety, anger, lack of empathy for others, posttraumatic stress, dissociation, impaired self-functioning (including affect regulation problems), substance abuse, and tension reduction behaviors;
- history of previous therapy and whether it was experienced as helpful;
- current emotional resources and coping capacities;
- psychiatric status, including whether he or she is suffering from schizophrenia, bipolar disorder, or a severe personality disorder; and
- other stressors, including those related to single parenting, domestic violence, poverty, unemployment, homelessness, cultural or religious pressures to not seek help from others or permit governmental intervention, substance abuse in the family, and other children in the home requiring parenting.

In addition, Gil and Drewes (2005) suggest that assessment of the client's and family's culture(s) should include information on family values, spirituality, child-rearing principles, and culture-specific ways that families resolve conflict, express anger, and deal with aggression.

## Overall Assessment Sequence for ITCT-A

Although there is a variety of approaches to the assessment component of ITCT-A, we suggest that it occur in the following stepwise fashion:

1. Conduct one or more clinical interviews, as outlined in this chapter, accessing as many sources of information (e.g., from the client, caretakers, the school, child welfare system, etc.) as possible, in combination with any

relevant medical, psychological, or forensic records. Based on this assessment process, consider additional psychological testing.

2. If psychological testing is possible, employ assessment instruments known to be reliable and valid indicators of issues identified by the interview(s). In order to facilitate this process, refer to the ITCT-A Assessment Locator, presented here and also found in Appendix II. Acronyms are explained in the table, or refer to the tests described earlier in this chapter. The column *ATF-A Item* refers to clinical issues potentially relevant to adolescents and young adults with complex trauma exposure. Detailed coverage of the ATF-A is found in Chapter 4.

3. Based on the interview, record and (if possible) test data and complete the ATF-A, as outlined in Chapter 4.

### ITCT-A Assessment Locator

<i>ATF-A Item</i>	<i>Assessment (Tests applicable only for relevant age ranges)</i>
1. Safety—environmental	Adolescent self-report in session (A-S), parent/ caretaker-report in session (C-R)
2. Caretaker support issues	A-S, C-R, and clinical impressions during parent interview
3. Anxiety	A-S, C-R, CBCL, BASC-2, PAI-A, MMPI-A, TSCC, TSSA, TSI, TSI-2
4. Depression	A-S, C-R, CBCL, CDI, BDI-II, BASC-2, TSCC, TSSA, TSI, TSI-2
5. Anger/aggression	A-S, C-R, BASC-2 (parent report), CBCL, PAI-A, TSCC, TSSA, TSI, TSI-2
6. Low self-esteem	A-S, C-R, BASC-2, TSCS, TSSA
7. Posttraumatic stress	A-S, C-R, PAI-A, MMPI-A, TSCC, TSSA, TSI, TSI-2, DAPS, UPID
8. Attachment insecurity	A-S, C-R, BASC-2, TSI-2, TSSA
9. Identity issues	A-S, C-R, IASC, TSI, TSI-2
10. Relationship problems	A-S, C-R, BASC-2, CBCL, TSSA

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<i>ATF-A Item</i>	<i>Assessment (Tests applicable only for relevant age ranges)</i>
11. Suicidality	A-S, C-R, TSCC, PAI-A, TSI-2, TSSA, DAPS, SIQ
12. Safety—risky behaviors	A-S, C-R, BASC-2, TSI, TSI-2
13. Dissociation	A-S, C-R, TSCC, TSSA, TSI, TSI-2, DAPS
14. Substance abuse	A-S, C-R, BASC-2, PAI-A, TSI, TSI-2, DAPS
15. Grief	A-S, C-R
16. Sexual concerns and/or dysfunctional behaviors	A-S, C-R, TSCC, TSSA, TSI, TSI-2
17. Self-mutilation	A-S, C-R

## Note

1. It is sometimes the case that the caretaker has only occasional visits with the youth, is uninvolved with his or her care, or is a new foster parent. In such instances, caretaker report may be inaccurate or even misleading (Briere, 2005).