Trauma-Informed Screening and Assessment

- Universal Trauma Screening and Specific Trauma Assessment Methods Are Necessary To Developing Collaborative Relationships With Trauma Survivors and Offering Appropriate Services

  Harris & Fallot 2001

- They are also necessary in order to avoid retraumatization, honoring the dictim to "Above all, Do No Harm".

Definition of Trauma-Informed Screening and Assessment

- Trauma-informed **screening** refers to a brief, focused inquiry to determine whether an individual has experienced specific traumatic events
- Trauma **assessment** is a more in-depth exploration of the nature and severity of the traumatic events, the sequelae of those events, and current trauma-related symptoms.

Harris & Fallot 2001

NASMHPD Position Statements

- *" It should be a matter of best practice to ask persons who enter mental health systems, at an appropriate time, if they are experiencing or have experienced trauma in their lives"*

NASMHPD 1998

- *"Asking persons who enter mental health systems, at an appropriate time, if they are experiencing or have experienced trauma in their lives is becoming a standard of care.*"

NASMHPD 2005

NASMHPD Position Statements

- *"As part of the intake and ongoing assessment process, staff should assess whether or not an individual has a history of being sexually, physically or emotionally abused or has experienced other trauma, including trauma related to seclusion and restraint or other prior psychiatric treatment.*

- *Staff should discuss with each individual strategies to reduce agitation which might lead to the use of seclusion and restraint. Discussion could include what kind of treatment or intervention would be most helpful and least traumatic for the individual."*

NASMHPD 1999

Lack of Trauma Screening and Assessment

- Many clinicians acknowledge that significant trauma concerns are frequently overlooked in professional settings. Harris & Fallot 2001, Cuzack, 2004
- Alarmingly high rates of childhood trauma exposure, PTSD co-morbidity and current victimization exist among people with severe mental illness treated in public sector settings Rosenberg 2002; Cusack et al 2004; Mueser 1998; Kessler et al 1995; Goodman et al 2001; Hiday et al 1999, Hanson 2002,
- In spite of this, clinicians often don't screen for abuse or detect current or historic victimization in their clinical caseloads. Briere & Zaidi 1989; Jordan & Walker 1994; Saunders et al 1989; Wurr & Partridge 1996, Lipschitz et al 1996, Goodwin et al 1988, Jacobson et al 1987, Rose et al 1991

Lack of Trauma Screening and Assessment

- In contrast to statistics showing incest histories in 46% of chronically psychotic women on a hospital unit (Beck & van der Kolk 1987); and significant trauma exposure in 90% of patients in a multi-site program for co-morbid substance-abuse and mental illness, 35% of whom carried a diagnosis of PTSD (Mueser 2001) ,
- 3 years of data from NYS-OMH showed that only 1 in 200 adult inpatients and only 1 in 10 child/ adolescent inpatients carried either a primary or secondary diagnosis of PTSD. NYS-OMH, 2001; Tucker, 2002

Lack of Trauma Screening and Assessment

- Although the high prevalence of significant psychological trauma among people/patients with serious and persistent mental illness is well known, and even where it is duly recorded in initial psychiatric histories, such trauma is rarely reflected in the primary (or secondary) diagnosis.
- A history of trauma, even when significant, generally appears only in the category of "developmental history", and as such does not become the focus of treatment. Tucker 2002

Lack of Trauma Screening and Assessment

- In a multi-site study where 98% of 275 patients with severe mental illness (schizophrenia and bipolar disorder) reported at least 1 traumatic event, the rate of PTSD was 43%, but only 3 (2%) of the 119 patients with PTSD had this diagnosis in their charts.

Mueser et al, 1998

Lack of Trauma Screening and Assessment

- PTSD symptoms are often not evaluated and therefore go unrecognized and untreated. In one multi-site study where 43% met diagnostic criteria for PTSD, only 2% carried the diagnosis in medical records. Mueser 1998; Frueh 2002
- Even in academic and community mental health settings, rates of recognition of trauma are low with a clinical diagnosis of PTSD occurring in as few as 4% of individuals with the disorder. Davidson 2001 Sher et al 2004
- Routine assessment of trauma in persons presenting to mental health services is often "overlooked" in the absence of PTSD symptomotology as the presenting complaint. Zimmerman 1999

Lack of Trauma Screening and Assessment

- Most clinicians underestimate the prevalence of trauma in inpatients. Less then 30% estimate that trauma prevalence is greater than 40%. Freuh 2001
- Even where one event (e.g. rape) has been identified in a given client, it is common for clinicians to overlook the possibility of other relevant forms of maltreatment (e.g. child physical and/ or sexual abuse). Briere 2004
- Although mandated inquiry regarding histories of trauma contributes to knowledge of its prevalence in psychiatric populations, it has done little to affect their care. Tucker 2002

Lack of Trauma Screening and Assessment

- Disclosures of childhood abuse made by psychotic patients are often dismissed, ignored or marginalised on the grounds that discussion of such issues will make symptoms worse. Hammersley 2004
- Patients with psychosis are asked less often about abuse (Read & Fraser 1998), and are less likely to receive a response if they do disclose abuse (Agar & Read 2002)
- This is especially true if assessments are conducted by professionals with strong beliefs about genetic causes of psychosis. Hammersley 2004

Lack of Trauma Screening and Assessment

- Despite state mandated inquiry into trauma history for all psychiatric outpatients, PTSD was rarely diagnosed, and few clinicians incorporated trauma history into their treatment plans. Eilenberg et al 1996
- A parallel may be drawn between the lack of awareness a decade ago of substance use disorders in patients with SMI, whereas in recent years there has been growth of assessment of these disorders and recognition of their negative effects on the course of SMI. Drake et al 1996
- Understanding the role of trauma and PTSD in influencing the course of SMI may lead to similar changes – with assessment of trauma becoming routine and accepted as a necessary standard of practice. Mueser et al 2002

Consequences of Failing to Screen and Assess for Trauma

- In public-sector settings, and especially, institutional ones, instead of being diagnosed with trauma-related syndromes, patients are likely to receive diagnoses of schizophrenia, psychosis NOS, borderline personality disorder, and, in children, conduct or oppositional-defiant disorder.

Tucker 2002

Consequences of failing to screen and assess for trauma

- Failure to diagnosis PTSD as co-morbid disorder in severely mentally ill patients has important implications for assessment and management of their illnesses:
  - Increases patient's vulnerability to substance abuse disorders Stewart 1996
  - Leads to a worse course of serious mental illness. Drake, 1996
  - Contributes to social isolation and loss of social support, increasing vulnerability to relapse in persons with serious mental illness. Cresswel et al 1992

Consequences of Failing to Screen and Assess for Trauma

- As a consequence of inaccurate diagnosis, patients in psychiatric hospitals generally fail to respond to the treatments prescribed for more easily recognized disorders. This failure, in turn, leads to a cascade of further ones:
  - Receiving excessive doses of medication, with the development of unnecessary side-effects, including tardive dyskinesia
  - Continued guilt and low self-esteem;
  - Excessively long hospital stays;
  - Inability to access appropriate, available treatment in community settings

Tucker 2002

Consequences of Failing to Screen and Assess for Trauma

- Many users of mental health services are upset at not being asked about abuse. Lothioan & Read 2002
- Inhibiting or holding back one's thoughts, feelings and behaviors is associated with long-term stress and disease.
- Failure to confront traumatic experiences forces a person to live with it in an unresolved manner

  Pennebaker et al, 1988
- Not to inquire may further revictimize the client

  Doob, 1992

Consequences of Failing to Screen and Assess for Trauma

- Misdiagnosis: In public-sector settings, and especially, institutional ones, instead of being diagnosed with trauma-related syndromes, patients are likely to receive diagnoses of schizophrenia, psychosis NOS, borderline personality disorder, and, in children, conduct or oppositional-defiant disorder.

  Tucker 2002

Factors contributing to the failure to screen and assess for trauma

2 factors contribute to the fact that significant trauma concerns are frequently overlooked in professional settings:

1. **Underreporting of trauma by survivors**
2. **Underrecognition of trauma by providers**

Cusack 2004; Harris & Fallot 2001

Underreporting of trauma by survivors

- Immediate safety concerns e.g. violent retaliation by abuser; lack of housing, fear of loss
- Fear of stigmatizing service system responses e.g. disbelief; blame of victim; pathologizing of attempts to cope; being thought of as sexually devient, as homosexual, or as a perpetrator
- Shame and guilt about being victimized and vulnerable
- Tendency, especially men, to withdraw and isolate vs talk.

Underreporting of trauma by survivors

- Difficulty in remembering
- Lack of trust in professional
- Minimization of the trauma (it was just discipline)
- Not connecting the trauma to their feelings, symptoms, behaviors
- Feeling they should have put the trauma behind them

Harris & Fallot 2001, Tucker 2002

- For young children, inability to verbalize the abuse

Underreporting of trauma by survivors

- Lack of peer support can lead to a consumer/ survivors lack of disclosure and/or minimization of their trauma. Many consumers have learned from the mental health system to understand themselves as "mentally ill" (vs. injured, or a person who awful things had happened to) and their feelings, thoughts and behaviors as "mental illness symptoms", (vs. understandable responses to the traumatic impacts of what happened to them).

Underrecognition of Trauma by Providers

- Inquiry may not be part of usual intake or assessment procedures
- Clinician lack of trauma training or uncertainty about how to respond to disclosures of trauma
- Concern that asking questions about trauma will upset consumers and that they won't know how to respond
- Questions about sexual abuse may be avoided because of the providers own history of such abuse, their own discomfort with talking about sex, their own fears about sexual violence, or their lack of awareness of resources
- Lack of accessible and effective trauma services

Harris & Fallot 2001

Underrecognition of Trauma by Providers

- Lack of accessible and effective trauma services
- Their language e.g. referring generally to "trauma" or "abuse" may not be explicit enough to elicit information from consumers e.g. violent physical abuse in childhood may be thought of as "discipline", and "normal"
- Institutional factors may inhibit focus on trauma, e.g. reimbursement policies, certification for consumer entitlements or criteria for research, may depend on Axis I Diagnoses and neglect other trauma-based diagnoses such as PTSD

Harris & Fallot 2001

Underrecognition of Trauma by providers

- Many providers have been concerned about reliability of disclosures of abuse by persons with serious mental illness whose disorder may result in psychotic distortions or delusions involving themes of sexual or physical abuse. Rosenberg et al 2002
- However, several recent studies show that reliable and valid assessments of trauma exposure and PTSD can be conducted with clients with SMI (including clients with schizophrenia and bipolar disorder).

  Mueser et al 2001; Meyer it al 199; Goodman et al 1999; Nijenhuis et al 2002; Rosenberg 2002

Underrecognition of Trauma by providers

- One possible obstacle to the routine assessment of trauma in men and women with serious mental illness is the absence of clear treatment guidelines for these individuals. Clinicians may not address trauma history in their patients simply because they do not know what to do. Meuser et al 2002
- One of the major, but often unacknowledged reasons, that children are currently not more actively screened for possible trauma is that all states have laws that require certain persons to report any and all suspicions of child abuse or neglect to the proper authorities under legal penalty for failure to do so.

  Harris et al, 2004

Reasons why questions about sexual abuse may be avoided

A Nursing Study's Perspective

- Many providers are reluctant to ask question about trauma because of lack of adequate treatment resources.
- There is belief on part of some providers that assessment is a job for specialists and too complex for someone like a generalist nurse
- Findings from one study suggest that providers (in this case nurses) may not want to hear about abuse because of their own histories, their own discomfort with talking about sex, their own fears about sexual violence, or their lack of awareness of resources

Gallop et al 1995

Reasons why questions about trauma are not asked

A Primary Care Physician's Perspective

- These problems are painful to recognize and difficult to deal with. The nature of the material is such as to make one uncomfortable
- Most physicians would far rather deal with traditional organic disease, treating symptoms rather than underlying causes
- Why would one want to leave the relative comfort of traditional organic disease and enter this area of threatening uncertainty that none of us has been trained to deal with?
- Though it is easier to do so, the (the traditional) approach also leads to troubling treatment failures and the frustration of expensive diagnostic quandaries where everything is ruled out but nothing is ruled in.
- Studies find that the clear majority of children and adults in psychiatric care were sexually or physically abused as children.
- What does it mean that this abuse is never spoken of? How does that affect a person later in life? How does it show up in a psychiatric setting?
- Most providers are initially uncomfortable about obtaining or using such information

Felitti 2002

Reasons why questions about trauma are not asked
A Primary Care Physician's Perspective

- "This is not a comfortable diagnostic formulation because it points out that our attention is typically focused on tertiary consequences, far downstream. It reveals that the primary issues are well protected by social convention and taboo. It points out that we physicians have limited ourselves to the smallest part of the problem, that part where we are comfortable as mere prescribers of medication. What diagnostic choice shall we make? Who shall make it? And, if not now, when?" Vincent Felitti, MD, 2002

Reasons why public-sector psychiatrists may fail to connect earlier trauma with current symptoms
A psychiatrist's perspective

- They must consider too many broad etological categories already (major mental illness, anxiety and depression, substance abuse, neuropsychiatry, and then, trauma
- Even when trauma has occurred, it does not routinely or even usually lead to PTSD, and can result in a variety of symptoms consistent with other diagnoses, such as major affective disorder, dissociative disorders, other anxiety disorders

  Kessler et al 1995; Yehuda et al 1995
- Complexity of relationship of current symptoms to trauma history combined with variety of consumer perceptions about the abuse, its import, its impacts

  Tucker 2002

Reasons why public-sector psychiatrists may fail to connect earlier trauma with current symptoms
A psychiatrist's perspective

- They must consider a variety of possible relationships between the trauma and their working diagnoses:
  - Trauma an incidental finding, unrelated to symptoms
  - Trauma drives and intensifies symptoms of the more familiar illness, making it refractory to treatment
  - Trauma issues are managed by patient in course of treatment for another major mental illness, but leave patient vulnerable to recurrences when "triggers" occur after discharge

Tucker 2002

Reasons why public-sector psychiatrists may fail to connect earlier trauma with current symptoms
A psychiatrist's perspective

- Trauma symptoms can be misinterpreted and attributed to other conditions
  - Flashbacks mistaken for hallucinations
  - Shame producing what is mistaken as a delusion of guilt
  - Trauma-triggered parasuicidal behaviors mistaken for symptom of borderline personality disorder (Self-injury is not equivalent to BPD)
- Vagueness of some diagnostic categories allow premature closure. E.G., Psychosis NOS or schizoaffective disorder, permit inclusion of many symptom clusters
- Socioeconomic and environmental insults, co-morbidities, and chronic and relapsing nature of PTSD symptoms, create impression of more familiar psychotic illnesses, where there may be no illness other than PTSD

Tucker 2002

Reasons why public-sector psychiatrists may fail to connect earlier trauma with current symptoms

A psychiatrist's perspective

- Assessment of symptoms as attributable to trauma, rather than to psychotic or affective disorders, is not routinely taught during psychiatric residency training
- Non-specificity of current pharmacopoeia for treating PTSD makes it less attractive as a diagnosis than those for which specific pharmacological treatments have been demonstrated.
- Concern that identifying the presenting symptoms as trauma-related would necessitate extra-medical procedures, such as taking legal action against the perpetrator Tucker 2002

Denial of Trauma and PTSD

- Consistent observations suggest that denial of PTSD and blaming of its victims are not isolated omissions or distortions but a pattern that spans over time, crosses national and cultural boundaries, and defies accumulated knowledge
- Mental health professionals are unable to transcend prevailing cultural and social norms
- They are "blinded" by professional theories; and
- Denial of trauma and PTSD (on the part of both survivors and providers) may stem from a fundamental human difficulty in comprehending and acknowledging our own vulnerability. Solomon 1995

Benefits of Inquiry

- A common belief among clinicians is that asking vulnerable consumers detailed questions about their trauma history may be too upsetting. Goodman 1999
- Studies conducted with public mental health consumers indicate otherwise. Goodman 1999
- There is no evidence in the literature that clients resent or object to being asked about a history of child sexual abuse. Gallop et al 1995
- On the contrary, there is increasing evidence that failing to ask represents colluding with society's denial of either prevalence or impact. Bryer 1992; Doob 1992

Benefits of Inquiry:

- Detailed Survey interviews of men and women with histories of psychiatric hospitalization – consumers reported finding inquiry helpful.
- Some said they wanted to further address trauma issues in their treatment. Cuzack et al, 2003
- The notion that screening for trauma is helpful for subjects is consistent with other studies conducted with public mental health consumers. Goodman et al, 1999

Assessing for Trauma May Help to Prevent Suicide

- Childhood sexual abuse is the single strongest predictor of suicidality regardless of other factors.

  Read et al 2001

- Any attempt to address suicide reduction that does not include assessment of childhood sexual trauma will fail.

  Hammersley 2004

- Failure to confront trauma forces a person to live with it in an unresolved manner.

  Pennebaker, 1988

Consumers say:

- "There were so many doctors and nurses and social workers in your life asking you about the same thing, mental, mental, mental, but not asking you why."
- "There was an assumption that I had a mental illness and because I wasn't saying anything about my abuse I'd suffered, no-one knew."
- "My life went haywire from thereon in… I just wished they would have said: "What happened to you? What happened?" But they didn't"

  Lothioan & Read, 2002

Benefits of Inquiry

- A "thorough trauma assessment with children and adolescents is a prerequisite to preventing the potentially chronic and severe problems in biopsychosocial functioning that can occur when PTSD and associated or comorbid behavioral health disorders go undiagnosed and untreated". Wolpaw & Ford, 2004

Benefits of Inquiry

- Data suggest hallucinations can be a marker for prior childhood trauma and therefore a history of child maltreatment should be obtained from patients with current or past history of hallucinations.
- This is important because the effects of trauma are treatable and preventable

Briere, 1996; Herman, 1992; Whitfield, 1995, 2003a, 2003b, 2004

Benefits of Inquiry

- Finding underlying related trauma is important factor in making a diagnosis, treatment plan, and referral
- This may help patients by lessening their fear, guilt or shame about their possibly having a mental illness
- Trauma may underlie numerous other conditions and identifying it may provide clinicians with valuable information that may lead to more effective management of these conditions.

Whitfield et al 2005

Benefits of Inquiry

- ACE study recommends routine screening of **all** patients for adverse childhood experiences must take place at the earliest possible point.
- This identifies cases early and allows treatment of basic causes rather than vainly treating the symptom of the moment
- A neural net analysis of records of 135,000 patients screened for adverse childhood experiences as part of their medical evaluation – showed *an overall reduction in doctor office visits during the subsequent year of 35%.*
- Biomedical evaluation without ACE questions reduced DOV's during the subsequent year by 11% .

Felitti, 2003

Benefits of Inquiry

- Disclosure of Trauma may have positive neurological effects on immune function
- A study of persons writing about their traumatic experiences (including interpersonal violence) suggested that confronting trauma experiences was physically beneficial. Positive effects included:
  - 2 measures of cellular immune-system function (mitogen responses and autonomic changes) were positive
  - Visits to the health center were reduced
  - Self-reports of subjective distress decreased
- Inhibiting or holding back one's thoughts, feelings and behaviors is associated with long-term stress and disease.

Pennebaker et al, 1988

Benefits of Inquiry

- The clinical importance of gathering abuse histories in both inpatient and community settings, especially with concurrent use of safety planning, includes possible reduction in seclusion and restraint incidents.
- Routine inquiry into abuse history assists the clinician in treatment planning. Specifically, by addressing prior abuse experiences, multiple abuse-related symptoms can be addressed together rather than as isolated experiences. Shack 2004

Benefits of Inquiry
A nurse's perspective

- Revealing a history of CSA may be the first step in dealing with a history that has been a psychological burden for many years and affected many aspects of a person's life
- Inquiring about abuse may prevent misdiagnosis and increase understanding of signs and symptoms

Gallop et al 1995

- Asking about trauma can open the issue to the consumer, give the consumer a meaningful context within which to understand her or his feelings, thoughts and behaviors, empower the consumer to search for and find the kind of help she or he needs

Trauma-Informed Service Systems Employ Universal Trauma Screening

- Because of the high prevalence and powerful impact of abuse on nearly all consumers
- Because of underreporting and underrecognition of trauma
- Because trauma screening communicates institutional awareness of and responsiveness to the role of violence in the lives of consumer

Harris & Fallot 2001

- Because of the benefits to the consumer of opening an area of concern often long kept hidden, and asking questions about his or her traumatic experiences

Universal Trauma Screening

- Based on overwhelming prevalence, trauma-informed services ask **all** consumers about trauma, as part of the initial intake or assessment process.
  - To determine appropriate follow-up and referral
  - To determine imminent danger requiring urgent response
  - To identify need for trauma-specific services
  - To communicate to all consumers that the program believes abuse and violence are significant events
  - To communicate staff recognitions of and openness to hearing about and discussing painful events with consumers
  - To open possibility of later disclosure if consumer decides not to talk about trauma experiences at early stage

Harris & Fallot 2001

The Screening Questions

- Trauma screening is usually limited to several questions
- Range of events may include natural disasters, serious accidents, deaths, physical and sexual abuse
- Is clear and explicit, particularly about physical and sexual abuse
  - Physical abuse: ask if person has ever been beaten, kicked, punched, or choked
  - Sexual abuse: ask about experiences of being touched sexually against their will or whether anyone has ever forced them to have sex when they did not want to

Harris & Fallot 2001

Guidelines for trauma screening

- If traumatic events are reported
  - Ask about recency (In the past 6 – months?)
  - Ask about current danger (Are you afraid now that someone may hurt you?)
- Use unambiguous and straightforward language to avoid confusion and encourages straightforward responses

Harris & Fallot 2001

Guidelines for trauma screening

- Interviewer training to maximize clinician competence in dealing with responses
- As a general rule, do screening as early as possible in intake process
- If not advisable to screen during initial meeting or in the event of a negative screen, repeat the brief set of questions periodically. With establishment of safety and trust, consumer may be more willing to disclose

Harris & Fallot 2001

Guidelines for trauma screening

- Maximize consumer choice and control and place priority on consumer preferences regarding self-protection and self-soothing needs
  - Explain directly the reasons for the screen and offer explicit options of not answering questions
  - Give option of Delaying the interview
  - Give option of Self-administering the questionnaire
  - Offer Having something to drink during the screening

Harris & Fallot 2001

Guidelines for trauma screening

- Conclude the brief interview with a discussion of its implications for service planning, and for any necessary immediate intervention.
- This will begin to connect trauma concerns with the rest of the consumer's problems and goals.

Self-Report

- Self-report is generally an accurate method of obtaining psychiatric and medical history, including among trauma survivors Berger et la 1998; Bifulco et al 1997; Brewin et al 1993; Brown et al 1999; Fergusson et al 2000; Robins et al 1985; Wilsnack et al 2002
- Even people with schizophrenia and other psychoses have been found to report accurate histories Read & Argyle 1999; read & Fraser 1998; Read et al 2001; Read & Ross 2003; Read et al 1997; Goodman et al 1999, Mueser et al 2001

Whitfield 2005

Sample Trauma Screening for Adults

This list is representative of <u>some</u> screening tools used in public sector settings currently:

- *Trauma Assessment for Adults: Brief Revised Version (TAA).* Used for intake followed by more comprehensive TAA and PCL in South Carolina. Resnick, 1993
- *Trauma Assessment for Adults (TAA)* Resnick, 1993
- *PTSD Checklist for Adults (PCL)* A 17 item self-report scale. Weathers 1994
- *Brief Trauma History Questionnaire (THQ)* Green&Mueser
  Used with *PTSD Checklist for Adults (PCL)* at intake to NH Hospital Psychiatric. Resnick 1993
- Traumatic Events Screening Inventory (TESI) Ford et al 2000
- Life Stressor Checklist – Revised (LSC-R) Initial assessment of trauma history Wolfe & Kimmerling, 1997
- WCDVS version of LSC-R – used with women with substance abuse, mental health and trauma-based issues. McHugo, 2005
- *Post-traumatic Stress Diagnostic Scale (PDS)* Self Report used with comprehensive PDS-Modified, interview Foa et al, Rosenberg 2004

For detailed reviews of trauma exposure interviews and measures see Wilson & Keane, 2004, and Briere, 2004

De-escalation Preference Surveys

- Use of de-escalation preference surveys, a secondary prevention intervention, represents an indirect method of finding out about trauma exposure. E.g. in indicating a desire not to be touched, a child may be reflecting past sexual abuse. NETI, 2003
- In institutional settings, use of a risk assessment tool to determine potential contraindications to use of restraint (and other coercive measures) requires that information on past abuse be obtained Hodas 2004
- **Include Sample Survey in participants handouts**

Trauma-Informed Assessment

- An in-depth exploration of:
  - the nature and severity of traumatic events
  - The sequelae of those events
  - Current trauma-related symptoms
- In the context of a comprehensive mental health assessment, the trauma information may contribute to a formal diagnostic decision

Harris & Fallot

Trauma-Informed Assessment as a Process

- Sets the tone for early stages of consumer engagement and is built on the development, rather than assumption, of safety and trust
- Clinicians must be aware of
  - Understandable fears many survivors bring to situations that call for self-disclosure
  - The boundary difficulties of some survivors that impair self-protection and the intensity of their trauma experiences, making them unable to modulate their responses to clinician inquiries.
- Helping trauma survivors contain and manage intense feelings and use of grounding and centering techniques are key clinical skills in assessment situations

Harris & Fallot 2001

Trauma-Informed Assessment as a Process

- Exploration of trauma unfolds over time, and for persons whose experiences of powerlessness and lack of choice have been pervasive, having control over the pace and content of trauma discussions is very important

Harris & Fallot 2001

Guidelines for Trauma-Informed Assessment as a Process

- Clinicians must follow the consumer's lead and contribute to his/her sense of control during this process by
  - Being clear about the steps and process of assessment (e.g. I would like to ask you some questions about….)
  - Being clear about the reason for the questions (e.g. We have found that many people who come here for services have been physically or sexually abused at some time in their lives. Because this can have such important effects on people's lives, we ask everyone about whether they have ever been a victim of violence or abuse)
  - Being clear about the consumer's right not to answer questions (e.g. If you would rather not answer any question, just let me know, and we'll go on to something else)

Harris & Fallot 2001

Trauma and Related diagnoses

- A wide range of conditions (e.g. depression, anxiety disorders, substance abuse, personality disorders) accompany posttraumatic disorders.
- In a trauma-informed system, these co-occurring difficulties (involving such symptoms as splitting, self-injury, substance abuse, hallucinatory experiences) are more helpfully understood as adaptations to and outcomes of traumatic events
- *This extensive comorbidity of trauma-related and other disorders makes careful attention to differential diagnosis a necessity*

Harris & Fallot 2001

A trauma-informed diagnostic assessment

- Misdiagnosis and underestimation of trauma symptoms are significant concerns. Many diagnoses given to survivors fail to take into account the trauma experiences themselves
- Especially among persons with extensive psychiatric histories, previous documented diagnoses may become self-perpetuating, dominating and prematurely foreclosing the assessment process.
- A trauma-informed diagnostic assessment must take seriously the wide range of problems that flow from experiences of violence.

Harris & Fallot 2001

A trauma-informed diagnostic assessment

- For a trauma-informed assessment, reaching a diagnosis is a decidedly secondary goal
- The primary goal of a trauma-informed assessment is development with the consumer of a shared understanding of the role that trauma has played in shaping the survivor's life.
- Rather than seeing their "symptoms" and "disorders" as evidence of fundamental defects, clients are enabled to understand their strengths (adaptive capacities) as well as weaknesses that have grown out of their responses to horrific events.

Harris & Fallot 2001

Avoiding Misdiagnosis

Always maintain an *index of suspicion* about the primary diagnosis, particularly:

- in the absence of family history of psychosis
- when age of onset is atypical
- when psychotic symptoms themselves are atypical (e.g. taking off one's clothes)
- When there is history of repeated episodes of behavior typical of PTSD, such as excessive guilt, unusual forms of "hallucinations", symptoms atypical of other disorders (e.g. self-punishment without intent to harm)
- ***When the response to treatment has been largely unsatisfactory***, in ways difficult to explain (e.g. failure of even clozapine to affect "psychotic" symptoms).

Tucker 2002

Assessing PTSD and Complex PTSD

- Numerous structured interviews and questionnaires have been developed to assess PTSD

  Keane, 2000
- Current conceptualization of PTSD as a diagnostic category may limit recognition and exploration of the more complicated, expansive, and long-term effects of the kind of repeated and severe trauma experienced by clients in the public service sector
- This has important implications for trauma-informed assessments.

Harris & Fallot 2001

Assessing PTSD and Complex PTSD

- Trauma-informed assessments recognize that the traumas experienced by clients of the public mental health system
  - constitute a core, life-shaping experience with complicated and shifting sequelae over the course of one's life
  - is not a discrete event with a definable course and relatively circumscribed time limits
  - Cause impacts that may appear in multiple life domains that may not be apparently related to the traumatic event
- A trauma-informed assessment recognizes the importance of Complex PTSD Herman, 1992, Ford, 2004, or Disorders of Extreme Stress Not Otherwise Specified van der Kolk 1996

Complex PTSD

- Recognizes the fundamental changes in the survivor's affect regulation, consciousness, self-perception, perception of the perpetrator, relations with others, and systems of meaning
- Captures much more effectively the experience of many trauma survivors than does the more specific PTSD diagnosis

Harris & Fallot, 2001

A trauma-informed approach to diagnosis

- Recognizes the tremendous diversity, range, and duration of trauma sequelae and places these sequelae in the context of the person's life history
- Understands that experiences of physical, sexual , and emotional abuse can shape fundamental patterns of perceiving the world, other people, and oneself
- Prioritizes exploring the possible role of trauma in the development of not only "symptoms" and high-risk or self-defeating behaviors but of self-protective and survival-ensuring ones.
- Incorporates these possibilities in a shared assessment process, collaborating with the client in discussing and clarifying connections and sequences in the relationships among trauma, coping attempts, and personal strengths and weaknesses

Harris & Fallot, 2001

A trauma-informed assessment of Trauma Histories and Impact

Assesses For:

- ***Range of Abusive or Traumatic Experiences***
- ***Dimensions Related to Severity of Impact***
- ***Live domains Affected by Trauma***
- ***Identification of Current Triggers or Stressors***
- ***Identification of Coping Resources and Strengths***

Harris & Fallot, 2001

Assess for the *Range of Abusive or Traumatic Experiences*

- 2 dimensions of trauma must be considered:
  - The actual or threatened death or injury or threats to physical integrity APA 1994
  - The individual experiences of helplessness, fear, and horror these events elicit among survivors

APA 1994

- Clinicians must be aware that survivors may not share their views about what constitutes abuse or trauma. E.g. Male client may understand child sexual abuse by older female to be "initiation", or may accept physical abuse as "toughening him up".

Harris & Fallot 2001

Assess for *Dimensions Related to Severity of Impact*

- Certain factors may contribute to more severe long-term sequelae and should be addressed in assessment.
- Abuses that began earlier life, persisted over time, occurred frequently may have especially negative impact
- Assessment should attend to the invasiveness, degree of violence, and potentially life-threatening aspects of abusive events, and to the survivor's relationship with the abuser (family member, trusted adult, stranger)
- Responses of other adults to traumatic events and to disclosure of the events should be understood in the assessment process. Survivors often report debilitating effects of being disbelieved, or having their accounts minimized or dismissed. Often however, survivors' stories begin with the experience of being believed, taken seriously and protected by an adult. Harris & Fallot 2001

Assess for *Life Domains Affected by Trauma*

- Assessment should address core PTSD criteria of reexperiencing, arousal, and avoidance
- Assessment should also look for nonobvious connections - trauma sequelae seen in a wide range of life domains that affect the client in ways not apparently related to abuse or violence

Harris & Fallot, 2001

Assess to *Identify Current Triggers or Stressors*

- Identify current circumstances that may trigger trauma responses. E.g. Unexpected touching, threats, loud arguments, violations of privacy ro confidentiality, being in confined spaces with strangers, or sexual situations
- Also be watchful for other less obvious triggers that become evident as you know the consumer better and as he or she recognizes and can express her or his individual stress responses more accurately

Harris & Fallot, 2001

Assess to *Identify Coping Resources and Strengths*

- A trauma-informed assessment takes a whole-person approach, highlighting trauma survivors' strengths and resources as well as identifying problems, deficits and weaknesses.
- With re-framing of some symptoms to recognize their origins in attempts to cope with extreme threats and violence, a catalogue of existing coping skills can be created.
- This catalogue may include survival itself, self-protection skills, assertiveness, self-soothing.
- Explore non-obvious advantages of specific coping responses and work with survivor to affirm positive responses and incorporate them into ongoing service plan

Harris & Fallot 2001

Assess to *Identify Coping Resources and Strengths*

- Identify with client personal and interpersonal resources such as social support, self esteem and resilience, self-comforting, sense of meaning and purpose – to help them to recognize and draw on underused strengths
- To deal with current stressors, help client to identify strategies helpful in the past in dealing with overwhelming emotions. These strategies can then become part of the shared service plan (such as advanced directives, or safety plans. If crisis occurs again, professionals can draw on the clients own knowledge of what has previously helped and hurt.

Harris & Fallot 2001

Involve Multi-Perspectives

- The perspective of the individual her or himself is crucial to identify subjective symptoms or needs
- The perspective of others (e.g. family, treatment provider) may identify needs, problems, and changes that may not be evident to the individual her or himself.

Ford, 2005

Involve Several Measures

- There is no one "perfect" measure for assessing trauma or post-traumatic sequelae.
- Measures vary in reliability, validity, sensitivity, specificity, and clinical utility for different settings and populations
- Time permitting, use of both self-report and interview-based assessments are recommended.

Ford 2005

- Both structured and semi-structured observational assessments can provide ecologically valid behavior samples Newman 2002

Recognize 3 Stages of Assessment

Stage 1:

- Ensure safety and stability
- Screen for past and current traumatic experiences and symptomatic difficulties without in-depth exploration
- Provide education about the effects of trauma in non-stigmatizing, non-pathologizing, and user-friendly manner
- Teach/strengthen basic self-regulation skills and social supports

Ford 2005

3 Stages of Assessment

Stage 2:

- Assess past and current traumatic experiences and symptomatic and self-regulatory difficulties thoroughly with standardized replicable measures
- Provide education about the "traumagenic dynamics" and related alterations in core beliefs, self-regulatory strategies, interpersonal attachments, and spiritual/existential outlook (Herman, 1992) that begin as healthy self-protective reactions to trauma and can become persistent post-traumatic difficulties
- Provide a safe therapeutic environment for individual to disclose and gain more organized and self-regulated schemas or narratives for understanding current or past trauma-related experiences and problems in living
- Teach/strengthen skills for complex self-regulation and interpersonal relatedness

Ford 2005

3 Stages of Assessment

Stage 3:

- Monitor current stressful or traumatic experiences, symptoms, self-regulation, social support and personal strengths/resources on an ongoing periodic basis

Ford 2005

Sample Trauma Screening and Assessment Measures for Adults

Trauma Exposure/History: Self-Report and Structured Interview

- Life Stressor Checklist – Revised (LSC-R) Initial assessment of trauma history — Wolfe & Kimmerling, 1997
- WCDVS version of LSC-R – for women with substance abuse, mental health and trauma issues. — McHugo, 2005
- *Post-traumatic Stress Diagnostic Scale (PDS)* Self-Report used with PDS-Modified — Foa et al,
- *PDS-Modified;* comprenensive; interview/prompts — Rosenberg 2004
- *Trauma Assessment for Adults: Brief Revised Version (TAA).* Used for intake followed by comprehensive *TAA* and *PCL* SC Inpatient, CMHCs — Resnick, 1993
- *Trauma Assessment for Adults (TAA)* — Resnick, 1993
- *PTSD Checklist for Adults (PCL)* 17 item self-report scale. — Weathers 1994

Sample Trauma Screening and Assessment Measures for Adults

Trauma Exposure/History: Self-Report and Structured Interview

- Traumatic Events Screening Inventory (TESI) Ford et al 2000
- *Brief Trauma History Questionnaire (THQ)* Green&Mueser used with *PCL* at intake to NH Hospital Resnick 1993
- *Trauma Experiences Checklist (TEC)* Nijenhuis,
- *Sexual Abuse Exposure Questionnaire (SAEQ)* Rodriguez et al
- *Revised Conflict Tactics Scale (CTS2)* Straus et al,

For detailed reviews of trauma exposure interviews and measures see Wilson & Keane, 2004, and Briere, 2004.

Sample Trauma Screening and Assessment Measures for Adults

PTSD Symptoms: Self-Report and Structured Interview

- *Clinician Administered PTSD Scale for Adults (CAPS)* Blake et al, 1995
- *PTSD Checklist for Adults (PCL-C) for DSM IV* *Weathers et al 1994* Blanchard et al 1996
- PTSD Checklist for Adults (PCL-M for DSM IV) for veterans Weathors et al 1994
- *PTSD Symptom Scale-Interview* Foa et al, 1993
- *Post-traumatic Stress Diagnostic Scale (PDS)* Self Report (Foa et al,) used with comprehensive *PDS-Modified,* interview Rosenberg 2004
- *Trauma Symptom Checklist (TSC-40)* Symptoms related to sexual abuse trauma. Briere & Runtz 1989

Sample Screening and Assessment Measures for Adults

Psychosocial and Psychiatric Symptoms: Self-Report and Structured Interview

- *Trauma Symptom Inventory (TSI)* Briere 1997
- *Diagnostic Interview Schedule for adults (DIS)* Helzer & Robins 1988
- *Schedule for Affective Disorders and Schizophrenia Present and Lifetime Version (SADS-PL)* Kaufman et al 1997
- *Structured Clinical Interview for DSM-IV (SCID-P, SCID-II)* Kaufman et al, 1997
- *Global Appraisal of Individual Needs (GAIN)* substance abuse, legal and vocational issues, depression, anxiety, demographics (includes GPRA data categories) Dennis et al, in press

Sample Screening and Assessment Measures for Adults

Self-Regulation: Self-Report

- *Inventory of Interpersonal Problems-Short Form (IIP-32)* Barkham et al 1996
- *Post-Traumatic Cognitions Inventory (PTCI)* Foa et al, 1999
- *Generalized Expectancies for Negative Mood Regulation (NMR)* Cantanzaro & Mearns 1990
- *Meta-Experience of Mood Scales (Meta-Scales).* Mayer & Stevens, 1994
- *Positive Affect Negative Affect Scales (PANAS)* Watson et al 1988
- *Parenting Stress Index Short Form (PSI)* Abidin 1995

In Ford, 2005

Sample Screening and Assessment Measures for Adults

Social Support

- *Crisis Support Scale (CSS)* Joseph et al 1992
- *Homeless Families Social Support Scale.* SAMHSA

Personal Strengths

- *Hope Scale* Snyder 1996

In Ford, 2005

- **For additional measures see National Center for Posttraumatic Stress Disorder at www.ncptsd.org**

Screening and Assessment for Children and Adolescents

Screening and Assessment for Children and Adolescents

- A public health focus on prevention requires identification of trauma exposure in children
- A "thorough trauma assessment with children and adolescents is a prerequisite to preventing the potentially chronic and severe problems in biopsychosocial functioning that can occur when PTSD and associated or comorbid behavioral health disorders go undiagnosed and untreated" Wolpaw & Ford 2004

Screening and Assessment for Children and Adolescents

- Questions about trauma should be part of the routine mental health intake of children, with parallel questions posed to the child's parent or legal guardian
- Screening and assessment for trauma should occur also in juvenile justice and out-of-home child protection settings as well
- Assessment for trauma exposure and impact should be a routine part of psychiatric and psychological evaluations, and of all assessments that are face to face.

Hodas 2004

Screening and Assessment for Children and Adolescents

3 Basic approaches to assessment of trauma and post-traumatic sequelae in children through tools and instruments:

- Instruments that directly measure traumatic experiences or reactions
- Broadly based diagnostic instruments that include PTSD subscales
- Instruments that assess symptoms not trauma specific but commonly associated symptoms of trauma

Wolpaw & Ford 2004

Screening and Assessment for Children and Adolescents

- Use of de-escalation preference surveys, a secondary prevention intervention, represents an indirect method of finding out about trauma exposure. E.g. in indicating a desire not to be touched, a child may be reflecting past sexual abuse. NETI, 2003
- In institutional settings, use of a risk assessment tool to determine potential contraindications to use of restraint (and other coercive measures) requires that information on past abuse be obtained Hodas 2004

Trauma-Informed Screening and Assessment for Children and Adolescents

- Determine if child is still living in a dangerous environment. This must be addressed and stress-related symptoms in the face of real danger may be appropriate and life saving
- Provide child a genuinely safe setting and inform him/her about the nature, and limitations, of confidentiality
- Seek multiple perspectives about trauma (e.g. child, parents, legal guardians)
- Use combination of self-report and assessor-directed questions
- Recognize potential impact of both culture and developmental level while obtaining trauma information from children.

Wolpow & Ford, 2004

Screening and Assessment for Children and Adolescents

- Because trauma comes in many different forms for children of varying ages, gender, and cultures, there is no simple, universal, highly accurate screening measure.
- Screening approaches should identify risk factors such as poverty, homelessness, multiple births during adolescence, and other environmental vulnerabilities of trauma-related symptoms and behavior problems associated with trauma histories
  - PTSD symptoms (which vary with age)
  - Behavioral symptoms associated with trauma

Hodas 2004

Screening and Assessment for Children and Adolescents

- Parents, guardians or other involved adults would have to participate in screenings of younger children
- Older children and adolescents could complete a self-report measure
- Positive screens will require a more comprehensive follow-up evaluation conducted by a professional familiar with manifestations of childhood trauma

Hodas 2004

Sample Trauma Screening and Assessment measures for Children and Parents

For Trauma Exposure/History: Self-Report and Structured Interview:

- A simple screening measure published in JAMA that predicts PTSD in children who were seriously injured in accidents or burned in fires: asks 4-questions of child, parent, and medical record each. Winston et al 2003
- *Childhood Trauma Questionnaire*: Bernstein et al, 1994

For PTSD Symptoms: Self-Report and Structured Interview

- *Clinician Administered PTSD Scale for Children and Adolescents. (CAPS-CA)*: Newman, 2002
- *UCLA PTSD Reaction Index for Children:* Steinberg et al, 2004
- *Trauma Symptom Checklist for Children (TSC-C):* Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation and Sexual Concerns. Wolpaw et al, in press
- *PTSD Checklist for Parents (PCL-C/PR)* Blanchard et al 1996
- *Child Behavioral Checklist (CBCL)* General behavioral measures

Sample Trauma Screening and Assessment Measures for Children and Parents

For Psychosocial and Psychiatric Symptoms: Self-Report and Structured Interview:

- *Diagnostic Interview Schedule for Children (DISC):* Shaffer et al 1992
- *Diagnostic Interview for Children and Adolescents-Revised (DICA-R)* *Reich et al, 1991*
- *Schedule for Affective Disorders and Schizophrenia Present and Lifetime Version, Kiddie* version (K-SADS-PL) for children and adolescents: Kaufman et al, 1997

For Self-Regulation: Self Report

- *Parenting Stress Index Short Form (PSI)* Abidin, 1995

Screening and Assessment Measures for Childhood Trauma

- The SAMHSA-sponsored National Child Traumatic Stress Network (NCTSN) is well situated to undertake validation of these and other measures across a wide range of age groups, service sectors, cultural settings, and types of trauma.
- NCTSN is comprised of 50+ centers that provide treatment and services to traumatized children and families in 32 states and DC
- **See www.nctsnet.org**

In summary

- Excellent measures have been developed to aid in assessment of trauma history and diagnosis of PTSD.
- These measures have been shown to possess excellent psychometric properties (Blake et al, 1990; Weathers et al, 1999), and to be reliable and valid even with persons suffering serious mental illness (Goodman et al, 1999; Mueser et al 2001)
- There are increasing examples of state public mental health systems implementation of trauma screening and assessment. (NASMHPD 2005)
- Universal Screening and Assessment for trauma should be standard operating procedure for all organizations serving public sector clients

Lack of Trauma Screening and Assessment

- In a multi-site study where 98% of 275 patients with severe mental illness (schizophrenia and bipolar disorder) reported at least 1 traumatic event, the rate of PTSD was 43%, but only 3 (2%) of the 119 patients with PTSD had this diagnosis in their charts.

Mueser et al, 1998

Lack of Trauma Screening and Assessment

- Disclosures of childhood abuse made by psychotic patients are often dismissed, ignored or marginalised on the grounds that discussion of such issues will make symptoms worse. Hammersley 2004
- Patients with psychosis are asked less often about abuse (Read & Fraser 1998), and are less likely to receive a response if they do disclose abuse (Agar & Read 2002)

- This is especially true if assessments are conducted by professionals with strong beliefs about genetic causes of psychosis. Hammersley 2004