AnibalTORRES BERNAL DianaMILLE

Healing from trauma: Utilizing effective assessment strategies to develop accessible and inclusive goals

Zdravljenje travm: Uporaba učinkovitih strategij za oceno travme in za razvoj dostopnih in inkluzivnih ciljev

Abstract

Trauma is the fifth most common psychiatric disorder and is said to be the number one cause of suicide. Yet, research clearly demonstrates that trauma-related ailments are "under- recognized, under-diagnosed and under-treated" (Hanson et al., 2002). Research indicates that across various cultural groups there is an absence of effective assessment protocols. Additionally, many trauma-focused individual and group psychotherapy, self help and support groups have proven to be ineffective. Our manuscript examines the need for, and importance of, developing accessible and inclusive trauma assessment protocols that support the well-being of families around the world. In this article the authors will consider the efficacy of comprehensive universal screening and assessments, standardized questionnaires and self-reports. Methods for evaluating resources, establishing treatment plans and outcome measurements will also be considered.

Key words

psychological trauma, posttraumatic stress disorder, posttraumatic growth, resources, assessment instruments, inclusivity, accessibility, family therapy, multicultural strategies

Povzetek

Travma je peta najpogostejša psihiatrična duševna motnja in je glavni vzrok samomora. Vendar pa študije jasno kažejo, da so travma in z njo povezane težave pogosto "neprepoznane, nediagnosticirane in nezdravljene" (Hanson in dr., 2002). Raziskave prav tako kažejo, da v različnih kulturnih okoljih primanjkuje instrumentov za oceno travme. Poleg tega so se številne oblike individualnih in skupinskih psihoterapij, skupin za samopomoč in podpornih skupin, ki so osredotočene na zdravljenje travme, pokazale kot neučinkovite. V članku raziskujeva potrebo po in pomen razvijanja dostopnih in inkluzivnih instrumentov za oceno travme, ki podpirajo dobrobit družin širom po svetu. Preučujeva učinkovitost univerzalnega presejevanja in ocenjevanja, standardizirane vprašalnike in samo-ocene. Prav tako prikaževa metode za oceno virov, za pripravo načrtov obravnave in za merjenje izida.

Ključne besede

psihološka travma, posttravmatska stresna motnja, posttravmatska rast, viri, instrumenti za oceno, inkluzivnost, dostopnost, družinska terapija, multikulturne strategije

Note:Both authors contributed equally to the development of this manuscript. Aníbal Torres Bernal would like to acknowledge Isabelle Wilczewski for her invaluable help and support in the development of this manuscript.

Aníbal Torres Bernal, Ph.D., Department of Marriage and Family Therapy;

Diana Mille, Ph.D., Department of Marriage and Family Therapy. Fairfield University, Walsh Gallery, 1073 North Benson Road, Fairfield, CT 06824-5195; dmille@fairfield.edu

INTRODUCTION

Mental health professionals are often the first professionals to encounter and service clients dealing with the effects of a traumatic experience. Unfortunately, research supports that trauma is under-recognized, under-diagnosed and under-treated. For example, one recent study, conducted at agency level in the United States of America (USA) State of Connecticut, provided a particularly "eye-opening" description of the current functioning of trauma services (Hanson et al., 2002).

This study identified trauma as being prevalent across 19 agencies with 56% of clients having a written diagnosis directly related to a traumatic experience. Even though the majority of clients were dealing with the effects of trauma the study shows limited evidence of the utilization of best practices. The following 'best practice' treatment protocols: mandatory, formal screening and assessing, (with little use of both direct questioning and a written self-report and continuing reliance on spontaneous self-disclosure and records); trauma-specific interventions, (the majority offering no specific trauma services with the exception of safety planning for victims of domestic violence and sexual abuse); cross-referral mechanisms; and trauma-related supervision and education (Hanson et al., 2002) were missing from the agencies services. This study is one in many that raises questions regarding how prevalent is the adoption of best practices in diagnostic and treatment protocols for trauma.

Thus, our intention is to first address how trauma is defined and its impact on those who suffer from it. Having established a more accessible and inclusive definition of trauma and its impact, our manuscript seeks to explore how the following domains: diagnostic criterias, symptomatology, and assessment can foment increased accessibility and inclusivity to the treatment of trauma. The authors will also discuss how specific topics (e.g., gender, culture, chronicity and context) affect the therapeutic milieu, especially as it relates to accessibility and inclusivity.

DEFINITION OF TRAUMA

The definition of psychological trauma is fairly broad and complex – even within trauma-specific literature. While we all use the word "trauma" in our daily language to refer to an event that is stressful, a real "trauma," however, is something that overwhelms the individual from an emotional and cognitive perspective, and affects their ability to cope, function and communicate. Most researchers and clinicians are in agreement that psychological trauma has three main components – the traumatic experience was unexpected, the individual or individuals were unprepared to deal with the traumatic experience, and there was nothing they could do to prevent the traumatic experience from happening.

The Sidran Institute for Traumatic Stress Education and Advocacy (2010) broadly summarizes psychological trauma as the unique individual experience of an event or enduring condition, in which the individual's ability to integrate his/her emotional experience is overwhelmed or the individual experiences (subjectively) a threat to life, bodily integrity or sanity (Giller, 2010). OMHAS (2010) defines psychological trauma as a cluster of symptoms, adaptations, and reactions that interfere with the functioning of an individual who has extreme suffering (including neglect and deprivation) and which result from serious bodily harm, physical abuse and assault,

sexual abuse, neglect, witnessing or surviving an accident, natural disaster or combat.

A more accessible and inclusive definition of psychological trauma is given by leading psychology professor John P. Wilson, "It is important to note that semantically the word 'trauma' derived from the Greek and Latin roots (cf. traumatos, in which "trauma" means injury to the body and results in a state of being wounded). Physical trauma causes injury to bodily integrity and normal biological functioning. Psychological trauma causes injury to the mind and its inherent processes and functions, including the ego, identity, and self-structure. Psychological trauma is caused by an external event that affects internal psychological phenomena at multiple levels of functioning and in conscious and unconscious modalities of awareness and behavior" (Wilson et al., 2001, p.54).

THE IMPACT OF TRAUMA

The impact of trauma is powerful and multidimensional in terms of invading the self-structure and our inter-personal connections. The whole of the person is "wounded." Trauma affects all dimensions of behavioral functioning and psychological responses to physical and psychological injuries. The effects of trauma can also challenge our belief systems concerned with meaning, faith and expectancies about humanity and life itself. The effects of trauma can also create changes in worldview, beliefs about human nature, patterns of intimacy, interpersonal relationships and conceptions of oneself and personal identity (Wilson et al., 2004).

The Impact on Self-Structure

According to Wilson and colleagues (2004): Self-structure is a central organizing component of personality and has both structural and functional dimensions that are critical in understanding our responses to trauma. Extreme trauma attacks the individual's core self, resulting in structural damage to the organization of self (e.g., causing loss of ego and continuity, doubt, guilt, shame, helplessness, uncertainty, vulnerability, self-destructive tendencies and loss of spirituality) (Wilson et al., 2004). Traumatic events such as assault, violence, abuse and combat experiences attack the self and our constructs of personal meaning.

However, clinicians must consider an individual's subjective experience in determining the extent to which damage to the self-structure has taken place. It is often the case that it is not the event that determines whether an experience or event is traumatic to someone, but their experience of the event. This is often dependent on the severity of the event, the individual's personal history, the broader meaning that the event represents for the individual, the available coping mechanisms, values and beliefs of that individual and the relational support that they receive from those around them. Thus, the subjective experience and perceptions of an individual exposed to trauma becomes of critical importance during assessment and treatment.

The Impact on Interpersonal Relationships

Extreme fragmentation to the self-structure leads to an adverse impact on interpersonal behaviors and functioning, which is often described as a loss of connection. The impact on interpersonal relationships is manifested through the following symptom clusters: alienation, mistrust, isolation, anhedonia, impulsiveness, impaired sensuality, anger, inability to relax, inappropriate personal boundaries and self-defeating behaviors (Wilson et al., 2004). Several studies confirm the negative effects of social withdrawal, low levels of self-disclosure and expressiveness, ne-

gative view of self and difficulties with trust associated with Wilson's interpersonal trauma construct on intimate relationships.

For example, one study conducted by researchers Sherman et al., (2006), which employed reliable and valid measures (e.g., Conflicts Tactics Scale, the Locke-Wallace Marital Adjustment test and the Inclusion of Other in the Self Scale), examined the interpersonal effects of trauma amongst members of the USA armed services returning from Iraq and Afghanistan. They concluded that domestic violence, hostility (most likely a result of a partners attempt at engagement), marital instability, relationship dissatisfaction rates and negative intimacy issues (the latter consistently demonstrating a high inter-predictability) were much higher (45%) than those found in veterans not suffering from trauma. This study employed a convenience sample – couples presenting for therapy at one VA medical center – which suggests that the estimates for violence may actually be lower than those which might be found in a random controlled study due to the stigma of reporting violence and the tendency of patients to minimize the severity of violence (Ehrensaft and Vivian, 1996).

The Impact of Secondary Traumatic Stress on Interpersonal Relationships

The presence of secondary traumatic stress suggests that family members in close contact with a traumatized person will often experience similar symptoms since they come to identify with the experiences of the victim and begin to internalize them. However, empirically supported, theory-based literature that identifies the mechanisms by which interpersonal or "secondary trauma" occurs in response to traumatic events is limited. In the past, the fields of traumatic stress and marriage and family therapy have only occasionally intersected in the development and conceptualization of psychological trauma (e.g., finding high levels of secondary trauma in one-third of spouses of Holocaust survivors) (Goff and Smith, 2005; Lev-Wiesel and Amir, 2001).

In their study, Goff and Smith (2005) developed The Couple Adaptation to Traumatic Stress Model (CATS). This model helps track variables such as pre-disposing factors (e.g., individual characteristics, unresolved stress experience and preexisting vulnerabilities) and resources (e.g., financial, educational, self-esteem, social support and coping strategies), level of functioning (e.g., emotional, behavioral and cognitive) in both the primary and secondary trauma survivors. These variables were deemed to meaningfully impact the interpersonal relationship of the couple, thus measuring the potential for a mutual process of individual trauma symptoms of both partners and supporting a systemic theory of traumatic stress (Goff and Smith, 2005).

Although the CATS model shows how individual and couple systems often transmit trauma related problems, (e.g., attachment, identification, empathy and projective identification and conflict responses), further empirical research is required to validate the direct relationship of the variables used in the model. Additionally, more data is needed to further identify and understand the mechanisms used in the transmission of traumatic stress. Current research does not address what mechanisms are at play in the transmission processes (Goff and Smith, 2005).

Extricating marital problems or relational difficulties from trauma related difficulties could be a challenge. Unfortunately, contemporary research does not provide clear guidance in this matter. In our subsequent discussion we will consider how this challenge has been partially met. What research clearly shows is that the relational life of clients affected by traumatic experiences often revolves around their subjective experiences of the traumatic event(s). It changes how clients see themselves, how they see the world around them and how they interact with those

around them.

POST-TRAUMATIC STRESS DISORDER

One of the most common and undertreated diagnostic labels associated with traumatic experiences is post-traumatic stress disorder (PTSD). Nearly 8% of all individuals have enough symptoms to meet the diagnostic criteria of PTSD. Research shows that many patients who seek physical healthcare have been exposed to trauma and show PTSD symptomatology, but have not yet received appropriate mental health care. (National Center for PTSD, 2010).

Definition

DSM-IV-TR (APA, 2000) defines PTSD stressors as the experience, witnessing or confrontation with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (Criterion A1), and the person's subjective response involving fear, helplessness, or horror (Criterion A2). The core symptom criteria of PTSD are grouped into three categories: re-experiencing symptoms and intrusive emotional memories (Criterion B), emotional numbing and stimulus avoidance (Criterion C), and hyper-arousal (Criterion D). In order to establish a diagnosis, some cluster of these symptoms must remain past one month (Criterion E) and cause clinically significant impairment in social, occupational, or other areas of functioning (Criterion F).

Expanded View

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease (Weathers, 2007).

While the diagnostic criteria for PTSD has served as a unifying construct to recognize common conditions regarding the core of trauma and its aftermath, researchers have found that Criterion A presents a dichotomy that clinicians must consider. While some critics, for example, find the definition for Criterion A1 an excessively broad construct -- allowing for too many events to be considered in PTSD evaluation – Researchers McNally, Breslau and Kessler (2001, 2004) maintain that this increased specificity actually enable clinicians to locate a "real" increase in exposure of traumatic events and may be an asset in providing clinicians with an added flexibility in considering a wide variety of stressors as predicting trauma (Weathers, 2007). Furthermore, while some critics argue that the broad language in Criterion A2 (e.g., a distress response of fear, helplessness or horror) – can lead the shift away from an objective standard to a subjective standard – implying that trauma could be defined as any event that the patient finds intensely distressing, others argue that this somewhat broad language is helpful as a screening tool for early identification of trauma survivors who will most likely develop PTSD and should include

other general, heightened emotions such as anger, shame and grief (Weathers, 2007, Brewin et al., 2000).

PTSD and Shame

Psychological traumas have been characterized as threats to the social self. At the same time, shame has been identified as the main emotion stemming from threats to the social self. It is a painful awareness of anxiety, negative judgment, unwanted exposure, inferiority and failure. Thus, as a dimension of self, shame has both internal and external/collective orientations (Budden, 2009).

Wilson et al. (2006) defines posttraumatic shame as both acute and prolonged feelings and secondary appraisals of the damaged social-self, and identify its core maladaptive dimensions. One subset constellates around diminished personal value including the loss of face, esteem, and self-worth; diminished wholeness, virtue and moral integrity; and feelings of powerlessness, inadequacy, failure and smallness. Another subset encompasses compromised social relations and integrity of self in the eyes of others. These include loss of self-respect and self-continuity within culturally defined roles, status and expectations; self-consciousness over letting down intimate relations; and social condemnation and failure (Wilson et al., 2006).

Shame plays an active role in the development of PTSD symptoms in the course of traumatic events such as torture, sexual abuse, combat, physical injury, accidents and unexpected loss. Furthermore, while the degree of severity in the experienced shame has been linked to helplessness/stigma and horror (Criterion A), re-experiencing events (Criterion B), hyper-arousal (Criterion D) and to emotional numbing and avoidance (Criterion C), and is the only emotion that predicts PTSD symptoms past the one-month diagnostic threshold and beyond six months (Brewin et al., 2000, Wilson et al., 2006). Unfortunately, the critical role that shame plays on symptom development and maintenance goes largely unrecognized in DSM-IV-TR (APA 2000).

In their efforts to re-evaluate Criterion A -- and by including shame in the prevailing understanding of PTSD -- researchers argue that PTSD can be understood less as a scientific, single-dimension diagnosis with a limited set of clinical symptoms, and more as an inclusive (e.g., physical, psychological, social, spiritual and interpersonal) phenomenon. As Wilson et al., (2007) summarizes that given the capacity of traumatic events to impact adaptive functioning, including inner and outer worlds of psychic activity, it is critically important to look beyond simple diagnostic criteria such as PTSD to identify both pathogenic and salutogenic outcomes as individuals cope with the effect of trauma in their lives. The history of scientific research on PTSD is badly skewed towards the study of psychopathology rather than on human growth, self-transformation, resilience, and optimal functioning (Wilson et al., 2007).

Cultural Considerations

While globalization has generated trends towards the homogenization of cultures, it has also heightened our awareness of distinct cultural differences (Friedman, 2005). As Wilson et al., (2007) notes that the relationship between trauma and culture is an important one because traumatic experiences are part of the life cycle, universal in manifestation and occurrence, and typically demand a response from culture in terms of healing, treatment, interventions, counseling, and medical care. The experience of psychological trauma can have differential effects to personality, self and developmental processes, including the epigenesist of identity within culturally-shaped parameters. We cannot assess trauma impact and trauma response without examining cultural sources of resilience at both the personal and community level.

While the study of PTSD has clearly generated an impressive body of scientific knowledge, it lacks carefully crafted cross-cultural studies of traumatic healing and human adaptation. It cannot be assumed that well-documented western psychotherapies for PTSD are necessarily useful in non-western cultures (Fairbanks et al., 2000). And the fact remains that multicultural populations living in war-zones, veterans of armed conflict, and victims of a range of criminal acts such as sexual assaults, terrorist attacks and torture are generally considered to be at the greatest risk for PTSD (Fairbank et al., 2000). There are currently two positions among researchers regarding the interpretation of culture within the trauma construct -- one that validates PTSD as a universal and psychobiological cross-culturally valid response to trauma cured by western influenced mental health therapies, and another that maintains that trauma can only be interpreted, diagnosed and treated in the context of a particular culture (Kienzler, 2008).

The APA describes PTSD as a universal and cross-culturally valid psychopathological response to traumatic distress. It also supports the application of many Western influenced psychotherapeutic approaches (e.g., emotional support, psycho-education, sympathetic reassurance and recognition of "core" problems) in relation to the disorder. To a certain extent these approaches have been proven to be effective – psychosocial, pharmacological and cognitive-behavioral have helped many working through trauma (Young, 2006).

In recent years, however, disagreement has surfaced over the concept of PTSD in the context of culture. Researchers, for example, now criticize programs that are unfamiliar with the situations they have to address – claiming the destructiveness of unilateral ignorance of the history of a region, its' culture, social and political systems in an effort to implement "quick fixes."

The globalization of western ideas about "suffering" in general has also become critical in the discussion of the cultural construct. Although suffering is a universal human experience in which individuals and groups undergo or bear certain burdens, troubles and serious wounds to the body and the spirit, there is no single way to suffer as pain is perceived and expressed differently, even in the same community (Kleiman, 1997).

According to researchers Almedom, Jones and Summerfield (2004), for example, the western approach to suffering de-contextualizes human problems. The larger context of suffering can only be resolved in a social context. For those who suffer from trauma, it is the familial, sociocultural, religious and economic activities that make the world comprehensible during and after trauma. Trauma, then, can only make sense in the context of a particular culture and social setting where -- while considerations must be given to universal biological/genetic risk factors such as trauma severity, gender, prior experiences, and personality characteristics -- considerations must also be given to culture-specific forms of coping, vulnerability and resilience.

For example, in their recent study, Landau et al., (2008) use the Link Approach – which is at once "culturally informed," "multilevel," and "multi-informant" -- to focus on locating the strengths (e.g., resilience) and promote healing and reconnection in individuals, families and communities affected by mass trauma. This view recognizes PTSD, not as a product of trauma in itself, but instead as a construct of trauma and culture acting together, and where psychological knowledge is a product of culture at a particular point in time. More specifically, it follows that intrusion-avoidance and hyper-arousal symptoms (Criterion C) are related to the search for meaning, and meaning is always related to cultural backgrounds (Almedon and Summerfield, 2004; Kienzler, 2008).

THE TRANS-CULTURAL FRAME

In recent years, the focus in trauma research has shifted to a more culturally-reflective and holistic approach. This new approach considers how Western approaches to healing trauma might become imbedded in western and non-western cultural and social settings in the form of community-oriented psychological trauma intervention programs. Proponents of this approach advocate for the comprehension of the victims story/narrative and for the understanding of suffering as a unique social experience.

Trans-cultural researchers strongly support the inquiry and understanding of the roles of psychosocial factors such as resilience, social cohesion, coping skills and support networks in the healing of trauma – while maintaining connections with universal, psychobiological and western clinical concerns – especially as the trauma becomes more severe. More importantly, supporters of the trans-cultural view seek to heighten our awareness of traditional practices of healing – which speak to the central values of the individual and the community -- within the generalized PTSD construct. For the supporters of this view, for example, it is imperative to take into account the indigenous expressions of disorder, idioms of distress and ethno cultural sensitivities in assessing norms, formats, language and concepts within the PTSD construct (Kienzler, 2008). Presently, only a few programs (e.g., Transcultural Psycho-Social Organization) providing large-scale aid to trauma victims, actually combine western protocol with traditional healing strategies. TPO is a multidisciplinary collaborative and culturally sensitive intervention program focusing on community- oriented response and culturally sensitive health responses to the psychosocial problems of refugees.

Only continued interdisciplinary research will lead to a more holistic approach to treating trauma/PTSD. It will need to take into account local perceptions

of health and illness, ways of healing, capacities and desires. The time is now for clinicians and researchers to find culturally sensitive and ecologically valid instruments designed for the assessment of trauma, since, at present, we have no standardized, universal measurements of trauma and PTSD are lacking as well as standardized cross-cultural treatment protocols (Wilson et al., 2007).

INCLUSIVE AND ACCESSIBLE ASSESSMENT

Assessment explores the nature and severity of traumatic events/PTSD and trauma-related symptoms. It differs from traumatic screening in that the latter is only a brief inquiry to determine whether and individual has suffered from a traumatic event (Harris and Fallot, 2001). It is of particular importance because it is widely recognized that PTSD symptoms often go unevaluated, unrecognized and untreated mainly due to underreporting of trauma (e.g., shame, guilt, vulnerability) and under -recognition of trauma by mental health providers.

In USA community mental health settings rates of recognition are low, with as few as 4% of individuals receiving the diagnosis of PTSD. Moreover, in one multi-site study, it was found that although 43% of clients met the diagnostic criteria for PTSD, only 2% actually received the diagnosis in their records (Frueh, 2004, Sherman et al., 2004). According to the literature

inclusive and accessible assessment protocols and processes must include: the importance of regular screening and assessing for trauma; the importance of recognizing what we are specifically assessing for from within the trauma construct, largely the domains that comprise the diagnosis of PTSD (e.g., trauma exposure (Criterion A1/DSM-IV-TR), trauma symptomatology (Criterion A2/DSM-IV-TR); the frequency and duration of symptoms; the presence of single or multiple traumas; the specific population that requires assessment; the specifics of gender, culture and race and the corresponding risk factors for these specialized groups. We also recognize the importance of identifying co-morbidity in the assessment process -- since it dictates the appropriate treatment response – a discussion on this is beyond the scope of this paper.

Numerous measurements have been created to assess traumatic events and exposure. As researchers Gray and Slagle (2006) notes that there does not appear to be one PTE measure above others for all purposes or inquiries about all incidents. In addition, there are a number of differences in language and the domains covered among these measures and their appropriateness regarding the psychometric properties of reliability and validity. Furthermore, while self-reporting inventories of trauma histories can be more accessible, more cost effective, and less time consuming than structured clinical interviews, the former still presents a challenge in obtaining external corroboration of the events reported – especially when multiple events occur.

In addition, failure to report traumatic events largely due to the perceived stigma or shame attached to the event makes it equally challenging for clinicians to assess the presence of trauma/PTSD. Clinicians can face this challenge by first establishing rapport with their clients and insuring confidentiality before the assessment process and by selecting measures that demonstrate a strong correlation between the number of events and symptom severity – according to PTSD scales. As Gray and Slagle (2006) note that it has been consistently observed that PTSD symptom severity is strongly correlated with the frequency of PTE exposure.

The rest of this paper intends to summarize some of the most widely-used and successful means for assessing trauma/PTSD. As is the case throughout this paper, accessibility, inclusivity, reliability, and validity are given priority when focusing on these measurements (e.g., self-reports and structured clinical interviews) – as well as their strengths and limitations. Finally, in an effort to determine what the future direction should take regarding the improvement of the assessment process of trauma/PTSD in clinical research and practice, a more holistic and mixed-method assessment model will be offered which promotes a more subjective inquiry into the individual's perception of traumatic events and their social support systems and which could be incorporated into our existing scientific/objective measurements. The ultimate goal is to develop a salutogenic paradigm where traumatic experiences have the capacity to provide a catalyst for the development of deeper meaning and personal growth after trauma (Rieck, 2005).

ASSESSMENT INSTRUMENTS

TLEQ

Is a 23-item checklist that assesses broad traumatic exposure and trauma symptomatology associated with Criterion A2 in behaviorally descriptive terms, and in event frequency. Due to its broad trauma coverage, the TLEQ can identify traumas that other measurements cannot detect. It has proved effective, for example, in assessing trauma from natural disasters and in distinguishing various forms of trauma caused by sexual assault and accidents (Gray and Slagle, 2006).

While TLEQ has good psychometric properties (reliability and validity) and can be administered in 10-15 minutes, it is not freely available to clinicians and researchers. Additionally, Kubany et al (2000) identify the presence of underreporting and false reports – as is typically found with many self-report measurements.

Clinician-Administered PTSD Scale (CAPS)

This instrument is one of the most widely-used structured interview based assessments in the diagnosis and measurement of trauma/PTSD. It is used in assessing a wide variety of trauma populations – including combat veterans and victims of rape, crime, incest, torture and illness. It has served as the primary diagnostic measure in more than 200 empirical studies.

CAPS is a semi-structured interview that assesses the features, frequency and intensity of PTSD according to the diagnostic criteria presented in the DSM-IV. While initial questions target each symptom, follow-up items help provide additional -- and often needed -- clarification. CAPS is particularly useful in assessing for three symptom clusters within DSM-IV – re-experiencing, avoidance and numbing/Criteria B-D as well as chronology (Criterion E), and functional impairment (Criterion F).

A unique feature of CAPS is that it affords the clinician or researcher greater flexibility into the inquiry about symptom occurrence -- over the past week, month, or lifetime. As such, it is used to track changes in diagnostic status and symptom severity over time, which is critical in establishing treatment outcomes. In a series of psychometric studies, CAPS has demonstrated great inter-rater reliability, test-re-test reliability, and internal consistency (e.g., relating to other studies). Furthermore, CAPS has the means to evaluate the all-important concerns of social and occupational functioning. While it is time-consuming, taking up to 60 minutes to complete, it is readily available and promotes uniform administration and scoring across interviewers with its use of clear behavioral referents and also has the capacity to ensure equality in scores across diverse settings and trauma populations (National Center for PTSD, 2010).

LEC (with CAPS)

Developed concurrently with CAPS, The LEC is a screening measure that consists of 16 items inquiring about the experience of 16 different potentially traumatic events (PTE) known to result in PTSD. A unique feature of LEC is that it inquires about multiple types of exposure to potentially traumatic events such as direct experiencing or witnessing of a violent assault or accident, and assesses their intensity. It is particularly useful when assessing recent combat populations since it inquires about sexual assault, toxic substance exposure, fires and explosions.

LEC, however, lacks attention to other traumatic stressors such as intimate partner abuse and childhood physical abuse (Gray and Slagle, 2006). Psychometrically, The LEC compares favorably with TLEQ and demonstrates consistency with other trauma-specific measurements such as the PTDS Checklist (PCL-M), CAPS, and the Mississippi Scale for Combat-Related PTSD. One of the disadvantages of LEC is that it does not assess for Criterion A2 – emotional response within the DSM-IV diagnosis -- and should, therefore, not be used as a "stand alone" measure. Many researchers and clinicians typically use the LEC as a brief screening measure followed by CAPS.

Stressful Life Events Screening Questionnaire (SLESQ)

SLESQ is a 13 item self-report inventory of exposure to a broad range of traumatic life events where there is widespread agreement regarding the capacity of these events – with the exception

of disasters -- to cause PTSD. While SLESQ successfully assesses for exposure frequency, it does not formally assess for Criterion A2 (response of intense fear, helplessness and horror). Like LEC, then, it cannot be used as a "stand alone" measure. Its uniqueness, however, lies in the fact that it measures trauma-event details such as the age of the victim at the time of the incident, injuries, hospitalization enabling clinicians to access important trauma information within the frame of a quick screening process (Gray and Slagle, 2006).

Traumatic History Questionnaire (THQ)

THQ is a self-report that assesses PTSD Criterion A1 and can easily be adapted into a structured interview. THQ allows for a broad definition of trauma and provides a comprehensive assessment of trauma history (e.g., crime-related experiences, exposure to man-made and natural disasters, witnessing of those injured or killed, death/unexpected of a loved-one, life-threatening illness, military combat, physical attack with and without a weapon and sexual assault). While THQ demonstrates sound reliability, information on the validity of this measure – the extent to which the evidence exists to support the various interpretations, hypothesis and conclusions or measures what it is supposed to – is limited.

The Harvard Questionnaire (HTQ)

Generated in the mid-1980s at the Harvard Program in Refugee Traumas, and currently available in six different languages, however, The HTQ is a cross-cultural instrument designed for the assessment of trauma and torture related to mass violence. The HTQ consists of a checklist for measuring trauma, torture and trauma event symptoms. The HTQ is open-ended and subjective in its inquiry and has been used to uniquely assess social functioning, disability and culturally-specific symptoms associated with PTSD among traumatized refugees (Mollica et al, 2004)).

According to researchers Mollica et al., (2004), the HTQ has demonstrated efficacy in the identification of PTSD symptoms and psychological distress in culturally diverse environments. A major contribution of HTQ is its adaptability to context. While statistically correlated to symptoms of PTSD, additional items on the HTQ, for example, measure personal perceptions of psychosocial functioning in response to persecution, violence and displacement (Shoeb et al., 2007). Furthermore, the HTQ has the unique capacity to be modified and adapted to the characteristics of each new cultural group of refugees being assessed with their specific set of traumas and trauma-history. DSM-IV items, for example, are back-translated and tested thus identifying new refugee- specific symptoms (Shoeb et al., 2007).

FUTURE DIRECTIONS IN TRAUMA / PTSD ASSESSMENT

Symptoms of PTSD have been strongly correlated with emotions and feelings of anger, hostility and aggression – especially with combat populations -- within the first years after experiencing the traumatic event. There is also strong agreement among clients, spouses, clinicians and researchers that anger and aggressive behavior are major concerns in the families of patients suffering from PTSD. These findings suggest that clinicians need to screen for anger and aggression among this population when they exhibit symptoms of PTSD and incorporate relevant anger treatments into early intervention strategies. Furthermore, researchers need to examine possible factors that place this specific population at risk and how they impact female and minority populations (Jakupcak et al., 2007).

Cultural Factors in Assessment

Researchers and practitioners, such as Wilson et al., (2007) have asked the important question: How does psychology standardize the assessment of trauma across cultural boundaries? This is a critical question. Especially when you take into account the trend of globalization and our evolving understanding of the relationship between trauma and culture. At present, most researchers agree that we have no standardized, universal ethic measurements of trauma and PTSD.

Clinicians and researchers recognize the need to incorporate a cultural-ecological perspective within our clinical and field-based community interviews as a starting point in assessing world trauma. Linguistic equivalences, response bias and cultural validity issues are just a few of the problems faced by those assessing trauma around the world. In other words, existing self-report instruments used in the trauma field, for example, concerned with traumatic experience and symptoms have not been culturally validated. Furthermore, there is a lack of instrumentation to measure resilience and coping – two important constructs in the development of PTSD – within specific cultural contexts.

Culturally Adapting Assessment Instruments: HTQ in Practice

Having recognized the value of culturally specific idioms of distress in assessing trauma in non-western conflict situations, one study conducted by researchers Shoeb et al. (2007), adapted the HTQ to the Iraqi context in an effort to measure torture, trauma and PTSD in 60 Iraq Refugees living in Dearborn, Michigan. This study attempts to balance – within the trauma assessment process -- consideration of cross-cultural standardization (e.g., western psychiatric diagnosis) with cultural specificity (e.g., local language, traditional practices and faith). Furthermore, the study illustrates how ethnography – as it relates to well-being, illness and suffering in relation to the socio-cultural contexts in which they occur -- can and did inform the development of the Iraqi version of the HTQ and offers promise in examining other local paradigms and developing appropriate assessment tools in other cross-cultural settings (Shoeb et al., 2007).

MIXED-METHOD ANALYSIS AND POSTTRAUMATIC GROWTH

Current research is just beginning to contribute to the empirical literature that examines both negative and Posttraumatic Growth/PTG outcomes for trauma. Rieck et al., (2005) holistic study conducted in Queensland, Australia, for example, examines the effects that trauma severity and social support have on trauma outcomes. Utilizing three scales demonstrating good reliability – the Impact of Events Scale – Revised, Posttraumatic Growth Inventory (PTGI) and Social Support for Trauma Scale -- this study demonstrates that an individual's perception of traumatic experience and the social support they receive will strongly impact posttraumatic growth/PTG outcomes.

This study demonstrates that experiences of trauma may not only consist of negative outcomes, but may also provide an individual with new perceptions that can result in intensely positive changes regarding personal growth and healing – one again embracing Wilson et al., (2007) more salutogenic paradigm of trauma where traumatic experiences provide a catalyst for the development of deeper meaning and personal growth in one's life (Rieck et al., 2005). In another trauma study of Bosnian refugees conducted by Powell et al., (2003), The Posttraumatic Growth Inventory actually measured high levels of PTG in individuals reporting severe

trauma (e.g., grief, physical injury, illness, terrorism and disasters) and demonstrated that social support – derived from health care professionals, family and friends – also enhanced one's sense of intimacy, appreciation of others, ability to cope and personal growth -- suggesting that the difficulty of personal struggle in overcoming adversity can be predictive of PTG. In other words, an individual's intense thinking may interact with other cognitions including deeper and philosophical meanings (e.g., culture, religion and social values) to produce co-existing but diverse outcomes such as ruminations and coping skills.

There are, however, certain limitations of this study which include the use of Social Support for Trauma Scale -- a newly constructed scale without proven efficacy -- a sample restricted to self-selected university students, the lack of a control or non-trauma group to compare to a random group, and a lack of longitudinal study to identify significant times, ages and events after trauma that help promote PTG. The research in this study in no way suggests that negative symptomatology should be ignored or unmeasured, but provides clinicians with an opportunity to help those suffering from trauma to connect to others and to recognize that they have survived a difficult challenge. In other words, rather than falling victim to the trauma, these survivors are encouraged to move on. This more positivist view, however, requires the existence of a special therapeutic relationship wherein the therapist and client demonstrate an optimist attitude towards trauma and work towards involving significant others in the therapeutic process.

REFERENCES

Almedon, A. and Summerfield, S. (2004). Mental well-being in settings of complex emergency: an overview. *Journal of Biosocial Science, 36*, 381-388.

American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders. (4th ed.,text rev.). Washington DC: Author.

Breslau, J. (2005). Response to Commentary: Deconstructing Critiques on the Internationalization ofPTSD. *Culture, Medicine & Psychiatry, 29*, 371-376.

Brewin, C. R., Andrews, B. and Valentine, J.D. (2000). Meta analysis of risk factors for PTSD in trauma-exposed adults. *Journal of Consulting & Clinical Psychology, 68*, 748-766.

Budden, A., (2009). The role of shame in posttraumatic stress disorder: A proposal for a socio- economic model for DSM-V. *Social Science and Medicine, 69*, 1032-1039.

Ehrensaff, M.K. and Vivian, D. (1996). Spouses' reasons for not reporting existing physical aggression as a marital problem. *Journal of Family Psychology, 10*, 443-453.

Fairbank, J., Ebert, L. and Costello, E. (2000). Epidemiology of traumatic events and post-traumatic stress disorder. In D. Nutt, J. Davidson and J. Zohar (Eds.), *Post-traumatic Stress Disorder*, (pp.17-28). London: Martin Duniz Ltd.

Foa, E.B., Keane, T.M. and Friedman, M.J. (2000). *Effective Treatments for PTSD*. New York: Guilford Press.

Friedman, M. (2005). Veterans mental health in the wake of the war. Posttraumatic stress disorder among military returnees from Afghanistan and Iraq. *American Journal of Psychiatry, 163*, 586-593.

Frueh, B.C., Elhai, J.D. and Kaloupek, D.G. (2004). *Unresolved issues in the assessment of trauma exposure and posttraumatic relations*. New York: Wiley.

Giller, E. (2010). What is Psychological Trauma. *Sidran Institute for Traumatic Stress Education and Advocacy*, Available at: www.sidran.org/sub.cfm?contentID=88&sectionid=4

Goff and Smith, D.B. (2005). Systematic Traumatic Stress: The Couple Adaptation to

Traumatic Stress Model. *Journal of Marital and Family Therapy*, 31, 145-157.

Gray, M.J. and Slagle, D.M. (2006). Selecting a Potentially Traumatic Event Screening Measure. Practical and Psychometric Considerations, *Journal of Trauma Practice, 5*, 1-19.

Hanson, T.C., Hesselbrook, M., Tworkowski, S. and Swan, S. (2002). The Prevalence and Management of Trauma in the Public Domain: An Agency and Clinical Perspective. *The Journal of Behavioral Health Services and Research, 29,* 365-380.

Harris, M. and Fallot, R.D. (2001). *Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services*. New York: Jossey-Bass.

Hoshmand, L.T. (2007). Cultural-Ecological Perspectives on the Understanding and Assessment of Trauma In J.P. Wilson and C.S. Tang (Eds.), *Cross Cultural Assessment of Psychological Trauma and PTSD*, (pp.31-50).

Jakupcak, M., Conybeare, D., Hunt, S., Holmes, H., Felker, B. and Klevens, M. (2007). Anger, Hostility and Aggression Among Iraq and Afghanistan War Veterans. *Journal of Traumatic Stress, 20*, 945, 954.

Kienzler, H. (2008). Debating war-trauma and posttraumatic stress disorder in an interdisciplinary area. *Social Science and Medicine, 67*, 218-227.

Kleinman, A. (1995). *Writing at the Margin: Discourse between Anthropology and Medicine.* Berkeley CA: University of California Press.

Kleinman, A., Das, V. and Lock, M. (1997). *Social Suffering*. Berkeley, CA: University of California Press.

Kubany, E.S. and Watson, S.B. (2000). Development and Preliminary Validation of a brief broad-spectrum measure of trauma exposure. *Psychological Assessment, 12*, 210-24.

Landau, J., Mittal, M. and Wieling, E. (2008). Linking Human Systems: Strengthening Individuals, Families and Communities in the Wake of Mass Trauma. *Journal of Marital and Family Therapy, 34*, 193-209.

Lev-Weisel, R. and Amir, M. (2001). Secondary Traumatic Stress, Psychological Distress, Sharing of Traumatic Reminisces and Marital Quality Among Spouses of Holocaust Child Survivors. *Journal of Marital and Family Therapy, 27*, 433-444.

Litz, B. and Orsillo, S. (2007). The Returning Veteran of the Iraq War: Background Issues and Assessment Guidelines. U.S. Department of Veteran's Affair (National Center for PTSD). Available at: www.ptsd.va.gov/professional/pages/VETS-Iraq-war-guideline.asap

McNally, R.J., Breslau, N. and Kessler, R.C. (2004). Conceptual problems with the DSM-IV Criteria for PTSD. In G.M. Rosen (Ed.), *Posttraumatic Stress Disorder: Issues and Controversies*, (pp. 1-14). New York: Wiley.

Miliken, C.S. (2007). Longitudinal Assessment of mental health problems among active and reserve components: soldiers returning from the Iraq War. *Journal of American Medical Association, 298*, 2141-2145.

Mollica, R., McDonald, L., Massagli, M. and Silove, D. (2004). *Measuring Trauma, Measuring Torture: Institutions and Guidance on the Utilization of the Harvard Program in Refugees Trauma's. Versions of the Hopkins Symptom checklist-25 and the Harvard Trauma Questionnaire.* MA: Harvard Program in Refugee Trauma.

Monson, C.M., Schnurr, P., Stevens, S.P. and Guthric, K.A. (2004). Cognitive behavioral couples treatment for posttraumatic stress disorder. *Journal of Traumatic Stress*, 17, 341-344.

Monson, C.M., Resick, P., Friedman, M.J., Young-Xu, Y. and Stevens, S. (2006). Cognitive Processing Therapy for Veterans with Military-Related Posttraumatic Stress Disorder. *Journal of Consulting and Clinical Psychology, 74*, 898-907.

OMHAS. (2002). Trauma. Available at: www.oregon.gov/DHS/addiction/trauma.shtml.

Powell, S., Rosner, R., Butollo, W., Tedeschi, R.G. and Calhoun, L.G. (2003). Posttraumatic growth after war. A study of former refugees and displaced people in Sarajevo. *Journal of Clini-*

cal Psychology, 59, 71-83.

Reich, M., Shakespeare-Finch, J., Morris B. and Newberry, J. (2005). A Mixed-Method Analysis of Posttraumatic Outcomes: Trauma Severity and Social Support from a Psychological and Therapeutic Perspective. *Canadian Journal of Counseling, 39*, 86-100.

Seal, K., Maguen, S., Cohen, B., Gima, K., Metzler, T.J., Ren, L., Bertenthal, D. and Marmar. (2010). VA Mental Health Services Utilization in Iraq & Afghanistan. Veterans in the first year of Receiving New Mental Health Diagnosis. *Journal of Traumatic Stress, 23*, pp. 5-16.

Sherman, M.D., Sautter, F., Jackson, M.H., Lyons, J. and Han, X. (2006). Domestic violence in Veterans with PTSD who Seek Couples Therapy. *Journal of Marital and Family Therapy, 32*, 479-490.

Shoeb, M., Weinstein, H. and Mollica, R. (2007). The Harvard Questionnaire. *International Journal of Social Psychiatry, 53*, 447-463.

Veterans Health Administration and Department of Defense. (2004). PTSD Screening and Referral For Health Care Providers. Available at: www.ptsd.va.goc/professional.

Weathers, F. and Keane, T.M. (2007). The Criterion A Problem Revisited: Controversies and Challenges in Defining and Measuring Psychological Trauma. *Journal of Traumatic Stress*, 20,107-121.

Wilson, J.P., Drozdek, B. and Tumkovic, M. (2006). Posttraumatic Shame and Guilt. *Trauma,Violence and Abuse, 7*, 122-141.

Wilson, J.P., Friedman, M.J. and Lindy, J.D. (2001). *Treating Psychological Trauma and PTSD*. New York: Guilford Press.

Wison, J.P. and Keane, T.M. (2004). *Assessing Psychological Trauma and PTSD*. New York: Guilford Press.

Wilson, J.P. (2007).The Lens of Culture. In J.P. Wilson and C.S. Tang (EDS), *Cross Cultural Assessment of Psychological Trauma and PTSD*, pp. 3-30. New York: Springer.

Young, A. (1996). The harmony of illusion: Inventing posttraumatic stress disorder. Princeton NJ: Princeton University Press.