CHAPTER 26

Assessment in Psychological Trauma: Methods and Intervention

F. BARTON EVANS AND ALI KHADIVI

CHAPTER OVERVIEW

Psychological trauma is complex and sometimes difficult to understand, and its various manifestations can be challenging for the treating counselor. Psychological assessment and testing can provide the counselor with tools to hone clinical judgment and understanding of clients' trauma experiences beyond what is available in the counseling interview. After providing an overview of psychological assessment in general, we discuss the types of assessment methods available and provide specific instruments that can be of use in the assessment of psychological trauma. These methods include structured interviews, trauma-specific tests, and broad-based personality assessment tests, including self-report and performance-based methods. The chapter ends with a discussion of best practices in the psychological assessment of trauma along with recommendations for integrating assessment into counseling practice.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Understand the value of standardized assessment in psychological trauma;
2. Identify major assessment methods when working with trauma-affected clients;
3. Describe the advantages and disadvantages of different methods for assessing trauma;
4. Understand the best practices for conducting psychological assessment; and,
5. Integrate psychological assessment methods into the practice of trauma counseling.

INTRODUCTION

The purpose of this chapter is to introduce the reader to the wide variety of available clinical psychological assessment methods that can aid the counselor in identifying and understanding the experience of the adult trauma victim. This chapter starts with a brief overview of psychological assessment in general. It will follow with a discussion of available psychological instruments for assessment of psychological trauma and its implication for counseling.

CONTEXT FOR ASSESSMENT

What Is Psychological Assessment?

For the purposes of this chapter, *psychological assessment* refers to the use of psychological tests in conjunction with a clinical interview to measure personality attributes, psychological symptoms, or cognitive functions with an eye toward developing hypotheses and predictions about the person's inner experience, interpersonal behavior, and performance. There are

about the person's inner experience, interpersonal behavior, and performance. There are considerable advantages for counselors to incorporate psychological assessment into their clinical practice, either through consultation with an assessment professional or by receiving the education and training on how to administer, score, and interpret psychological assessment in a professionally ethical manner. Perhaps the major advantage is that psychological assessment is empirically grounded (see Kubiszyn et al., 2000; Meyer et al., 2001), providing objective information that considerably enhances the accuracy of clinical judgment.

Psychological assessment instruments include structured interview measures, self-report symptom-specific tests, multi-scale personality inventories, and performance-based personality tests. *Clinical interviews* are naturally at the heart of all mental health practice. They provide counselors with a powerful way to understand their client's history, interpersonal relationships, personal experience, and subjective reactions to these experiences and relationships. However, relying on unstructured clinical interviews alone has some important disadvantages, the first of which is that it runs the risk of missing important information. Additionally, as noted by Garb (1998) and R. Rogers (1995), all mental health professionals have their set of biases based on their own experience, education, and values. In contrast, psychological testing has a potential to improve accuracy and reliability of clinical judgments and reduce bias.

Structured interview-based measures are important psychological tests that systematically can assess signs and symptoms of psychological disorders. Sullivan's (1954) classic work, *The Psychiatric Interview*, skillfully introduced the idea of increasing reliability through a standard interview. With the advent of the *Structured Clinical Interview for DSM III (SCID-II, Ver. 1.0)* (Spitzer et al., 1990), the structured interview increasingly has become a gold standard for the most reliable diagnosis of mental disorder for research and clinical purposes.

Self-report symptom-specific tests are psychological assessment instruments, which include straightforward, face-valid instruments measuring a particular disorder or clinical phenomenon. They range from highly specific instruments (e.g., Beck Depression Inventory II [BDI-II]; Beck et al., 1996) and the Beck Anxiety Inventory (BAI; Beck, 1997) for depression and anxiety to comprehensive assessment measures for psychological sequelae of traumatic experiences (e.g., Briere's Trauma Symptom Inventory-2 [TSI-2], 2011).

Among the most useful psychological assessment instruments are *personality tests*, which are designed to assess psychological symptoms broadly, as well as personality traits, behavioral predispositions, and inner experiences. Examples of personality tests include *multi-scale self-report tests*, that is, inventory-type, question-and-response tests, such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher et al., 1989), Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF: Ben-Porath, 2011; Ben-Porath & Tellegen, 2008), and the Personality Assessment Inventory (PAI; Morey, 2007).

Additionally, *performance-based tests* like the *Rorschach Inkblot Method* (using either the Comprehensive System [CS; Exner, 2003; Weiner, 2003] or the Rorschach Performance Assessment System [R-PAS; Meyer et al., 2011] and *storytelling tests* (see Teglasi, 2010) such as the Thematic Apperception Test (TAT; Murray, 1943) are used to assess more subtle aspects of personality. The value of these comprehensive personality assessment measures is that they assess a wide variety of psychological states and personality traits, allowing the counselor to understand comorbid mental disorders and underlying personality issues better, as well as posttraumatic states.

Why Psychological Assessment for Posttraumatic States?

The context for assessing traumatic experience is broad, ranging from combat experiences to sexual assault, automotive accidents to life-threatening illness. Yet survivors of psychological trauma frequently express their experience in comprehensible ways that can be accurately assessed.

When a counselor first sees a person with psychological trauma, they are faced with a complex and daunting task. What is the nature of their trauma, and how severe was it? Who was the perpetrator—a stranger or someone the client counted on for protection? How long

ago did it occur? Was the trauma a single episode or a series of repeated events over an extended period? What are the trauma victim's vulnerabilities and strengths? How has the inner experience and outer behavior manifested, both in terms of symptoms of psychopathology and disturbed interpersonal relations? These are but a few of the many issues and concerns that confront us when we enter the lives of individuals facing the impact of overwhelming, terrifying, horrific, and often incomprehensible life experiences. Psychological trauma is so profoundly destabilizing that it may be hard to imagine mistaking, overdiagnosing, or entirely ignoring it. Yet trauma disorders present in different and confusing ways, often with symptoms similar to other mental disorders, creating complex diagnostic and treatment challenges. To provide some groundwork for understanding the complexity of assessing psychological trauma, a brief description of trauma theory is presented here, along with implications for trauma assessment.

Prevalence studies of psychiatric clients show rates of trauma exposure that range from 60% to more than 80% (Bryer et al., 1987). Carlson's (1997) review concludes that counselors can expect at least 15% of their adult clients to have current or past trauma symptoms. As stated in the following text, presentations of psychological trauma can range from straightforward and clear to complex and disguised. As such, it is likely that counselors may be challenged with understanding clients with a wide variety of psychological trauma presentations. Therefore, counselors who become acquainted with a range of psychological assessment tools can increase their ability to understand and treat a wide range of trauma responses. When faced with this daunting task, psychological assessment methods can help quickly and reliably to provide a comprehensive view of the person and their struggles. In effect, as suggested by Finn and Tonsager (1997), psychological testing can serve as an "empathy magnifier."

In particular, there are two circumstances under which traumatized people come to the attention of counselors. First, individuals seek treatment following a clearly identified trauma such as a natural disaster, assault, rape, or life-threatening accident, illness, or injury. In these instances, the presenting psychological trauma is overt. Yet, posttraumatic stress disorder (PTSD) is only one of many possible ways in which traumatic experience presents itself (van der Kolk & McFarlane, 1996), and it not infrequently presents with comorbid mental disorders such as depression (Kessler et al., 1995). That is, a person may develop another psychiatric disorder in addition to the PTSD in response to the traumatic events. The psychological trauma also can activate a previously existing psychiatric disorder. For example, a person with a history of past panic disorder may re-experience panic attacks as a result of exposure to traumatic events. Further, the client may have past traumatic experiences that are activated by the current traumatic experience. Psychological assessment can shed light on the client's view of themselves, the ability to regulate emotions, interpersonal capacities, and coping mechanisms. In doing so, the counselor can better address the complexities of different trauma presentations in terms of symptoms, diagnosis, and, most importantly, effective treatment.

Second, counselors may see individuals with past psychological trauma, in which their trauma presentation is less obvious. In this instance, the clients may be unaware of the link between past traumatic experiences and their current suffering and symptoms and may not even see such experiences as relevant. For adult clients with past chronic childhood abuse and neglect, it is likely that traumatic dissociation has been used to cope with and survive the ordeal, which can limit clear memory of traumatic events and make it difficult for such clients to express their experiences in a coherent fashion. In such instances, psychological assessment, especially performance-based measures like the Rorschach or Adult Attachment Projective (Finn, 2011; George & Buchheim, 2014), can provide the counselor with the first indication of such buried trouble.

What Are the Faces of Trauma?

The word "trauma" is used increasingly in the common parlance as a word to indicate an unpleasant event, for example, "My girlfriend is giving me a lot of trauma these days about going out with the guys." Therefore, a more precise definition of psychological trauma is

going out with the guys." Therefore, a more precise definition of psychological trauma is important. Unlike a distressing experience, the trauma response involves specific psychophysiological responses that are more extreme and enduring than the psychophysiology of distress (see Southwick et al., 2005). Such traumatic physiological reactions underlie the biphasic psychological response to trauma, which is the phasic alternation between intrusive (flashback/nightmares) and constrictive (avoidance/numbing) symptoms (van der Kolk & Ducey, 1984). Assessing the biphasic trauma response is critical in determining how to approach the client in treatment.

The best-known definition of the traumatic stressor is the stressor criteria used for PTSD described by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013). Criterion A-1 PTSD stressor criterion must include an "exposure to actual or threatened death, serious injury, or sexual violence." The *DSM-5* specifies that there are four different ways the person may be exposed to the traumatic events: (a) the person directly experiences the traumatic event(s); (b) the person witnesses the traumatic event(s) occurring to others; (c) the person learns that the traumatic event(s), which must be violent or accidental in nature, has occurred to a close friend or a family member; and (d) the person repeatedly experiences or is being exposed to extreme aversive details of traumatic event(s). Following traumatic exposure Criteria A, there are four symptom clusters: (a) intrusive symptoms, including re-experiencing the traumatic events; (b) persistent avoidance of any stimuli associated with the traumatic events; (c) negative alteration in mood and cognition, such as developing a persistent negative belief about oneself; and (d) marked alteration in arousal, such as becoming hypervigilant or having an exaggerated startle response. Finally, these symptoms must cause distress and/or social and emotional impairment.

The advantage of this definition is that it is relatively easy to quantify and therefore provides criteria that are reliable and researchable. The disadvantage is that it focuses on symptoms rather than experience and does not capture the terrible reality of protracted traumatic experience such as torture, domestic violence, and child abuse, where understanding the impact of captivity, degradation, and emotional abuse is critical.

A second, more liberal, and perhaps more satisfactory definition is found in the *International Classification of Diseases, Tenth Revision* (*ICD-10*; World Health Organization, 1992), which defines PTSD in the following way:

> [A] delayed and/or protracted response to a stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (e.g., natural or man-made disaster, combat, serious accident, witnessing the violent death of others, or being the victim of torture, terrorism, rape, or other crime) (World Health Organization, as cited in Houghton College, 1998, p. 1).

The three symptom clusters in the *ICD-10* are largely similar to those in the *DSM-IV*, instead of the four-factor symptom structure of *DSM-5* (see Zoellner et al., 2013 for a more comprehensive review of the change in the PTSD criteria in *DSM-5*). The ICD-10 stressor definition is closer to the one in *DSM-III-R*, but was rejected for a more narrow definition in *DSM-IV* (and even more narrowly for *DSM-5*), because it was harder to quantify. The emphasis on a stressor that would cause pervasive distress in almost everyone provides a broader understanding of the power of events that are not strictly life threatening or integrity threatening (see M. J. Friedman et al., 2014, and van der Kolk, McFarlane, & Weisaeth, 1996, for two excellent comprehensive books on PTSD).

A third definition arises from the work of Herman (1992, 2015), who indicated that current PTSD diagnosis frequently does not capture the severe psychological harm from prolonged, repeated trauma and suggested a new diagnosis, complex PTSD, or disorders of extreme stress not otherwise specified (DESNOS), to describe the pervasive psychological and physiological effects of long-term trauma. The stressor criterion for diagnosis of complex PTSD is that the individual experienced a prolonged period (months to years) of total control by another. Six clusters of symptoms have been suggested for diagnosis of complex PTSD: (a) alterations in regulation of affect and impulses, (b) alterations in attention or consciousness, (c) alterations in self-perception, (d) alterations in relations with others, (e) somatization, and (f) alterations in systems of meaning (Pelcovitz et al., 1997). While *DSM-IV* field trials

(f) alterations in systems of meaning (Pelcovitz et al., 1997). While *DSM-IV* field trials indicated that 92% of individuals with complex PTSD/DESNOS also met criteria for PTSD, complex PTSD was not added as a separate diagnosis (Roth et al., 1997). On the other hand, because of the different and more severe symptom pattern, assessment of complex PTSD is critical for determining special psychotherapeutic approaches. Herman (1992), Chu (1998), and Courtois and Ford (2009) offer more comprehensive discussions regarding the etiology, clinical phenomena, and treatment approaches of complex PTSD. Unfortunately, *DSM-5* did not add a diagnosis of complex PTSD, although extensive research (see Brewin et al., 2017) has been done to justify its inclusion in the forthcoming *ICD-11*.

In addition to these three specific diagnostic presentations of PTSD, other symptoms commonly found in individuals experiencing trauma include somatization, panic reactions, emotional lability, anxiety, agitation, depression, hopelessness, loss of life purpose, sleep problems, inability to self-soothe, and disturbances in thinking and reality testing. Symptoms of physiological dysregulation in chronic trauma and emotional lability can mask accurate diagnosis, because they are core symptoms in many other psychological disorders, such as bipolar disorder, panic disorder, and borderline personality disorder. Affective dysregulation can increase cognitive confusion, intrusions can be experienced on a cognitive level as hallucinatory flashbacks, and psychotic-like thinking has been observed in traumatized people who were previously clinically normal (Weisaeth, 1989), giving the impression of a psychotic disorder. Efforts to avoid re-experiencing traumatic memories may make traumatized clients appear withdrawn, uncooperative, and exhausted, causing difficulties connecting with them and complicating counselors' efforts to understand.

It is important to remember that not all individuals experiencing trauma show clinical signs and symptoms. There is no one-to-one relationship between an external trauma and the person's psychological response. Researchers estimate that only 25% to 30% of those exposed to trauma develop PTSD (Kessler et al., 1995; Ozer et al., 2003), although risk rates vary and depend on the kinds of stressors such as combat, rape, childhood abuse, or assault with a weapon. The studies indicate that women consistently show higher risk rates than men. However, many people spontaneously resolve the trauma and, in the process, may even develop greater coping skills (Solomon et al., 1988). Such findings underscore the importance of assessing individuals' strengths as well as vulnerabilities (Sullivan, 1954), further complicating the counselor's task.

PSYCHOLOGICAL ASSESSMENT METHODS, CONCERNS, AND PRACTICES

Several methods of psychological assessment are best indicated for use with survivors of trauma, and several important practice issues arise when considering relevant methods. These methods and associated issues and practices are discussed in the following sections: Clinical Interview, Trauma-Specific Scales, Personality Assessment Instruments, Performance-Based Tests, Feigning/Malingering, and Best Practices in Assessing Psychological Trauma.

Clinical Interview

The clinical interview is the most common psychological assessment strategy used by counselors, psychiatrists, social workers, psychiatric nurses, and psychologists alike. During interviews at the beginning of counseling, the counselor forms an initial opinion about the client's problems, subjective reactions to these problems, symptoms, diagnosis of mental disorder(s), and treatment strategy. Throughout the course of treatment, the counselor reassesses initial hypotheses about problems and alters the treatment course accordingly. Although the clinical interview is the core tool used for assessing and understanding the client, as stated earlier, all counselors are vulnerable to their biases and the limitations of understanding from a single source of data. G. A. Miller's (1956) classic article on the limits of our capacity to process information indicates that at any one time, we can hold seven pieces of information, plus or minus two. The implication for this psychological reality is that in order to deal with the complexity of psychological trauma, the counselor does well to operate from multiple information sources beyond a structured clinical interview. The

assessment of symptoms and reactions to psychological trauma is aided by additional methods such as structured interviews. Four of the major structured interviews for the assessment of psychological trauma, along with several supporting methods, are described later. Although there are many others, it is beyond the scope of this chapter to be exhaustive.

Dimensional, Scale-Based Structured Interviews

When the presenting problem includes a clear description of a traumatic stressor, structured interviews of posttraumatic stress employing dimensional rather than categorical (presence/absence) rating scales can be invaluable in understanding the severity and nature of PTSD symptoms. Two examples of such interviews are the gold standard Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5; Weathers et al., 2018; Weathers, Blake, et al., 2013) and the PTSD Symptom Scale-Interview Version (PSS-I-5, Foa & Capaldi, 2013).

Clinician-Administered PTSD Scale for DSM-5

Of all the structured interviews for PTSD, the CAPS-5 is the most comprehensive for assessing core and associated symptoms of PTSD. Weathers et al.'s (2001) literature review of more than 200 studies indicated impressive evidence of its reliability and validity. Several advantages of the CAPS over other structured interviews for PTSD are that it assesses the frequency and intensity of each symptom; has excellent prompt questions to elicit clinical examples; assesses both current and lifetime PTSD symptoms; and provides explicit, behaviorally anchored rating scales. The CAPS can be scored, providing both continuous and dichotomous scores with several scoring rules to assist the counselor (Weathers et al., 1999). The CAPS's primary disadvantage is its long assessment time of about 50 to 60 minutes. The Life Event's Checklist (LEC; Gray et al., 2004) is a brief, 17-item self-report measure designed to screen for potentially traumatic events in a respondent's lifetime. The LEC was developed concurrently with the CAPS and is administered before the CAPS.

PTSD Symptom Scale—Interview Version

When time is at a premium, PSS-I is a reasonable alternative. Studies indicate that the PSS-I is reliable and valid in civilian trauma survivors, making it a good instrument for most clients in the counselor's usual practice. In a comparison study with the CAPS (Foa & Tolin, 2000), the PSS-I performed about equally well in arriving at a diagnosis of PTSD, decreasing assessment time without sacrificing reliability or validity. On the other hand, what is gained in time savings is lost in providing a detailed rich description of the client's past and present psychological trauma.

Structured Interviews for Complex Posttraumatic Disorder and Dissociation

If the counselor has a practice involving adult victims of child abuse, the PTSD structured interviews mentioned earlier are likely not sufficient to assess the pervasive and complex psychological sequelae of complex PTSD. A groundbreaking study by Herman et al. (1989) found a strong association between a diagnosis of borderline personality disorder and a history of abuse in childhood, including physical abuse, sexual abuse, and witnessing serious domestic violence. This research was instrumental in developing the diagnosis formerly called DESNOS and now more commonly called complex PTSD.

Structured Interview for Disorders of Extreme Stress

As part of the field trials for *DSM-IV* (Roth et al., 1997), the aforementioned research team developed the Structured Interview for Disorders of Extreme Stress (SIDES; Pelcovitz et al., 1997), a validated structured interview assessment for complex posttraumatic stress, which subsequently was found to have considerable clinical utility (van der Kolk & Pelcovitz, 1999). The SIDES is a 45-item interview that consists of six subscales corresponding to the six complex PTSD symptom clusters. Like the CAPS, the SIDES measures current and lifetime presence of complex posttraumatic stress symptoms as well as symptom severity. In a recent study of individuals diagnosed with borderline personality disorder using the SIDES, McLean

study of individuals diagnosed with borderline personality disorder using the SIDES, McLean and Gallop (2003) concluded that "some women with a history of childhood sexual abuse may be extricated from the diagnosis of borderline personality disorder and subsumed under that of complex PTSD" (p. 371).

Dissociation and the Structured Interview for DSM-IV Dissociative Disorders-Revised

Dissociative responses and disorders (formerly called "*multiple personality disorders*") account for additional clinical phenomena closely associated with psychological trauma and its assessment. Dissociation is a state of fragmented consciousness involving amnesia, a sense of unreality, and a feeling of being disconnected from oneself or one's environment. Dissociation is a psychological process common to everyone, although in the extreme, it can become a severe disorder with fragmented identity states, previously and inaccurately referred to as "*multiple personalities*." Putnam (1997) estimated that most, if not all, dissociative disorders are caused by severe sexual, physical, and emotional abuse in childhood. Because of the complex and shifting affective and identity states in dissociative disorder, comprehensive evaluation provides the counselor with a significant advantage over the simple clinical interview.

One of the best methods for the comprehensive assessment of dissociative states and disorders is Steinberg's (1994) *Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised* (SCID-D-R). Rigorously developed through the National Institute of Mental Health (NIMH) field trials, the SCID-D-R is a structured diagnostic interview that is specific to the assessment of *DSM-IV* dissociative disorders and acute stress disorder. It provides a careful and detailed decision tree approach, arriving at accurate *DSM-IV* diagnosis of Dissociative Amnesia, Depersonalization Disorder, Dissociative Disorder Not Otherwise Specified, Acute Stress Disorder, and Dissociative Trance Disorder. Perhaps of more importance to counselors, the SCID-D-R assesses a broad variety of posttraumatic dissociative symptoms that clients may not spontaneously share in unstructured interviews. Many dissociative clients have long learned that their dissociative experiences are treated by others as strange and bizarre and indeed some counselors may feel this way toward the clients as well. As a result, such clients have learned to avoid discussion, automatically, of these symptoms. Careful and empathic administration of the SCID-D-R can help dissociative clients better share their experiences and can reveal symptoms and psychological states that can be the focus of treatment intervention. Steinberg and Schnall's (2001) book is an approachable overview of dissociative disorder.

It is important to note that dissociative disorders underwent changes with *DSM*-5 to include certain possession-form phenomena and functional neurological symptoms. It is specific that transitions in identity may be observable by others or self-reported and that individuals with DID may have recurrent gaps in recall for everyday events and not just for traumatic experiences. Dissociative fugue is no longer a distinct diagnosis but is subsumed as a specifier with fugue under dissociative amnesia. Depersonalization disorder has been revised to include derealization, as both often co-occur. To date, there is no published update to the SCID-D-R, though Ross (2019) has an unpublished updated version of his Dissociative Disorders Interview Schedule.

Trauma-Specific Scales

The next set of assessment tools, for use with psychological trauma, is the *trauma-specific scales*, a group of self-report instruments that focuses specifically on the symptoms and phenomena of PTSD and psychological trauma. They range from instruments with high "face validity"—that is, instruments that assess specific symptoms of PTSD—to more subtle instruments, which include associated traumatic symptoms and experiences as well as, in some instances, validity scales. The advantages of trauma-specific scales include the following features: (a) they focus on specific psychological trauma symptoms and phenomena; (b) they provide ratings of symptom severity and frequency; and (c) they allow the counselor to select specific scales that best match specific populations, for example, sexual assault, combat trauma, and partner or domestic abuse. Such instruments allow the counselor to

focus treatment on specific symptoms that are most distressing to the client. As mentioned earlier, there are variations in posttraumatic symptom presentation, that is, the biphasic response in which the client may have predominantly avoidant/numbing presentations; intrusive/flooding presentations; or, in some instances such as with torture victims, alternations between the two. For example, some trauma victims may so repress trauma memories that they do not have current intrusive symptoms. As Foa and Rothbaum (1998) report, rape victims with an avoidant presentation have poorer treatment outcomes generally than, and require a very different approach from, victims with active intrusive symptoms. Trauma-specific assessment tools can alert the counselor early on to the client's particular dilemmas, increasing the counselor's understanding of and empathy for the client and developing a more specific treatment approach.

Frequently Used Scales

Two commonly used PTSD-specific scales are the clinical version of the PTSD Checklist for *DSM-5* (PCL-5; Weathers, Litz, et al. (2013) and the Posttraumatic Stress Diagnostic Scale (PDS-5; Foa et al., 2016). These are described briefly in the following subsections.

PTSD Checklist-5

The PCL-5 is a brief, 20-item self-report measure of the 20 *DSM-5* symptoms of PTSD that assesses both symptoms and their severity. The PCL can be used for screening individuals for PTSD, diagnosing PTSD, and assessing symptom change during treatment. Blanchard et al.'s (1996) study of motor vehicle accident victims and sexual assault victims found a high correlation with the CAPS, concluding that the PCL is effective as a brief screening instrument for core symptoms of PTSD. Because of the high incidence of trauma victims among individuals presenting for psychotherapy, the PCL-5 also can be used as an important screening tool during intake with all clients. A problem with the PCL-5 is that it assesses only PTSD symptoms and not the specific trauma causing the symptoms. It assesses only severity of symptoms (i.e., "How much have you been bothered by each PTSD symptom?") but not frequency of symptoms (i.e., "How often have you experienced these symptoms?"). The PCL-5 asks about symptoms in the past month, so lifetime incidence is not assessed. The research on the initial version of the PCL (and very likely the PCL-5) even can be significant for individuals going through severe life events that do not specifically meet *DSM-IV* stressor criteria for PTSD (Robinson & Larson, 2010), making it a sensitive but not specific assessment instrument.

Posttraumatic Stress Diagnostic Scale for DSM-5

The PDS-5 is a 52-item self-report measure best used when assessing the severity of PTSD symptoms related to a single identified traumatic event. The PDS is one of only two among specific trauma self-report inventories to assess all of the *DSM-5* criteria for PTSD and can assist in a clear, formal diagnosis. Further, it asks about the presence and frequency of symptoms in the past month, although other time frames can be used. Unlike the CAPS-5 and PCL-5, the PDS-5 does not ask about severity of PTSD symptoms. It does not assess for past traumatic events or their impact on the client's current life.

Assessing Combat-Related Trauma

Since the Vietnam War, and most recently Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom, no survey of PTSD assessment would be complete without mention of the assessment of combat-related trauma. Since 1989, the U.S. Department of Veterans Affairs (USDVA, 2011) and its research and training arm, the National Center for PTSD (NCPTSD), have sought to understand better, and therefore better assess, the needs of veterans with military-related PTSD. Particularly, NCPTSD's Behavioral Science Division, headed by Dr. Terence Keane, has been the world's leader in the development and research of psychological assessment instruments for combat-related trauma. A core battery for the assessment of combat-related PTSD would include the following instruments: the Combat

assessment of combat-related PTSD would include the following instruments: the Combat Exposure Scale (CES; Keane et al., 1989), the PTSD Checklist-Military (PCL-M; Bliese et al., 2008), and the Mississippi Scale for Combat-Related PTSD (M-PTSD; Keane et al., 1988).

Combat Exposure Scale

The CES is a seven-item self-report measure that assesses wartime combat stressors experienced by combatants. Respondents are asked to respond, based on their exposure to various combat situations, such as firing rounds at the enemy and being on dangerous duty. The CES is administered and scored easily, providing a classification for combat exposure that ranges from light to heavy and provides the counselor with information that the veteran may find difficult to describe fully.

PTSD Checklist-Military

The PCL-M is a military version of the PCL mentioned earlier, although it asks specifically about symptoms in response to stressful military experiences (Bliese et al., 2008). It is often used with active service members and veterans to gauge the presence and severity of symptoms of PTSD.

Mississippi Scale for Combat-Related PTSD

The M-PTSD is a 35-item self-report measure that assesses combat-related PTSD in veteran populations. Veterans rate how they feel about each item using a 5-point scale. These items are added together to provide an index of PTSD symptom severity, with cutoff scores for a probable PTSD diagnosis, for use primarily with veteran populations. Not only does it assess primary symptoms of PTSD, but it also taps features often associated with PTSD such as substance abuse, suicidality, and depression.

Disadvantages

While the trauma-specific self-report assessment methods mentioned earlier are very useful, these measures also have several notable disadvantages, which are shared in common with all other self-report assessment measures. Self-report measures depend on the clients' ability both to *understand* themselves sufficiently to respond accurately to the questions and to *be willing* to report what they experience. In the case with clients who are emotionally shut down, they may not realize and report symptoms that are obvious to others. Alternatively, other clients may carelessly respond or underreport or overreport symptoms and experiences on self-report measures for a variety of motivations such as compensation for injury or worries about who will see the clients' records if they report fully and honestly. These tendencies are known in assessment circles as *response styles*, that is, test-taking approaches that can bias or skew the interpretation of self-report measures.

Additional Inventories

Following the lead of major self-report inventories such as the MMPI-2 and PAI, Dr. John Briere has created several excellent, comprehensive trauma-specific self-report inventories, which not only measure traumatic experience comprehensively but also assess response style. The most widely used and best researched of his scales is the TSI-2 (Briere, 2011), which takes about 20 to 30 minutes to administer and is scored easily. Briere's TSI-2 includes validity scales that assess defensiveness (denial of difficulties) and symptom overendorsement (endorsement of atypical symptoms not common to PTSD). Additionally, the TSI-2 includes a validity scale for inconsistent, random reporting.

Trauma Symptom Inventory-2

Briere's TSI-2 is based on a well-conceptualized and well-researched understanding of traumatic phenomena and yields excellent information about the client's experiences and behaviors, which makes it exceptionally useful for framing empathic interventions. It surveys on both acute and chronic posttraumatic symptoms and experiences and has been widely

used to assess the effects of sexual assault, domestic partner abuse, physical assault, combat experiences, major accidents, and natural disasters. In particular, the TSI-2 is an excellent instrument to use with adults subjected to childhood abuse and other early traumatic events. In addition to assessing common PTSD symptoms such as angry/irritable affect, intrusive symptoms, avoidance/numbing, and hyperarousal, the TSI-2 also assesses comorbid symptoms of both mood and cognitive distortions found in trauma-related depression, as well as dissociative symptoms. Further, this measure goes beyond the immediate posttraumatic symptoms and evaluates the long-term self-disturbance and interpersonal difficulties frequently found as a part of the chronic sequelae of earlier psychological trauma. The self-scales include sexual concerns (sexual dissatisfaction and distress), dysfunctional sexual behaviors (indiscriminate and self-harming sexual relations), impaired self-reference (identity confusion and poor self-care), and tension-reducing behavior (external ways of reducing inner tension such as suicidal threats, self-mutilation, and dysregulation of anger).

Dissociative Experience Scale II

No brief survey would be complete without mention of the Dissociative Experiences Scale II (DES II; Bernstein & Putnam, 1986), the widely used screening instrument for the frequency of dissociative experiences. As noted earlier, severe dissociative reactions are common in adult survivors of severe childhood trauma. Identification of these experiences is important, diagnostically and therapeutically, for treatment of such disorders as dissociative identity disorder. The DES is a brief self-report measure that assesses a continuum of dissociative experiences with normative data for normal, traumatized, and dissociative clients. It can be obtained online from the Sidran Institute at www.sidran.org.

Abusive Behavior Observation Checklist

The Abusive Behavior Observation Checklist (ABOC) is a powerful assessment measure for counselors working with both women and men who are the victims of domestic battery. Often, such individuals have extreme difficulty articulating their domestic abuse experience in interviews with even experienced counselors (see Dutton, 2000; Walker, 2000). Dutton's (2000) ABOC was developed to document the types and degree of interpersonal violence in domestic abuse such as physical, sexual, and psychological abuse, as well as victims' behavioral and cognitive adaptation to such abuse. The ABOC provides an exhaustive survey of the ways in which batterers abuse their spouses and spouses' adaptations to these abuses. Used together with the TSI, the ABOC provides an important avenue for battered spouses to share their traumatic experiences and effects on their functioning and view of themselves.

It should be noted that there are many trauma-specific self-report inventories for psychological trauma, although it is beyond the scope of this chapter to survey most of them. The

reader is referred to two excellent books (Briere, 2004; Wilson & Keane, 2004) for a more detailed survey of psychometric issues as well as a wide variety of self-report trauma instruments for both adults and children.

Personality Assessment Instruments

Psychological trauma occurs within the context of the person and their personality. Individuals undergoing distressing life experiences may adapt in a variety of ways, depending on their past experiences and common patterns of response (Sullivan, 1953). While factors such as intensity of traumatic experience and a history of prior traumatic events clearly influence posttraumatic response (van der Kolk, 1987), M. W. Miller's (2004) review highlighted the intricate interplay between personality and the development and expression of PTSD. Personality assessment methods can be useful in helping to understand the impact of psychological trauma on the person, especially the long-term effects found in individuals with severe past trauma. As stated earlier, there are two kinds of personality assessment methods: *self-report tests* (formerly called "objective tests") and *performance-based tests* (formerly called "projective tests"). Meyer and Kurtz (2006) offer a helpful explanation of why this previous distinction did not accurately communicate the nature of these tests. As discussed in the following text, training for the use of the major personality tests requires a significant level of education, supervision, and experience, although in our opinions, it is well worth the effort.

Self-Report Tests

The most widely used and researched personality instrument is the MMPI-2. Based on the client's response to 567 True/False items, it yields 10 clinical scales and three primary validity scales, as well as literally hundreds of other scales. For the well-trained assessor, the MMPI-2 provides a rich palate of personality variables to understand the complexities of the client's personal functioning. Further, the strong actuarial base of the MMPI-2 deeply enhances the accuracy of clinical judgment with some psychologists, even arguing for the superiority of actuarial methods (see Grove, 2005). While it is beyond the scope of this chapter to discuss the psychometric properties of the MMPI-2, there are many excellent books on the MMPI-2, including A. F. Friedman et al. (2015) and Greene (2011), as well as on the MMPI-2-RF (Ben-Porath, 2011).

Understanding psychological trauma on the MMPI-2 can be a daunting task without adequate knowledge of how the instrument captures traumatic experience, and perhaps most importantly, how traumatic experience interacts with the individual's personality. It is important to remember that the MMPI-2 and its predecessor, the MMPI, were not developed with the assessment of psychological trauma in mind. Traditional interpretation of MMPI-2 clinical scales with trauma victims can be extremely misleading. A common code type (i.e., a configuration of significantly elevated clinical scales; see Greene, 2011) for traumatized individuals is a highly elevated 2-8/8-2, often with other scales elevated in the clinical range. The traditional interpretation for this configuration, especially when it is highly elevated, suggests an individual with serious and chronic psychopathology. Common diagnoses are bipolar disorder and schizoaffective disorder. Without careful analysis of subscales and supplementary scales, the traumatized individual with hallucinatory and dissociative flashbacks, vivid nightmares, and intrusive daydreams readily could be misdiagnosed with a psychotic disorder with severe depressive features, using standard interpretations on the MMPI-2.

One approach to the MMPI-2 has been to find a code type that definitively diagnoses PTSD. The results of this endeavor have been mixed and elusive, largely because the approach is nomothetic, that is, looking at group level findings. For example, Wilson and Walker (1990) found a 2-8/8-2 code type with an elevation on F to be the most common profile, whereas Lyons and Wheeler-Cox (1999) noted a 2-7-8 code type to be the most prominent. Glenn et al. (2002) found different predominate code types for Gulf War and Vietnam era veterans (1-8/8-

1 and 2-8/8-2, respectively). Elhai et al. (2000) found that adult survivors of child sexual abuse and combat veterans were more similar than not on the MMPI-2. Griffith et al. (1997) found an 8-4 code type with women having histories of childhood sexual abuse, although scales 1, 2, 6, and 9 were elevated as well. Additionally, there have been several supplementary subscales developed to identify PTSD, the most enduring being the Keane PTSD Scale (Keane et al., 1984). The disadvantage of the PTSD subscales is that they were developed without specific PTSD items, and they do not include the specific symptoms common to PTSD.

Another approach to the MMPI-2 is Caldwell's (2001) adaptive approach, which focuses on how psychopathological behaviors measured by the test are positive adaptations to painful or overwhelming life experience. He stated that "[u]nderstanding all such behaviors as adaptive leads to a notable enhancement of empathy" (p. 1). Caldwell reframed several of the classic MMPI-2 scales, thus providing important insight into traumatic experiences. For example, his description of Scale 8 (Schizophrenia) emphasizes the mental confusion that frequently is attendant with early traumatic experiences. Caldwell elaborates,

> If, at an early age, your body was the object of someone's sexual gratification, someone who was cold to your distress or—worse yet—excited to greater sexual aggression by your pleadings that he or she stop, you end up deeply alienated and knowing yourself to be permanently damaged goods. (p. 13)

Such an approach is preferable for an individual-based (idiographic) interpretation of the MMPI-2, as it is ideally suited for giving feedback (Finn, 1994) and providing powerful assessment-based therapeutic intervention such as the therapeutic assessment (TA; Finn, 2007).

Another important and increasingly popular comprehensive self-report personality assessment instrument is the PAI (Morey, 2007). The PAI has fewer items and takes less time to complete than the MMPI-2. Instead of the *True or False* format of the MMPI-2, the PAI rates items on a 4-point scale, ranging from *false* to *very true*. It has 22 non-overlapping full scales, including four validity scales, 11 clinical scales, five treatment scales, and two interpersonal scales. The 11 clinical scales were developed to be consistent with current diagnoses in mind, making for an easier diagnostic description. The 11 clinical scales also contain conceptually derived subscales. Among the most useful of the clinical subscales is traumatic stress, which uses items more directly indicative of symptoms of PTSD.

Performance-Based Tests

As stated earlier, the performance-based (PB) personality assessment measures include what previously have been called projective tests. Through either storytelling methods, such as the TAT and the AAP (George & West, 2001), or inkblot methods, such as the Rorschach, PB personality tests are more open structured and elicit individuals' powerful inner narratives and emotional experience. Such instruments can allow the trauma victim a path to reveal inner experiences that are not readily available to conscious verbalization. Of these PB methods, the Rorschach is the most researched and best conceptualized.

In our opinion, the Rorschach is one of the most powerful personality assessments, when used by a sensitive examiner trained in the Rorschach comprehensive system (CS; Exner, 2003; R-PAS, Meyer et al., 2011), an empirically based method for administration, scoring, and interpretation. The advantage of the CS and R-PAS over other Rorschach methods is that interpretation is based on a very large body of literature, confirming the reliability and validity of the variables. Rorschach CS and R-PAS is therefore an idiographic instrument with normative data to assist in understanding the highly individualized results.

The Rorschach has been used extensively with individuals with psychological trauma, and the reader is referred to Armstrong and Kaser-Boyd (2003) and Kaser-Boyd and Evans (2007) for a comprehensive overview of its use. The CS has an important trauma indicator called the *Trauma Content Index* (TCI; Armstrong & Loewenstein, 1990), which has been used to help identify victims of sexual abuse (Kamphuis et al., 2000) and individuals with dissociative identity disorder (Brand et al., 2006). Recent work by Finn (2011) has hypothesized that the Rorschach and other PB measures in particular allow access to unconscious negative affect

Rorschach and other PB measures in particular allow access to unconscious negative affect states and implicit models of the self that result from traumatic experience, especially early developmental trauma. He contrasts PB measures with self-report tests, which are more sensitive to explicit models of the self and to conscious affect states. Because an important dilemma in the treatment of victims of trauma is accessing their damaged view of themselves and easily triggered fear, the Rorschach and other PB tests hold a unique place in the assessment and treatment of individuals with psychological trauma.

Feigning/Malingering

No discussion regarding the assessment of psychological trauma would be complete without mentioning potential problems of feigning, which is defined as deliberate symptom exaggeration or fabrication. Psychological tests can measure feigning. Malingering is feigning for an external gain. Frueh et al. (2003) found up to 50% significant overreporting of symptoms among disability compensation seeking among veterans evaluated for PTSD. Rosen (2006) cautions that overreporting of PTSD in compensation cases is so common that it raises concern about inflating rates in the epidemiological PTSD database. While most individuals entering treatment for psychological trauma or for psychological problems eventually may find their root cause in traumatic experience, some individuals seek counseling, often on the advice of their attorneys, as a part of legal proceedings in which they are claiming PTSD as a consequence of an accident, personal injury, or disability claim.

The alert counselor is aware of this possibility and understands that there are important differences between clinical and forensic assessment (see Greenberg & Shuman, 1997). Many well-meaning counselors have been drawn into complex and contentious legal matters, making expert opinions without a proper basis, which is readily and successfully attacked by skillful defense attorneys. Such experiences often are painful and humiliating for the counselor and may lead to a loss of status in the professional community and even to malpractice suits. It is our advice that counselors always ask on intake whether the client is involved with or anticipates being involved with a legal matter related to their psychological state. If this is the case, we strongly advise developing a policy regarding the counselor's willingness to participate in such matters and only to become involved in such matters with extensive and rigorous training and supervision in forensic assessment.

Best Practices in Assessing Psychological Trauma

Having introduced the reader to the various kinds and benefits of assessment methods for psychological trauma, we would like to address the important issue of what constitutes best practices in psychological assessment and testing, especially the training necessary to engage in competent practice. Psychological assessment is a practice requiring special care because of the impact that it could have on clients' lives. As noted in the Society for Personality Assessment's (2006) "*Standards for Education and Training in Psychological Assessment*," unlike counseling or psychotherapy, where the counselor gets to know the client through many hours of interaction, psychological assessment may be a brief encounter in which mistakes can be magnified by misinterpretation. Further, psychological test reports usually become a part of clients' records, and mistakes may affect their entire lives. Additionally, psychological assessment can have a significant influence on important decisions about clients' lives, such as a need for hospitalization, assessment of dangerousness, custody of children, and employment situations. As such, inadequately trained psychological assessors can cause considerable emotional and personal damage.

Professional societies for psychology and counseling have provided important guidance on what constitutes ethical practice in psychological assessment. Some of the key resources are listed in the following texts:

- the American Psychological Association's *Guidelines for Test User Qualifications: An Executive Summary* (Turner et al., 2001),
- the *Standards for Qualifications of Test Users* (American Counseling Association, 2003),
- the *Responsibilities of Users of Standardized Tests* (Association for Assessment in Counseling, 2003), and

Counseling, 2003), and the interdisciplinary *Standards for Educational and Psychological Testing* (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 2014).

Knowledge of these guidelines and standards is necessary for any mental health professional wishing to engage in psychological assessment and testing. Unfortunately, these professional societies have not addressed what constitutes acceptable levels of education, training, and practice, leaving individuals who have not had a specific psychological assessment training sequence in graduate school with little place to turn for guidance. With this in mind, the Society for Personality Assessment (2006) promulgated a set of standards for education and training in psychological assessment to provide interdisciplinary guidance for mental health professionals in any jurisdiction with licensure permitting independent practice of psychological assessment. This document arose from the Society's concern about what it saw as an increasing number of individuals using psychological testing without proper knowledge of its complexities. The standards outline necessary courses, practicum, and supervisory experiences that can provide a basic education for adequate practice in psychological assessment. The standards also emphasize the important distinction between psychological appraisal and psychological assessment. The standards are publicly available on the Society's website, which is listed later in the online Resources section.

Three other topics regarding the adequate practice of psychological assessment are important to mention. First, as stated earlier, all individuals practicing psychological assessment should take into consideration the importance of response style in interpreting psychological tests, such as underreporting, overreporting, and inconsistent or confused reporting. Without some measure of response style, it is difficult to understand the true meaning of psychological test data. Second, the importance of a multimethod assessment (e.g., Erdberg, 2007; Meyer, 1996, 1997) cannot be overemphasized because of problems inherent in using only one test or one type of test, especially without at least one test with a measure of response style. Third, extreme caution should be used in relying solely on computer interpretive reports for interpretation of clients' problems. The direct use of computer interpretive statements in psychological assessment reports (often referred to as "plug and chug") is not an adequate practice. Greene (2011) reports research indicating that 15% to 20% of statements of MMPI-2 computer interpretative reports do not give an accurate interpretation of clients' psychopathology when additional scales and client history are taken into account. This is especially true with interpretation of the MMPI-2 with psychological trauma, in that computer interpretive reports are not trauma specific. As stated earlier, common code types for trauma victims give a very different picture, depending on whether psychological trauma is taken into consideration.

COUNSELING IMPLICATIONS

The issue of assessing survivors of trauma raises several implications for counselors. Perhaps most important is that careful assessment of psychological trauma can lead to clearer and more focused treatment interventions. Counselors are better able to assist their clients if they tailor their treatment to the problems in living that are troubling their clients. For example, focused assessment can let the counselor know if a client is struggling with intrusive experiences, upsetting their daily living, or if the client is emotionally shut down and socially detached because of a preponderance of numbing and avoidant symptoms. The client might be severely dissociated and disconnected in the treatment. Each of the psychological trauma presentations calls for a different treatment approach, and careful use of assessment instruments can assist the counselor in becoming more empathically linked to the client. Psychological assessment makes considerably more information available about the client's psychological functioning than the counselor can gain from unstructured clinical interviews alone.

Further, as Finn (2007) pointed out, psychological assessment is an empathy magnifier. Indeed, personalized, collaborative feedback using psychological assessment has been

increasingly used as a powerful therapeutic and empirically valid treatment intervention in its own right. Models for integrating counseling with psychological assessment often are called collaborative assessment (see Fischer, 1985/1994) or Therapeutic Assessment (Finn, 2007). More detail about how this approach can be used in the treatment of psychological trauma can be found in the parallel chapter in the first edition of this book (see Evans, 2012).

Another important implication is that more powerful assessment instruments provide more incisive information about the trauma survivor. Whereas clinical interviews are the "meat and potatoes" of counseling practice, structured interviews and face-valid PTSD scales add greater specificity in assessing the client's dilemmas in living. More elaborate measures such as comprehensive PTSD scales and the TSI allow the counselor to see the client's difficulties in a more complex way, whereas personality assessment measures such as the MMPI-2 and the Rorschach allow the counselor a better understanding of how the individual's psychological trauma fits into the overall picture of the personality. As the counselor employs more powerful psychological assessment instruments, they have a greater responsibility to receive advanced training in these methods that perhaps were not part of the graduate training curriculum. Best Practices in Assessing Psychological Trauma was presented earlier in the chapter to provide guidance for the counselor desirous of advanced practice in the psychological assessment of trauma.

CONCLUSION

In closing, we have tried to present a brief overview of the importance and potential power of psychological assessment with victims of trauma. Apart from presenting the many useful methods of assessing psychological trauma, it is our hope that counselors reading this book will see ways in which assessment can enhance their practice by assisting in more accurate and focused ways to intervene with trauma victims. Working with the broken narrative of psychological trauma is complex and challenging, but ultimately highly rewarding, when the counselor can help trauma victims repair deeply damaged views of themselves and their relationships with others. While becoming proficient in psychological assessment may appear daunting at first, there is a large and responsive professional community to support this learning. We personally wish to extend an invitation for counselors to embrace this challenge.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

The following resources may be helpful to students, clinicians, and instructors.

National Center for PTSD (www.ptsd.va.gov)

The assessment link of the National Center for PTSD is an indispensable resource for anyone interested in psychological trauma. Some instruments can be obtained for free from: https://www.index.va.gov/search/va/va_search.jsp?NQ=URL%3Ahttps%3A%2F%2Fwww.ptsd.va.gov%2F&QT=Assessment+of+PTSD&submit.x=49&submit.y=8

Sidran Institute: Traumatic Stress Education and Advocacy (www.sidran.org)

Society for Personality Assessment. (2006). *Standards for education and training in*

Society for Personality Assessment. (2006). *Standards for education and training in psychological assessment* (located under publications tab). Retrieved from www.personality.org

More information about training in Therapeutic Assessment can be found at www.therapeuticassessment.com

REFERENCES

American Counseling Association. (2003). *Standards for qualifications of test users*. Author.

American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (2014). *The standards for educational and psychological testing*. Authors.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Armstrong, J. G., & Kaser-Boyd, N. (2003). Projective assessment of psychological trauma. In M. J. Hilsenroth & D. L. Segal (Eds.), *Comprehensive handbook of psychological assessment: Personality assessment* (Vol. *2*, pp. 500–512). Wiley.

Armstrong, J. G., & Loewenstein, R. J. (1990). Characteristics of patients with multiple personality and dissociative disorders on psychological testing. *The Journal of Nervous and Mental Disease, 178*(7), 448–454. https://doi.org/10.1097/00005053-199007000-00006

Association for Assessment in Counseling. (2003). *Responsibilities of users of standardized tests* (3rd ed.). Author.

Beck, A. T. (1997). *Beck anxiety inventory manual*. Psychological Corporation.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck depression inventory manual* (2nd ed.). San Psychological Corporation.

Ben-Porath, Y. S. (2011). *Interpreting the MMPI-2-RF*. University of Minnesota Press.

Ben-Porath, Y. S., & Tellegen, A. (2008). *MMPI-2-RF (Minnesota Multiphasic Personality Inventory-2-Restructured Form): Manual for administration, scoring, and interpretation*. University of Minnesota Press.

Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease, 174*(12), 727–735. https://doi.org/10.1097/00005053-198612000-00004

Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., & Forneris, C. A. (1996). Psychometric properties of the PTSD checklist (PCL). *Behaviour Research and Therapy, 34*(8), 669–673. https://doi.org/10.1016/0005-7967(96)00033-2

Bliese, P. D., Wright, K. M., Adler, A. B., Cabrera, O., Castrol, C. A., & Hoge, C. W. (2008). Validating the primary care posttraumatic stress disorder screen and the posttraumatic stress disorder checklist with soldiers returning from combat. *Journal of Consulting and Clinical Psychology, 76*(2), 272–281. https://doi.org/10.1037/0022-006X.76.2.272

Brand, B. L., Armstrong, J. G., & Loewenstein, R. J. (2006). Psychological assessment of patients with dissociative identity disorder. *The Psychiatric Clinics of North America, 29*(1), 145–168. https://doi.org/10.1016/j.psc.2005.10.014

Brewin, C. R., Cloitre, M., Hyland, P., Shevlin, M., Maercker, A., Bryant, R. A., Humayun, A., Jones, L. M., Kagee, A., Rousseau, C., Somasundaram, D., Suzuki, Y., Wessely, S, van Ommeren, M., & Reed, G. M. (2017). A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD. *Clinical Psychology Review, 58*, 1–15. https://doi.org/10.1016/j.cpr.2017.09.001

Briere, J. (2011). *Trauma symptom inventory-2 professional manual*. Psychological Assessment Resources.

Briere, J. (2004). *Psychological assessment of adult posttraumatic states: Phenomenology, diagnosis, and measurement* (2nd ed.). American Psychological Association.

Bryer, J. B., Nelson, B. A., Miller, J. B., & Krol, P. A. (1987). Childhood sexual and physical abuse as factors in adult psychiatric illness. *The American Journal of Psychiatry, 144*(11), 1426–1430.

Butcher, J. N., Dahlstrom, W. G., Graham, J. R., Tellegen, A. M., & Kaemmer, B. (1989). *MMPI-2: Manual for administration and scoring*. University of Minnesota Press.

Caldwell, A. B. (2001). What do the MMPI scales fundamentally measure? Some hypotheses. *Journal of Personality Assessment, 76*, 1–17. https://doi.org/10.1207/S15327752JPA7601_1

Carlson, E. B. (1997). *Trauma assessments: A clinician's guide*. Guilford Press.

Chu, J. A. (1998). *Rebuilding shattered lives: The responsible treatment of complex posttraumatic and dissociative disorders*. John Wiley & Sons.

Courtois, C. A., & Ford, J. D. (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. Guilford Press.

Dutton, M. A. (2000). *Empowering and healing the battered woman*. Springer Publishing.

Elhai, J. D., Frueh, B. C., Gold, P. B., Gold, S. N., & Hamner, M. B. (2000). Clinical presentations of posttraumatic stress disorder across trauma populations: A comparison of MMPI-2 profiles of combat veterans and adult survivors of child sexual abuse. *Journal of Nervous and Mental Disease, 88*, 708–713. https://doi.org/10.1097/00005053-200010000-00010

Erdberg, P. S. (2007). Multimethod assessment as a forensic standard. In C. B. Gacono & F. B. Evans (Eds.), *The handbook of forensic Rorschach assessment* (pp. 561–566). Routledge.

Evans, F. B. (2012). Assessment in psychological trauma: Methods and intervention. In L. L. Levers (Ed.), *Trauma counseling: Theories and interventions* (pp. 471–492). Springer Publishing.

Exner, J. (2003). *The Rorschach: A comprehensive system, basic foundations* (4th ed.). Wiley.

Finn, S. E. (1994). *Manual for using the MMPI-2 as a therapeutic intervention*. University of Minnesota Press.

Finn, S. E. (2007). *In our clients' shoes: Theory and techniques of therapeutic assessment*. Lawrence Erlbaum Associates.

Finn, S. E. (2011). Journeys through the valley of death: Multimethod psychological assessment and personality transformation in long-term psychotherapy. *Journal of Personality Assessment, 93*(2), 123–141. https://doi.org/10.1080/00223891.2010.542533

Finn, S. E., & Tonsager, M. E. (1997). Information gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment. 9*, 374–385. https://doi.org/10.1037/1040-3590.9.4.374

Fischer, C. T. (1994). *Individualizing psychological assessment*. Lawrence Erlbaum Associates. (Original work published 1985.)

Foa, E. B., & Capaldi, S. (2013). *Manual for the administration and scoring of the PTSD symptom scale-interview for DSM-5 (PSS-I-5)*. https://www.apa.org/ptsd-guideline/assessment

Foa, E. B., McLean, C. P., Zang, Y., Zhong, J., Powers, M. B., Kauffman, B. Y., Rauch, S., Porter, K., & Knowles, K. (2016). Psychometric properties of the Posttraumatic Diagnostic Scale for DSM-5 (PDS-5). *Psychological Assessment, 28*(10), 1166–1171. https://doi.apa.org/doiLanding?doi=10.1037%2Fpas0000258

Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress, 6*(4), 459–473. https://doi.org/10.1002/jts.2490060405

Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive-behavioral therapy for PTSD*. Guilford Press.

Foa, E., & Tolin, D. F. (2000). Comparison of the PTSD symptom scale-interview version and the clinician-administered PTSD scale. *Journal of Traumatic Stress, 13*, 181–191. https://doi.org/10.1023/A:1007781909213

Friedman, A. F., Lewak, R., Bolinskey, P. K., & Nichols, D. S. (2015). *Psychological assessment with the MMPI-2/MMPI-2-RF*. Routledge.

Friedman, M. J., Keane, T. M., & Resick, P. A. (Eds.). (2014). *Handbook of PTSD: Science and practice* (2nd ed.). Guilford Press.

Frueh, B. C., Elhai, J. D., Gold, P. B., Monnier, J., Magruder, K. M., Keane, T. M., & Arana, G. W. (2003). Disability compensation seeking among veterans evaluated for posttraumatic stress disorder. *Psychiatric Services, 54*(1), 84–91. https://doi.org/10.1176/appi.ps.54.1.84

Garb, H. N. (1998). *Studying the clinician: Judgment research and psychological assessment*. American Psychological Association.

George, C., & Buchheim, A. (2014). Use of the adult attachment projective picture system with a severely traumatized patient: A psychodymanic perspective. *Frontiers in Psychology, 5*. https://doi.org/10.3389/fpsyg.2014.00865

George, C., & West, M. (2001). The development and preliminary validation of a new measure of adult attachment: The adult attachment projective. *Attachment & Human Development, 3*, 30–61. https://doi.org/10.1080/14616730010024771

Glenn, D. M., Beckham, J. C., Sampson, W. S., Feldman, M. E., Hertzberg, M. A., & Moore, S. D. (2002). MMPI-2 profiles of Gulf and Vietnam combat veterans with chronic posttraumatic stress disorder. *Journal of Clinical Psychology, 58*, 371–381. https://doi.org/10.1002/jclp.1149

Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). The psychometric properties of the life events checklist. *Assessment, 11*, 330–341. https://doi.org/10.1177/1073191104269954

Greenberg, S. A., & Shuman, D. W. (1997). Irreconcilable conflict between therapeutic and forensic roles. *Professional Psychology: Research & Practice, 28*, 50–57. https://doi.org/10.1037/0735-7028.28.1.50

Greene, R. (2011). *The MMPI-2/MMPI-2-RF: An interpretive manual* (3rd ed.). Pearson.

Griffith, P. L., Myers, R. W., Cusick, G. M., & Tankersley, M. J. (1997). MMPI-2 profiles of women differing in sexual abuse history and sexual orientation. *Journal of Clinical Psychology, 53*, 791–800.

sexual abuse history and sexual orientation. *Journal of Clinical Psychology, 53,* 791–800. https://doi.org/10.1002/(sici)1097-4679(199712)53:8<791::aid-jclp2>3.0.co;2-j

Grove, W. M. (2005). Clinical versus statistical prediction: The contribution of Paul E. Meehl. *Journal of Clinical Psychology, 61,* 1233–1243. https://doi.org/10.1002/jclp.20179

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5,* 377–391. https://doi.org/10.1002/jts.2490050305

Herman, J. L. (2015). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror.* Basic Books.

Herman, J. L., Perry, J. C., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry, 146,* 490–495. https://doi.org/10.1176/ajp.146.4.490

Houghton College. (1998). *F43.1 Post-traumatic stress disorder (ICD-10).* http://campus.houghton.edu/orgs/psychology/ptsd/icd-10.htm

Kamphuis, J. H., Kugeares, S. L., & Finn, S. E. (2000). Rorschach correlates of sexual abuse: Trauma content and aggression indexes. *Journal of Personality Assessment, 75*(2), 212–224. https://doi.org/10.1207/S15327752JPA7502_3

Kaser-Boyd, N., & Evans, F. B. (2007). Rorschach assessment of psychological trauma. In C. B. Gacono & F. B. Evans (Eds.), *The handbook of forensic Rorschach assessment* (pp. 255–276). Lawrence Erlbaum Associates.

Keane, T. M., Caddell, J. M., & Taylor, K. L. (1988). Mississippi scale for combat-related posttraumatic stress disorder: Three studies in reliability and validity. *Journal of Consulting and Clinical Psychology, 56,* 85–90.

Keane, T. M., Fairbank, J., Caddell, J., Zimering, R., Taylor, K., & Mora, C. (1989). Clinical evaluation of a measure to assess combat exposure. *Psychological Assessment, 1,* 53–55. https://doi.org/10.1037/1040-3590.1.1.53

Keane, T. M., Malloy, P. F., & Fairbank, K. A. (1984). Empirical development of an MMPI subscale for the assessment of combat-related posttraumatic stress disorder. *Journal of Consulting & Clinical Psychology, 51,* 888–891. https://doi.org/10.1037//0022-006x.52.5.888

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52,* 1048–1060. https://doi.org/10.1001/archpsyc.1995.03950240066012

Kubiszyn, T., Meyer, G. J., Finn, S. E., Eyde, L. D., Kay, G. G., Moreland, K. L., Dies, R. R., & Eisman, E. J. (2000). Empirical support for psychological assessment in clinical health care settings. *Professional Psychology: Research and Practice, 31*(2), 119–130. https://doi.org/10.1037/0735-7028.31.2.119

Lyons, J. A., & Wheeler-Cox, T. (1999). MMPI, MMPI-2 and PTSD: Overview of scores, scales, and profiles. *Journal of Traumatic Stress, 2,* 175–183. https://doi.org/10.1023/A:1024710803042

McLean, L. M., & Gallop, R. (2003). Implications of childhood sexual abuse for adult borderline personality disorder and complex posttraumatic stress disorder. *American Journal of Psychiatry, 160,* 369–371. https://doi.org/10.1176/appi.ajp.160.2.369

Meyer, G. J. (1996). The Rorschach and MMPI: Toward a more scientifically differentiated understanding of cross-method assessment. *Journal of Personality Assessment, 67*(3), 558–578. https://doi.org/10.1207/s15327752jpa6703_11

Meyer, G. J. (1997). On the integration of personality assessment methods: The Rorschach and MMPI. *Journal of Personality Assessment, 68*(2), 297–330. https://doi.org/10.1207/s15327752jpa6802_5

Meyer, G. J., Finn, S. E., Eyde, L. D., Kay, G. G., Moreland, K. L., Dies, R. R., Eisman, E. J., Kubiszyn, T. W., & Reed, G. M. (2001). Psychological testing and psychological assessment: A review of evidence and issues. *American Psychologist, 56*(2), 128–165.

Meyer, G. J., & Kurtz, J. E. (2006). Advancing personality assessment terminology: Time to retire "objective" and "projective" as personality test descriptors. *Journal of Personality Assessment, 87*(3), 223–225. https://doi.org/10.1207/s15327752jpa8703_01

Meyer, G., Viglione, D., Mihura, J., Erard, R. E., & Erdberg, P. (2011). *Rorschach performance assessment system: Administration, coding, interpretation, and technical manual.* Author.

Miller, M. W. (2004). Personality and the development and expression of PTSD. *PTSD Research Quarterly, 15*(3), 1–7. https://www.ptsd.va.gov/publications/rq_docs/V15N3.pdf

Morey, L. C. (2007). *Personality assessment inventory: Professional manual* (2nd ed.). Psychological Assessment Resources.

Murray, H. A. (1943). *Manual of thematic apperception test.* Harvard University Press.

Ozer, E. G., Best, S. R., Lipsey, T. L., & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin, 129,* 52–73. https://doi.org/10.1037/0033-2909.129.1.52

Pelcovitz, D., van der Kolk, B. A., Roth, S., Mandel, F., Kaplan, S., & Resick, P. (1997). Development of a criteria

Pelcovitz, D., van der Kolk, B. A., Roth, S., Mandel, F., Kaplan, S., & Resick, P. (1997). Development of a criteria set and a structured interview for the disorders of extreme stress (SIDES). *Journal of Traumatic Stress, 10*, 3–16. https://doi.org/10.1023/a:1024800212070

Putnam, F. W. (1997). *Dissociation in children and adolescents: A developmental perspective*. Guilford Press.

Robinson, J. S., & Larson, C. (2010). Are traumatic events necessary to elicit symptoms of posttraumatic stress? *Psychological Trauma, 2*, 71–76. https://doi.org/10.1037/a0018954

Rogers, R. (1995). *Diagnostic and structured interviewing: A handbook for psychologists*. Psychological Assessment Resources.

Rosen, G. M. (2006). DSM's cautionary guideline to rule out malingering can protect the PTSD data base. *Journal of Anxiety Disorder, 20*, 530–535. https://doi.org/10.1016/j.janxdis.2005.03.004

Ross, C. A. (2019). *The Dissociative Disorders Interview Schedule—DSM-5 Version*. https://www.rossinst.com/ddis

Roth, S., Newman, E., Pelcovitz, D., van der Kolk, B., & Mandel, F. S. (1997). Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV field trial for posttraumatic stress disorder. *Journal of Traumatic Stress, 10*, 539–555. https://doi.org/10.1023/a:1024837617768

Society for Personality Assessment. (2006). Standards for education and training in psychological assessment position of the Society for Personality Assessment. *Journal of Personality Assessment, 87*(3), 355–357. https://doi.org/10.1207/s15327752jpa8703_17

Solomon, Z., Mikulincer, M., & Avitzur, E. (1988). Coping, locus of control, social support, and combat-related posttraumatic stress disorder: A prospective study. *Journal of Personality and Social Psychology, 55*, 279–285. https://doi.org/10.1037//0022-3514.55.2.279

Southwick, S. M., Rasmusson, A., Barron, J., & Arnsten, A. (2005). Neurobiological and neurocognitive alterations in PTSD: A focus on norepinephrine, serotonin, and the hypothalamic-pituitary-adrenal axis. In J. J. Vasterling & C. R. Brewin (Eds.), *Neuropsychology of PTSD: Biological, cognitive, and clinical perspectives* (pp. 27–58). Guilford Press.

Spitzer, R. L., Williams, J. B., Gibbon, M., & First, M. B. (1990). *Structured clinical interview for DSM-III (SCID-II, ver. 1.0)*. American Psychiatric Press.

Steinberg, M. (1994). *Structured clinical interview for DSM-IV dissociative disorders-revised*. American Psychiatric Press.

Steinberg, M., & Schnall, M. (2001). *The stranger in the mirror: Dissociation—the hidden epidemic*. New Harper Collins.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. Norton.

Sullivan, H. S. (1954). *The psychiatric interview*. Norton.

Teglasi, H. (2010). *Essentials of TAT and other storytelling assessments* (2nd ed.). Wiley.

Turner, S. M., DeMers, S. T., Fox, H. R., & Reed, G. (2001). APA's guidelines for test user qualifications: An executive summary. *American Psychologist, 56*(12), 1099–1113. https://doi.org/10.1037/0003-066X.56.12.1099

U.S. Department of Veterans Affairs. (2011). *National center for PTSD*. https://www.ptsd.va.gov

van der Kolk, B. A. (1987). *Psychological trauma*. American Psychiatric Press.

van der Kolk, B. A., & Ducey, C. (1984). Clinical implications of the Rorschach in post-traumatic stress disorder. In B. A. van der Kolk (Ed.), *Post-traumatic stress disorder: Psychological and biological sequelae* (pp. 29–42). American Psychiatric Press.

van der Kolk, B. A., & McFarlane, A. C. (1996). The black hole of trauma. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress* (pp. 3–23). Guilford Press.

van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (Eds.). (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. Guilford Press.

van der Kolk, B. A., & Pelcovitz, D. (1999). Clinical applications of the structured interview for disorders of extreme stress (SIDES). *National Center for PTSD Clinical Quarterly, 8*, 21–26. https://web.archive.org/web/20050420081045/http://www.ncptsd.va.gov/publications/cq/v8/n2/V8N2.PDF

Walker, L. E. (2000). *Abused women and survivor therapy: A guide for the psychotherapist*. American Psychological Association.

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)*. National Center for PTSD. https://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp