

Phenomenology and Psychological Assessment of Complex Posttraumatic States

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The authors offer a framework for the assessment of psychological responses associated with exposure to early onset, multiple, or extended traumatic stressors. Six prominent and overlapping symptoms clusters are described: altered self-capacities, cognitive symptoms, mood disturbance, overdeveloped avoidance responses, somatoform distress, and posttraumatic stress. A strategy for the structured, psychometrically valid assessment of these outcomes is introduced, and specific recommendations for use of various generic and trauma-specific child and adult measures are provided. Implications of trauma assessment for treatment planning are discussed.

Reactions to overwhelming psychological stressors can be viewed as residing on a complexity continuum. At one end are responses to adult-onset, single-incident, traumatic events (e.g., a motor vehicle accident, a mugging) that occur in individuals with adequate childhood development, a normoreactive nervous system, and no comorbid psychological disorders. At the opposite end are responses to early onset, multiple, extended, and sometimes highly invasive traumatic events, frequently of an interpersonal nature, often involving a significant amount of stigma or shame, that occur in individuals who, for a variety of reasons, may be more vulnerable to stress effects.

Individuals at the high end of this complexity continuum are the subject of this article. These individuals are likely to experience a variety of posttraumatic symptoms and negative mood states, and often present with chronic affect regulation and interpersonal difficulties (Herman,

1992). The implications of this heterogeneity for the process and content of psychological assessment are significant. For example, it is unlikely that a single, overarching diagnostic label or construct will encompass the complexity of posttraumatic outcomes for the majority of these traumatized individuals. Accordingly, we emphasize a phenomenologically based framework to guide psychological assessment of the many psychological responses associated with exposure to more extreme or sustained traumatic stressors.

Etiology

The modern literature on posttraumatic stress suggests that the development of distress and disorder following a traumatic event is typically the result of an interaction among a number of factors, of which the specific traumatic experience is only one. For example, more severe and complex posttraumatic outcomes frequently are associated with a life history of multiple interpersonal victimization experiences, often beginning with extended childhood abuse and neglect, and associated disruption of the parent-child attachment system (e.g., Ford & Kidd, 1998; Zlotnick et al., 1996). Such maltreatment not only may produce lasting sequelae itself, but also is a risk factor for

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being revictimized in the future (Neumann, Houskamp, Pollock, & Briere, 1996) and for responding to later traumatic events with more severe and complex symptoms (e.g., Bremner, Southwick, Johnson, Yehuda, & Charney, 1993). Also associated with more extreme posttraumatic responses are a range of person-level variables, including nervous system hyperreactivity (Yehuda, 1997), the presence of other anxiety, depressive, or personality-level disorders (Breslau, Davis, & Andreski, 1991), and excessive use of drugs or alcohol (Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999) — all of which both moderate the effects of trauma exposure and may arise themselves, from previous traumatic events (McCauley et al., 1997). Finally, response complexity is often affected by environmental variables such as inadequate social support (Steketee & Foa, 1987), lower socioeconomic status (e.g., Bassuk, Dawson, Perloff, & Weinreb, 2001), and stigmatization associated with certain traumatic experiences (e.g., Lebowitz & Roth, 1994), and may vary according to whatever idioms of distress are most acceptable within a given culture (Marsella, Friedman, Gerrity, & Scurfield, 1996).

Phenomenology

Given the complexity of some posttraumatic outcomes, psychological assessment in this area must potentially address a wide range of symptom clusters in addition to classic posttraumatic stress disorder (PTSD). Most broadly, these can be subsumed under the intrinsically overlapping headings presented below.

Altered Self-Capacities

The literature on the effects of severe or extended childhood abuse and neglect, especially when such maltreatment involves disruption of early parent–child attachment, often emphasizes dysfunctions in the areas of identity, affect regulation, and interpersonal relatedness (Cole & Putnam, 1992; Herman, Perry, & van der Kolk, 1989). These domains have been subsumed under the general notion of "self-capacities" (Briere, 2000a; McCann & Pearlman, 1990; Pearlman, 1998) because such disturbance involves dysfunction in one's abilities to regulate one's internal experience and one's interaction with others. Problems in the self domain, in turn, have been implicated in the development of dysfunctional behaviors often seen in complex posttraumatic outcomes, including suicidality (e.g., Zlotnick, Donaldson, Spirito, & Pearlstein, 1997), impulse control problems (e.g., Herpertz et al., 1997), substance abuse

(e.g., Grilo et al., 1997), and the "tension reduction" behaviors (e.g., self-mutilation) described in a separate section below.

Cognitive Disturbance

Interpersonal victimization (e.g., child abuse or adult assault) has been associated with subsequent low self-esteem, self-blame, helplessness, hopelessness, expectations of rejection and loss, and an overestimation of the amount of danger in the world (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999; Janoff-Bulman, 1989; McCann & Pearlman, 1990). When these cognitions are developed early in life in the context of sustained abuse or neglect, they may form complex *relational schemata* (Baldwin, Fehr, Keedian, Seidel, & Thompson, 1993) or *internal working models* (Bowlby, 1988) involving negative self-perceptions and expectations of maltreatment or abandonment by others. These schemata, in turn, are easily evoked by later stimuli that are somehow reminiscent of the original abusive experience (e.g., perceived or real rejection or criticism), leading to reactivated experiences of, for example, self-hatred, anger, or abandonment fears (Baldwin et al., 1993; Briere, 2002a).

Mood Disturbance

A number of studies indicate that exposure to interpersonal traumas can result in symptoms or disorders involving anxiety, depression, and anger or aggression (e.g., Heim & Nemeroff, 2001; Pollock et al., 1990). Anxiety and depressive disorders are commonly comorbid with posttraumatic stress (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), and may be associated with traumatic events irrespective of PTSD (Heim & Nemeroff, 2001; Prigerson, Maciejewski, & Rosenheck, 2002). Such outcomes may arise from the enduring physiological effects of some traumatic experiences and trauma-related cognitive distortions, as described above, or in some cases, may reflect conditioned emotional responses to activated trauma memories (Eckhardt, Barbour, & Davison, 1998; Foa et al., 1999; Heim & Nemeroff, 2001).

Overdeveloped Avoidance Responses

Exposure to traumatic events—especially when it occurs early in life and is sustained over time—can lead to the overdevelopment of avoidance activities that appear to reduce the experience of trauma-related dysphoria. Examples of such responses are dissociation, substance abuse, and tension reduction activities.

Dissociation

Dissociative symptomatology can be broadly defined as alterations in conscious awareness that arise, in part, from defensive changes in otherwise integrated thoughts, feelings, memories, and behavior. Examples of this group of responses are depersonalization, derealization, fugue states, and dissociative identity disorder (American Psychiatric Association [APA], 2000). Although dissociative symptoms may function as a way to reduce the emotional distress associated with traumatic events, they also may be invoked long after the traumatic event in an attempt to reduce the emotional responses associated with triggered traumatic memories (Briere, 2002a; Chu, Frey, Ganzel, & Matthews, 1999).

Substance Abuse

A number of studies indicate that individuals with complex and chronic trauma histories are more likely to use drugs and alcohol (e.g., Grilo et al., 1997). Such use may constitute a form of emotional avoidance, whereby substances are taken to anesthetize negative affect associated with traumatic experiences or subsequent trauma memories (e.g., Khantzian, 1997). Conversely, clinical experience suggests that substance use can also serve to alleviate affective numbness in some trauma survivors by inducing transient and predictable pleasurable bodily sensations or emotions. Unfortunately, substance abuse, in turn, can be related to further victimization (Acierno et al., 1999), and thus may result in further (and potentially more complex) posttraumatic symptomatology.

Tension Reduction

Absent sufficient affect regulation skills, traumatized individuals often rely on external ways of avoiding or reducing activated abuse-related distress. These include not only substance abuse, but also what are referred to as *tension reduction behaviors* (Briere, 2002a), such as compulsive sexual behavior (Briere & Elliott, 2003), bingeing and purging (Webster & Palmer, 2000), self-mutilation (Briere & Gil, 1998), and suicidality (Zlotnick et al., 1997). Along with substance abuse, tension reduction activities are thought to work by providing temporary distraction or by inducing distress-incompatible affective states.

Somatoform Distress

Somatoform symptoms refer, most broadly, to bodily distress or dysfunction that arises from (or is significantly

intensified by) psychological phenomena (American Psychiatric Association, 2000). Somatoform distress has been linked to a variety of traumas, most notably sustained child abuse (Walker et al., 1988) and ongoing adult victimization (Kimerling & Calhoun, 1994). In addition, somatic symptoms may serve as an idiom of posttraumatic distress for cultures or subcultures that deny or reinterpret psychological dysfunction (Marsella et al., 1996).

Posttraumatic Stress

Although exposure to traumatic events does not always lead to posttraumatic stress disorder (e.g., Kessler et al., 1995), those clinically affected by such exposure often present with some degree of intrusive re-experiencing (e.g., flashbacks or nightmares), avoidance (e.g., emotional numbing or efforts to avoid traumatic reminders), or autonomic hyperarousal (e.g., heightened startle responses or insomnia). In this regard, posttraumatic stress may be viewed as a multidimensional, spectrum-level phenomenon—involving some combination of three separate but moderately correlated symptom clusters—that (somewhat arbitrarily) reaches disorder status when certain numbers of symptoms per cluster are reported at specified levels. Although a dichotomous diagnosis of PTSD has obvious clinical utility, a dimensional perspective may allow more precision in understanding the posttraumatic symptoms of a given trauma survivor.

Assessment

Given the broad range of potential posttraumatic outcomes, it is unlikely that the psychological assessment of traumatized individuals can be accomplished through the mere administration of a single measure, for example a test for PTSD. Instead, once it has been determined that exposure to a potentially traumatic event is part of the clinical picture, the number of possible assessment targets proliferate. In the remainder of this article we address the technical aspects of this expanded assessment process.

Psychometric Issues

As is true of psychological tests in general, those used to evaluate the effects of complex trauma-related outcomes should have adequate reliability and validity, and should be standardized on demographically representative samples of the general population. Such tests also should have good sensitivity and specificity if they are offered as diagnostic instruments. For example, a measure purporting to identify posttraumatic stress disorder should

be able to predict with reasonable accuracy both true cases of PTSD (sensitivity) and those cases where no PTSD is present (specificity).

Unfortunately, because of the relative recency of our understanding of posttraumatic conditions, some currently available trauma-specific instruments do not meet existing standards for clinical psychological tests. Although such tests may be internally consistent, and may correlate with relevant trauma variables, their actual clinical utility (i.e., sensitivity and specificity) in clinical contexts is often unknown or less than encouraging. At least as problematic, many trauma measures have not been normed on the general population. Without normative data, the clinician is unable to compare a given client's score on a measure with the average individual's score on that measure, and thus cannot determine the extent to which said score represents dysfunction or disorder. In the case of solely diagnostic screening instruments, the absence of normative data is generally not a problem, because the primary issue is whether a given set of symptoms are—or are not—present.

For these reasons, the clinician is advised to avoid, when possible, the use of nonstandardized self-report measures in the assessment of trauma effects, complex or otherwise. In this regard, most of the measures recommended in this article have been fully standardized and normed or, in the case of diagnostic measures, have been shown to have adequate sensitivity and specificity. As a result, several measures with good psychometric properties but lacking normative or standardization data are not reviewed here.

Approach to Assessing Complex Posttraumatic Outcomes

Posttraumatic outcomes vary widely; hence, the initial approach to assessment is critically important. In a sense, the clinician must make an educated guess as to what are likely to be the relevant areas of distress or dysfunction for a given client, even though he or she has yet to determine them psychometrically. In most cases, this determination is made during the initial interview, when a traumatic event history and presenting complaints are elicited and the client's overall clinical presentation is considered. This process may be assisted by a structured review of potentially traumatic events and the administration of broad-spectrum screening instruments that evaluate a number of different areas of symptomatology simultaneously.

Assessing Exposure to Traumatic Events

Although we devote much of this article to the evaluation of symptomatology, a complete trauma assessment also must consider the client's specific history of exposure to traumatic events. Various studies indicate that psychotherapy clients and other individuals often fail to reveal significant traumatic experiences if not specifically asked (Read & Fraser, 1998). Ideally, such inquiry is done in a sensitive manner, using behavioral descriptions of the events (as opposed to merely asking about "rape" or "abuse"), and employing some sort of structured measure or interview that assesses exposure to the major types of traumatic events (Hanson, Kilpatrick, Falsetti, & Resnick, 1995).

Especially relevant to the issue of complex posttraumatic states, many of those presenting with more complex symptomatology have undergone a significant number of adverse experiences, often beginning with childhood abuse. Because both childhood and adult traumatic events can produce psychological difficulties, current symptomatology in such individuals may represent (a) the effects of relatively recent (i.e., adult) traumatic experiences, (b) the chronic effects of childhood abuse, (c) the additive effects of childhood abuse and adult traumatic experiences (e.g., flashbacks to both childhood and adult victimization), or (d) the exacerbating interaction of child abuse and adult traumatic experiences (e.g., especially severe, regressed, dissociated, or even transiently psychotic responses; Briere, 2004). Beyond the interaction between different traumatic events, a general finding in the trauma literature is that the greater the number of traumatic events that have occurred in an individual's life, the more posttraumatic symptomatology is likely to be present (e.g., Follette, Polusney, Bechtle, & Naugle, 1996). For this reason, the client's recent and remote trauma history should be taken into account before his or her symptoms can be attributed solely to a given event—especially when the symptomatology is complex or pervasive.

There are a range of trauma exposure interviews and inventories available to the clinician, in most cases applicable to adolescents and adults. Among these are the Potential Stressful Events Interview (PSEI; Falsetti, Resnick, Kilpatrick, & Freedy, 1994; Kilpatrick, Resnick, & Freedy, 1991), Stressful Life Events Screening Questionnaire (SLESQ; Goodman, Corcoran, Turner, Yuan, & Green (1998), and Traumatic Events Scale (TES; Elliott, 1992). In addition, there are trauma exposure sections in two frequently used trauma symptom measures: the Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995) and the Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001).

Symptom Measures for Children and Adolescents

As opposed to the assessment of adults, there are relatively few approaches to complex posttraumatic outcomes available for use with children and adolescents. The three most popular of these—one generic and two trauma-specific—are reviewed below. A number of other tests are also potentially relevant to complex posttraumatic symptoms in children, but, by virtue of their less frequent use with this population, are not reviewed here.

Child Behavior Checklist. The Child Behavior Checklist (CBCL; Achenbach, 2002) is one of the most widely used clinical instruments for the assessment of general psychological distress in children, and often is used to evaluate those who have experienced childhood abuse (Friedrich, 2002). The current version appears to be an improvement over the previous one, with new norms, more items and scales, and specific reference to the disorders detailed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV;* American Psychiatric Association, 1994). Unfortunately, the age ranges for each normative group remain quite broad. The most popular form of the CBCL is completed by a caretaker or teacher, although there also is a self-administered "Youth Self-Report" version for children from ages 11 to 18, and a new Young Adult Self-Report for individuals ages 18 to 30. The CBCL measures a range of problems that may arise from abuse or other traumatic events, such as withdrawal, somatic complaints, thought problems, and delinquent behavior, as well as examining competencies that may modify or reduce these problems.

Trauma Symptom Checklist for Children. The Trauma Symptom Checklist for Children (TSCC; Briere, 1996) evaluates self-reported trauma symptoms in children ages 8 to 16. It has two validity scales (Underresponse and Hyperresponse) and six clinical scales: Anxiety, Depression, Anger, Posttraumatic Stress, Sexual Concerns (with two subscales), and Dissociation (with two subscales). An alternate version of this measure (the TSCC-A) does not evaluate sexual symptomatology. The TSCC was normed on over 3,000 children from urban, suburban, and inner city environments, and demonstrates good reliability and validity in a number of studies (Briere, 1996; Wolpaw, Ford, Newman, Davis, & Briere, 2005). Because it examines both trauma symptoms and common comorbidities, this instrument can evaluate complex posttraumatic outcomes. There is now a parent report version of the TSCC for children 3 years of age or older, the Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005; Briere et al., 2001), that approximates TSCC item content, but examines PTSD symptom clusters in greater detail.

Child Sexual Behavior Inventory. The Child Sexual Behavior Inventory (CSBI; Friedrich, 1998) is a reliable and valid measure that evaluates the sexual behaviors observed in children, ages 2 to 12, during the prior 6 months (Friedrich, 1998). Nine domains frequently associated with childhood sexual abuse are tapped by this instrument: Boundary Problems, Exhibitionism, Gender Role Behavior, Self-Stimulation, Sexual Anxiety, Sexual Interest, Sexual Intrusiveness, Sexual Knowledge, and Voyeuristic Behavior. The CSBI yields a total score and two scale scores: Developmentally Related Sexual Behavior, which reflects the level of age and gender-appropriate sexual behavior; and Sexual Abuse Specific Items, which consists of items that have been empirically related to a history of sexual abuse. Normative data for the CSBI were collected on over 1,000 children.

Recommendation

Because the number of standardized tests available to evaluate complex posttraumatic symptoms in children and adolescents is small, the options for the evaluator are limited. Generally, the recommendation is to administer both the Youth Self-Report form (if the child is age 11 or older) and the parent report versions of the CBCL, as well as the TSCC and the TSCYC. If there is a possibility of sexual victimization, the CSBI also should be administered. Additional, more generic tests may be added to this battery as needed. Unfortunately, there are few standardized tests available to assess children's impaired self-capacities. The situation is only slightly better for older adolescents, whose self-disturbance also may be assessed, to some extent, with the Minnesota Multiphasic Personality Inventory–Adolescents (MMPI-A; Butcher et al., 1992). As a result, the evaluator is forced to rely to a greater extent on subjective interview data for children than for adults.

Adult Self-Report Measures

Psychological tests of complex trauma effects in adults can be divided into two groups: instruments that tap a wide range of generic (i.e., nontrauma-specific) psychological symptoms, and tests that directly assess various forms of posttraumatic disturbance.

Generic Measures

A variety of psychological tests are available for the assessment of nontrauma-specific symptoms in those exposed to traumatic events. Several evaluate syndromes relevant to Axis I of the *DSM-IV* (e.g., the Millon Clinical

Multiaxial Inventory, 3rd Edition [MCMI-III], Millon, 1994; Minnesota Multiphasic Personality Inventory, 2nd Edition [MMPI-2], Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989; and the Psychological Assessment Inventory [PAI], Morey, 1991). Each of the above-mentioned tests also yield detailed information on those personality (e.g., Axis II) and self-capacity difficulties frequently associated with complex posttraumatic outcomes, and include PTSD scales—albeit ones of less than optimal sensitivity and specificity. Some generic instruments also include validity scales, developed to detect under- or over-reporting of symptoms. Although validity scales can be helpful, research indicates that traumatized individuals—perhaps by virtue of the unusual quality of some posttraumatic symptoms—tend to score higher than others on negative impression scales, even when not attempting to malingering (e.g., Elhai, et al., 2002; Jordan, Nunley, & Cook, 1992).

Posttraumatic Stress Measures

Tests of posttraumatic stress can be divided into those that tap symptoms without reference to a specific trauma, and thus yield scores representing the overall "amount" of posttraumatic symptoms currently experienced by an individual in a variety of different areas, and those that examine responses to a specific traumatic event and typically provide a provisional diagnosis of PTSD. Among standardized tests, only one is available for the evaluation of overall posttraumatic disturbance, whereas several (two of which are reviewed below) can be used to determine a possible diagnosis of trauma-specific PTSD.

Trauma Symptom Inventory. The Trauma Symptom Inventory (TSI; Briere, 1995) taps the overall level of acute and chronic posttraumatic symptomatology experienced by an individual without any specific reference to any given traumatic event. It has been shown to have good reliability and to demonstrate various indices of validity (Briere, 1995). Each symptom item is rated according to its frequency over the prior 6 months. The TSI has three validity scales (Response Level, Atypical Response, and Inconsistent Response) and 10 clinical scales (Anxious Arousal, Depression, Anger/Irritability, Intrusive Experiences, Defensive Avoidance, Dissociation, Sexual Concerns, Dysfunctional Sexual Behavior, Impaired Self-Reference, and Tension Reduction Behavior), the latter of which appear sensitive to the effects of a variety of different traumatic events (e.g., Green et al., 2000; Runtz & Roche, 1999). The variety of symptoms assessed by the TSI has resulted in the use of this measure as a broad spectrum measure of complex posttraumatic outcomes (e.g., Resick, Nishith, & Griffin, 2003).

Posttraumatic Stress Diagnostic Scale. The Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995) evaluates four domains: exposure to potentially traumatic events, characteristics of the most traumatic event, 17 symptoms corresponding to *DSM-IV* PTSD criteria, and extent of symptom interference in the individual's daily life. The PDS demonstrates good sensitivity and specificity with respect to a PTSD diagnosis (.82 and .77, respectively) and reasonable diagnostic efficiency ($\kappa = .59$). The PDS has not been normed on the general population and thus does not yield standardized *T*-scores. Instead, PTSD symptom severity estimates are based on extrapolation from a clinical sample of 248 traumatized women.

Detailed Assessment of Posttraumatic Stress. The Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001) provides information on an adult client's history of exposure to various types of traumatic events (Trauma Specification and Relative Trauma Exposure), as well as containing scales that tap his or her immediate cognitive, emotional, and dissociative reactions (Peritraumatic Distress and Peritraumatic Dissociation), subsequent posttraumatic stress symptoms (Reexperiencing, Avoidance, and Hyperarousal), and level of experienced disability (Posttraumatic Impairment) in the context of a specific traumatic event. Like the PDS, the DAPS provides a potential *DSM-IV* diagnosis of PTSD. This measure has two validity scales that evaluate under- and over-reporting of symptoms (Positive Bias and Negative Bias, respectively), and three scales that measure common trauma and PTSD-related comorbidities (Trauma-specific Dissociation, Substance Abuse, and Suicidality). The DAPS is normed on over 400 general population men and women with a history of exposure to at least one *DSM-IV* criterion A traumatic event. The scales of this measure are internally consistent and demonstrate various forms of validity. The posttraumatic stress scales have good sensitivity (.88) and specificity (.86) with respect to a CAPS PTSD diagnosis, with an associated κ of .73 (Briere, 2001).

Self-Capacity Measures

Complex posttraumatic outcomes often include difficulties in identity and boundary awareness, affect regulation, and interpersonal relationships. As a result, an accurate evaluation of complex trauma usually includes tests of the self domain.

Several tests have scales or subscales that tap one or more aspects of impaired self-capacities, including the Borderline Features subscales of the PAI, the Impaired Self-reference scale of the TSI, and various personality scales of the MCMI-III. In addition to the Rorschach (Rorschach, 1981; described later), there are also two

stand-alone standardized tests available to assess psychological functioning in this area.

Bell Object Relations and Reality Testing Inventory. The only standardized test of what is generally referred to as *object relations*, the Bell Object Relations and Reality Testing Inventory (BORRTI; Bell, 1995) has scales that yield data on four constructs: Alienation, Insecure Attachment, Egocentricity, and Social Incompetence. The BORRTI item content also reflects identity issues and affect regulation difficulties, although there are no scales specifically tapping those domains. A very small literature in this area suggests that the BORRTI may be helpful in evaluating self-capacity and attachment issues in traumatized populations (e.g., Santina, 1998). Because this measure reflects a specific underlying theoretical perspective (i.e., object relations), its use may be somewhat limited in general trauma practice.

Inventory of Altered Self Capacities. The Inventory of Altered Self Capacities (IASC; Briere, 2000a) is a standardized test of difficulties in the areas of relatedness, identity, and affect regulation. The scales of the IASC assess the following domains: Interpersonal Conflicts, Idealization-Disillusionment, Abandonment Concerns, Identity Impairment, Susceptibility to Influence, Affect Dysregulation, and Tension Reduction Activities. The IASC scales have been shown to predict self-reported child abuse history (especially sexual and emotional maltreatment), adult attachment style, "borderline" and "anti-social" personality features, relationship problems, suicidality, dysfunctional sexual behavior, and substance abuse (Briere, 2000a; Briere & Runtz, 2002). It is also designed to predict certain issues (e.g., abandonment fears, idealization/devaluation, and hypersusceptibility to influence) that otherwise might disrupt or derail the client-therapist relationship during treatment. The IASC is standardized on the general population and various clinical and university samples, and has been found to be reliable and to have convergent and discriminant validity.

Cognitive Disturbance Measures

As noted in the introduction, complex or sustained traumatic events often produce relatively chronic cognitive symptoms. Fortunately, there are available measures that tap cognitive distortions and negative relational schemata. Two of these scales, especially helpful in the assessment of complex posttraumatic outcomes, are presented below.

Cognitive Distortions Scale (CDS). The Cognitive Distortions Scale (CDS; Briere, 2000b) is a 40-item test that measures five types of cognitive symptoms or dis-

tortions found among those who have experienced interpersonal victimization: Self-Criticism, Self-Blame, Helplessness, Hopelessness, and Preoccupation with Danger. The CDS scales are internally consistent and have convergent validity with other cognitive distortion measures in various clinical and nonclinical samples. The CDS scales are predictive of childhood and adult interpersonal victimization history, as well as suicidality, depression, and posttraumatic stress (Briere, 2000b).

Trauma and Attachment Belief Scale. The Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) measures disrupted cognitive schemata and need states associated with exposure to traumatic events. This instrument taps five related content areas: Safety, Trust, Esteem, Intimacy, and Control. There are reliable subscales for each of these domains, rated both for "self" and "other." Earlier versions of the TABS have been shown to predict vicarious traumatization in therapists and to vary as a function of trauma exposure on college students, outpatients, battered women, and the homeless (Pearlman, 2003). In contrast to more symptom-based tests, the TABS measures the self-reported needs and expectations of trauma survivors as they predict self in relation to others. As a result, the TABS is likely to be helpful in understanding important assumptions that the client carries in his or her relationships to others, including the therapist.

Dissociation Measures

Despite the potential importance of dissociation in complex posttraumatic disturbance, until recently clinicians have had to rely on unstandardized measures when assessing this domain. The most popular of such instruments, the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986) has good psychometric characteristics, including predictive validity for dissociative identity disorder when a cut-off score of 30 is used (Carlson et al., 1993). However, as noted earlier, the absence of normative information means that a specific score on this measure (other than its position above or below the cut-off) is not easily interpreted in terms of its extremity from "normal" dissociative responses (Armstrong, 1995). Further, like most other dissociation measures, the DES sums across all items to yield a single "dissociation" score, and thus does not discriminate between those who experience depersonalization or derealization from, for example, those with dissociative identity disorder. Because dissociation appears to be a multidimensional phenomenon (e.g., Briere, Weathers, & Runtz, 2005), single-score measures in this area sometimes are problematic.

Currently, there are three scales within larger standardized tests that tap dissociative symptoms (the Dissociation scale within the TSI, and the Trauma-Specific Dissociation and Peritraumatic Dissociation scales of the DAPS), as well as one freestanding standardized test of dissociative responses, the 30-item Multiscale Dissociation Inventory (MDI; Briere, 2002b). In contrast to the TSI, DAPS, or DES, which yield a single score, and thus overlook dimensionality, the MDI consists of six internally consistent scales (Disengagement, Depersonalization, Derealization, Memory Disturbance, Emotional Constriction, and Identity Dissociation) that, together, form an overall "dissociation profile." The MDI correlates as expected with victimization history, PTSD, and other measures of dissociation. Analyses in a sample of over a thousand clinical and nonclinical individuals indicate that the MDI has substantial factorial validity (Briere et al., 2005). In another study, the Identity Dissociation scale had a specificity of .92 and a sensitivity of .93 with respect to a dissociative identity disorder diagnosis (Briere, 2002b).

Measures of Dysfunctional Behavior

As noted earlier, many individuals who suffer complex posttraumatic symptoms (perhaps especially those with affect regulation problems) engage in externalization or other tension reduction behaviors when confronted with trauma-related memories and affects. In addition to the Tension Reduction Behavior (TRB) scale of the TSI, and the Tension Reduction Activities (TRA) of the IASC, various measures can be used to assess specific dysfunctional behaviors common to complex posttraumatic distress. These include the Dysfunctional Sexual Behavior (DSB) scale of the TSI, the Suicidality scale of the DAPS (as well freestanding suicide measures, such as the Adult Suicidal Ideation Questionnaire [ASIQ], Reynolds, 1991), the Eating Disorders Inventory [EDI-2], Garner, 1990), and the Substance Abuse scale of the DAPS.

The Rorschach

The Rorschach differs from the other instruments described in that it is a projective test, rather than a self-report or interview measure. Although there is some controversy regarding the general clinical utility of the Rorschach (e.g., Hunsley & Bailey, 2001), a review of the extant literature indicates a significant empirical relationship between various Rorschach indicators and both trauma exposure and posttraumatic stress (Luxenberg & Levin, 2004). Unfortunately, when interpreted by those

without specific trauma training, some complex posttraumatic outcomes may be misrepresented as impaired reality testing or personality disorder on this test (e.g., Van der Kolk & Ducey, 1989).

Adult Interview-Based Measures

Posttraumatic Stress Disorder Interviews

There are several structured clinical interviews for the diagnosis of PTSD. In several cases, these instruments were developed and validated for *DSM-III* (APA, 1980) or *DSM-III-R* (APA, 1987), and have less psychometric data available for their *DSM-IV* (APA, 1994) versions. Two interviews, however, demonstrate good psychometrics in their *DSM-IV* versions; they are widely used in research and clinical applications. See Briere (2004), Carlson (1997), and Wilson and Keane (2004) for more detailed reviews of trauma-relevant interviews.

The Clinician-Administered Posttraumatic Stress Disorder Scale. The Clinician-Administered Posttraumatic Stress Disorder Scale (CAPS; Blake et al., 1995) is a structured diagnostic interview that generates both dichotomous and continuous scores for current and lifetime PTSD. Often considered the "gold standard" for a *DSM-IV* PTSD diagnosis, the CAPS demonstrates good reliability and validity in a variety of contexts (Weathers, Keane, & Davidson, 2001). In addition to diagnostic items, this interview also examines trauma exposure, posttraumatic impacts on social and occupational functioning, response validity, and overall PTSD severity, as well as guilt and acute dissociative symptoms. One potential limitation of the CAPS is that its detail and length can extend administration time to an hour or longer in some instances.

The PTSD Module of the Structured Clinical Interview for DSM-IV. The *DSM-IV* version of the SCID (First, Spitzer, Gibbon, & Williams, 1997) includes a PTSD module, a component that was optional in the *DSM-III-R* version of this interview. The SCID has the advantage of screening for a variety of disorders in addition to PTSD, although, as with previous versions, it does not assess for the dissociative disorders. Its broad diagnostic range provides a more comprehensive clinical picture than is available with most trauma-specific measures, thereby making it potentially appropriate for the assessment of more complex posttraumatic outcomes.

Interviews for Other Disorders or Constructs

The Structured Clinical Interview for DSM-IV Dissociative Disorders. The Structured Clinical Interview

for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1994) evaluates the existence and severity of five dissociative symptoms: amnesia, depersonalization, derealization, identity confusion, and identity alteration. This interview provides diagnoses for the five major *DSM-IV* dissociative disorders, along with acute stress disorder. Also evaluated by the SCID-D are "intra-interview dissociative cues," such as alterations in demeanor, spontaneous age regression, and trance-like appearance that are coded in a postinterview section.

The Structured Interview for Disorders of Extreme Stress. The Structured Interview for Disorders of Extreme Stress (SIDES; Pelcovitz et al., 1997) was developed as a companion to existing interview-based rating scales for PTSD. The 45 items of the SIDES measure the current and lifetime presence of the proposed diagnosis, disorders of extreme stress—not otherwise specified (DESNOS; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). The SIDES evaluates the presence of the total DESNOS construct and each of six symptom clusters: Affect Dysregulation, Somatization, and Alterations in Attention or Consciousness, Self-Perception, Relationships with Others, and Systems of Meaning. Item descriptors contain concrete behavioral anchors to facilitate clinician ratings. The SIDES interview has good interrater reliability ($\kappa = .81$), internal consistency ($\alpha = .96$), and construct validity (Pelcovitz et al., 1997; Zlotnick & Pearlstein, 1997).

Recommendations

Several recommendations can be made for the assessment of adult complex posttraumatic symptoms. First, in most cases, at least two broadband screening instruments should be administered: one for general psychological symptomatology (e.g., the PAI or MMPI) and at least one for general trauma-related disturbance (e.g., the TSI or SIDES). If, based on these tests or the general clinical interview, PTSD is suspected, a diagnostic test or interview such as the PDS, DAPS, or CAPS may be indicated. When additional trauma outcomes are possible, the interviewer should administer whatever tests or interviews seem most relevant, including those tapping dissociation (e.g., the SCID-D or MDI), cognitive issues (e.g., the CDI), self-other schema (e.g., the TABS), suicidality (e.g., the ASIQ or DAPS), or disturbed self-capacities (e.g., the IASC, BORRTI, or Rorschach).

Conclusions

Complex posttraumatic responses reflect the wide variety of potential adverse experiences in the world and

the many biological, social, cultural, and psychological variables that moderate the impact of these experiences. In this context, the notion of a "one-size-fits-all" diagnosis (e.g., PTSD or DESNOS) often is untenable. Instead, the clinician should consider the entire range of posttraumatic responses potentially attributable to a given client's history and risk factors. In many cases, this may require the administration of wide-range psychological tests, both generic and more trauma-specific, followed by, or concurrent with, other tests relevant to the individual's specific clinical presentation.

Evaluation of complex posttraumatic outcomes not only informs diagnosis, but can assist in treatment. Assessment approaches that examine the full range of potential trauma responses may highlight treatment targets that otherwise might be overlooked, both in terms of identifying trauma symptoms within more generic syndromes (e.g., dissociative symptomatology in the context of a major depressive disorder) or generic symptoms within a stress disorder (e.g., significantly distorted cognitions in an instance of PTSD). In addition, because most tests of complex posttraumatic outcomes measure symptoms as continuous variables (as opposed to dichotomous diagnoses), assessment may help determine the relative *extent* of posttraumatic symptomatology, rather than solely the presence or absence of a *DSM-IV* disorder. Further, such continuous measures can be administered periodically to evaluate increments of treatment-related improvement or exacerbation over time.

Measures of complex posttraumatic symptomatology also may identify phenomena that interfere with effective treatment. For example, information that a given client has a significant drug abuse history or suffers from affect regulation difficulties may lead the clinician to eschew a prolonged exposure approach to the client's posttraumatic stress symptoms and, instead, use an empirically supported intervention approach that increases self-capacities (e.g., Cloitre, Koenen, Cohen, & Han, 2002), focuses more on cognitive phenomena (e.g., Resick & Schnicke, 1993), or more directly addresses substance abuse issues (e.g., Najavits, 2002).

The last decade has witnessed the development of a growing number of psychometrically valid tests and interviews that evaluate trauma-related outcomes. As clinicians become more aware of the range and potential complexity of at least some posttraumatic psychological disturbance, the importance of such psychological assessment becomes clear. With greater quantitative focus and clinical specificity, the full range of trauma outcomes can be more clearly delineated and, as a result, more directly addressed in treatment.

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