Trauma Informed Assessments

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A clinician's guide to safely identifying and exploring connections between clients' current struggles and prior histories of trauma, abuse, and neglect.

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Introduction

The good news is many mental health organizations and private practitioners have embraced the idea that assessing for a history of trauma — and then knowing how to effectively treat it once it's uncovered — should be the standard of care in our work with clients. Supervisors are mandating that treatment paradigms are "trauma-informed." Therapists are investing time and money in trainings that promise "trauma-informed approaches."

For me, the troubling news was the term "trauma-informed" seemed to include a wide range of definitions that mostly focused on asking questions about trauma as early in the process as possible. And in their haste to endorse the approach, many agencies tacked on pointed, intimate questions posed on intake. Oftentimes, questions about abuse, neglect, domestic violence, or rape were asked without the safety net of a trusting therapeutic relationship. In fact, these intimate and potentially shame-inducing questions were asked by total strangers, some of whom are administrative assistants, not even clinicians. In addition, questions about trauma were being explored before there was any clear assessment of clients' external support systems or their capacities to do affect regulation. I was concerned that this approach, although well meaning, left clients triggered and re-traumatized, and actually decreased the likelihood that they will return for subsequent visits.

I believe the push to do trauma-informed therapy is important and necessary. But so is the ability to do assessments that are "trauma-informed." It is my hope that as you read through the following chapters, they will strengthen your ability to explore trauma-related content in ways that keep your clients grounded and emotionally safe. In the long run, taking the time to first create a trusting connection, a safe therapeutic environment, and simple resourcing for self-soothing *before* asking questions about trauma, will yield more information and make therapy the reparative, "trauma-informed" experience that it should be.

Part 1.
Doing an Intake Without Doing Harm

Recently, the concept of "trauma-informed" care has permeated many mental health agencies and clinical practices. It has become clear that many of the "symptoms" and presenting problems that bring clients into mental health systems have their roots in prior experiences of trauma, abuse, and neglect. This represents a giant step forward in our field.

Therapists are learning to look at issues such as generalized anxiety, body pain, depression, struggles with intimacy and parenting, dissociation, workplace dissatisfaction, low self-esteem, and debilitating cognitive distortions and shame through the lens of possible unresolved trauma. When that connection is made it allows clients and therapists alike to have greater insight about causation and also informs the subsequent focus of therapy so genuine healing can occur.

In order to make this connection between presenting problems and trauma, therapists are including deeply personal but important questions related to potential physical, sexual, and emotional abuse and neglect in the early phases of intake and assessment. I would argue that in addition to asking questions about a history of trauma, therapists also have the responsibility of asking questions in a way that is properly paced and doesn't re-traumatize their clients.

Many agencies pressure clinicians to complete an intake within the first or second visit. I believe assessment is a fluid process that happens over time. It's not reasonable to expect clients to trust a therapist and divulge intimate and often shame-based information on an initial intake. If there is a trauma narrative to reveal, therapists must allow it to unfold slowly and safely and need to have the tools to help clients get re-grounded and emotionally contained after they have found the courage to open up during the interview process.

Given the inevitable discomfort, or even the initial sense of threat clients feel when they begin a new therapeutic relationship, we must consider the possibility that they may be in either a hyper or hypo-aroused state; either agitated or somewhat frozen and shut down. This means they're in their limbic system — the emotional and survival part of the brain— rather than in their pre-frontal cortex. When answers to triggering questions about trauma or abuse come from the limbic system, they're not coming from the reasoning or analytical part of the brain. The limbic system is never capable of insight. This calls into question a client's ability to fully and effectively answer intake questions. It also reinforces the notion that therapists must first help clients to feel comfortable, present, and safe before useful information can be obtained and explored.

Asking questions with clarity and compassion

SPOTLIGHT

In subsequent installments to this series, we will look at some additional factors that must be taken into consideration when doing a "trauma-informed assessment." We'll look at important areas that need to be addressed in order to get a more complete picture of possible trauma. We'll also begin to explore gentler, more "back door" ways of asking about trauma that don't increase a client's sense of vulnerability and actually allow for an exploration of their resiliency and strengths.

Part 2. Asking Questions With Clarity and Compassion

In Part 1 of Trauma Informed Assessments, I suggested that it's not only important for clinicians to put presenting problems in a historical context of possible trauma, abuse or neglect, I also suggested that the way in which that information is obtained needs to be done in a "trauma-informed" fashion. In addition to appropriate pacing while getting an assessment and making sure to re-ground clients after opening up potentially triggering narratives, I'd like to offer some other thoughts about how to address these issues with clients.

When asking about a history of trauma, be sure the client understands how you are defining "trauma" and "traumatic experience." For example, many clients assume "sexual abuse" or "sexual trauma" only means penetration. Therapists need to offer a broader definition that includes any experience of unwanted touching or invasion of bodily privacy, being forced to touch or engage in sexual activity with someone else, or having to witness anything sexually inappropriate. Remember that "witnessing" threatening or inappropriate behavior can be just as traumatizing as experiencing it firsthand. In fact, there may be added layers of trauma including: feelings of shame; guilt; powerlessness; or fear, when a client witnesses something like sexual assault, and is unable to change the outcome. It's equally important to remember that most people do not consider neglect, emotional, verbal or psychological abuse manifestations of trauma and they should be included in assessments as well.

Witnessing threatening or inappropriate behavior can be just as traumatizing as experiencing it first hand.

When it comes to difficult life experiences there is a phenomenon that therapists need to take into account.

Oftentimes, clients compare their painful life experiences to other people who seem to have it "much worse" than they do. The end result is often a minimization or total discounting of their own narratives. They might compare their dysfunctional childhoods or adult stressors to other people they know or to the testimonials of strangers on talk shows. In either case, it's important for therapists to discourage comparisons of any kind, and to reinforce the idea that there isn't a hierarchy of pain or traumatic experience. All pain is legitimate in its own right.

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When asking about trauma, I find it helpful to preface it by saying, "As far as you can remember" were you ever abused or neglected?

Given the reality that early in life, untenable trauma is often managed through dissociation and fragmentation, it makes sense that these experiences might be split off from conscious awareness. In fact, it's quite common for memories to "return" once a safe therapeutic relationship has been created and enough trust has been established. By putting the question within the context of a client's current awareness, the therapist is giving them permission to change a "no" answer to a "yes," should memories surface later on in treatment.

It's equally important to remember that most people do not consider neglect, emotional, verbal or psychological abuse manifestations of trauma and they should be included in assessments as well.

It's all about asking the right questions at the right time.

The next chapter will look at some specific areas that should be included when conducting an assessment for trauma, abuse and neglect. These will also include important questions that assess for clients' strengths and resiliency, allowing therapists and clients alike to identify potential resources for healing.

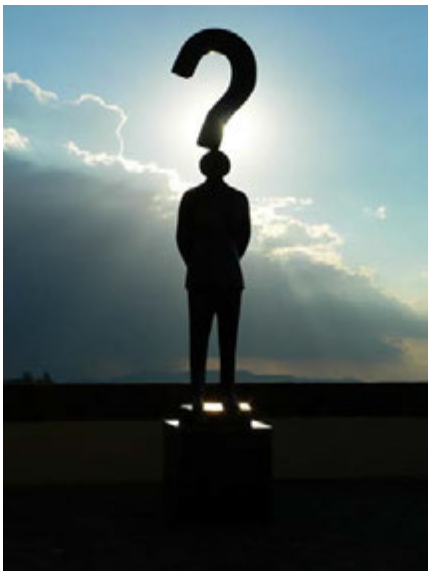
Part 3. It's All About Asking the Right Questions at the Right Time

Trauma informed assessments is an ongoing conversation worth having as the assessment process can really set the tone for subsequent sessions, and even dictate whether or not a client continues with therapy. In this installment I focus on some questions that should be woven into assessment in order to have a more thorough and balanced understanding of the client who sits across from you.

An assessment that is "trauma-informed" includes both an awareness and sensitivity to pacing and timing, as well as an exploration of a wide range of possible trauma, abuse, and neglect experiences of a wide range of possible trauma, abuse, and neglect experiences. Asking about potential physical and sexual abuse is on most clinicians' radar. When the time is right, it's equally important to ask about the dynamics of physical and emotional neglect, verbal and psychological abuse, the witnessing of intimate partner violence, prolonged disruptions in parental caretaking, and the possibility of insecure, avoidant, or disorganized attachment styles. In addition, assess for the presence or absence of a protector versus a "non-protective bystander" parent, as that can add additional layers of trauma.

Creating a timeline that parallels trauma to the evolving phases of development can be revealing and helpful.

When looking at family-of-origin factors, explore the possibility that the client's caretakers had unresolved trauma, undiagnosed and untreated depression or anxiety, chronic medical issues, or a history of addiction or other self-destructive behaviors. Those experiences profoundly impact attachment, create affect dysregulation, and can model a lack of self-care and dysfunctional coping strategies that get normalized for the client and play out in their adolescent and adult behavioral choices. Therapists also need to ask about environmental factors. Did the client live in a neighborhood that was inherently safe or unsafe? Was there a positive sense of community and "belonging" versus feeling isolated or ostracized? Cultural influences, expectations, and pressures should also be identified and processed as they can profoundly impact identity, assimilation, and the degree to which a client felt empowered and supported to be their most authentic self.



It can be extremely valuable to look at traumatic events along various stages of development. Trauma that coincides with the age appropriate milestones of trust versus mistrust, autonomy versus shame and doubt, or identity versus role confusion may create symptoms and scarring that are specific to those developmental stages. Creating a timeline that parallels trauma to the evolving phases of development can be revealing and helpful. Other issues that are worthy of exploration in a trauma-informed assessment include: the client's capacity to modulate affective arousal and their ability to process emotionally-charged material without hurting themselves; the extent to which they stay grounded or exhibit dissociative symptoms; and how they non-verbally communicate and react during sessions. This encompasses dynamics such as breaking eye contact, psychomotor agitation, defensiveness, belligerence, loss of words, constricted or collapsed body postures or "spacing out."

Although it's necessary and important to get information about a client's current struggles, or the tipping point that brought them into treatment, remember to also explore a client's "pre-morbid" history. This should include levels of competence in a variety of arenas as well as the availability of past resources for comfort and coping. I always ask about the presence of a protector, someone who mitigated the impact of stress or developmental challenges.

The next chapter focuses on the ***strengths-based*** part of the assessment, as well as how therapists can get information about trauma through a more subtle and more nuanced line of questioning that is less likely to feel threatening or overwhelming.

Identifying what is "right" with the client, rather than looking for what is "wrong" with them.

Part 4.
The Strengths-Based Approach

For those of you who may be familiar with my work, it will come as no surprise that I look at clients and their issues through a strengths-based lens. This means staying curious about, pursuing, and identifying what is "right" with the client, rather than looking for what is "wrong" with them. Unfortunately, the process of assessment and the pressure to find a DSM diagnosis to justify treatment and increase the likelihood of insurance reimbursement often steers clinicians down a more pathologizing path. We have already looked at the potential hazards of asking intimate and emotionally loaded questions too quickly. In Part 4 of this series, I emphasize the importance of including questions that will help the therapist, as well as the client, identify areas and characteristics of strength.

When a client's strengths are openly acknowledged and honored, new resources for coping can be accessed and reinforced. In addition, a focus on strengths brings hope back into the process. By the time a client lands in a therapist's office their hope is significantly diminished and they typically view themselves through a negative lens. I have actually had clients attempt to give me a long list of their perceived deficits and "weaknesses" during the assessment phase. They assume it's "important" for me

to know about their shortcomings or former diagnoses, but it doesn't occur to them that it's even more critical for me to know about their strengths. The following are some potential prompts that therapists can use to help open the door to an exploration of a client's internal and external resources and positive attributes. Finding opportunities to weave these questions into the earliest stages of assessment gives the client the message that they're more than their trauma and shows them that treatment can unfold from a more positive perspective.

- *Where do you find the courage to manage your challenges?*
- *How do you remain so resilient?*
- *What creative coping strategies did you use to survive in the past?*
- *How did you not give up?*
- *Can you give me three positive adjectives to describe yourself?*
- *What are three positive adjectives that someone else who cares about you would use to describe you?*
- *Tell me one thing you feel proud of about yourself.*
- *Can you tell me about a time when you were faced with something difficult and you overcame it?*
- *How have you managed stress in healthy ways?*

If the client is not able to easily respond to these questions, reassure them that they don't need to come up with the answers right away.

By asking the questions and offering the prompts, you are "planting seeds." As the process of therapy nurtures those seeds they often take root. It's a good idea to revisit those same questions at a later stage of treatment. As the client begins to formulate answers, it becomes tangible evidence of their growth and progress in therapy. If the client does feel compelled to reveal what they perceive to be a "deficit" let them know it "makes sense" given where they've come from and what they've endured. This helps them make a connection between past trauma and current struggles-moving them away from the idea that they're "defective" or inherently "bad."

You can also suggest the possibility that what they think of as a weakness or flaw was in actuality a life-saving and necessary coping strategy that speaks to their creativity, determination, and cleverness. That also allows for an exploration of whether or not that strategy is still needed in the present.

As I have alluded to before, whenever possible, therapists should hold off on the more emotionally loaded assessment questions until there has been ample opportunity to establish some rapport and trust in the relationship. Think about starting with less threatening questions that don't demand graphic content.

By asking questions and offering the prompts, you are planting the seeds.

Enhancing safety with an indirect approach.

The next chapter offers some specific questions that provide information about family of origin dynamics in a more "backdoor" fashion. These are questions that can set the scene for deeper emotional and cognitive processing down the road.

Part 5. Enhancing Safety With an Indirect Approach

I am delighted to continue this conversation. The feedback I've received confirms just how important the issue of assessment is in our work. I have described the pressure that many clinicians feel when supervisors insist upon thorough assessments that delve deeply and quickly into a client's background. Working in this way often stirs up emotionally loaded memories that can easily overwhelm and re-traumatize.

Here are some suggestions about what to do when clients start to prematurely reveal graphic details of their abuse or neglect experiences.

I'd like to offer some questions that can be woven into the assessment process. They are designed to get beginning information about issues such as family of origin attachment and safety, dysfunctional family dynamics, healthy and unhealthy coping strategies, and potential sources of emotional and psychological struggle.

As always, when asking potentially triggering questions, I encourage clinicians to pay as much attention to the client's non-verbal responses, such as dissociation, lack of eye contact, muscle tension, change in voice tone and posture, psychomotor agitation,

and shifts in emotional states. These responses can be more telling than the verbal ones. In the earliest stages of assessment, don't ask for specific details in regards to these questions, sometimes just the "title" of the experience is enough.

- When you think about growing up, do you have pleasant or unpleasant memories about mealtime?
- Do you have happy or unhappy memories about holidays?
- Do you have good or bad memories about family vacations?
- How did various family members handle stress?
- Without specifically identifying them, are there things that have happened in your life that you find difficult to talk about?
- Are there times when you struggle with thoughts, feelings or behaviors and you're not sure why?
- Are there times when you feel troubled or angry by your thoughts, feelings or behaviors?
- Are there times when you feel disconnected from other people?

Even if the client does not directly answer these questions, when a therapist asks them he or she communicates a willingness and an ability to explore the answers with the client when the time feels right. These questions can also evoke curiosity in clients, and than can serve as a catalyst for memory retrieval and subsequent healing.

Part 6.
Additional Questions to Pace the Work

I hope that some of the questions I offered in Part 5 from this series provided you with a safer, less emotionally loaded, or triggering way to get information about the dynamics in a client's family of origin and a potential history of trauma. I'd like to suggest some additional questions that support this "backdoor approach" while still giving therapists the opening to explore deeper issues from a 'trauma informed' perspective.

Keep in mind that in the earliest stages of treatment, graphic disclosures and in-depth details are unnecessary and often contraindicated. Simple, brief answers are enough to guide the direction of subsequent treatment while addressing the need for pacing and containment. Even when the information is limited, it plants the seeds for further exploration after a safe and trusting therapeutic relationship has been established.

- Are there times when you feel disconnected from your own emotions?
- Do you typically feel safe or unsafe in your house, school, job, community?
- What five adjectives would you use to describe your mother? Your father? Your partner?
- What five adjectives would you use to describe yourself?
- Did you grow up in a family that encouraged secret keeping?
- How would you describe the quality of your significant relationships?
- Who are the people you typically turn to for comfort and support?
- If you could change something in your life or your relationships what would it be?
- What would YOU like to get support with or guidance about in this program, or therapy?

Part 7, A Safer Way to Disclose Trauma, *will focus on how therapists can navigate a session when clients feel compelled to give a lot of trauma-based information too quickly. We'll also look at some important and compassionate ways to respond when clients disclose experiences of trauma, abuse, or neglect.*

Part 7. A Safer Way to Disclose Trauma

Here are suggestions about what to do when clients start to prematurely reveal graphic details of their abuse or neglect experiences.

When clients who have been silent for years recognize that their therapists can be compassionate, nonjudgmental witnesses to their pain, it's not uncommon for the "dam to break," releasing an intense and uncensored account of the trauma.

Trauma survivors often have histories of violated boundaries and weren't given many opportunities to feel safe in childhood. As a result, in therapy they often plow ahead with potentially triggering narratives without any regard for their emotional or psychological wellbeing. It becomes the responsibility of therapists to create and hold boundaries, and to introduce the concept of safety in the therapy process.

During intake or an ongoing assessment, if a client starts to unload graphic details of their abuse or neglect, therapists should try to do the following:

- Slowly put up a hand and encourage the client to "pause." This will feel less invalidating and abrupt than saying "stop."
- Use a simple hand gesture to non-verbally put on the brakes so the session doesn't become a "runaway train."
- Invite the client to take a few slow, deep breaths to reactivate their parasympathetic system, evoke a sense of calm, and reduce a fight, flight or freeze response.
- Explain the rationale for pausing is to avoid re-traumatization and to model pacing so the work unfolds safely.
- Reassure the client that the full story can be explored and witnessed in as much detail as they need, as long as that process stays manageable for them.
- Model the concepts of boundaries and pacing by encouraging the client to just start with the title of the traumatic experience- not the details.
- Explain that disclosures are genuinely healing when they happen within the context of a safe and trusting therapeutic relationship and that takes time to develop.
- Invite the client to put any images they associate with the trauma "on a computer screen across the room." This helps the client get some emotional distance from the memory by observing it rather than participating in it.

Rushing through a trauma narrative can inadvertently reinforce the idea that what happened wasn't all that important and isn't worthy of much attention. The steamroller approach to a disclosure can be a re-enactment of the abuse itself: relentlessly painful without any regard for safety or the emotional impact. When clients rush through their painful stories they may also be re-enacting the coping strategy of "hurry up and get it over with." This is a mindset many trauma survivors have to cling to while their abuse is unfolding. Slowing down the process allows the client to get a safe, titrated release, and lets therapists get a beginning idea of the trauma so they can offer words of compassion and support. At the same time, it keeps the work boundaried until the client has learned some basic skills for self-soothing and containment.

Trauma survivors often have histories of violated boundaries and weren't given many opportunities to feel safe in childhood.

Responding with Compassion

The final chapter will provide some additional ways in which therapists can respond when trauma is revealed in therapy.

Part 8. Responding with Compassion

To conclude this series on "Trauma Informed Assessments," it seems fitting to end with a brief analysis of helpful ways to respond when clients do find the courage to disclose a part of their trauma narratives. Keep in mind that due to traumatic transference, clients might assume therapists will either be disinterested, overwhelmed, or even disgusted by their painful life experiences. This can be a projection of their own unresolved feelings of guilt or shame. It might also reflect the way other people in their lives responded to their disclosures in the past.

Before a deeper exploration of trauma begins, it makes sense that clients need and deserve reassurances that therapists can be compassionate, non-judgmental, fully present and attuned. They also need to know that the person who will be helping them on their healing journey is emotionally equipped and psychologically knowledgeable. The ways in which therapists initially respond helps set the tone for future sessions and can begin to reduce the anxiety, fear, or shame that clients might experience.

When therapists incorporate strategies for containment, affect regulation, and self-soothing, the work truly is "trauma informed."

The following are some suggestions regarding sensitive and appropriate responses. I encourage clinicians to consider incorporating these messages into the treatment process, and remind clients that they deserve to hear these kinds of messages from the helping professional:

- I appreciate the courage that it took to share that with me.
- Thank you for trusting me enough to share it.
- I want you to know that what happened was not your fault.
- I am so sorry that you were harmed/betrayed/hurt.
- You don't have to be alone with your feelings.
- Know that you deserve support.
- Know that you deserve to be safe.
- You will be in charge of pacing the work so it stays manageable for you.

These kinds of responses communicate a sensitivity to disclosures of trauma, and they acknowledge the courage it takes to share intimate information with another person. They can also have a beginning reparative effect since many survivors have never heard these messages expressed by their abusers or other non-protective people in their lives. The work should still unfold slowly, and therapists should always incorporate strategies for containment, affect regulation, and self-soothing. When this is done, the work truly is "trauma informed."

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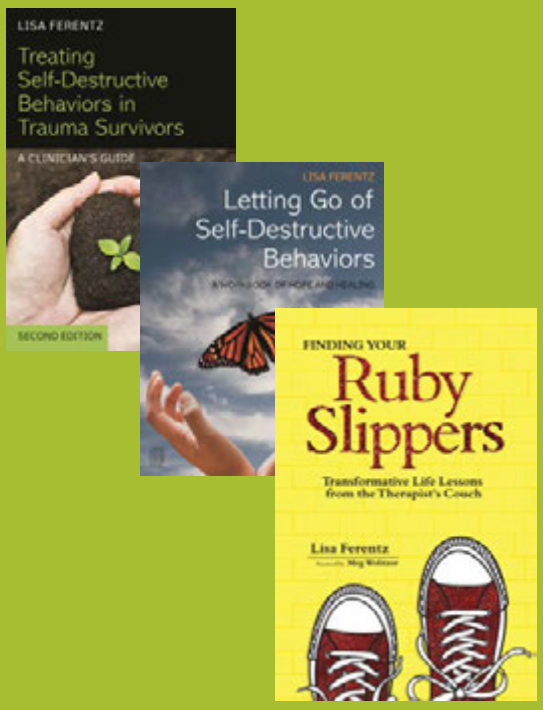

Lisa is a recognized expert in the strengths-based, depathologized treatment of trauma and has been in private practice for 32 years. She presents workshops and keynote addresses nationally and internationally, and is a clinical consultant to practitioners and mental health agencies in the United States, Canada, and the UK.

She has been an Adjunct Faculty member at University of Maryland School of Social Work, University of Baltimore at Maryland, University of Maryland Department of Family Medicine, and is the Founder of The Ferentz Institute, formerly known as The Institute for Advanced Psychotherapy Training and Education, now in its tenth year of providing continuing education to mental health professionals and graduating over 900 clinicians from her two Certificate Programs in Advanced Trauma Treatment.

In 2009, she was voted the "Social Worker of Year" by the Maryland Society for Clinical Social Work. Lisa is the author of "*Treating Self-Destructive Behaviors in Traumatized Clients: A Clinician's Guide*," now in its second edition, "*Letting Go of Self-Destructive Behaviors: A Workbook of Hope and Healing*," and "*Finding Your Ruby Slippers: Transformative Life Lessons from the Therapist's Couch*."

Lisa hosted a weekly radio talk show in 2014—2015. She writes for Psychologytoday.com, and publishes her own blog. You can follow Lisa's work on Facebook, LinkedIn, and Twitter.

The art and science of asking questions is the source of all knowledge.
- Thomas Berger

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