PSYCHOLOGICAL ASSESSMENT OF INTERPERSONAL VICTIMIZATION EFFECTS IN ADULTS AND CHILDREN

JOHN BRIERE Department of Psychiatry and the Behavioral Sciences University of Southern California School of Medicine

Because clinical awareness of victimization effects is a relatively recent phenomenon, the field is only now developing assessment methodologies relevant to victims of interpersonal violence. This article reviews current information on the psychological assessment of children and adults with victimization histories, both in terms of general psychological tests such as the MMPI. Rorschach. and Child Behavior Checklist, and trauma-specific measures such as the Trauma Symptom Inventory, Trauma Symptom Checklist for Children, and Child Sexual Behavior Inventory. In addition, issues associated with overlapping traumas, symptom underreporting and overreporting, measurement distortion and misidentification effects, and psychometric quality are discussed.

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The prevalence and psychological impact of interpersonal violence have been recognized by North American clinicians and researchers only recently. Although there have been anecdotal reports of the effects of war throughout recorded

DIANA M. ELLIOTT

Department of Psychiatry Harbor—UCLA Medical Center

history, much of our empirically validated information on the impact of rape, physical assault, spouse abuse, child maltreatment, and other types of victimization has been published in the 1980s and 1990s. As a result, psychologists generally have had less access to clinical data regarding victimization-related responses than, for example, generalized anxiety, depression, or psychosis.

Fortunately, the recent increase in empirical studies of interpersonal violence and psychological trauma has changed this situation considerably. Although interpersonal violence is still underassessed (American Psychological Association, 1996), there are now a number of clinical books and articles available on the evaluation and treatment of victims of violence. This article reviews some of this newly available information and offers suggestions regarding the psychological assessment of people who have experienced interpersonal violence.

Issues Associated with Assessing Victims of Violence

Several issues associated with the evaluation of victimization may affect test data and their interpretation. These include: (1) the specific versus general effects of trauma; (2) comorbid sources of trauma-related distress; (3) avoidance and underreporting; (4) overreporting and malingering; (5) misidentification and distortion; and (6) psychometric quality. Each of these are discussed below.

Specific Versus General Effects

Research on interpersonal violence suggests that victimization can produce general responses such as anxiety, depression, anger, cognitive distortions, somatization and medical problems, and substance abuse, as well as more trauma-specific

Correspondence regarding this article should be addressed to John Briere, Ph.D., USC Psychiatry, 1937 Hospital Place, Los Angeles, CA 90033.

effects such as posttraumatic intrusion, avoidance, and hyperarousal, dissociation, and fearrelated sexual difficulties (see reviews by Briere, 1992, 1997a; Hanson, Kilpatrick, Falsetti, & Resnick, 1995; Nader, 1997; Resick, 1993; Walker, 1984). Because violence can produce psychological effects that are otherwise less common in the general population, it is important that victims be evaluated in these areas. Unfortunately, generic psychological tests, even those with newly developed Posttraumatic Stress Disorder (PTSD) scales, often do not address posttraumatic symptomatology well (Carlson, 1997).

Given the need to evaluate the full range of potential victimization impacts, psychological assessment for those exposed to violence should include both general tests of psychological dysfunction and measures that include more traumaspecific scales. Forgoing the latter, for example, might produce a substantially incomplete clinical picture of a rape or spouse abuse victim—in some cases even suggesting an absence of effects in someone with significant posttraumatic stress or sexual difficulties. On the other hand, administering only trauma-specific measures to an abuse survivor easily might lead to underestimation of the depressive or anxious symptoms associated with his or her victimization.

Event Comorbidity and Sources of Distress

A central problem in the psychological assessment of victimized individuals is that of connecting a specific symptom pattern to a specific event, given that many victims have experienced multiple traumas (e.g., Briere, Woo, McRae, Foltz, & Sitzman, 1997; Elliott, 1997). In fact, being victimized appears to be a risk factor for further victimization (e.g., Runtz, 1987; Wyatt, Newcombe, & Riederle, 1993). The coexperience of multiple traumatic events by the same individual may be referred to as event comorbidity. For example, a rape victim may also have been battered in a previous relationship and sexually abused as a child. In addition, she may have experienced other noninterpersonal traumas in her life, such as an earthquake or a severe automobile accident. The multiple and potentially interactive psychological effects of these various traumas may result in a complex symptom picture.

Problems associated with event comorbidity may be further complicated when the trauma in question occurred far in the past, for example, as in the case of child abuse. The symptoms may be less clear-cut than what is found in acute posttraumatic stress, and other more recent traumas or victimization experiences may have intervened between the stressor and the observed clinical state. In such cases, and in the absence of other relevant data, the evaluating clinician may not be able to link specific symptoms to a given traumatic event.

In other less frequent instances, there may be sufficient corroborated historical data that the clinician is able to hypothesize, with some level of confidence, the development of specific symptoms associated with specific traumas. In such cases, important issues may include the temporal sequence of events and symptoms (i.e., did the posttraumatic disturbance only occur after the traumatic event, in the absence of other significant intervening traumas?) and the nature of the intrusive/reliving symptoms (e.g., does the client report flashbacks or intrusive images and memories of the specific rape experience in question?).

Avoidance and Underreporting

Given the (by definition) aversive quality of traumatic events, it is not surprising that such phenomena can motivate the development and use of avoidance strategies. This may present as emotional or cognitive suppression, denial, dissociation, memory distortion, or involvement in activities that numb or distract. Although such avoidance strategies may be superficially adaptive, they also can interfere with accurate psychological evaluation. The victim's tendency to avoid or attenuate distress may decrease his or her response to psychological assessment, in some instances leading to a significant underpresentation of trauma history and/or trauma effects. This may especially occur if a given assessment technique requires the victim to recall or reexperience traumarelated events.

Elliott and Briere (1994), for example, described a subsample of children for whom there was direct evidence of sexual abuse (e.g., unambiguous medical findings, explicit photographs, or abuser confession) but who, nonetheless, both denied that they had been abused, and scored significantly lower than nonabused subjects on the Trauma Symptom Checklist for Children (TSCC) (Briere, 1996). As noted in that article, it is likely that these children were using denial and other cognitive avoidance strategies to keep from confronting both their abuse and its psychological impacts.

As a result of avoidance-related phenomena, the clinician should not rule out the possibility of unreported trauma-related disturbance in a given clinically presenting individual. Unfortunately, symptom underreporting is difficult to identify in any given individual. At present, the practitioner is limited to reliance on validity scales that, for example, index defensiveness or "fake good" responses (e.g., the K scale of the Minnesota Multiphasic Personality Inventory [MMPI] [Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989; Hathaway & McKinley, 1943]; Disclosure and Desirability indices of the Millon Clinical Multiaxial Inventory [MCMI] [Millon, 1983, 1987, 1994], or the Response Level scale of the Trauma Symptom Inventory [TSI] [Briere, 1995]). Unfortunately, although these validity indicators identify some cases of underreporting, it is likely that less extreme instances will go unrecognized unless the clinician can somehow detect it during the evaluation interview.

Overreporting and Malingering

In addition to underreporting, some individuals overreport or misrepresent traumatic events and/ or trauma-related symptomatology. Because this article focuses on assessment of symptomatology, as opposed to reports of traumatic events, per se, the issue of event misrepresentation or pseudomemories of nonexistent traumatic events will not be addressed here. The interested reader is referred to Pope and Brown (1996) and Reviere (1996) for extensive coverage of "false" versus "recovered" memories of traumatic events, especially with reference to childhood sexual abuse.

Beyond memory concerns for specific traumatic events, some individuals with victimization histories may consciously or unconsciously magnify their symptoms as a "cry for help" or an attention-getting device. Thus, for example, a sexual abuse survivor who expects to be discounted or minimized by the mental health system may overstate the level of her depression or flashbacks, even though her actual level of these symptoms deserves compassion and clinical attention.

Because our legal system entitles victims to file suits against those alleged to have done them harm, and some institutions appropriately provide financial compensation to those who have been traumatized, there also may be a financial motivation for some symptom endorsements. In this regard, the evaluator should not overlook the possibility of intentional misrepresentation, since such phenomena obviously require different sorts of intervention strategies. This possibility should be a normal "rule out" issue, however, as would be appropriate for any other potentially moderating phenomena, such as psychosis or organic disorder. The clinician should be careful not to act out undue skepticism or countertransference regarding actual traumatic events and posttraumatic states. Clinical experience suggests that false reports of victimization-related symptomatology are relatively rare in nonforensic clinical settings, and should not be automatically assumed. Good clinical judgment requires that the clinician neither automatically accept nor reject any report, trauma-based or otherwise, but rather allow the clinical data to unfold over the course of the assessment period, until an overall, empirically derived impression can be formed.

Unfortunately, as per underreporting, it may be difficult to reliably identify cases of symptom overreporting through the use of psychological tests. Some overreporting may be detected through validity scale scores, such as elevations on the F and D scales (along with F-K) of the MMPI, the Debasement scale of the MCMI, the Atypical Response scale of the TSI, or the Hyperresponse scale of the TSCC. However, those who have experienced interpersonal victimization tend to score in a more deviant manner on validity scales, thereby decreasing the usefulness of such scales with trauma victims. Several studies, for example, suggest that Vietnam combat veterans and child abuse survivors may have elevated F scale scores as a result of chronic posttraumatic difficulties or comorbid affective symptoms, as opposed to motivated symptom overendorsement (e.g., Elliott, 1993; Jordan, Nunley, & Cook, 1992).

Misidentification and Distortion

Because most standard psychological tests were not developed at a time when psychological trauma was well recognized, such measures are prone to underidentifying or distorting trauma effects. For example, older instruments may (1) confuse intrusive/reliving posttraumatic symptomatology with hallucinations, obsessions, primary process, or "fake bad" responses; (2) misinterpret dissociative avoidance as fragmented thinking, chaotic internal states, or the negative signs of schizophrenia; and (3) misidentify trauma-based cognitive phenomena (e.g., hypervigilance or generalized distrust) as evidence of paranoia or other delusional processes (Briere, 1997a). Furthermore, the effects of childhood trauma may be mislabeled as personality disorders to the extent that they involve interpersonal difficulties, chaotic internal states, and tensionreduction behaviors or other affect-avoidance activities in an individual who does not meet diagnostic criteria for a personality disorder, per se.

The tendency for traditional measures to misinterpret victimization effects might appear to preclude their use in trauma assessment. The issue, however, may be less that of intrinsically bad data than erroneous interpretation of that data. For example, as described later in this article, although many sexual abuse survivors have elevations on scales 4 and 8 of the MMPI or MMPI-2, it is often inappropriate to view them as potentially schizophrenic, psychopathic, or borderline. Instead, examination of subscale scores may indicate the presence of nonpsychotic reexperiencing symptoms, interpersonal distrust or social alienation, and dissociative responses, as well as accurate reporting of familial discord during childhood. To the extent that subscale analysis can reveal such potential victimization effects, standard psychological tests can be a helpful part of the trauma-assessment process. Further, generic tests can assist in providing data about aspects of the client that are less specific or essentially unrelated to trauma but that are, nevertheless, an important part of the overall clinical picture.

Psychometric Quality and Standardization Data

As is true of psychological tests in general, those evaluating the effects of interpersonal victimization must have adequate reliability and validity, and should be normed on large, sociodemographically representative samples of the general population. Further, such measures should have good sensitivity and specificity if they are offered as diagnostic instruments. For example, a measure purporting to identify PTSD should be able to predict both true cases of it (sensitivity) and those cases where no PTSD is present (specificity) with reasonable accuracy.

Fortunately, most commonly available psychological tests demonstrate adequate reliability and validity, and many appear to be acceptable predictors of the construct they were developed to address. Less fortunately, however, many instruments that evaluate trauma-related symptoms lack usable norms. As a result, the clinician is unable to interpret a given score on such measures based on its statistical extremity in the general population, and thus he or she cannot determine the extent to which this score represents dysfunction or disorder. There are, however, a very small number of normed, standardized tests available in this area, as described later in this article.

Generic Psychological Tests

As noted earlier, the fact that traditional psychological tests can distort victimization issues and impacts does not preclude their careful application in the assessment of victimization effects. Discussed below are four well-known generic psychological tests—the MMPI, MCMI, Rorschach, and Child Behavior Checklist—and the most typical responses of victims on these measures.

Minnesota Multiphasic Personality Inventory (MMPI) and MMPI-2

The MMPI (Hathaway & McKinley, 1943) and the more recent MMPI-2 (Butcher et al., 1989) have been used in a number of studies to assess victimization-related states and dysfunction. Overall, it appears that individuals suffering from posttraumatic stress, including some victims of adult violence, often have an 8-2 profile on the MMPI and MMPI-2, as well as an elevated F scale (Keane, Malloy, & Fairbank, 1984; Munley, Bains, Bloem, & Busby, 1995; Wilson & Walker, 1990). When the trauma involves interpersonal victimization, this profile is often augmented with an elevated 4 scale, sometimes followed by an elevation on scale 6 (e.g., Belkin, Greene, Rodriguez, & Boggs, 1994; Engles, Moisan, & Harris, 1994; Khan, Welch, & Zillmer, 1993; Rhodes, 1992).

The inevitability of an F-8-2, F-4-8, or related profile is in no way guaranteed, however. Because of the complexity of many traumatic events, as well as the mediation by individual and environmental variables, violence victims' MMPI profiles may vary considerably.

In addition, as suggested earlier, the standard interpretation of a 4-8-type profile may be less relevant for victims of interpersonal violence, partially because victims' patterns of endorsement may differ from others on these scales. Lundberg-Love, Marmion, Ford, Geffner, and Peacock (1992) found that the sexual abuse survivors in their sample accomplished a 4-8 profile through the differential endorsement of certain Pd and Sc items (as measured by Harris & Lingoes [1968]

subscales) over others. Abuse survivors' scale 4 elevations were due primarily to endorsement of familial discord and feelings of alienation, rather than the authority and social imperturbability items often endorsed by more antisocial individuals. Similarly, their sexual abuse sample scored highest on the social alienation and reduced egomastery items of scale 8, as opposed to the clinical levels of bizarre sensory experiences and emotional alienation endorsements often found in true schizophrenics. In another study, Rhodes (1992) found that although battered women scored significantly higher on 4 than did nonbattered women, the most elevated Harris and Lingoes subscale was Family Discord. Like Lundberg-Love, Rhodes draws on such findings to highlight the importance of content subscales in the interpretation of victims' MMPI scale scores.

Because traditional MMPI scales can distort or misidentify those who have been traumatized, the authors of the MMPI-2 added two PTSD scales: the PS (Schlenger et al., 1989) and the PK (Keane et al., 1984). Of these, the PK scale is more widely used in the evaluation of victimized individuals.

As noted earlier, however, there has been some criticism of the PK scale. Among the concerns are the possibility that, given its development in veteran samples, this scale may be more sensitive to war-related PTSD than to that arising from civilian events such as rape, assault, or child abuse. Further, the scale contains a number of non– PTSD–like symptom items, in contrast to a relatively small number of PTSD–specific items. Despite these and other potential issues, there is little question that this scale is a welcome addition to the MMPI-2 in terms of assessing posttraumaticstress-type symptomatology in victims of violence.

Less developed than the PK scale are those attempting to measure trauma-related dissociation. Although several MMPI or MMPI-2 dissociation scales have been devised (e.g., Mann, 1995; Phillips, 1994), none have sufficient psychometric data to justify their general clinical use at this point in time. Part of the problem in this area is that dissociation was not a focus of MMPI/MMPI-2 item writers, and thus, few items may tap the construct sufficiently to warrant their inclusion in a dissociation scale.

Millon Clinical Multiaxial Inventory

The MCMI (Millon, 1983), MCMI-II (Millon, 1987), and MCMI-III (Millon, 1994) have

been applied to victims of interpersonal violence relatively infrequently. This may be due, in part, to the absence of a PTSD scale in the MCMI and MCMI-II. Lacking such a scale, chronic PTSD symptoms are easily misinterpreted as evidence of personality dysfunction (e.g., borderline personality or, prior to the MCMI-III, the ill-conceived construct of selfdefeating personality). This absence has been partially remedied with the advent of the MCMI-III, which contains a PTSD scale (R) that is loosely tied to some posttraumatic symptomatology. However, the content domain of this scale is problematic, since the majority of items are not directly associated with DSM-IV PTSD diagnostic criteria, but instead tap comorbid symptomatology. These include items examining sadness, feelings of worthlessness, having "strange" thoughts, rapid mood changes, emptiness, and suicidality.

The few studies available on MCMI adult trauma profiles are limited to the MCMI and MCMI-II and deal almost exclusively with Vietnam veterans. They suggest that those suffering combat-related posttraumatic stress may have elevations on some combination of the Avoidant, Schizoid, Passive-Aggressive, and Borderline scales, along with, in many cases, Anxiety and Dysthymia (e.g., Hyer, Woods, Boudewyns, Bruno, & O'Leary, 1988; Hyer, Woods, Boudewyns, Harrison, & Tamkin, 1990; McDermott, 1987). Unfortunately, the relative absence of equivalent data on victims of interpersonal violence limits the known applicability of such findings to, for example, rape or spouse abuse victims. Apropos of this concern, in one of the only studies of victims of recent interpersonal violence, no differences were found between recently victimized and nonvictimized individuals on the MCMI-II, although there were differences on other measures (Elliott, 1993).

The MCMI has been used to evaluate the lasting impacts of child abuse on adults in a few studies (e.g., Bryer, Nelson, Miller, & Krol, 1987; Busby, Glenn, Steggell, & Adamson, 1993). Clinically presenting physical and/or sexual abuse survivors tend to score in the clinical range on a variety of MCMI-I/MCMI-II scales, most typically on the Avoidant, Dependent, Passive-aggressive, and Borderline personality scales, along with elevated Anxiety, Somatoform, Thought Disorder, Major Depression, and Delusional Disorder scales.

Despite these various elevations, clinical experience suggests that most victims of interpersonal violence who have elevated scores on, for example, the MCMI Thought Disorder or Delusional Disorder scales do not have a psychotic disorder, or do all of those with a clinically elevated Borderline scale score necessarily have borderline personality disorder. Instead, the MCMI psychosis scales (like the Rorschach and MMPI in various trauma contexts) are likely to tap the posttraumatic symptoms (especially intrusion and avoidance) and chaotic internal experience of severe abuse survivors, whereas the Borderline scale may be affected by the greater tensionreduction activities and interpersonal difficulties of the severely abused.

To the extent that the R scale operates as reported in the manual, it may facilitate the interpretation of victims' MCMI scores by indicating the presence of posttraumatic stress. In such an instance, although other less relevant scales might also be elevated (e.g., Thought Disorder), the presence of a high PTSD score may alert the examiner to the possibility of alternate explanations for such scale elevations. Unfortunately, because of the substantial overlap between R items and those for other less-trauma-related scales, posttraumatic stress should not be assumed based solely on elevations of this scale.

Rorschach

As is true of the other standard measures reviewed here, the Rorschach (Rorschach, 1981/ 1921) has both positive and negative qualities with regard to the assessment of victimization effects. On one hand, this test provides an opportunity to avoid the constraints of objective testing. wherein the client typically is forced to respond to a specific test item and therefore to specific traditional (i.e., nonvictimization-related) notions regarding the structure of psychological disturbance. On the other hand, some manifestly nonpsychotic PTSD sufferers present with signs of thought disorder and/or impaired reality testing on the Rorschach (e.g., van der Kolk & Ducey, 1989), and similar problems have been documented with reference to misdiagnosis of personality disorder in some trauma protocols (e.g., Levin & Reis, 1997; Saunders, 1991). In fact, the potential overlap between psychotic, personalitydisordered, and posttraumatic Rorschach presentations requires the clinician to be familiar with all three diagnostic scenarios and their Rorschach representations when evaluating victimizationrelated dysfunction or disorder. The interested reader is referred to Levin and Reis (1997) for an excellent overview of these issues as they relate to trauma victims.

A number of studies note a specific cluster of Rorschach indicators that are associated with a history of traumatic events, including interpersonal victimization. For example, protocols with unusually extratensive Erlebnistypus (Experience Balance [EB]), low human movement (M), and elevated unstructured color responses (CF and pure C > FC) have been interpreted as reflecting posttraumatic intrusion and reliving (e.g., van der Kolk & Ducey, 1989). Posttraumatic avoidance and psychic numbing, on the other hand, often present as low affective ratios (Afr) and high Lambdas (Hartman et al., 1990; Kaser-Boyd, 1993). Dissociation also may produce potentially elevated form dimension responses (FD) and introversive/superintroversive EB styles (Armstrong, 1991; Lovitt & Lefkoff, 1985). Hypervigilance in response to victimization often presents. not unexpectedly, as HVI (Levin & Reis, 1997). Also present in such protocols may be evidence of feelings of helplessness and powerlessness, such as inanimate movement responses (m) and diffuse shading determinants (Y) (Levin & Reis, 1997; van der Kolk & Ducey, 1989). Indices of bodily concern or somatic preoccupation have been documented in victim protocols (e.g., Meyers, 1988; Saunders, 1991). Frequently present are ideographic responses, such as morbid, aggressive, blood, sex, and anatomy content (e.g., Armstrong, 1991: Leavitt & Labott, 1996: Levin & Reis, 1997), as well as, in the case of dissociation in particular, content indicating disorientation, perceptual distortion, or objects viewed through obscuring media such as fog or mist (Leavitt & Labott, 1997). Finally, thought disorder and confabulation indicators are sometimes present in victim protocols (Hartman et al., 1990; Saunders, 1991; van der Kolk & Ducey, 1989), although they are typically understood in terms of the destabilization and intrusive symptomatology associated with severe victimization experiences (Armstrong, 1991).

Child Behavior Checklist

The Child Behavior Checklist (CBCL) (Achenbach, 1991) is one of the most widely used clinical instruments for the assessment of psychological distress in children. It contains 116 items that are completed by a caretaker or teacher. Separate norms for sex and age (2-3; 4-11; and 12-18)are available. There is also a self-administered version for children 11 years of age or older, and an observation form in which the clinician records his or her direct observation of the child. The most common version is the parent version for 4-18-year-olds. This instrument has scales that measure both psychopathology (e.g., withdrawn, somatic complaints, thought problems, delinquent behavior) as well as competencies (e.g., activities, social, and school). The α s for the competencies range from .42 to .64, while the α s for the problem scales range from .72 to .92. Test-retest reliabilities are quite good, with a mean for the problem scales of .89.

One of the difficulties associated with the CBCL is its assumption that norms are the same for children throughout the four- to 11-year-age range. It is likely that there is a higher prevalence of behaviors categorized as delinquent among 11-year-old children than those 4 years of age. Conversely, aggressive behaviors may be seen at a much higher rate among 4-year-olds than children at age 11. As well, when the clinician relies solely on parent-report, problems may arise. Elliott and Cox (1995), for example, found that whether the caretaker was supportive of the child significantly impacted the scores on the CBCL. Getting cross-reports from teachers or other caretakers may be a helpful way of addressing this problem.

Several studies have shown that abused children score higher on both the internalization and externalizing scales of the CBCL (e.g., Lanktree, Briere, & Hernandez, 1991). As well, the sexual items contained within this instrument have been shown to discriminate sexually abused from nonabused children (Friedrich, Beilke, & Urquiza, 1987).

Two recent studies suggest the possibility of post-hoc trauma subscales within the CBCL (Friedrich et al., 1997; Friedrich, Lengna, & Sadowski, 1997). Friedrich and his colleagues generated a 17-item PTSD scale that evaluates intrusion, avoidance, and arousal, and has an α reliability of .86. The scale's sensitivity in predicting abused children ranges from .76 to .95 for males and .80 to .86 for females. The scale, however, has only moderate specificity, ranging from .57 to .71. Also identified by Friedrich and colleagues are three items that form a dissociation scale that appears to have reasonable reliability ($\alpha = .70$) despite its brevity. The utility of these scales will become clearer as further research is conducted on them.

Psychological Tests Especially Relevant to Victimization

In response to the problems associated with generic psychological tests, a small number of trauma- or victimization-relevant instruments have been developed. These include the Impact of Event Scale (IES) (Horowitz, Wilner, & Alvarez, 1979) and its revision (IES-R) (Weiss & Marmar, 1997), Child Sexual Behavior Inventory (CSBI) (Friedrich, 1998), Children's Impact of Traumatic Events Scale—Revised (CITES—R) (Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991), Los Angeles Symptom Checklist (LASC) (Foy, Sipprelle, Rueger, & Carroll, 1984; King, King, Leskin, & Foy, 1995), Posttraumatic Stress Diagnostic Scale (PDS) (Foa, 1995), Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986), Traumatic Stress Institute Belief Scale (TSIBS) (Pearlman, 1996), Trauma Symptom Inventory (TSI) (Briere, 1995), and Trauma Symptom Checklist for Children (TSCC) (Briere, 1996).

As noted earlier, many of these trauma-specific measures do not have associated normative or standardization data, and thus, their usefulness in the clinical evaluation of victims may be limited to qualitative interpretations of individual symptom items. For this reason, although a number of these serve well as clinical research measures or descriptive clinical tools, and some (e.g., the DES) provide quasinormative information on scale scores in clinical groups, only those with complete standardization and normative data, or those not requiring normative data (i.e., diagnostic measures), will be discussed here: the PDS, TSI, TSCC, and CSBI.

PDS

The PDS evaluates the presence of PTSD by examining four different 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 frequency of each symptom is rated on a four-point scale, ranging from 0 ("not at all or only one time") to 3 ("5 or more times a week/ almost always").

The PDS demonstrates positive psychometric characteristics, including high internal consis-

tency ($\alpha = .92$ for the 17 items), good test-retest reliability ($\kappa = .74$), and good sensitivity and specificity with respect to PTSD diagnosis (.82 and .77, respectively). Although the PDS has not been normed on the general population, Foa (1995) reports PDS data for a group of 248 individuals, sampled from treatment and research centers that have high numbers of PTSD sufferers. Because this instrument is criterion-based (i.e., evaluates whether a client meets or does not meet diagnostic criteria for PTSD), general population norms are not required for its central function. In this regard, the PDS does not yield standardized T scores, but rather defines PTSD symptom severity as "mild," "moderate," "moderate to severe," or "severe." The cut-off scores used to determine these severity levels were derived from a sample of 376 women with sexual or physical assault histories. Foa (1995) notes that these cut-offs are only rough estimates of PTSD severity, probably because the severity of assaultrelated posttraumatic stress in her female assault victim sample may or may not compare to those of female victims of other types of trauma or of males with trauma histories of any type.

Beyond any problems associated with assessing relative symptom severity, the PDS is the only published test that yields a reliable and meaningful DSM-IV PTSD diagnosis. For this reason, it can be helpful when PTSD is a possibility. As with all psychological tests, however, assessment data should be coupled with a formal diagnostic interview before a specific diagnosis can be made (Briere, 1997a).

TSI

The TSI contains 100 items, and taps acute and chronic posttraumatic symptomatology, including the lasting sequelae of childhood victimization. Each symptom item is rated according to its frequency of occurrence over the prior six months on a four-point scale ranging from 0 ("never") to 3 ("often"). Because of the length of this time frame, the TSI identifies traumatic responses that may have occurred farther in the past, and thus is not intended to generate a DSM-IV PTSD diagnosis.

The TSI has three validity scales and 10 clinical scales, all of which yield normative T scores. There are 12 critical items covering issues such as self-mutilation, suicidality, and potential violence against others. The validity scales of the TSI are: *Response Level* (RL), measuring general underendorsement or a need to appear unusually symptom-free; Atypical Response (ATR), evaluating general overendorsement, psychotic thinking, or an attempt to appear especially disturbed or dysfunctional; and Inconsistent Response (INC), measuring unusually inconsistent responses between similar TSI item-pairs. These validity scales correlate as expected with similar scales from other measures (Briere, 1995). The 10 clinical scales of the TSI are Anxious Arousal, Depression, Anger/Irritability, Intrusive Experiences, Defensive Avoidance, Dissociation, Sexual Concerns, Dysfunctional Sexual Behavior, Impaired Self-Reference, and Tension-Reduction Behavior.

The TSI was standardized on a random sample of 828 adults whose demographics are representative of the United States general population. There are also normative data for military personnel, derived from a sample of 3,659 Navy recruits. Norms are available for four combinations of sex and age (males and females ages 18-54and 55 or older). TSI scores vary slightly as a function of race (accounting for 2-3% of the variance in most scales), and minor adjustments for validity scale cutoffs are suggested for certain racial groups.

The clinical scales of the TSI are relatively consistent internally (mean α s ranging from .84 to .87 in general population, clinical, university, and military samples), and exhibit reasonable convergent, predictive, and incremental validity (Briere, 1995). In a standardization subsample, TSI scales demonstrated good convergent validity with independently assessed PTSD status (using Astin, Lawrence, & Foy [1993] joint scoring of the IES and LASC), with a specificity of .92 and a sensitivity of .91. In a psychiatric inpatient sample, TSI scales identified 89% of those independently diagnosed with borderline personality disorder. Studies indicate that specific TSI scale elevations and configurations are associated with a wide variety of childhood and adult traumatic experiences (e.g., Briere, 1995; Briere, Elliott, Harris, & Cotman, 1995; Elliott & Briere, 1995; Runtz & Roche, in press).

TSCC

The TSCC is a 54-item self-report instrument that evaluates trauma-related symptomatology in children ages eight to 16, including the effects of child abuse (sexual, physical, and psychological) and neglect, other interpersonal violence, witnessing trauma to others, major accidents, and disasters (Briere, 1996). A parent-report version for younger children (ages three to seven) is currently being validated (Briere, 1997b). Unlike most child measures, the TSCC has two validity scales: Underresponse (UND), measuring abnormally low endorsement of commonly endorsed symptoms; and Hyperresponse (HYP), measuring excessive endorsement of rarely endorsed symptoms. There are six clinical scales within the TSCC: Anxiety, Depression, Posttraumatic Stress, Sexual Concerns, Dissociation, and Anger. Two of these scales have subscales (Sexual Concerns contains Sexual Preoccupation and Sexual Distress: Dissociation contains Fantasy and Overt Dissociation). The items of the TSCC are explicitly written at a level thought to be understood by children eight years of age or older. Each symptom item is rated according to its frequency of occurrence using a four-point scale ranging from 0 ("never") to 3 ("almost all of the time"). There is a 44-item Alternate version of the TSCC (the TSCC-A) that does not contain Sexual Concerns items.

Various studies using the TSCC (and TSCC-A) indicate that it is internally consistent (α s in the mid to high 80s for all scales but Sexual Concerns, which tends to be in the high 60s and low 70s), and has convergent and predictive validity in samples of traumatized and nontraumatized children (e.g., Elliott & Briere, 1994; Friedrich, Jaworski, Huxsahl, & Bengtson, 1997; Lanktree & Briere, 1995; Singer, Anglin, Song, & Lunghofer, 1995).

Normative data on the TSCC/TSCC-A were derived from large samples (total N > 3,000) of nonclinical urban, inner city, and suburban children across the United States. Separate norms and T scores are available according to sex and age (8–12 and 13–16). Seventeen-year-olds can be evaluated on the TSCC using 16-year-old norms, with only minor adjustments (Briere, 1996). Data on race differences are included, although race was not a major predictor of TSCC scores.

CSBI

The CSBI is a 38-item instrument upon which a caretaker describes the sexual behaviors observed in a child, between the ages of two and 12, during the prior six months (Friedrich, 1998). Currently, an adolescent version is in the process of being validated (Friedrich, 1997). The CSBI is intended for use with children who have been or are suspected of being sexually abused. Nine domains are evaluated by the 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* that reflects the level of age and gender-appropriate sexual behavior; and *Sexual Abuse Specific Items* that consists of items that have been empirically related to a history of sexual abuse.

Normative data for the CSBI were collected on 1,114 nonclinical children. The scale is relatively reliable, with an α of .72 in the normative sample, and a test-retest coefficient of .85. Separate norms and T scores are available by sex and age (2-5, 6-9, 10-12). The manual also reports adequate convergent and discriminant validity.

As previously mentioned in terms of the CBCL, instruments that rely on parent report are subject to any bias the parent may have in underor overreporting the child's symptoms. Although the CSBI has two items to ensure that the caretaker is reading the items, there are no validity scales to assess the manner in which the caretaker approached the reporting. If the clinical interview with the caretaker suggests significant bias, or that he or she is unable to accurately report events, use of this instrument is typically contraindicated as with the CBCL. As well, it should be generally determined whether the caretaker has had sufficient opportunity to view the behaviors in question, including the range of setting in which he or she sees the child (e.g., during caretaking, in peer relationships, and in contact with adults).

Conclusion

This article has reviewed a number of issues relevant to the psychological assessment of victims of interpersonal violence. Perhaps most importantly, it appears that traditional or generic psychological tests may overlook some of the specific impacts of victimization, or may misidentify them as evidence of other, relatively severe psychological problems. On the other hand, it is often important to include generic tests when evaluating victims of interpersonal violence, because of the need to determine the entire clinical picture, including the possibility of other, less-victimization-related symptoms or disorders.

Given the potential insensitivity of generic measures to victimization effects, a number of

more trauma-relevant instruments have been discussed. Several of these measures are standardized and normed, and possess good psychometric characteristics. Further, a few contain validity scales, so that the possibility of underreporting or overreporting—both of which are relevant to victimization reports—can be assessed. Due to the complexities of event comorbidity, however, even the best of tests may not necessarily allow accurate determination of the specific impact of a given traumatic event on current psychological functioning.

As suggested by the number of new instruments and findings reviewed here, the area of victim mental health services is undergoing rapid development. As the field continues to grow, increasingly more sophisticated evaluation methodologies are becoming available. As a result, our ability to accurately assess victimization-related distress and disorder continues to improve, potentially leading to more focused and effective treatment for this underserved population.

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J. Briere & D. M. Elliott

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