CHAPTER 16

Assessment of Trauma, PTSD, and Substance Use Disorder

A Practical Guide

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The wish to escape pain through alcohol and drugs occurs across cultures and across history (Lowinson, Ruiz, Millman, & Langrod, 1997). Trauma and substance use disorder (SUD) thus represent a natural pairing. One victim of childhood physical and sexual abuse said, “When I was twelve I had my first drink, and I knew immediately this was my answer. I felt relaxed for the first time in my life. I became an instant alcoholic.” Substances are also used by trauma perpetrators, whether they are under the influence while committing harm (many violent assaults are committed while intoxicated) or whether they use a substance to sedate the victim (Bureau of Justice Statistics, 1992). Community-wide traumatic disasters are also known to lead to increased substance use, including the September 11, 2001, attacks, Hurricane Hugo, and the Oklahoma City bombing (Clark, 2002; North et al., 1999). Various populations tend to have particularly high rates of trauma and SUD, including women, teens, prisoners, the homeless, gays and lesbians, veterans, rescue workers such as firefighters and police, victims of domestic violence, and prostitutes (e.g., Davis & Wood, 1999; Jacobsen, Southwick, & Kosten, 2001; Najavits, Weiss, & Shaw, 1997; North et al., 2002; Substance Abuse and Mental Health Services Administration (SAMHSA), 2001; Smith, North, & Spitznagel, 1993; Tarter & Kirisci, 1999; Teplin, Abram, & McClelland, 1996).

Posttraumatic stress disorder (PTSD), the psychiatric disorder most directly related to trauma, is highly associated with SUD. In the United States, among men with PTSD, 51.9% are estimated to have alcohol use disorder and 34.5% have drug use disorder (lifetime rates); for women the rates are 27.9%
and 26.9%, respectively (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Their clinical needs are urgent and serious. Those with the dual diagnosis have worse outcomes than those with either disorder alone, higher rates of subsequent trauma, and a more severe clinical profile, including other Axis I and II disorders, medical problems, HIV risk, legal problems, lower work functioning, suicidality, and self-harm (Brady, Killeen, Saladin, Dansky, & Becker, 1994; Hien, Nunes, Levin, & Fraser, 2000; Najavits, Gastfriend, et al., 1998; Najavits et al., 1997; Ouimette, Finney, & Moos, 1999). Misuse of substances may represent reenactment of trauma, whether conscious or not: an act of harming the body that echoes familiar traumatic experiences; giving up on oneself after having been violated by others; or playing the role of the marginalized “bad one” or rebel (Najavits, 2002b; Teusch, 2001). It is notable that one of the major predictors of both trauma and SUD is a family history of these—the repeating cycle over generations of this seemingly inexorable combination (Kendler, Davis, & Kessler, 1997; Yehuda, Schmeidler, Wainberg, Binder-Brynes, & Duvdevani, 1998).

THE PROBLEM OF UNDERDIAGNOSIS

Accurate assessment is thus essential. It is the precursor to effective treatment, without which the patient may not receive adequate attention to one or both disorders. Of particular challenge is the fact that, quite unique among Axis I disorders, both PTSD and SUD are highly prone to minimization, whether through lying, denial, or the shame and guilt inherent in both. Patients may say, “Growing up, I was blamed for the sexual abuse, so I learned never to talk about it”; or “I hid my cocaine use from others, but also from myself; I couldn’t admit I had a problem.” Moreover, both PTSD and SUD were quite late in joining the mainstream of the mental health field. PTSD was established as a diagnosis only in 1980, with Freud’s disavowal of trauma as “fantasy” contributing to a lack of attention to PTSD for much of the 20th century (Herman, 1992). SUD, though a diagnostic category, was often ignored by mental health clinicians, viewed as a surface issue rather than a genuine clinical concern, and addressed primarily through grassroots 12-step movements (Najavits & Weiss, 1994).

The systemic neglect of both PTSD and SUD have historically resulted in a lack of adequate assessment and a marked separation of the two fields that only lately has begun to improve. A culture of exclusion continues to exist, with many mental health clinicians believing they cannot adequately assess or treat SUD and many SUD clinicians believing they cannot assess or treat PTSD (Najavits, 2002b; Read, Bollinger, & Sharansky, 2002). More and more, there is recognition that a no-wrong-door approach is the most helpful (Clark, 2002). Regardless of how they enter the system, patients should be assessed for both disorders and provided with treatment. Split systems, in which a patient who uses substances is rejected from mental health programs until absti-
nent or in which the patient with mental health issues is rejected from substance abuse treatment until stabilized, are believed to be less effective than integrated or concurrent treatment, according to most current experts (Brady, 2001; Ouimette & Brown, 2002). Yet it remains the case that most SUD patients are not adequately assessed for PTSD nor given treatment for it (Brown, Stout, & Gannon-Rowley, 1998; Danksy, Roitzsch, Brady, & Saladín, 1997; Hyer, Leach, Boudewyns, & Davis, 1991; Najavits, Sullivan, Schmitz, Weiss, & Lee, 2004). Many mental health clinicians, similarly, may fail to assess and treat SUD or, alternatively, may take an overly harsh stance, such as withholding treatment unless the patient agrees to attend Alcoholics Anonymous or terminating treatment if a patient relapses. Newer approaches to SUD, such as harm reduction, offering the patient choices, and an emphasis on support rather than confrontation, may be unfamiliar to some mental health clinicians (Fletcher, 2001; Marlatt, Tucker, Donovan, & Vuchinich, 1997). Yet these modifications of standard SUD treatment may be especially helpful for dual diagnosis patients in general and for those with PTSD specifically (Marlatt et al., 1997; Najavits, 2002b).

The lack of assessment of both disorders occurs for other reasons as well. Gender, for example, plays a role. Some women who do not fit the classic image of addicts—such as professional women, college women, housewives, and middle- and upper-class women—are underassessed for SUD (Najavits, 2002c). Men may be underassessed for PTSD, particularly civilian men who experienced physical or sexual abuse (which violate the image of the masculine role), crime witnessing, or victimization, which may not be recognized as traumatic in subcultures in which these events are common (Lisak, 1994). Establishing norms for measures based solely on dominant gender or ethnic group also has historically resulted in a lack of accurate assessment. For example, SUD measures were normed primarily on men and may be less accurate for women, who are known to become addicted more quickly and with lower levels of use than men (Mendelson & Mello, 1998; Najavits, 2002c). The reality is that both PTSD and SUD tend to be underdiagnosed according to empirical studies, and it remains a public health concern to increase valid assessment of them (Brown et al., 1998; Danksy et al., 1997; Davidson, 2001; Hyer et al., 1991; Najavits, 2002c).

The goal of this chapter is to provide a practical assessment guide for clinicians in both the mental health and substance abuse fields. Three topics are addressed: (1) myths, (2) suggestions for the assessment of PTSD and SUD, and (3) resources.

**MYTHS**

Perhaps because of the historic schism between the fields of PTSD and SUD, several misperceptions persist about diagnosis of the disorders. Before discussing assessment strategies, it may be helpful to describe some of these.
"Labels aren’t good for patients; it’s better not to give a PTSD or SUD diagnosis.” This view tends to be held by staff without formal training in psychopathology, such as domestic violence advocates, paraprofessional addiction counselors, and nonclinicians. Some may distrust the mental health field as a system of social control, coercion, or hierarchy. Others may simply view diagnosis as outside their realm of training. They are well intentioned in their attempt not to impose views on patients or disempower them, particularly as those with the dual diagnosis of PTSD/SUD are often marginalized by society. This perspective also arises from a legacy of some very real diagnostic distortions, such as misuse of the label “borderline personality disorder,” which became notoriously pejorative and inaccurately applied to patients with PTSD (Herman, 1992). However, it is borne out by clinical experience that accurate labeling of PTSD and SUD is, in fact, usually highly therapeutic. Most experts view the diagnoses as beneficial guides to treatment planning that are important to identify early (Brady, 2001; Brown et al., 1998; Davidson, 2001; Jacobsen et al., 2001; Ouimette & Brown, 2002; Triffelman, 1998). The diagnoses provide a framework that helps organize patients’ experience to promote recovery. One SUD patient, on learning about her PTSD diagnosis, said:

At first I thought, “Oh no, not another condition,” but then I was relieved to find I had something with a name. I thought it was just me—I’m crazy. But I can deal with this now. It’s different when you don’t know, but when you find out, it’s like a person with cancer—you can work on it. Now I can put down the cocaine and work on what’s behind it. (quoted in Najavits, 2002c)

For many patients with SUD, learning about the PTSD diagnosis allows them to view their addiction in a new light, as a way to cope with overwhelming emotional pain (particularly as the PTSD usually occurs first; Jacobsen et al., 2001; Najavits et al., 1997). They may feel less alone, less “crazy,” and more understanding of themselves. Indeed, the majority of patients with SUD who are educated about PTSD report that they want treatment for it (Brown et al., 1998; Najavits et al., 2004). Similarly, the SUD diagnosis can reduce denial and minimization. Exploring the definition of SUD can help move the patient out of debates with clinicians or family members, and into the more objective realm of how SUD is defined in DSM-IV. Reading it on paper can make it more acceptable. Of course, for all patients, sensitivity to how they react to the diagnoses and careful education are key. A collaborative stance is also important, rather than just asserting the clinicians’ views.

“SUD itself is trauma or PTSD.” This view arises from the observation that addiction can be extremely destructive. It causes physical and psychological harm, and it leaves the patient feeling out of control, all of which parallel the trauma experience. However, though SUD is highly destructive, it does not meet criteria for trauma or PTSD. Trauma is generally understood to be unpredictable and occurring from some force external to the patient—another person, a natural disaster, an accident, or combat, for example. Substance
abuse relies on the person picking up the drink or drug. Also, the PTSD and SUD criteria have little or no overlap (American Psychiatric Association, 1994). Ultimately, clear use of the terms “SUD,” “trauma,” and “PTSD” conveys respect for patients’ experience. To merge terms until they become undifferentiated does not do justice to the importance and character of each. One can help a patient understand the destructiveness of SUD without resorting to the conceptual imprecision of merging terms that each have their own meaning.

“Assessing for trauma is enough.” In many clinical settings, at least some assessment of trauma occurs on intake. For example, asking patients if they have a history of physical, sexual, or emotional abuse is part of the Addiction Severity Index, one of the most widely used assessment tools in the addiction field (Najavits, Weiss, Reif, et al., 1998). Assessing for PTSD, however, is much more rare (Danksy, Roirzsch, Brady, & Saladin, 1997), and, indeed, some clinicians simply equate trauma with PTSD. Yet trauma itself is not a diagnosis; it is an event that may or may not still cause problems for the patient. Most people who experience a trauma do not develop PTSD (Kessler et al., 1995). According to a literature review by Ruzek, Polusny, and Abueg (1998), the diagnosis of PTSD is associated with SUD much more than with trauma per se. Effective treatment thus requires assessment of whether the patient is actually experiencing problems from the trauma, such as nightmares, flashbacks, hypervigilance, and intense distress when reminded of the event. One cannot assume that the trauma no longer creates problems for the patient, nor the opposite, that trauma is always problematic. Accurate assessment of both trauma and PTSD is key. Also, it is important to have a clear understanding of their definitions. Some believe that trauma means “any upsetting event” or that emotional abuse counts as a trauma in DSM-IV (American Psychiatric Association, 1994). In fact, in DSM-IV, trauma must involve some sort of physical harm, whether experienced, confronted, or witnessed. It also involves an emotional response at the time: It is not just an event (e.g., a car accident) but also the experience of fear, helplessness, or horror.

“SUD means . . . use of drugs/amount of use/how the substance is used.” Clinicians sometimes use idiosyncratic definitions of SUD. For example, alcohol may be viewed as acceptable because it is legal and socially sanctioned, whereas illegal drugs may be regarded as more pathological. Or the clinician may try to ascertain the amount or form of alcohol or drug use and make a judgment from that. For example, three drinks per week is fine, but drinking every day is not; or, drinking with others is acceptable but drinking alone is not. However, the essential feature of SUD is not the presence or amount of substance use per se, nor whether it is taken alone or with others, nor based on the patient’s motivation (e.g., to get “wasted,” to relax). Rather, it is based on criteria such as physiological impact (tolerance, withdrawal), inability to stop using, and its consequences (whether the substance use causes demonstrable problems—legal, medical, social, psychiatric, or vocational—yet the person continues to use anyway). One may have opinions on what is healthy or socially acceptable, but a diagnosis of
SUD requires evaluation of specific criteria. The definitions are complex, filling 97 pages of DSM-IV, and clinicians may not have formal training in addiction. Yet it is important to provide patients with an accurate diagnosis of SUD rather than an ill-informed or moral judgment, which for so long was part of society’s historical response to it.

"I need to wait until the patient is through substance use and withdrawal before assessing PTSD." This is a fascinating and complex issue. The idea is that substance use or withdrawal may either dampen PTSD symptoms (thus obscuring the diagnosis, i.e., false negatives) or increase PTSD symptoms (thus inflating rates of the diagnosis, i.e., false positives; Read et al., 2002; Ruzek et al., 1998). Thus it is sometimes said that until 4 to 6 weeks of abstinence are achieved, PTSD or other mental disorders should not be diagnosed. However, there appear to be no studies at this point on whether, in fact, the diagnosis of PTSD during substance use or withdrawal is less accurate after a period of abstinence. Although some psychiatric disorders can indeed be confusing to assess clearly in the context of substance use or withdrawal (e.g., depression, generalized anxiety), the PTSD diagnosis appears quite robust through these states, even if some symptoms intensify or diminish (Pamela Brown, Paige Ouimet, personal communications, March 31, 2003). Thus the PTSD diagnosis may be more stable and accurate in the context of SUD than are other Axis I diagnoses, highlighting the point that all dual diagnoses are not the same (Weiss, Najavits, & Mirin, 1998). Moreover, from a clinical perspective, it is problematic to wait before diagnosing PTSD. Many patients with the dual diagnosis are unable to achieve such a stable period of abstinence, and their difficulty may arise in part from inadequate attention to PTSD. Clinically, the most sensible approach appears to be to assess for trauma and PTSD immediately and to reconfirm the diagnosis, if needed, once the patient achieves sustained abstinence.

SUGGESTIONS FOR THE ASSESSMENT OF PTSD AND SUD

Several suggestions may help guide the assessment of this dual diagnosis.

Choose Measures Based on the Question of Interest and Practical Considerations

Numerous measures are available for PTSD and SUD. Selection depends on the goal of the assessment (e.g., screening, diagnosis, clinical work, research, outcome assessment), as well as on the practical limitations of the assessment context. For example, it is easy to recommend that all patients be given the best available assessment of both disorders, such as the Structured Clinical Interview for DSM-IV (Spitzer, Williams, & Gibbon, 1997); yet in many settings, this is impossible due to heavy workloads, lack of training in psycho-
pathology or assessment, and some patients’ unwillingness or inability to
answer lengthy questioning. Moreover, only a few trauma/PTSD measures
have been validated in SUD samples (e.g., Bernstein, 2000; Coffey, Danksy,
Falsetti, Saladin, & Brady, 1998; El-Bassel et al., 1998), but most have not. In
general, it is better to pursue some assessment, even in a limited fashion, than
to take an all-or-none stance (i.e., state-of-the-art rigorous assessment or no
assessment).

Tables 16.1 and 16.2 provide key areas of assessment for both PTSD and
SUD, with examples of measures. To obtain actual measures, see “Resources
for Assessment,” the final section of this chapter. Many are in the public do-
main, free, and can be directly downloaded from online sources. Note that
SUD measures span a wide range of questions, including screening for SUD,
diagnosis of SUD, level of substance use, verification of substance use, nega-
tive consequences of SUD, motivation for SUD treatment, acute medical de-
toxification issues, and cognitions. Similarly, for PTSD, questions might in-
clude screening, diagnosis, other trauma-related diagnoses, other trauma-
related symptoms, and cognitions. No one measure or set of measures can be
recommended for all purposes, but the following guidelines may be helpful.

SUD treatment programs are typically interested in adding trauma and
PTSD assessment, as they are already well versed in SUD. They usually seek
short self-report measures that do not require interviewer time or formal
training. Many programs are underfunded and understaffed, and the chief aim
is to add assessment without additional burden. Many SUD clinicians do not
have access to computers or training in assessment, and thus searching for
measures may be impractical. “Do more and do it better” is a continual de-
mand on SUD treatment staff (Gustafson, 1991). Suggested measures follow,
with emphasis on those that are brief (i.e., approximately one page) and that
can be obtained and distributed for free.

- For a trauma screen, consider the Stressful Life Experiences Screening
  (Stamm et al., 1996), which can be downloaded from www.isu.edu/
  bhstamm/tests.htm, along with scoring and psychometric information.
- For assessment of PTSD, consider the PTSD Checklist—Civilian ver-
  sion (Weathers, Litz, Herman, Huska, & Keane, 1993), which trans-
  lates the DSM-IV PTSD definition into a pencil-and-paper format and
  requires no training to administer; it too can be downloaded from
  www.isu.edu/bhstamm/tests.htm.
- For trauma-related symptoms, a widely used free measure is the
  Trauma Symptom Checklist-40, which can be downloaded from www.
  johnbriere.com (click “TSC-40”), including scoring information and
  psychometric information. Other measures, some of which can be or-
  dered from Psychological Assessment Resources (800-331-TEST) for a
  fee, are also described on that site, including versions for children and
  adolescents.
TABLE 16.1. Areas of Substance Use Disorder Assessment

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<th>Screening for substance use disorder</th>
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<tr>
<td><strong>Key question:</strong> Might the patient have a substance use disorder?</td>
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<td><strong>Examples of measures:</strong> For alcohol—Michigan Alcohol Screening Test (Seltzer, 1971); for drugs—Drug Abuse Screening Test (Skinner, 1982)</td>
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<td><strong>Notes:</strong> Brief, requires little or no training, some available online or in community programs (e.g., National Alcohol Screening Day).</td>
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<th>Diagnosis of substance use disorder</th>
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<td><strong>Key question:</strong> Does the patient truly have a substance use disorder?</td>
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<td><strong>Examples of measures:</strong> Structured Clinical Interview for DSM-IV (Spitzer et al., 1997); Mini-International Neuropsychiatric Interview (Sheehan et al., 1998)</td>
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<td><strong>Notes:</strong> Alcohol and drug use disorders have separate diagnostic criteria. Training in both the measure and diagnostic criteria are required (usually DSM-IV, but may be ICD-9 or other system). Interrater reliability usually needs to be established. Most measures are interview based, but some self-report computerized versions also exist.</td>
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<th>Level of substance use</th>
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<td><strong>Key question:</strong> What, how much, and how often is the patient using?</td>
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<td><strong>Examples of measures:</strong> Addiction Severity Index (McLellan et al., 1992); Timeline Follow-Back (Sobell &amp; Sobell, 1992)</td>
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<td><strong>Notes:</strong> For clinical practice, the clinician often simply asks the three questions at each session: What type of substances have you used in the past week? How much of each (e.g., number of drinks)? How often for each? More formal measures are typically used for research. Related are measures of cravings for substances (see Abrams, 2000, for a review).</td>
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<th>Verification of substance use</th>
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<td><strong>Key question:</strong> Is the patient telling the truth about use?</td>
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<td><strong>Examples of measures:</strong> Biological measures include urinalysis testing (home kit or laboratory), breath alcohol testing, and blood or hair analysis. Collateral informant measures involve corroboration by family members or others (Maisto, Sobell, &amp; Sobell, 1982).</td>
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<td><strong>Notes:</strong> Accuracy of biological measures depend in part on how long ago the patient used (e.g., alcohol may be detected only within a few hours, whereas marijuana may be detected days later). Random testing and chain-of-custody procedures enhance accuracy. Collateral informant measures require the patient's written consent.</td>
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<th>Negative consequences of substance use</th>
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<td><strong>Key question:</strong> How is the substance use affecting the patient's life?</td>
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<td><strong>Examples of measures:</strong> Inventory of Drug Use Consequences (Tonigan &amp; Miller, 2002); Addiction Severity Index (McLellan et al., 1992)</td>
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<td><strong>Notes:</strong> Typical areas of assessment include impact of substance on legal, psychiatric, social, vocational, medical, and family functioning.</td>
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<th>Motivation for substance abuse treatment</th>
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<td><strong>Key question:</strong> How motivated is the patient to engage in substance abuse treatment?</td>
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<td><strong>Examples of measures:</strong> Stages of Change Readiness and Treatment Eagerness Scale (Miller &amp; Tonigan, 1994); University of Rhode Island Change Assessment Scale</td>
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<td><strong>Notes:</strong> The widely used stages of change model evaluates the patient's readiness in terms of stages (e.g., precontemplation, action, maintenance).</td>
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(continued)
**TABLE 16.1. (continued)**

**Acute detoxification issues**

*Key question:* Does the patient have any immediate medical issues related to addiction that need attention?

*Examples of measures:* Clinical Institute Withdrawal Assessment (Sullivan, Sykora, Schneiderman, Naranjo, & Sellers, 1989).

*Notes:* A patient who has had heavy abuse of alcohol or prescription medication usually needs medical evaluation and treatment prior to stopping. Referral can be made to a detoxification program or to an outpatient physician or psychiatrist who can evaluate the patient’s needs.

**Cognitive measures**

*Key question:* How does the patient view the addiction?

*Examples of measures:* Beliefs about Substance Use (Wright, 1992); Cocaine Expectancy Questionnaire (Jaffe & Killey, 1994)

*Notes:* These are used to evaluate patients’ reasons for using substances and their expectations about their ability to stop using.

*Mental health treatment programs* typically seek to add SUD measures. Because there are so many different types of SUD assessment, per Table 16.1, it is beyond the scope of this chapter to review them. However, mental health clinicians may not be aware that there is an extraordinary amount of material on SUD assessment and treatment that can be obtained free from the government, either downloaded from the Internet or ordered by phone. Because SUD is a major public health problem (indeed the most common lifetime Axis I disorder; Kessler et al., 1994), there is probably more available on SUD than any other psychiatric disorder. (See the “Resources for Assessment” section of this chapter.)

*Research programs* usually seek state-of-the-art measures and have readily available staff and training. Depending on the research questions, there may be need for rigorous interview-based diagnostic measures (such as the SCID), outcome assessment, and description of the sample. (See the “Resources for Assessment” section for ways to obtain psychometric information on SUD and PTSD measures). Also, a helpful method is to read research reports related to one’s work and to obtain measures that others have used. For example, outcome research articles on the dual diagnosis of PTSD/SUD typically use the Structured Clinical Interview for DSM-IV (Spitzer et al., 1997), the Addiction Severity Index (McLellan et al., 1992), and the Timeline Follow-Back (Sobell & Sobell, 1992). By adopting these, one can more readily compare results with the existing literature. Other research considerations for SUD assessment include the need to establish whether psychoactive medications are taken as prescribed and to corroborate self-report of substance use with biological or collateral confirmation (see the section in Table 16.1, “Verification of Substance Use”). These considerations may also apply to clinical settings.
### TABLE 16.2. Areas of Trauma/PTSD Assessment

#### Trauma

**Key question:** Did the patient experience a trauma?

*Examples of measures:* Trauma History Questionnaire (Green, 1996); Stressful Life Experiences Screening (Stannum et al., 1996)

*Notes:* In addition to identifying the events a patient experienced (e.g., rape, assault, accident), a good trauma measure also evaluates the other trauma criteria of DSM-IV (e.g., presence of fear, helplessness, or horror).

#### PTSD

**Key question:** Does the patient meet criteria for PTSD (the disorder most directly associated with trauma)?

*Examples of measures:* Clinician-Administered PTSD Scale (Blake et al., 1995); PTSD Checklist (Weathers et al., 1993); Modified PTSD Symptom Scale (Falsetti, Resnick, Resick, & Kilpatrick, 1993)

*Notes:* The PTSD diagnosis requires that the person meet criteria for having experienced a trauma. Some measures include this; others do not. Thus a trauma measure would be needed (see previous section of this table). Some PTSD measures are interview; others are self-report measures that take less time.

**Other trauma-related diagnoses**

**Key question:** Does the patient have other disorders related to trauma? These include acute stress disorder, dissociative disorders, and disorders of extreme stress—not otherwise specified (NOS).

*Examples of measures:* Structured Interview for Disorders of Extreme Stress—NOS (Pelcovitz, van der Kolk, Roth, Mandel, & Kaplan, 1997); Structured Clinical Interview for DSM-IV (Spitzer et al., 1997)

*Notes:* For complex diagnoses such as dissociative disorders, interviews are typically recommended.

**Other trauma-related symptoms**

**Key question:** Does the patient have other symptoms related to trauma? These include self-harm, dissociation, sexuality problems, and relationship problems, such as distrust.

*Examples of measures:* Trauma Symptom Checklist-40 (Elliott & Briere, 1990); Trauma Symptom Checklist for Children (Briere, 1996)

*Notes:* These measures may be especially helpful for clinical purposes and for outcome assessment because they provide levels of symptoms (rather than the yes/no format of many diagnostic measures). Also, trauma-related symptoms are broader than diagnostic criteria, and thus useful to measure, even if the patient meets criteria for PTSD or other diagnoses.

**Cognitive measures**

**Key question:** How has trauma affected the patient’s beliefs?

*Example of measure:* World Assumptions Scale (Janoff-Bulman, 1989); Traumatic Stress Institute Belief Scale (1996)

*Notes:* Such scales address trauma-related beliefs, such as safety, trust, and loss.
Recognize the Complexity of the SUD Diagnosis

The SUD diagnosis is quite complex, requiring evaluation based on the substance (e.g., alcohol vs. cocaine), an understanding of remission categories (early full, early partial, sustained full, and sustained partial, depending on when and how many criteria the patient meets); and knowledge of symptoms of withdrawal and tolerance (which vary based on the substance). The complexity of the SUD diagnosis helps explain why it is so difficult to locate simple self-report diagnostic measures for SUD, as well as ones that evaluate both alcohol and drug use. Thus measures often come in two separate forms for alcohol and drugs (e.g., the Michigan Alcohol Screening Test for alcohol vs. the Drug Abuse Screening Test for drugs, Seltzer, 1971; Skinner, 1982; and the SCID alcohol module vs. the SCID drug use disorder module, Spitzer et al., 1997). SUD also does not usually lend itself to a direct translation into self-report format, in contrast to the PTSD diagnosis, which can easily be made into a short self-report (e.g., the PTSD Checklist; Weathers et al., 1993). Adding another layer of complexity is the assessment of nonsubstance addictions such as gambling, Internet use, sex, shopping, and other addictions, each of which has its own assessment measures (Lowinson et al., 1997).

When Assessing Trauma in Patients with SUD, “Less Is More”

In general, most assessment procedures assume that more information is better and that interviews (compared with self-report) obtain the best results. With SUD patients, the opposite may hold. When assessing trauma in this highly impulsive population, destabilization may occur if patients are asked to provide extensive details, which may evoke high levels of emotion that can lead to increased substance use or other unsafe behavior. Coffey et al. (2002), for example, found that substance cravings increase when patients are exposed to trauma memories. Indeed, studies of exposure therapy in this population, which ask patients to describe trauma in detail, have had mixed results (Brady, Dansky, Back, Foa, & Caroll, 2001; Ruzek et al., 1998; Keane, 1995; Ruzek et al., 1998; Solomon, Gerrity, & Muff, 1992), unless there is careful selection of patients (Coffey, Dansky, & Brady, 2002) or adaptation of exposure therapy for SUD (Najavits, Schmitz, Gotthardt, & Weiss, in press). Although an assessment of trauma is not exposure therapy per se, it is similar in potentially evoking intense emotions in patients who may not be prepared to cope with them and who may not be in a treatment context to process them sufficiently. The principle “first do no harm” applies to assessment as much as to treatment. Even if patients want to describe details of their trauma history, they often underestimate the level of emotion that results, and thus the assessor must serve as gatekeeper and limit the information to safe bounds. Thus it is suggested that only very basic trauma information be obtained at intake. A brief trauma screen, for example, does not require the patient to identify a
great deal of detail. Later, if a patient is in an ongoing therapy and the timing is appropriate, it may become an important part of the therapy to explore details of the trauma. At intake, however, it may be best to ask only the information needed for the specific purpose of the assessment. Routinely asking patients for intrusive detail is not justified. For example, if the goal is to screen patients for possible PTSD, the assessor simply needs to know the trauma that the patient currently perceives as the “worst” or the “most upsetting.” That trauma can be described in a word or phrase (e.g., “tape” or “stabbing”), from which the assessor may choose to conduct an assessment of PTSD. A related issue is whether to use an interview or written self-report format for trauma assessment. Results at this point are unclear. For example, one study found better results for interview (Bastiaens & Kendrick, 2002; another found better results for a checklist (Najavits, Weiss, Reif, et al., 1998). For some patients, it may be more difficult to say aloud to the assessor that one has been raped, for example, than to mark it on a checklist. The shame and embarrassment are more acute in an interview. Asking patients to use a written checklist increases their privacy and may be less destabilizing. It is suggested, however, that such a checklist be completed on site in the clinical setting, rather than filled out at home. It seems to work well to have the patient fill out the form in the waiting room with instructions to stop and ask for help if it becomes too upsetting.

**Obtain Age-Appropriate Measures for Children and Adolescents**

Measures of PTSD and SUD are now available for children and adolescents. A recent review of trauma measures for these age groups is provided by Ohan and Myers (2002), for example. For substance abuse, see recent reviews by Miller, Westerberg, and Waldron (1995) and Tarter and Kirisci (1999). See the “Resources for Assessment” section to obtain Treatment Improvement Protocol #31, Screening and Assessing Adolescents for Substance Use Disorders.

**Consider the Context of the Assessment**

For this dual diagnosis population, there may be contextual issues that affect honesty about SUD, PTSD, or both.

- A patient with SUD who reports high levels of psychiatric disturbance (e.g., depression, suicidality) may be refused entry into SUD treatment until stabilized; thus the patient may minimize such symptoms.
- A patient with PTSD who receives disability benefits for the disorder may not want to report a decrease in symptoms for fear of losing the benefits.
- A patient with SUD who reports recent substance use may be evicted from housing, lose custody of her children, or be fired from a job. SUD
is often inadequately addressed in rescue professions, for example, such as fire and police forces, because a diagnosis of SUD can result in removal from duty.

- Adolescents may fear restriction from friends or normal activities if they report substance use honestly.
- In some settings, such as prison or the military, reporting trauma perpetrated by those in power may result in punishment to the victim (Janofsky & Schemo, 2003).
- A patient going into surgery may not reveal a history of SUD for fear of obtaining inadequate pain medication, which is often restricted even if the patient has been abstinent for many years.

In short, various circumstances may lead to either increased or decreased reporting of PTSD or SUD symptoms. In the assessment, such contextual factors should be identified.

Know and Warn Patients of the Legal Implications of Assessment

Both PTSD and SUD may involve legal issues to a greater degree than other Axis I disorders. For example, SUD legal issues include drug dealing charges, driving under the influence, loss of custody of children, use of illegal drugs, and using while on the job. In a prison setting, if patients in treatment admit using a substance, they may have time added to their sentences. A helpful document from the federal government includes sample consent forms for SUD information, as separate consent may be needed for SUD assessment given the sensitivity of the information (Technical Assistance Protocol #13; see “Resources for Assessment”). Trauma assessment may, in some states, evoke mandatory reporting such that the clinician is required to report to authorities the name of and other information about a trauma perpetrator, even if the event was decades ago and the patient does not want the information reported. Another issue relevant to PTSD is the need for legal deposition prior to therapy for a patient who may want to initiate legal proceedings against a perpetrator; otherwise the therapist may be accused of creating false memories. For both PTSD and SUD, patients may not be aware that their records may be obtained by court order, even if the assessor assured them of confidentiality. Clinicians, particularly those in private practice or with little cross-training in both disorders, may inadvertently misinform or fail to inform patients of these various legal dilemmas. In research settings, some investigators are not aware that they can apply for a certificate of confidentiality for federally funded studies, which provides the highest level of protection of records, including from court orders (above and beyond standard institutional protections). Researchers can obtain information about the certificate from the institute that provided their funding.
Be Aware of Common Misdiagnoses

Misdiagnosis may involve errors of commission, omission, or both. An error of commission is giving a diagnosis that is not accurate (e.g., borderline personality disorder rather than PTSD, even though only the latter actually fits the patient). An error of omission is giving a diagnosis that is accurate but neglecting additional diagnoses that also may be present (e.g., a patient has both borderline personality disorder and PTSD, but receives only one of these diagnoses). As noted earlier, both PTSD and SUD are biased in the direction of being underdiagnosed. In addition to carefully assessing for both disorders, it is also important to ensure that additional psychiatric diagnoses, both Axis I and II, are accurate. Some common misdiagnoses for this population include the following.

- **Affective and anxiety disorders** (e.g., depression, bipolar disorder, generalized anxiety disorder). Affective disorders often co-occur with PTSD or SUD, and because they typically have less stigma and clearer medication regimens, they are more likely to be diagnosed. Yet such disorders may be secondary to PTSD or SUD or may be substance induced. For children and adolescents, attention-deficit/hyperactivity disorder may also be misdiagnosed.

- **Borderline personality disorder** (BPD). This diagnosis is known for being misused in place of a PTSD diagnosis (Herman, 1992). However, with growing recognition of this problem, some clinicians go to the opposite extreme, believing that BPD does not exist and that any patient who presents with such symptoms actually has PTSD. Both BPD and PTSD are legitimate diagnoses, and patients who have one do not automatically either have nor not have the other (Gunderson & Sabo, 1993). For example, in a sample of patients with SUD and PTSD, only about one-third also had BPD (Najavits, Weiss, Shaw, & Muenz, 1998); and vice versa, among patients with BPD and SUD, about one-third also had PTSD (Linehan et al., 1999).

- **Antisocial personality disorder** (ASP). Comparable to BPD, ASP may be diagnosed when, in fact, PTSD and SUD are more accurate. There is a clear gender pattern, with more males diagnosed with ASP and more females with BPD.

The best way to guard against misdiagnosis is to screen for major Axis I and II disorders. Asking the patient whether psychiatric symptoms occur only when using, only during withdrawal, or only when abstinent may also be helpful (Weiss et al., 1998). However, some patients will be unable to answer such questions because they have been using substances for so long that they cannot identify a period of nonuse. Finally, even the notion of “dual” diagnosis is a misnomer, as many patients with PTSD and SUD have additional co-occurring disorders, including affective disorders, other anxiety disorders, and Axis II disorders (Brady et al., 1994).
Be Prepared for Memory Problems

Patients with either disorder, or their combination, may have substantial memory problems. Indeed, patients with PTSD may use substances either as a way to forget trauma ("drinking to forget"; Stewart, 1997) or to remember (Ruzek et al., 1998). In PTSD, the issue of memory accuracy has received a great deal of research. A task force of the American Psychological Association came to the conclusion that although most trauma survivors remember all or part of what happened to them, there may be gaps in their memories, and pseudomemories are possible as well (i.e., memories the patient believes are accurate but that are not). They provide several helpful guidelines, including the precepts that hypnosis should not be used to uncover trauma memories and that clinicians need to maintain separate roles (e.g., forensic assessor from clinician) (Alpert et al., 1998). At least one study (Whitfield, 1998) found that patients with this dual diagnosis had difficulty remembering trauma and suggests that "soft signs" may be important to note, such as reenactments. In SUD, chronic use, acute use, withdrawal, and the tendency to deny or minimize use (conscious or not) all can impair memory. The assessor may need to be especially diligent in establishing rapport. It is also important not to assume that patients are willfully withholding information, although under some conditions this may occur.

Give Patients Feedback about Assessment Results

As described, the diagnoses of PTSD and SUD can be helpful for patients to understand that they are not alone and not "crazy." Diagnoses provide a way for patients to better understand their experiences, which can aid the recovery process. Some symptoms, too, even if not a full-blown disorder, may warrant discussion. For example, dissociation, depersonalization, and transient psychotic symptoms that may occur in severe PTSD or SUD may be very frightening to the patient. Learning that these occur in people with the dual diagnosis can help. It is thus suggested that patients be provided with an explanation of what was found in the assessment, if they want to know.

The Assessor's Style Is Important, Balancing Kindness with Directness

The assessor's style may determine the accuracy of information obtained. Given the stigma of both PTSD and SUD, patients often fear being judged, treated harshly, or misunderstood (Read et al., 2002). In some settings, they may have had very negative experiences with incompetent or uncaring professionals (Jennings, 1994). One study found that more than half of patients with this dual diagnosis report shame and blame as barriers to treatment (Brown et
Paranoia is also commonly associated with both disorders and may increase distrust of professionals and systems. Several traits are thus central. First, the assessor needs to be kind. This means being nonjudgmental, even when hearing about difficult scenarios such as sex-for-drugs exchanges or drug dealing. Second, the assessor needs to be comfortable asking direct and “taboo” questions that patients may not want to address (e.g., How much are you using? Are you using around your children?). Some clinicians are much stronger at support than at directness and may unwittingly collude with the patient’s illness by not asking such questions. Finally, the assessor needs to avoid power struggles and give the patient as much control as possible. Powerlessness is inherent in both trauma and SUD (Najavits, 2002b). Thus, it is suggested that the patient be given as much control as possible in the assessment process. This may include asking the patients’ permission throughout the interview (“I’d like to ask you now about your level of substance use—is that okay with you?”), informing the patient that they can stop at any point, and checking how the patient is doing (“Is this okay so far?”).

“Own” One’s Countertransference

Both PTSD and SUD may evoke countertransference in the assessor. PTSD, for example, may stir painful identification with the patient’s suffering, anger at patients’ victimization, or distancing based on not wanting to feel vulnerable (Najavits, 2002a; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). SUD, too, can evoke a range of responses, including hopelessness that the patient will ever improve and judgment of a lifestyle that may be far removed from the clinician’s world (Imhof, 1991; Najavits et al., 1995). Although these issues are more often discussed with regard to treatment, they may also occur during assessment. Providing assessors with support and open discussion may help improve the assessment process.

If a Patient Is Intoxicated, Delay the Assessment

It is a serious mistake to attempt assessment if the patient shows up high or drunk. The patient is less likely to be accurate, the assessment may be more prone to upset the patient, and it can reinforce substance use. It is thus standard in SUD clinical settings that neither assessment nor treatment occurs unless the patient is sober. This does not mean that the patient must have a period of abstinence before assessment, but rather that the assessment will not proceed if the patient is visibly intoxicated. The assessor is responsible for calling a family member or taxi service to pick up the patient and for not allowing the patient to drive home under the influence. Even if the patient denies being intoxicated, it is the assessor’s evaluation that determines how the situation is handled. Being kind but firm is key (e.g., “I will be happy to talk with you tomorrow, once you’re no longer high”).
Note That Prominence of PTSD Symptoms May Vary Based on Substance of Abuse

Some studies have evaluated PTSD symptom clusters in relation to SUD, with results varying based on the SUD population. For example, Stewart, Conrod, Pihl, and Dongier (1999) found that alcohol dependence correlated with PTSD arousal scores, anxiolytic dependence with arousal and numbing scores, and analgesic dependence with arousal, intrusions, and numbing scores (see also McFall, Mackay, & Donovan, 1992, for similar results). Najavits, Runkel, et al. (2003) found arousal the most common PTSD symptom cluster among cocaine-dependent patients. Also, those with the dual diagnosis differ from patients with PTSD alone in their symptoms. Saladin, Brady, Dansky, and Kilpatrick (1995) found that those with the dual diagnosis had more avoidance and arousal symptoms and more sleep disturbance than a PTSD-alone group. Brown (2000) found PTSD re-experiencing symptoms a key predictor of SUD relapse.

RESOURCES FOR ASSESSMENT

Online

A Web search with any key terms or combination ("assessment," "screen," "PTSD," "trauma," "substance abuse") will yield hundreds of hits. The resources listed here were selected because they offer (1) reputable sources, such as government or academic institutions; (2) extensive information, such as listings of measures and how to obtain them; and (3) searchable online databases, clearinghouses, free materials, and other resources.

Substance Use Disorders

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA)

The website www.niaaa.nih.gov/publications/ provides a table listing more than 85 measures related to alcoholism, many of which can be directly downloaded. It describes target populations, administration characteristics (e.g., self-report, number of questions, training required), psychometric and scoring information, how to obtain or download the measures, and references. Measures that can be downloaded include, for example, the Addiction Severity Index, the Alcohol Dependence Scale, the Alcohol Effects Questionnaire, and the Denial Rating Scale. Also, www.niaaa.nih.gov/publications/assessment.htm provides an overview of alcohol assessment (e.g., general considerations, such as giving clients feedback).
UNIVERSITY OF NEW MEXICO CENTER ON ALCOHOLISM, SUBSTANCE ABUSE, AND ADDICTIONS

The website http://casaa.unm.edu/inst/inst.html (click “downloads”) provides a wide variety of scales related to substance abuse that can be directly downloaded.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

The website http://store.health.org (or 800-729-6686) provides a catalogue from which one can order free publications and products on addiction topics. Of particular relevance are the “knowledge application product” (KAP) keys and “quick guides,” which provide brief, user-friendly assessment tools for clinicians.

The website www.health.org (National Clearinghouse for Alcohol and Drug Information) is one of the most widely known addiction resources, offering free publications, referral resources, and searchable online databases (www.health.org/databases). It provides journal article information (e.g., enter “assessment” to search on that topic).

The website http://samhsa.gov/centers/clearinghouse/clearinghouses.html provides links to federal information clearinghouses, including those of the Center for Substance Abuse Treatment, the Center for Substance Abuse Prevention, the Center for Mental Health Services, Department of Health and Human Services, Centers for Disease Control and Prevention, Department of Justice, and many others. Each clearinghouse provides numerous online resources such as free publications, databases, and referrals.

The website http://www.samhsa.gov (click “publications,” then “substance abuse treatment resources,” then “TIE—treatment improvement exchange forum”) provides free substance abuse assessment, prevention, and treatment resources that can be either downloaded or ordered free as hard copies. It includes the following:

- Click on “CSAT TIPS” for the Treatment Improvement Protocol (TIP) series of more than 35 guides written specifically for clinicians. Each provides a state-of-the-art consensus statement on best practices for a particular topic and includes a wide variety of materials that can be photocopied, such as assessment tools. Several focus on assessment, such as TIP 16 (Alcohol and Other Drug Screening of Hospitalized Trauma Patients), TIP 9 (Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse), and TIP 31 (Screening and Assessing Adolescents for Substance Use Disorders).
- Click on “CSAT TAPS” for the Technical Assistance Publications (TAP) series of more than 20 guides that provide information on practical is-
sues in the substance abuse field. For example, relevant to assessment are TAP 18 (Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance) and TAP 21 (Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice).

- Click on “Private online resources” for links to more than 60 professional and nonprofit organizations devoted to addictions.
- Click on “Federal online resources” for links to more than 20 federal agencies relevant to addictions.

NATIONAL INSTITUTE ON DRUG ABUSE

Clicking “Publications” on www.nida.nih.gov provides publications that can be downloaded or ordered, including assessment tools, information on specific drugs of abuse, treatment manuals (which may include assessments), posters, and videos.

FREE ALCOHOL SCREENING

By answering questions online at www.alcoholscreening.org, based on the Alcoholic Use Disorders Identification Test (Babor & Grant, 1989), respondents can obtain immediate feedback on their likelihood of having an alcohol problem. Referral information is also provided. Sponsored by Boston University and Join Together (a community-based drug prevention program).

HOME-TEST KITS FOR SUBSTANCE USE

Various companies provide low-cost home testing kits for urinalysis that can evaluate use of numerous substances. For testing alcohol use, a breathalyzer is typically used. Local pharmacies may stock both types of tests. Also, online, a search under the terms “drug test” or “breathalyzer” will locate numerous companies that offer these products. One example is www.drugtestsucces.com (or 888-280-4194). A central source is www.thomasregister.com, which provides a table of different companies (enter the term “alcohol drug test”).

Trauma/PTSD

NATIONAL CENTERS FOR PTSD

Clicking “assessment” on www.ncptsd.org provides tables on measures, including target group, administration (e.g., number of items, format), psychometrics, scoring, and information on obtaining them. Topics include assessment of trauma exposure, adult PTSD self-report, adult PTSD interviews, and child measures.
FREE TRAUMA/PTSD MEASURES

The website www.isu.edu/~bbstamm/tests.htm provides several free measures for trauma screening and PTSD assessment, including the Stressful Life Experiences Screening (Stamm et al., 1996) and the PTSD Checklist (Weathers et al., 1993).

The website www.johnbriere.com provides the Trauma Symptom Checklist–40 (click “TSC-40”), a free measure of trauma-related symptoms. Other trauma/PTSD measures by Briere are also described on the site, which can be ordered from Psychological Assessment Resources (800-331-TEST).

Books

Examples of books include the following:

Substance Use Disorders


Trauma/PTSD


Community Screenings

National outreach effort. Community-based annual screenings for alcohol and anxiety disorders (including PTSD) at local libraries, schools, workplaces, and clinics. See www.mentalhealthscreening.org for information, dates, and locations.
REFERENCES


Substance Abuse and Mental Health Services Administration. (2001). A provider's


