

APA GUIDELINES for Psychologists in the Assessment of Psychological Trauma in Adults

APA TASK FORCE ON THE ASSESSMENT OF TRAUMA

APPROVED BY APA COUNCIL OF REPRESENTATIVES
AUGUST 2025



**AMERICAN
PSYCHOLOGICAL
ASSOCIATION**



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Suggested Citation

American Psychological Association, APA Task Force on the Assessment of Trauma. (2025). *Professional Practice Guidelines for Psychologists in the Assessment of Psychological Trauma in Adults*. Retrieved from <https://www.apa.org/about/policy/guidelines-psychological-trauma-adults.pdf>



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APA Task Force on the Assessment of Trauma

Judith Armstrong, PhD (Co-Chair)

Retired

Tyson D. Bailey, PsyD (Co-Chair)

Private Practice

Constance Dalenberg, PhD

Alliant International University

Charles A. Benincasa, PsyD

Private Practice

Stacey M. Boyer, PsyD

CristinaCare

Bethany Brand, PhD

Towson University

John Briere, PhD

University of Southern California

Eve Carlson, PhD

Department of Veterans Affairs

Christine Courtois, PhD

Private Practice

Stephen Finn, PhD

Center for Therapeutic Assessment

Paul Frewen, PhD

Western University

Marta Miranda, PsyD

Private Practice

Kenneth J. Thompson, PhD

Alliant International University

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Introduction

Psychological trauma is common and can occur at any point across the lifespan, often with profound effects. *Trauma* can be defined as any event that exceeds an individual's capacity to cope or creates a significant rupture in attachment, and is severe enough to disrupt daily functioning (Eadie & Briere, 2025). This definition is intended to be broad and include not only the life-threatening or physically injurious events described in the *Diagnostic and Statistical Manual of Mental Disorders-5th Edition-Text Revision (DSM-5-TR*; American Psychiatric Association [APA], 2022),¹ but also psychosocial adversity² that may be experienced throughout the lifespan³ (Felitti et al., 1999).

Benjet et al. (2016) examined lifetime prevalence rates of exposure to 29 types of traumatic events in 24 different countries across six continents. Events were organized into six broad categories: (a) collective violence (e.g., civilian in a war zone, refugee); (b) caused or witnessed bodily harm (e.g., witnessing atrocities, causing serious injury or death, combat experience); (c) interpersonal violence (e.g., experiencing or witnessing physical violence); (d) intimate partner/sexual violence (e.g., sexual assault, stalking); (e) accident/injury (e.g., natural disaster, automobile accident, life-threatening illness); and (f) other (e.g., human-caused disaster, unexpected death of a loved one). They found that 70% of the international sample ($n = 126,718$; ages 18–100) had experienced one or more of these events. This study highlights the importance of assessing past and present trauma with clients of all ages. Although trauma or adversity exposure does not lead inevitably to the development of distress, there is an increased likelihood of mental health symptoms and long-term medical issues when these events are experienced (Hogg et al., 2023; Madigan et al., 2023).

The assessment of posttraumatic stress disorder (PTSD) has been elucidated in prior professional practice guidelines (APA, 2017a). However, much less attention has been given to the various consequences of traumatic events beyond the limited taxonomy of the PTSD construct. One of the largest studies of adverse childhood events (with over 9,000 participants), comparing those with zero versus four or more such experiences, found 2- to 4-fold increases in risky health-related activities in the trauma-exposed group (e.g., smoking, more than 50 sexual partners) and 4- to 12-fold increases in mental health outcomes (e.g., drug abuse, depression, suicidality; Felitti et al., 2019). Other studies investigating the consequences of adverse childhood experiences (Hakamata et al., 2022; Madigan et al., 2023) have shown a dose-response relationship, wherein the risk of developing physical, psychosocial, neurobiological, and functional syndromes and conditions increases relative to the number of adverse childhood events experienced. Specifically, the experiences of prior trauma and adversity have been shown to increase risk for the development of various psychiatric and physical health

1 Criterion A events such as directly experiencing or witnessing physical assault, sexual assault, natural disaster, fire or explosion, combat or war exposure, and motor vehicle accidents. This type of trauma is often labeled “acute trauma,” “catastrophic trauma,” or “shock trauma.”

2 Examples include sexual abuse, incest, and chronic physical abuse. This type of trauma is often labeled “complex trauma.”

3 This type of trauma is often labeled “developmental trauma,” “strain trauma,” or “little ‘t’ trauma.”

conditions across DSM and International Classification of Diseases (ICD) diagnostic categories (Hogg et al., 2023; Madigan et al., 2023).

Similarly, research findings have established mediating, moderating, and causal links between systemic oppression, identity-based discrimination, and institutionalized maltreatment and various posttraumatic reactions (Eadie & Briere, 2025). Epigenetics researchers have also demonstrated how interactions between biological and environmental factors contribute to the intergenerational transmission of trauma and phenotypic expressions of physiological stress responses (Hakamata et al., 2022). Although some of these experiences are consistent with the diagnostic definition of trauma (Criterion A; APA, 2022), many others would be less likely to qualify as a Criterion A event under the current PTSD diagnostic standards. (Hogg et al., 2023; Madigan et al., 2023)

Research has illustrated how the cumulative impact of trauma and adversity in childhood predicts across several domains of functioning throughout the lifespan. For example, trauma exposure in childhood is associated with myriad difficulties in adolescence, adulthood, and older adulthood. In addition, greater cumulative trauma throughout one's lifetime has been found to predict more severe symptoms of PTSD in older adulthood, by which time the vast majority of people will have been exposed to at least one traumatic life event (Duchowny et al., 2025; Ogle et al., 2014; Pietrzak et al., 2012), with the number of events increasing the likelihood of various physical and mental health conditions (e.g., pain, fatigue, depression). Recent evidence suggests that psychological trauma in general, and PTSD in particular, are linked to GrimAge, an epigenetic clock predicting lifespan from DNA methylation, strongly suggesting that trauma leads to an acceleration of cellular aging (Katrinli et al., 2020). This finding highlights how trauma is transmitted intergenerationally, also contributing to the compounding nature of cumulative trauma (Nagata et al., 2024).

The literature on the relationship of trauma to development, maintenance, and exacerbation of diagnosable mental illness is vast, including research centering on PTSD, major depression, psychotic disorders, and dissociative disorders (e.g., Hogg et al., 2022; Read, 2019; Watters et al., 2023). No domain of adult functioning that cannot potentially be undermined by trauma exposure, even when those events occur only in adulthood, as such exposure can have devastating effects on an individual's meaning-making systems and beliefs about the self, the world, and the future, in addition to undermining one's sense of actual safety (Eadie & Briere, 2025; Ford & Courtois, 2020; Magruder et al., 2017). This impact can be particularly true for marginalized age cohorts, wherein the effects of trauma and adversity experienced later in life can exacerbate the already known developmental difficulties in well-being, health outcomes, and connection to others in older adulthood (APA, 2024; Duchowny et al., 2025; Haczke-wicz et al., 2024).

Unfortunately, research, education, and training in the clinical evaluation of psychological trauma rarely describe assessment methodology beyond trauma- and stressor-related-disorder criteria (Cook et al., 2019). As a result, the additional consequences of psychological trauma are often misunderstood, omitted, overlooked, or underappreciated in clinical assessment (Simiola et al., 2018). Moreover, although the ACEs research has demonstrated the adverse psychosocial effects of childhood trauma and adversity throughout adulthood (Haczke-wicz et al., 2024; Madigan et al., 2023), research outside the confines of assessing for the symptoms of a specific diagnosis, such as PTSD, is also less common in the literature (Eadie & Briere, 2025).

The Purpose of the Guidelines

The prevalence figures presented previously suggest that psychologists providing services will inevitably encounter individuals who have been exposed to traumatic stress, regardless of whether these experiences have resulted in diagnosable psychological conditions. Such encounters are likely to involve both those with confirmed trauma histories and those who may not recognize or disclose that they have experienced traumatic events (Armstrong, 2017; Zammit et al., 2018). The purpose of the *Professional Practice Guidelines for Psychologists in the Assessment of Psychological Trauma in Adults* is to assist psychologists who deliver, or train others to deliver, psychological services or who support such delivery, regardless of the setting, in understanding how a trauma history and post-traumatic symptoms can increase the complexity of the clinical presentation, evaluation results, and course of treatment. Because training is often lacking, particularly regarding the effects of complex posttraumatic presentations, guidelines provide practicing psychologists and other professionals with information on trauma and posttraumatic distress that is directly relevant to the assessment (and, therefore, treatment) of traumatized adults.

Documentation of Need

APA policy suggests that professional practice guidelines "should be written only when there is a clearly demonstrated and documented need" (APA, 2015). This need could arise due to (a) professional guidance and public benefit, and (b) legal and regulatory issues.

Professional Guidance and Public Benefit

Traumatic events can have pervasive and potentially enduring biopsychosocial effects. Accordingly, psychologists, researchers, and educators would benefit from becoming competent in conducting trauma-informed psychological assessments. Many professionals conducting assessments appear unaware of how trauma exposure might manifest. They thus may mis-

diagnose this vulnerable population, particularly when the trauma survivor is a member of one or more other marginalized groups (see, for example, Bailey & Brown, 2020; Gutowski et al., 2022; Sanders et al., 2024). There are several compelling reasons why professional practice guidelines are needed to assist clinicians, forensic experts, and researchers in developing competence in trauma assessment, as well as to inform the work of psychology graduate programs in teaching assessment competence.

First, the prevalence of trauma and increased likelihood of various forms of psychological distress (Hogg et al., 2022) suggest that many people who are seeking mental health services will have one or more adverse events in their history. Indeed, there have been calls to consider trauma a public health concern that is most effectively addressed by policy changes that consider the impact of trauma across the lifespan (Magruder et al., 2017).

Second, the psychological science of trauma is an area of knowledge that is growing rapidly, and research continues to foster and refine our understanding of how the experience of trauma affects areas of functioning. Traumatic events can be experienced across the lifespan, whether as isolated events, protracted periods, or pervasive psychosocial circumstances—with potentially profound effects on an individual's ability to engage fully in self-care, social interactions, and work. In addition, trauma exposure can contribute to the development of a variety of other psychological disorders, even decades after the traumatic event. The effects of trauma can also be passed from one generation to the next through a combination of epigenetics and behavioral patterns, thus potentially having ramifications beyond the individual who experienced the original trauma. For psychologists to fulfill their responsibilities to vulnerable persons, practitioners must understand how to assess the emotional, cognitive, behavioral, and interpersonal effects of trauma exposures. They must also be able to diagnose these presentations competently and differentiate them from other similar symptoms unrelated to trauma exposure at any age.

Third, access to and utilization of mental health services vary widely based on socioeconomic and cultural factors (APA, 2017c). Nevertheless, despite a general increase in service utilization among trauma survivors, neither trauma-informed nor trauma-specific assessment in clinical and research practice has become routine. Many psychologists have not received systematic training in understanding, assessing, and treating the effects of trauma exposure, and, consequently, often misdiagnose what they are observing because they have not even considered the possibility of posttraumatic responses (Simiola et al., 2018). Though psychologists may take courses related to differential diagnosis and psychological assessment, without such systematic training, they may be unaware of their shortfalls in the effective assessment of trauma and the full range of symptoms that can develop in its wake (Cook & Newman, 2014; Simiola et al.). Psychology textbooks at all levels of education and training often have inadequate or even

inaccurate information about trauma and its sequelae (Nester et al., 2024), which may further contribute to misdiagnosis.

Fourth, if trauma is not recognized as a potential factor in the person's presenting problems, psychological assessments that are conducted with trauma-exposed individuals may lead to misinterpretation of test scores and even to misdiagnoses. Such missteps can, in turn, result in less effective treatment plans or treatment plans that fail to take the effects of trauma exposure into account in ways that can then harm vulnerable persons. Such consequences are particularly problematic when trauma-exposed individuals belong to marginalized groups that may have experienced historical, intergenerational, colonial, or insidious trauma (APA, 2017b). There is a pressing need for conducting psychological assessments that screen for lifetime and intergenerational history of trauma exposures, including the kinds of trauma common in marginalized groups and specific age cohorts. This consideration of trauma as a factor requires evaluation of both initial and longer-term presentations of the range of psychological and somatic distress that can emerge in the wake of trauma exposures, be they early in life or adulthood, single occurrence or repeated experience.

Fifth, and finally, psychologists must also understand that not all evaluatees will conceptualize their experiences as traumatic, particularly if the adversity is common or normalized in their environment (APA, 2017c). The timing of disclosure of traumatic or adverse events is multifaceted, and it is helpful for psychologists to maintain a compassionate stance toward when the evaluatee recognizes the effects and/or decides to provide information about personal or intergenerational events (Martinez-Clavera et al., 2017).

Legal and Regulatory Issues

Exposure to trauma and its consequences may have profound implications for criminal, civil, and family law proceedings. For example, various states have either eliminated the civil statute of limitations for survivors of sexual abuse (e.g., Vermont), extended the age by which such claims must be filed (e.g., California), or opened revival windows for previously expired child sexual abuse claims (e.g., North Carolina), with more than half of the states having introduced laws that either broaden or expand when claims of abuse can be asserted and by whom. Many children disclose sexual abuse in a gradual pattern, starting with peers who are unlikely to have the knowledge or skills to encourage action that might hold perpetrators accountable (Manay & Collin-Vezina, 2021). Further, if survivors do choose to discuss the abuse with adults, particularly family members, a majority report experiencing adverse reactions (Elliott et al., 2022) that may delay further discussion of the effects. These statutory changes and the knowledge about delays in disclosure highlight the need for forensic psychologists to be knowledgeable about assessing trauma and posttraumatic reactions across the lifespan.

There has been recognition of the growing need for more robust, intentional, and nuanced trauma assessment in psychological injury claims, employment discrimination, criminal sentencing mitigation, competency evaluations, and other forensic contexts (See edited volumes by Javier et al., 2020, and Young et al., 2025). Despite this growing need, knowledge and experience in trauma-inclusive assessment have not been incorporated in the currently published guidelines on forensic practice (e.g., APA, 2013). For example, Paulson et al. (2019) found that approximately 30% of surveyed forensic psychologists and psychiatrists were unaware of instruments that would improve the likelihood of an accurate diagnosis of PTSD in a clinical or forensic setting.

Many states also have statutes that require health care professionals to report suspected abuse of the elderly and other vulnerable adults, which requires competence in identifying trauma and posttraumatic reactions in this population (APA, 2024). Further, the Centers for Medicare & Medicaid Services (CMS) added provision F699 to the federal State Operations Manual in 2019, requiring that individuals with a history of trauma receive care that is trauma-informed and culturally sensitive. Additionally, individuals from marginalized communities may have experienced further trauma directly from being involved in a legal process. Psychologists strive to consider these factors as part of the evaluation process.

Audience

These guidelines are intended for psychologists and psychology trainees who are engaged in clinical practice, research, education, or training (e.g., supervisors, supervisees, consultants).

Distinction Between Standards and Guidelines

Guidelines are statements that suggest or recommend specific professional behavior, endeavors, or conduct. Guidelines differ from standards. Standards are mandatory and, thus, may be accompanied by an enforcement mechanism, whereas guidelines are not mandatory, definitive, or exhaustive. Rather, guidelines are aspirational in intent. They are designed to facilitate the continued systematic development of the profession and to promote a high level of professional practice. A particular set of guidelines may not apply to every professional and clinical situation. As a result, the present guidelines are not intended to supersede a psychologist's professional judgments that are grounded in the scientific and professional knowledge of the field (see standard 2.04; APA, 2017b). The guidelines are consistent with the current version of the *APA Ethical Principles of Psychologists and Code of Conduct* (APA, 2017b), the *Guidelines on Trauma Competences for Education and Training* (APA, 2015), and the *Standards for Educational and Psychological Testing* (American Educational Research

Association, APA, and National Council on Measurement in Education, 2014).

Trajectory of Guideline Development

Expert consensus on competencies in trauma-informed care was first developed to address the gap between the way individuals were being trained about trauma sequelae and the extensive body of research on traumatic stress (Cook & Newman, 2017). These competencies were later adopted as APA guidelines for training psychologists about trauma treatment and assessment, highlighting the importance of these skills in the provision of psychological services (APA, 2015). Given the consensus on the primary areas of trauma-relevant consequences, the Executive Committee of Division 56 (Trauma Psychology) recommended the development of professional practice guidelines to assist psychologists in applying this knowledge to psychological assessment settings. The Task Force on Psychological Assessment of Trauma was then established to develop these guidelines. This task force consisted of experts on trauma assessment, appointed by the president of Division 56. No funding was provided for the development of these guidelines, and there were no conflicts of interest among task force members.

Supporting literature for each guideline was gathered by content experts and reviewed by the task force. The guidelines were then reviewed by members of the Division 56 Executive Committee and were revised following input from other division members.

Guideline Expiration

The expiration date of these guidelines is set at 10 years from their release date, as determined by the Council of Representatives of the APA. Thereafter, the guidelines are to be reviewed and updated as necessary to reflect new findings and developments in the field.

Terminology

Throughout the guidelines, we will use the term “evaluee” to describe the individual being evaluated. We use this term to provide a general descriptor that is not explicitly tied to a particular setting, such as client (practice) or participant (research).

Definitions

Terms commonly used to describe aspects of psychological trauma lack a consistent definition. The task force arrived at the following definitions by reviewing how these terms have been used in other documents, synthesizing, delineating, and clarifying as necessary to provide consistency of terminology in the current guidelines. As traumatology nosology continues to evolve, along with the expansion of our knowledge, psychologists are encouraged to review the professional literature regularly. The following terms are used throughout the guidelines.

- **Psychological Trauma (also referred to simply as “trauma” in these guidelines):** An event that exceeds an individual’s capacity to cope, or creates a significant rupture to attachment, and can be severe enough to disrupt daily function.
- **Posttraumatic Reactions:** Manifestation of psychological distress following and causally linked to a traumatic experience. Such reactions may be short-term, or they may develop into a variety of clinical syndromes, depending on various factors (e.g., social support, previous mental health diagnoses).
- **Psychological Assessment:** The process of gathering data on behavioral functioning and mental health through some combination of interview, observation, and assessment measures.
- **Assessment Measure:** An instrument designed to gather information in the process of psychological assessment. Measures may include such diverse tools as symptom screening measures, psychometric tests, and semistructured/structured interviews, as well as measures of cognitive functioning and adaptive behavior.
- **Trauma-Informed Assessment:** A set of principles that dictate how psychological assessment is conducted to account for ways that psychological trauma impacts functioning across domains.

Guidelines for Psychologists Regarding the Assessment of Psychological Trauma in Adults

The use of individual and cultural characteristics as context is central to a trauma-informed assessment process. Psychologists are encouraged to familiarize themselves with all *Professional Practice Guidelines (PPG)* relevant to their area(s) of work, particularly when considering the influence of population-specific risk factors and symptom variations. As trauma is a common human experience, particularly for those with marginalized or oppressed identities, utilizing the psychological trauma PPG in conjunction with those focused on specific populations (e.g., girls and women [APA, 2018]; older adults [APA, 2024]) and areas of practice (e.g., forensic psychology [APA, 2013] and assessment [APA, 2020]) is consistent with culturally responsive practice (APA, 2017c). To enhance understanding of trauma assessment, the following eight guidelines are organized into three sections: Knowledge, Content, and Process.

The Knowledge section presents foundational factors to support the competent assessment of psychological trauma and the various posttraumatic reactions that may be experienced following single or repeated trauma. Familiarity with these factors provides a context within which the specific content and process of conducting assessments unfold. The Content section provides guidance on gathering information during an assessment and how to make sense of that information, considering an individual's trauma history. Finally, the Process section provides considerations on how evaluator-evaluated dynamics impact the evaluator's ability to gather reliable and trustworthy information effectively.

The supporting references in the literature review emphasize studies conducted typically within the past few decades, as well as classic studies that provide empirical support, clinical evidence, and examples for the guidelines. The literature review, however, is not intended to be exhaustive. Recommendations in this section are consistent with broad ethical principles (APA, 2017b) of beneficence and nonmaleficence, fidelity and responsibility, integrity, and respect for the rights and dignity of others.

Knowledge

GUIDELINE 1

Psychologists strive to understand trauma exposure as a possible etiology of common presenting problems.

Rationale

Though competencies have been defined and described (e.g., Cook et al., 2014), training in assessing and treating posttraumatic reactions remains limited within graduate school curriculum and internship sites (Cook et al., 2017; Simiola et al., 2018). This lack of training may lead to misperceptions about the nature and severity of posttraumatic responses. For example, short-term and self-limiting subclinical distress, including anxiety reactions or disruptions in sleep, is common after trauma exposure. The most common responses to a single-incident trauma in adults appear to be relatively short-lived and often decrease over time, even in the absence of treatment (Galatzer-Levy et al., 2018). Most individuals will gradually resolve those difficulties without significant disruption to their overall functioning, and without treatment, as far as our current knowledge allows. By comparison, repeated trauma, marginalization, and limited social support can significantly impact individuals, including increasing the likelihood of chronic and severe distress (Eadie & Briere, 2025; Nadal, 2018). Given the number of factors that can influence one's ability to cope with trauma effectively, psychologists strive to maintain awareness of how the presence of symptoms can affect a person's functioning, regardless of the length of time they are present.

However, due to the paucity of research regarding vulnerable and marginalized populations, it is currently unknown if these findings generalize to individuals who, in addition to having an index trauma exposure, have repeated exposures to insidious trauma (e.g., forms of structural and systemic oppression, microaggressions (APA, 2017b; Nadal, 2018). Further, the effects of trauma can be transmitted intergenerationally (Nagata et al., 2024), which can also be reinforced and exacerbated by systemic oppression across the lifespan (APA, 2017c). Responses that reach a subclinical level and then remit are standard, and they do not result in severe posttraumatic consequences. Of note, diagnosable psychological distress (e.g., PTSD, depression) does not necessarily emerge immediately after a traumatic event. Sometimes, this distress can emerge years later in response to internal or environmental triggers (e.g., loss of employment, cognitive decline/impairment, additional trauma), and may become chronic (Galatzer-Levy et al., 2018). Research indicates that the following variables are consistently linked with an increased risk for PTSD: preexisting psychiatric disorders, prior history of expo-

sure to traumatic events, exposure to interpersonal violence, greater perceived life threat, peritraumatic distress and/or dissociation, and family history of psychiatric disorders (Carlson et al., 2017).

Training is necessary so that evaluators do not, on the one hand, *overestimate* trauma by misinterpreting normal, transient reactions to high magnitude events or, on the other hand, *underestimate* the significance of traumatic reactions in the development and maintenance of a mental disorder. For example, adolescent onset is frequently reported for both major depression and psychosis, often following exposure to a highly distressing event (Mandelli et al., 2015; Stanton et al., 2020). Yet, providers have been found to underreport the evaluatee's traumatic events (Nagar et al., 2020).

As an additional layer of complexity, many individuals have experienced more than one trauma (Felitti et al., 2019). Trauma exposure in childhood has been shown to differ from acute trauma, leading to more frequent impairments in affect regulation, relational functioning, and disturbances in self-organization (Brewin et al., 2017). When multiple traumas have occurred and have affected development, the associated psychological reactions are more complex and severe (Brewin et al., 2017). Thus, the age at which trauma occurs, the presence of chronic traumatizing factors across ecological levels affecting the individual, and the chronicity of traumatization all have implications for symptomatology and treatment.

In summary, the cumulative evidence highlights both a set of well-established symptom subsets (e.g., PTSD, dissociative disorders) as well as heterogeneity of posttraumatic reactions that may or may not fit into our current diagnostic nosology (Olff et al., 2025). Psychologists strive to be knowledgeable regarding the central mechanisms of trauma-related disorders and the degree to which such disorders are expressed differently in context.

Application

Evaluators, clinicians, educators, and researchers benefit from understanding the expected course of posttraumatic conditions, thereby reducing the likelihood of over-pathologizing an evaluatee's reactions or underplaying their role. In addition, it is important to understand and assess biopsychosocial factors that have been associated with the development of diagnosable conditions, particularly when evaluating individuals shortly after exposure to trauma. Understanding the larger social context of systemic forms of danger and oppression that exist for marginalized populations is particularly important when assessing individuals who belong to such groups (e.g., Botelho et al., 2022; Sabri et al., 2024). Contextualizing this information is critical for determining whether a symptom presentation aligns with research findings

on the range of traumatic reactions. This contextualization informs treatment recommendations and aids in clarifying the diagnosis. Psychologists strive to explore victimization across the lifespan, as symptom severity, complexity, and comorbidity are frequently present for individuals who have been chronically traumatized, regardless of the age at which trauma is experienced (Briere et al., 2016; Briere et al., 2015; Duchowny et al., 2025).

views and standardized instruments can now be utilized that were not available to psychologists a decade ago. The informed psychologist is well advised to become familiar with a sufficiently broad array of these instruments and interviews, including those normed on traumatized populations, to enable adjustments to assessments based on the emerging needs and qualities of the particular evaluatee.

GUIDELINE 2

Psychologists strive to understand how interviews and assessment data can be used to measure traumatic consequences, relying on validated methods and instruments.

Rationale

Psychological trauma and its clinical consequences are optimally assessed using a combination of structured clinical interview, standardized instruments, and behavioral observation. It has long been accepted that psychological testing is more likely than unstructured interviews to yield accurate results (cf. Burton et al., 2020; Grove & Meehl, 1996); however, the complexity of the current diagnostic criteria for PTSD and the dissociative disorders adds to the general professional concern. For example, binomial analysis of current *DSM-5* criteria reveals that 636,120 symptom combinations would meet the criteria for PTSD alone (Galatzer-Levy & Bryant, 2013).

Absent training in the consequences of trauma and their appropriate measurement, biases may strongly influence the psychologist, who may then over- or underdiagnose trauma-related disorders. A misunderstanding of PTSD as *the* psychological consequence of trauma, rather than simply one diagnosis that may arise, contributes to the confusion. In a related vein, a misunderstanding of Criterion A of the PTSD criteria as *the* definition of trauma, rather than the definition of the types of traumas that link to this specific disorder, can contribute to failure to follow up diagnostically on the myriad of consequences of other types of trauma.

Application

When developing an assessment battery, psychologists have several types of measures from which to choose. When considering measurement selection, psychologists are encouraged to consider which measures function for which purpose as well as which measures have been normed to assess psychological trauma and posttraumatic reactions. Given the evaluatee's age, language preference, and gender, as well as the nature of the evaluation (forensic or clinical) and the nature of the trauma, if known, a variety of normed structured inter-

Content

GUIDELINE 3

Psychologists strive to assess routinely for exposure to trauma and stress/adversity, including details regarding the type, recency, and frequency of exposure.

Rationale

As noted earlier, population prevalence studies across the globe demonstrate lifetime prevalence rates of trauma exposure as high as 70% (Benjet et al., 2016). In addition, multiple traumas are common for individuals with any trauma exposure. As an example, approximately 31% of people who report trauma exposure have been exposed to four or more traumatic events (Benjet et al.). Delayed expression of trauma (e.g., delayed PTSD) is also easily missed in evaluation processes, given its lower prevalence and low salience if substantial time has passed since the traumatic incident but can be a serious problem for aging populations where cognitive decline may undermine psychological defenses and frontal lobe inhibition of impulses (see Martinez-Clavera et al., 2017, for a review).

In addition to the types of traumas described in Criterion A, the psychological science of trauma indicates that relational ruptures, such as betrayal trauma (Platt & Freyd, 2015) or institutional betrayal (Smith & Freyd, 2017) can lead to post-traumatic presentations.

Microaggressions, which can be a form of relational trauma, have also been identified as potentially leading to a posttraumatic presentation, even in the absence of a Criterion A event (Nadal, 2018). Thus, high magnitude negative events are of therapeutic significance regardless of whether they lead to a formal diagnosis of PTSD (which requires fulfilling Criterion A). Meta-analytic findings indicate that exposure to Criterion A events and to other high magnitude negative events that typically are *not* Criterion A-congruent (sexual harassment, racial discrimination) are *both* significantly associated with PTSD symptoms, with only a small difference in effect size (Larsen & Pacella, 2016).

A strong set of findings documents the impairments that arise most consistently after exposure to repeated/complex traumatic events. Such exposure leads to long-term adaptation to the traumatic environment, producing symptoms that are not frequently seen after single events. The relationship between dissociative symptoms and chronic childhood trauma, for instance, is well known (e.g., Pedone et al., 2025). With the addition of the dissociative subtype of PTSD to the *DSM-5-TR*, research has also begun to link a greater number of comorbidities, more severe PTSD symptoms, and more functional impairment to the dissociative (as compared to the nondissociative) PTSD subtype (Deen et al., 2022). In addition,

dissociative individuals often have patterns of amnesia that—if not addressed—can interfere with accurate trauma history reporting, thereby affecting assessment, diagnosis, and treatment (Brand, 2024). Evaluation methods that encourage disclosure of a history of cumulative trauma may alert the psychologist to the need to add instruments to an assessment battery that can measure dissociative symptoms directly.

A final crucial aspect of assessment for trauma concerns recency. To assess the evaluatee's safety, it is critical to identify the recency of trauma and stress/adversity exposures, including determining if traumatic occurrences are ongoing. Beyond lifetime screening for the presence of an exposure, psychologists strive to determine the timing of exposures, due to the implications for evaluatee safety. In general, knowing about trauma and stress/adversity that is occurring in the present or recent past will likely contribute to a better understanding of the evaluatee's presenting problems and inform recommendations for improving the evaluatee's overall wellbeing, although even traumatic events that occurred in the distant past or within family history can influence a evaluatee's present wellbeing (e.g., childhood trauma history in adults, Holocaust survivors, slavery).

Application

Given the relatively high prevalence rates for different types of trauma exposure, including both Criterion A and non-Criterion A experiences, as well as exposure to multiple traumatic events, psychologists strive to use assessment methods that allow for the collection of additional information about trauma exposures to determine exposure type(s) and frequency. A broad and general psychosocial interview (verbal and/or in writing) that has questions about trauma woven throughout typically anchors the trauma assessment. Measures have been developed to guide a comprehensive assessment of all events that meet *DSM* Criterion A, such as the Life Events Checklist for *DSM-5* (Weathers et al., 2013) and broader measures, such as the Trauma History Screen (Carlson et al., 2011). For evaluatees with a significant history of racial stress/trauma, a psychologist may choose to administer a measure such as the UConn Racial/Ethnic Stress and Trauma Survey (UnRESTS), a clinician-guided interview for assessing racial trauma within a *DSM-5-TR* framework, as the definition of a traumatic event does not currently include racism (Williams et al., 2018). These examples are not exhaustive, but instead serve as exemplars of measures that cover a range of events that may stimulate further discussion between evaluator and evaluatee.

Introduction to the assessment of prior traumatic events may be framed by asking evaluatees about a singular worst event that occurred in their lives. However, given the high

prevalence of multiple trauma exposures among the general population, it is likely that evaluatees with trauma histories have encountered multiple traumatic events. It is therefore important not to begin and end the assessment with the single worst event (or the target event that brought the evaluatee to the evaluator's attention). Instead, psychologists might consider using a list of commonly experienced high-magnitude stressors to initiate the discussion of trauma history.

There is a distinction to be made in the assessment of trauma between the individual's exposure to an objective event that typically produces negative consequences and the same individual's reactivity to those events. For example, when individuals describe chronic physical abuse as routine and acceptable in their community, this does not negate the possibility of physiological reactivity to chronic exposure to such violence. In addition, asking individuals about the specifics of what happened to them without using an emotional framework may provide evaluatees additional means to recognize traumatic experiences (e.g., the difference between "describe the most frightening experience you have encountered and "describe a time when your life was in danger").

When performing assessment, whether solely through discussion or with the addition of relevant, validated psychological measures, psychologists may ask questions that elicit the evaluatee's exposure to trauma and adverse stress across the lifespan, including past, current, and future risk. Unfortunately, many screening tools for trauma and stress/adversity do not include follow-up questions to determine the recency of exposure. Psychologists endeavor to ensure that these questions are included in an assessment, even if their formal screening tool does not contain them. Due to the implications for evaluatee safety, it is best practice to prioritize assessment of recent/ongoing exposures. Next, it is important to consider past trauma exposures, including the evaluatee's recent past, adverse early childhood experiences, and adult traumatic experiences.

Finally, in practical terms, it is important in the assessment of exposure to avoid labels such as "trauma" and "abuse" in initial evaluation (e.g., "Have you ever been physically/sexually abused?"). For example, research analyzing survivor labelling of sexually inappropriate events in childhood (touching that legally deserves the term "abuse") and domestic violence shows that a substantial minority of women do not apply the label "abuse" to their experiences (e.g., Kilimnik & Meston, 2019; Nordin, 2021). Such labels are dependent on a wide range of situational variables, including culture-specific use of the term "abuse." Consequently, attempts by a psychologist to label the experiences of an evaluatee may be met by denial for reasons related to cultural misunderstanding.

GUIDELINE 4

Psychologists strive to assess outcomes of trauma exposure broadly, including emotion, cognition, behavior, and interpersonal effects.

Rationale

The widespread understanding of PTSD as *the* trauma-relevant diagnosis, as opposed to one of many responses to trauma—combined with the evaluatees' routine nondisclosure of traumatic history and the complexity of the PTSD criteria—has led to substantial misdiagnosis of traumatized evaluatees. In differing settings, this can lead to both over- and underdiagnosis. Underdiagnosis has been documented as a problem in older samples, where differing norms of reactivity to trauma, particularly for older men, may interfere with disclosure of trauma-related distress (Pless Kaiser et al., 2018). Overdiagnosis is also reported, driven in part by a lack of recognition that resilience is the most common posttraumatic pathway (cf. Bonanno & Westphal, 2024). Experts on trauma assessment thus universally recommend a broad-based assessment, preferably through a funnel interview that gathers a range of symptom reports, with follow-up evaluation of clusters of reported problems (Eadie & Briere, 2025; Dalenberg & Briere, 2017).

Psychologists engaging in trauma-based assessment often must make practical tradeoffs between the breadth and depth of assessment. Such decisions will relate to the specific referral question(s). The guidelines herein are focused on general referral questions (e.g., What are the diagnoses that fit this individual? What are the psychotherapeutic needs of the evaluatee? How was the individual affected by a trauma?). The broad-based assessment recommended here in response to such inquiries may raise further questions that require more specialized and deeper assessment (e.g., a neuropsychological assessment).

Application

In conducting a broad-based evaluation of symptom domains, psychologists strive to include screens for PTSD, anxiety, dissociation, depression/grief, substance abuse, anger/aggression, emotion dysregulation, and cognitive changes—all well-established psychopathological outcomes of trauma exposure (Eadie & Briere, 2025). The inclusion of cognitive tests also may be valuable in determining the likely performance of the individual in occupational or educational systems, given the potential impacts of trauma on attention, working memory, and executive function (Dalenberg & Briere, 2017; Punski-Hoogervorst et al., 2023); cognitive measures may receive more weight in assessment with these foci. Additionally, although uniquely related to a specific diagnostic category, distortions in worldview and biased appraisals resulting from traumatization are widely implicated in the maintenance of

symptoms and may require a focus in treatment (Briere & Scott, 2014). Thus, measures of traumatic appraisal or traumatic-related belief system may be useful (see Eadie & Briere, 2025 for a review of available measures).

GUIDELINE 5

Psychologists take care to choose assessment techniques best suited for evaluation circumstances, including measures for feigning that have shown validity in the context of assessing trauma exposure and posttraumatic stress.

Rationale

Many psychological measures were not normed on trauma survivors, nor did they effectively capture cultural nuances. Other commonly used tests, such as the Minnesota Multiphasic Personality Inventory (MMPI), do contain subscales that relate to specific trauma-related disorders (such as PK, designed to measure PTSD on the MMPI-2 and Anxiety Related Experience, designed to identify a range of anxiety disorders on the MMPI-3; Keen et al., 2024). However, many such scales are not tied to current *DSM-5* criteria and/or were normed only for specific types of trauma survivors. Eadie and Briere (2025) provide a review of more appropriate broad-scale trauma measures. Such sources are helpful repositories for state-of-the-art measures critical to the trauma assessment process. The choice of appropriate measure will depend not only on the factors that influence any assessment (e.g., age, cultural embeddedness, language ability), but also on the nature and range of the trauma(s) being assessed (long-term or short-term symptoms, repetitive or single-incident traumas).

Validity scales, both standalone and embedded, provide information as to how the individual deviates from a normative sample and are widely recommended (Paulson et al., 2019). Therefore, the nature of this normative sample is critical. The Standards for Educational and Psychological Testing, approved by the American Educational Research Association, the APA, and the National Council on Measurement in Education, recommend separate standard errors of measurement, providing a foundation for separate cutoffs, when scoring and interpretation meaningfully varies across subgroups. Clearly, traumatized individuals are one such subgroup.

For example, the MMPI-2, does not perform as accurately with traumatized populations (Ambrose et al., 2024; Elhai et al., 2004), and standalone measures of symptom exaggeration, such as the Structured Inventory of Reported Symptoms-2, may also misclassify complex trauma-related conditions (Brand et al., 2014). Because validity scales often function by summing the number of atypical symptoms (present in only symptomatic individuals of a given type) and because trauma-related syndromes such as PTSD and dissociative disorders

typically present with an array of comorbid complaints (Campbell-Sills et al., 2022; Yanartas et al., 2015), false positives among traumatized individuals may be expected. Validity scales that take common trauma comorbidities into account, or those that have been separately normed on trauma-exposed populations, yield more accurate findings for clinical and forensic evaluators (Matto et al., 2019; Ambrose et al., 2023).

Application

Inclusion of validity scales is recommended in many settings, and such scales are widely used by forensic professionals (Paulson et al., 2019). Psychologists strive to recognize that an invalid response on an assessment measure for specific symptoms does not necessarily indicate that an evaluatee has described the trauma inaccurately. Instead, invalidity indicators may suggest that the evaluatee's responses are not interpretable without further evaluation. Psychologists strive to maintain awareness that an evaluatee may have complex reasons for over- or underreporting symptoms and attempt to ascertain the reasons or motivation for these types of responses. Among the explanations for invalid responding are overreporting due to compensation-seeking, a "cry for help," accurate representation of atypical symptoms, interpretive or disclosure differences resulting from cultural norms, or underreporting due to fear of stigma or limited self-knowledge. Further information on possible alternative interpretations for elevated validity scales can be elicited posttest and incorporated into the comprehensive interpretation and summary report. Validity tests that have been normed on relevant trauma groups and ages may be added to the assessment battery if necessary (for instance, if no trauma-relevant norms are available for the embedded validity scale).

GUIDELINE 6

Psychologists strive to consider how culture, identity, and membership in one or more oppressed groups affect an evaluatee's experience and understanding of trauma and posttraumatic reactions.

Rationale

Because idioms of distress vary across culture and an evaluatee's intersectional identities may lend meaning to a trauma that is not obvious to the evaluator, psychologists' accuracy of assessment results may be affected by presence or absence of culturally responsive practices. For instance, following a traumatic event, an assessment of anxiety and depression that follows traditions of Western culture may miss important trauma-related symptoms more commonly seen in the wider global community, such as somatic complaints and neuro-

cognitive symptoms (e.g., Hinton & Lewis-Fernández, 2018). Additionally, most trauma symptom measures developed for Western populations assess traumatic sequelae emanating from a single event, consistent with the *DSM-5-TR* definition of PTSD, and the very definition of what constitutes a traumatic event can differ by culture (Haering et al., 2024).

Moreover, individuals from non-Western cultures may experience traumatic events in the context of chronic debilitating environmental conditions, such as political persecution, loss of one's home, war, migration, and the stress of resettlement (Hoshmand, 2007). Consequently, a pretraumatic normality cannot be assumed (Hoshmand, 2007), and assessment of the traumatic event(s) must also include consideration of contextual factors, such as community response to the individual's trauma, stigma associated with the traumatic experience, and the impact of actions and behaviors the individual may have taken to respond to the traumatic event (e.g., the traumatic impact of migrant journeys; Goodman et al., 2017).

Application

To improve the likelihood of accurate assessment, psychologists strive to consider responses to traumatic event(s) in the context of the individual's gender; sex assigned at birth; sexual orientation; ethnic, cultural, race, and/or socioeconomic status, and other aspects of intersectional identity. Any or all of these, taken alone or in the ways in which they combine to increase exposure to risk of traumatization, may at least partially determine evaluatees' interpretation of the trauma and their expression of trauma-related distress. Accurate assessment of trauma sequelae focuses on the selection of ecologically valid measures of trauma and the identification of spheres of adaptation, including the resources of individuals' various cultural and social systems and areas of potential posttraumatic growth arising from intersectional identities.

When unfamiliar with how evaluatees understand and construct their intersectional identities, psychologists operate from a position of humble curiosity, and, when possible, strive to consult with colleagues or obtain further education to competently perform the assessment. Psychologists do not rely on the evaluatee as their primary source of education about that individual's intersectional identities; however, they honor and value the evaluatee's contributions to mutual understanding of what those identities mean for the evaluatee.

Process

GUIDELINE 7

Psychologists strive to understand how cultural variables and trauma-related responses (e.g., intense emotions, amnesia, interpersonal distrust) can create reasonable barriers to disclosure of information and affect the development of rapport.

Rationale

Developing rapport is critical to effective assessment, regardless of the psychological service being provided (e.g., Armstrong, 2017; Norcross & Wampold, 2019). It is of increased importance for individuals who have a history of trauma exposure, particularly when the source of the trauma was another human being. When the psychologist has visible intersectional identities that appear to represent the specific aspects of the individual(s) or systems who caused the trauma, the development of rapport becomes even more critical (Eadie & Briere, 2025). Furthermore, individuals belonging to cultural groups that have been the targets of harm by research, health care, and other academic institutions may face additional barriers to disclosure given the evaluator's unavoidable representation of medical and mental health systems (APA, 2017c).

Individuals who have experienced trauma, and particularly complex repeated events with a high degree of betrayal, often develop an extremely cautious relational stance that is considered adaptive for them in reducing the likelihood of revictimization (Ford & Courtois, 2020). With the possible exception of intake appointments at the beginning of treatment, assessment is typically a time-limited interaction that imposes some unique constraints on creating rapport with trauma survivors (Eadie & Briere, 2025).

The identity and behavior of the psychologist may also significantly affect the formation of rapport, as well as the data gleaned during the assessment process (Eadie & Briere, 2025). For example, evaluators who are shocked or frightened by the details of the trauma, or by the evaluatee's reactions and manner, may inadvertently avoid the most frightening and aversive material. Alternatively, evaluators who are fascinated with unusual and frightening aspects of a trauma story may inadvertently seek more detail than necessary, potentially overwhelming the evaluatee (Dalenberg, 2000).

Psychologists also strive to understand that an evaluatee may avoid the details of the trauma memory as well as emotional responses to the trauma; both types of avoidance can serve as natural short-term responses to traumatic experience and long-term hallmarks of a range of trauma responses, such

as PTSD and the dissociative disorders (Cavicchioli et al., 2021; Miethe et al., 2023). Trauma speech, the narratives provided by those reporting trauma, is widely reported to be at times fragmented, disjointed, and incomplete (Knutson & Jensen, 2019; Steele et al., 2016). These characteristics may lead the psychologist unacquainted with trauma speech to misunderstand the circumstances of the trauma or the evaluatee's reaction.

Application

A number of factors influence the development of rapport in this context, including those related to the evaluatee (e.g., reasons for the assessment, whether it is undertaken voluntarily, degree of fear or suspicion of the assessment process or the evaluator, trust), the psychologist/evaluator (e.g., level of comfort in inquiring and responding to trauma content, training or expertise, sensitivity, ability to relate to the evaluatee), and factors emerging in the evaluatee-evaluator interaction that can affect cooperativeness and the ability to tolerate the process emotionally.

Because trauma assessment can evoke a range of intense emotional and physical reactions that may influence the interpretation of measures or other assessment data, it is important that psychologists develop a professional support system to help them maintain their perspective and manage their reactions during the assessment. An attentive, humbly curious, nonjudgmental, and empathic stance can help facilitate a positive alliance, maximizing both evaluatees' well-being and the validity of their assessment data (Eadie & Briere, 2025). Rapport is likely to be improved when psychologists actively discuss how difficulty making a connection to others is a common reaction to traumatic experiences (Ford & Courtois, 2020).

Maintaining awareness of evaluatees' current state and soliciting feedback on their willingness to move forward, need for a break, or understanding of current intrapersonal states can help foster a sense of connection and trust within the assessment process. Other behaviors that may promote rapport and trust include extended time to complete various aspects of the assessment process (e.g., several hours for the interview), talking about the nature and depth of the questions that will be asked, using the evaluatee's language when reflecting the reported experience, and highlighting all areas where the evaluatee is in control of the process (e.g., being willing to end if activation becomes too high, skipping a question). Although many of these behaviors are considered important for assessment regardless of the presenting issue, psychologists strive to understand that they are more likely to be important for

individuals who have experienced trauma and that they affect the accuracy of the data when not consistently attended to during the assessment process.

Psychologists are reminded that managing their own reactions is an important element of building an alliance. They are encouraged to demonstrate appropriate empathy toward and connection with evaluatees (Eadie & Briere, 2015). At the same time, there may be moments in which hearing the stories of trauma survivors activates strong emotions within the psychologist that interfere with gathering information or engaging in the previously mentioned behaviors that foster rapport (McNeillie & Rose, 2021). Maintaining a consistent consultation relationship with a trauma-informed clinician can help mediate these reactions and reduce the likelihood of behavior that may interfere with addressing any mistrust that is present (e.g., avoidance, burnout, voyeuristic behavior).

Mitigating the effects of avoidance of trauma material may involve frank discussion with the evaluatee about avoidance as a natural feature of trauma response, rather than a pathology. Checking out one's understanding of the chronology or important features of the trauma, particularly in forensic settings, allows the evaluatee to fill in gaps that might contain particularly upsetting material or correct disjointed presentations.

GUIDELINE 8

Psychologists strive to be attentive to whether the evaluatee is experiencing posttraumatic symptoms during the assessment process and are prepared to help evaluatees manage distress related to the assessment.

Rationale

Although asking directly about trauma is not inherently retraumatizing, recalling and discussing traumatic events can involve mild to severe distress, intrusive symptoms (e.g., flashbacks), or detachment from one's experiences (e.g., dissociation). More specifically, detailed recounting of trauma can lead to such varied reactions as emotional dysregulation (e.g., anger, shame, or fear), avoidance, depersonalization/derealization, sensations of physical pain, and cognitive disorganization (Eadie & Briere, 2025). However, many individuals who have experienced trauma often appreciate the opportunity to discuss their experiences openly with someone in a nonjudgmental environment (Armstrong, 2017).

Severe reactions are more likely to happen when a psychologist is less attentive to the evaluatee's distress, becomes overly curious about the symptoms or experiences being discussed (especially in way that the evaluatee perceives to be a judging or critical manner rather than an empathic or humble

one), or fails to help the evaluatee feel supported and safe within the context of the assessment process (Eadie & Briere, 2025). Significant emotional activation may influence how individuals respond to the assessment measures, potentially decreasing the accuracy of the results (Eadie & Briere). Further, avoidant or dissociative reactions may interfere with providing a detailed report of current symptoms or functioning (Brand, 2024).

Application

Psychologists strive to consider the presence of possible posttraumatic reactions emerging during the assessment process itself, and they carefully consider the level of detail necessary for answering the referral question. However, it remains possible for an evaluatee to become either over-activated or hypoaroused based on the questions, assessment measures, or environmental stimuli (Ford & Courtois, 2020). Although it is critical to maintain the boundaries of the assessment process, psychologists strive to understand methods that assist evaluatees in modulating their activation level when needed, thereby increasing the likelihood of accurate results (Eadie & Briere, 2025). Examples of these skills may include grounding, distraction, taking a break, adjusting the pacing, or creating distance from the trauma narrative (e.g., by encouraging use of the past tense). The alliance is likely to be improved by informing the evaluatee that emotions of varying intensity can arise during the assessment process and then determining whether there are helpful actions that can be taken if the examinee becomes activated.

Psychologists will often find that they recognize the tension between the necessity (for clinical or forensic reasons) to elicit details about the trauma and the possibility that this facet of the evaluation will exacerbate existing symptoms. As noted earlier, emotional reactions can often be attenuated during the assessment process, at least initially, by limiting questions that elicit the emotional state of the trauma (e.g., asking the individual to visualize the events or revisit an emotional state). Trauma-informed evaluators strive to avoid encouraging evaluatees to re-experience the emotions related to the trauma that can occur when using present-tense verbs, closing their eyes, and acting as if the trauma is occurring in the "here and now." Such recommendations are found in research related to prolonged exposure treatment techniques (e.g., Foa et al., 2019) but can overwhelm evaluatees in the assessment process. Needed basic information about the type, frequency, nature, and severity of trauma exposure can often be collected through use of a brief trauma history measure, structured interview, or questions that are open-ended and that encourage free recall (Ford & Courtois, 2020).

Moreover, in some cases, the nature of the trauma will be known from external sources (e.g., crime reports, governmental records of torture), and assessment planning may begin tentatively before the evaluatee is able to discuss the

material in detail. When such documents are not available, and detailed information about the traumatic event is required, evaluators avoid assessing the evaluatee in a manner that resembles interrogation; instead, for example, they allow the evaluatee to remain in control of the process when possible. When circumstances of assessment force questioning that may be perceived as humiliating or confrontational (e.g., "Why didn't you leave?"), the evaluator may find it useful to explain the purpose of these questions and to acknowledge the potential difficulty in answering them. However, in general, it is recommended that such concerns not prevent the evaluator from eliciting the evaluatee's own description of the nature of the trauma and, if possible, the evaluatee's emotional reactions to the trauma.

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