

TEST REVIEW:
The Trauma Symptom Inventory
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I. General Information

- A. Title: Trauma Symptom Inventory (TSI).
- B. Authors: John Briere
- C. Publishers: Psychological Assessment Resources, Inc. P.O. Box 998, Odessa, FL 33556 Phone: 1-800-331-8378.
- D. Forms; groups to which applicable: The TSI has been standardized on a general population of men and women, ages 18 and above. It includes separate norms for men and women as well as by various age groups. Items are written at the fifth to seventh grade level. There is also an abbreviated version of the instrument which omits items relating to sexual concerns, making it more appropriate for adolescents and young adults.
- E. General Type: The TSI is intended for use in clinical settings to evaluate the presence of acute and chronic traumatic symptomatology. The ten clinical scales capture a wide range of affective, cognitive, and physical problems and/or issues.
- F. Date of Publication: The TSI was published in 1995.
- G. Practical Features: The TSI is a self-administered, paper and pencil inventory that is readily completed by clients. The item booklet is reusable and the response form is amenable to ready scoring and interpretation. Also available is a home computer scoring program with unlimited scoring. This program will profile not only 13 scales but provide three additional summary factor scales (Self-Factor, Trauma Factor, and Dysphoria Factor).
- H. Cost: Reusable item booklets cost \$24.00 for packages of 10 and hand scorable answer sheets cost \$35.00 for packages of 25. Packages of 100 answer sheets can be purchased for \$129.00. Male and female profile sheets are sold separately and cost \$25.00 for packages of 25. The home computer scoring program costs \$199.00.
- I. Time required to administer: It takes approximately 20 minutes to complete the TSI.

II. Purpose and Nature of the Instrument

- A. Stated Purpose: The TSI was developed to provide a comprehensive measurement instrument for assessing psychological trauma as a result of rape, spouse abuse, physical assault, combat, major accidents, and natural disasters. It also aims to capture the lasting impact of childhood abuse and other early traumatic events. The TSI is intended to capture a broad array of trauma-related symptom issues, spanning the intrapersonal, interpersonal, and physical functioning domains. The 10 clinical scales are fully normed by gender and age group. The TSI also includes three validity scales designed to detect efforts at dissimulation.

- B. Description of test, items, and scores: The TSI is a 100 item questionnaire where respondents indicate the frequency with which they engaged in various behaviors over the past 6 months on a (0) never to (3) often Likert-type scale. These items constitute 10 clinical scales: Anxious Arousal, Depression, Anger/Irritability, Intrusive Experiences, Defensive Avoidance, Dissociation, Sexual Concerns, Dysfunctional Sexual Behavior, Impaired Self-Reference, and Tension Reduction Behavior. There are also 3 "validity" scales aimed at identifying various efforts at either denying symptoms (the Response Level scale), at over endorsing dysfunctionality (the Atypical Response scale), or randomly responding (the Inconsistent Response scale). Raw scores on these scales are converted to age and gender specific T-scores. Scores greater or equal to a T-score of 65 warrant interpretation.
- C. Use in Counseling: The value of the TSI in counseling is that it can provide therapists with a normed index of symptomological distress in clients resulting from a traumatic experience. The scale is sensitive to not only recent traumatic events but also captures the residual, chronic effects of childhood trauma. The diversity of content scales offers an array of clinically useful insights into clients' functioning.

III. Practical Evaluation

- A. Usefulness of manual: The 61 page manual is filled with detailed information on the scoring and interpretation of the instrument. Four case studies are presented for detailed interpretation and help facilitate the user's sense of competence. The manual provides detailed information on the reliability and validity of the instrument. This is important given the lack of much published research on the TSI. Overall, the manual is clear, readable, and very informative.
- B. Adequacy of directions for administering the instrument: As noted above, the TSI manual is very clear and helpful in explaining how to administer, score, and interpret the instrument. Given that the TSI can be self-administered, there are few directions needed. What is important is how to hand score the instrument, which can be complicated, especially for a novice. However, the manual does take one through the procedure step-by-step.
- C. Qualifications of examiners: The TSI should be used by counselors who have an advanced degree from an accredited institution as well as having satisfactorily completed a course in psychological testing and statistics. Given the clinical nature of the instrument, it would be helpful if the user also had educational/practical experience with personality theory and psychopathology.
- D. Scoring Provisions: The TSI is hand scorable, which can be accomplished in 15-25 minutes. A home computer scoring program is also available which produces a multi-page client report.

IV. Technical Considerations

- A. Normative sample: The normative group consists of a national, stratified, random sample of 836 individuals who closely approximate demographics obtained in the 1990 Census, although one should not consider this norm group

to be demographically representative. Analyses did reveal significant differences in scores due to both gender and age. As a result, separate normative information for these groups were created. However, there are some slight differences in scores due to race, with African-Americans and Hispanics scoring significantly higher than the other racial groups on all three validity scales and three of the clinical scales. The author claims that the relatively small effect size for these differences mitigated against any separate racial norms. These differences need to be considered when interpreting the TSI for these racial groups. There is also normative information presented for a sample of over 3,500 male and female Navy recruits.

- B. Reliability: In the normative sample, alpha reliabilities for the ten clinical scales range from .74 (Tension Reduction Behavior) to .91 (Depression), mean alpha is .86. Comparable values are found in three other samples, a university group, a clinical sample, and the Navy recruits. No test-retest information is presented for the scales.
- C. Validity: The manual provides data on a series of studies examining various validity aspects of the TSI. Overall, the scales of the TSI represent 3 highly inter-correlated broad factors: Self, Trauma, and Dysphoria. Information presented in the manual shows that the TSI scales were significantly higher for those who had experienced various types of trauma. Scores on several of the clinical TSI scales were shown to correlate substantially with other measures of posttraumatic stress. The evidence presented in the manual is supportive of the TSI as being a useful indicator of traumatic symptoms and can be useful in identifying those who may have experienced trauma. An interesting set of analyses presented in the manual concern an evaluation of the incremental validity of the TSI: Does it provide additional information about trauma experience over and above what other currently available tests can provide? The results of these data were mixed. In predicting victimization history, the TSI provided significantly more explanatory variance over the Impact of Event Scale, Symptom Check List and Brief Symptom Inventory. However, this incremental validity was only evidenced for women. Thus, there is some evidence that the TSI captures unique aspects of trauma not available in other measures of symptom experience.

Runtz and Roche (1999) evaluated the validity of the TSI in a Canadian sample of university women and found that the scales were able to discriminate significantly between those physically and sexually abused and those not abused. The TSI also correlated with other measures of stress, behavior, and health. Briere, Elliott, Harris, and Cotman (1995) provided psychometric data on the TSI in a sample of 370 psychiatric inpatients and psychotherapy outpatients. Again, those individuals reporting incidents of abuse and trauma scored significantly higher on all ten clinical scales than those not making such reports. Also noted was that various client demographic variables (e.g., sex, age, inpatient versus outpatient status) were significantly related to TSI scores.

V. Evaluation

- A. Comments of reviewers: Due to the TSI's relatively recent publication, there are no available reviews.
- B. General Evaluation: The Trauma Symptom Inventory aims to evaluate a broad array of clinically salient dimensions relevant to posttraumatic stress experiences. Unlike other available instruments, the TSI examines issues around self functioning (e.g., sexual issues, tension experience), emotional dysphoria (e.g., depression, anxiety), and trauma impact (e.g., defensive avoidance, dissociation). Correlations with other measures of posttraumatic stress show the TSI to capture a broader personological spectrum. The internal consistency of the scales are quite adequate, although there are no extant data on the long term stability of the scales. This is especially important given the scale's aim to capture the long term, characterological effects of early trauma. Data do show that the TSI renders higher scores in traumatized samples than in non-traumatized samples; it still needs to be determined whether scores on the TSI decrease over the course of treatment. Showing such an effect would support the TSI as a useful outcome index for therapy dealing with traumatized individuals, and would seem an obvious next step for research using this tool. The author's attempt at demonstrating incremental validity for the TSI is to be applauded. Incremental validity studies provide more rigorous evaluations of a test's utility. The results of this analysis indicated that the TSI may be more useful for women than men. Clearly, the role of gender on response patterns needs to be examined further. Perhaps the items are more sensitive to the experiences and concerns of women than men.

One issue that needs to be addressed is the inclusion of "validity scales". The author clearly sees this as a "plus" for the instrument; individuals in clinical contexts may exaggerate or minimize their problems. Some may even dismiss the task of test completion entirely. Measures of response validity are very common in clinical instruments, but there is a growing body of evidence that such scales do not have much "validity" (Diener, Sandvik, Pavot, & Gallagher, 1991; McCrae & Costa, 1983; Smith, 1997). Piedmont, McCrae, Riemann, and Angleitner (2000) have shown that validity scales do not moderate test validity and that applying cutoff values to identify invalid protocols results in too many false positives to justify the use of validity scales. Also, some of the measures of response distortion used to validate the validity scales of the TSI have been shown to reflect substantive aspects of personality. Thus, clinical test users in general and TSI users in particular need to be careful in interpreting scores from such indices. Although validity scales seem to provide test users with some reassurances that a test may be valid, such security may not be well founded.

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