Sociometric Assessment:

A Variation of Relational Trauma Repair Symptom Floor Check[1]

Margaret A. O'Hara, LPCC, LMHC, CET II, NCC, DCC, CASAC[2]

INTRODUCTION

The Symptom Floor Check is an exercise developed by Tian Dayton, creator of the Relational Trauma Repair Model. In her *Therapist's Guide, Relational Trauma Repair (RTR): An Experiential Model for Working with PTSD Psycho Social Metrics* (2014, pp. 47–49) she lays out the goals and steps involved in carrying out a given process as well as variations of the exercise. In this article I will share an additional variation I have used with success in residential treatment and private practice for diagnostic and assessment purposes.

The original Symptom Floor Check is an experiential, psycho-educational group process that offers clients the experience of partnering with the therapist in identifying maladaptive behaviors and patterns and assessing the impact and consequences. The process itself involves a series of choice points that allow clients to self-select as to symptoms, thus creating a fluid flow of sociometrically aligned groupings (e.g., dyads and clusters). Initially the process involves placing sheets of paper with individual posttraumatic stress disorder (PTSD) symptoms scattered around the floor. The facilitator asks criterion questions, such as asking participants to go to a characteristic they identify as a problem in their life. Next they are invited to share a sentence or two about why they are where they chose to stand. Sharing on this question can be with the entire group or in dyads or other subgroupings. The facilitator repeats this process with additional questions until the group has reached a saturation point. The process is not only designed to unearth problem areas but also to identify strengths. For example,

[1] Assessment Floor Check is a variation of an exercise in Tian Dayton's Relational Trauma Repair Model called Symptom Floor Check. This article illustrates its use for diagnostic purposes at the onset of treatment as well as for ongoing assessment. Its use in individual sessions and group settings is presented.

[2] Margaret A. O'Hara is a nationally certified counselor and licensed therapist (LPCC) with a private practice in San Diego, CA. Correspondence concerning this article should be addressed to the author at Margaret.A.OHara@gmail.com.

ISSN 0731-1273

Dayton (2014, p. 48) suggests, "A resilience-building question might be, 'Which characteristic do you feel used to be a problem for you but you have worked your way through?' Additionally, 'invite group members to "upgrade" their symptoms, to trade in one for a trait they would like their symptom to morph into . . . let them write their "upgrade" on a sheet of paper and place it next to or on top of the symptom. For example, the symptom of helplessness might be upgraded to agency or depression to anger'."

A VARIATION OF SYMPTOM FLOOR CHECK USED IN ASSESSMENT

Using assessment for Alcohol Use Disorder I will describe a variation of the Symptom Floor Check I utilize regularly. During the initial meeting with a new client I conduct screenings and assessment after paperwork review. There is a lot of information exchanged verbally and in writing. In my informed consent I explain the use of experiential methods and we waste no time, jumping in at the first opportunity, which often is during assessment.

In the case of a client with a possible alcohol problem, we review the 11 criteria in the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*). To begin the client is handed 11 sheets of copy paper, each containing one of the *DSM-5* diagnostic criteria for Alcohol Use Disorder listed below (APA, 2013, pp. 490–491):

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
    1. Alcohol is often taken in larger amounts or over a longer period than was intended.
    2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
    3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
    4. Craving, or a strong desire or urge to use alcohol.
    5. Recurrent alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
    6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
    7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
    8. Recurrent alcohol use in situations in which it is physically hazardous.
    9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
    10. Tolerance, as defined by either of the following:
        a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.

b. A markedly diminished effect with continued use of the same amount of alcohol.

11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal, pp. 499–500).
    b. Alcohol (or a closely related substance, such as benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

The client is asked to place the symptom sheets on the floor with those they currently are experiencing on one side and those they have yet to experience on the other side. They are asked to count the number of symptoms they experience and are shown the severity levels in the *DSM-5*. Mild Alcohol Use Disorder includes the presence of two to three symptoms, whereas Moderate is four to five symptoms and Severe is six or more symptoms. Clients get it. They are active participants in the identification of their problems. This decreases the likelihood they will leave saying, "She diagnosed me an alcoholic." Often I ask them to rank the symptoms by ordering them on the floor, to gain understanding about which are most troublesome in their life. Sometimes we pull up two chairs by each of these symptoms, one for the therapist and one for the client and we will look together at the symptom and discuss specifically how each symptom manifests in the client's life. To instill hope, they are asked what their life will be like when this symptom is lifted. A positive vision is an essential component of recovery.

THE ASSESSMENT FLOOR CHECK OVER TIME OF TREATMENT

In future sessions, the Assessment Floor Check is used to continue to explore how individual symptoms developed over time and also to assess progress made in therapy. In addition to use with individual clients, I have also had good results with groups in treatment centers and private practice. The sharing as group participants gather around particular symptoms has been intense and rich in texture. For example, clients who have DUI convictions or are mandated to treatment due to alcohol use while operating machinery (i.e., train engineers, etc.) will often gather around symptom number eight, which has to do with recurrent alcohol use in situations that are physically hazardous. During subgroup sharing they hear from others experiencing similar consequences of their substance use disorder, which reduces their sense of shame, isolation, and uniqueness. Additionally, their defense mechanisms (especially denial) ease with the peer connections they develop. Dayton (2014, p. 49) explains that, "This subgrouping can make sharing feel safer and can allow clients to feel seen, supported and more open." Honest acknowledgement of the presence of the disorders' symptoms is met with identification and support from peers similarly affected. With clarity comes connection and vice versa. There's a loosening of the denial that masks the existence of a problem and the opportunity for truth telling. "To thine own self be true," as inscribed on recovery tokens. The Symptom Floor Check is another tool that supports honesty with self and others and promotes this important recovery concept and the spontaneous not only telling, but discovering the variegated pieces of one's story.

AS AN EXPERIENTIAL SUPPLEMENT TO STANDARDIZED SCREENINGS

The Assessment Floor Check can be used as a supplement to the standardized screenings and assessments used by clinicians. It takes the dry, talk form of assessment and makes it experiential. Rather than passively waiting for the therapist to diagnose them, it puts the client in the driver's seat. They become engaged in the process and personally accountable from the onset of treatment.

The client benefits by early exposure to experiential therapy. Rather than simply telling them about it (as is required in the informed consent process), they get hands-on experience. In addition to the knowledge received about this form of therapy, they experience the application of it. If they are entering a treatment program that utilizes experiential therapy, this also serves to orient them to the group process, prior to joining the community. As treatment progresses, and the Assessment Floor Check is revisited, clients can gauge their own progress as they see changes in the symptoms they select.

The Assessment Floor Check helps foster connection in a natural, unassuming manner. The clinician benefits by having a structured approach to beginning the rapport-building process. Some clients, for various reasons (such as cultural norms), find it difficult to begin the process of opening up to the professional sitting across from them. The Assessment Floor Check is an action method that focuses the client and clinician on the presenting problem and how it manifests. It shifts the focus from face-to-face communication to working side by side, client and clinician—collaborating together. This "breaks the ice" and provides further support for the information gathering begun at intake.

This article focused primarily on use of the Assessment Floor Check with PTSD and Alcohol Use Disorder. It can, however, be modified for use with many other disorders, for many of the same reasons given. In my experience, it is well-received by clients.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, DC: Author.

Dayton, T. (2014). *Relational trauma repair (RTR): An experiential model for working with PTSD psycho social metrics. Therapist's guide* (Rev. ed.). New York, NY: Innerlook.