

CHAPTER 1

An Introduction to Counseling Survivors of Trauma: Beginning to Understand the Historical and Psychosocial Implications of Trauma, Stress, Crisis, and Disaster

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CHAPTER OVERVIEW

This chapter introduces foundational knowledge necessary for understanding the effects of psychosocial trauma, stress, crisis, and disaster. It offers brief discussions about the historical implications of how psychosocial trauma has come to be defined as well as how the related diagnostic categories have developed. Finally, the importance of recognizing the human capacity for resilience and growth, in the face of trauma, is emphasized.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Identify basic concepts regarding trauma and the effects of trauma;
2. Discern the history of professional understandings about trauma;
3. Develop awareness of how the developing constructs of trauma and posttraumatic stress disorder (PTSD) have evolved into diagnostic criteria in the various iterations of the *Diagnostic and Statistical Manuals*; and,
4. Recognize that, in spite of stressful and traumatic experiences, individuals have the capacity to build resilience, to make meaning and derive purpose from what has happened to them, and to grow and develop as a result.

INTRODUCTION

Traumatic events are a part of life. The types of lived experiences of trauma that result from human violence, medical crises, natural disasters, and other disruptive circumstances have had repeated histories that span millennia. Scientific, religious, literary, and artistic traditions have captured and represented this history, and contemporary media continue to replay the effects of trauma on a daily basis. Perhaps the first narrative of interpersonal violence resides in the account of the offspring of Adam and Eve. Cain killed his brother Abel, thus committing the first homicide, as recorded in the Old Testament as well as in the Holy Quran. Adam and Eve not only had to deal with the existential consequences of “the fall,” but two of their children set the stage for the primordial discourse on the traumatic effects of homicide. Modern archaeological discoveries have revealed early evidence of killing and warfare (e.g., Handwerk, 2016; University of Wyoming, 2021). Representations of trauma continue to be depicted in contemporary art (e.g., Kulasekara, 2016; Pollock, 2009); film (e.g., Elm et al., 2014; Koehne & Kabalek, 2014; Levers, 2001; Lowenstein, 2005; Spallacci, 2019); and literary discourses (e.g., Heidarizadeh, 2015; Mambrol, 2018; Stringer, 2009). With 24/7 cable news, horrific traumatic images are aired in our living rooms and on our personal devices, sometimes in real time or only moments after an event has occurred.

The reality is that there always have been, and, unfortunately, there most likely always will be, perpetrators who prey on the vulnerable, as well as natural disasters and accidents that decimate populations and dramatically alter the lives of individuals and families. In other words, the experience of trauma is a long-lived human dilemma, and in spite of everything that we have learned over the millennia, we continue to deal with the overwhelming consequences of trauma and associated elements of stress, crisis, and disaster. Most mental health-related training programs have seemed relatively reluctant to include issues of trauma as a part of preservice training, at least until very recently (Courtois & Gold, 2009; Kumar et al., 2019; Levers, 2020). The *Council for the Accreditation of Counseling and Related Educational Programs* (CACREP, 2016) requires that counselors receive preservice training on the effects of crisis, disasters, and trauma on clients, but without further specificity (Tarvydas et al., 2017, 2018). The *American Psychological Association* (APA, 2015) has published guidelines on trauma competencies for education and training but does not mention trauma in its accreditation manual for health service psychology. Likewise, the accreditation manual for the *Council on Social Work Education* (CSWE, 2015) also does not mention trauma. Major mental health-related preservice training programs have been slow to design and offer trauma-informed curricula to students, while at the same time, based upon the actual needs of the field, it is essential for all mental health professionals to have received preservice training in areas related to working with trauma. It is important for all mental health professionals to grasp just how ubiquitous trauma is among the clients who see us, and how the stressors of trauma, crisis, disaster, and modern life affect both the psyche and the body. In fact, recent brain science continues to illuminate the powerful physiological effects of trauma on our bodies (e.g., Gerge, 2020; Porges, 2011; Portwood et al., 2021), which has moved the trauma-response paradigm, significantly, from talk-only therapy to modalities that incorporate relevant somatic work with clients.

People experience and live through traumatic events in many different ways. This textbook aims to explore these variations in a manner that can help social science and human service students and clinicians to understand trauma from neurobiological, psychosocial, systemic, and contextual perspectives. It also aims to illuminate the best-practice theories and interventions for managing trauma as well as managing stress, crisis, and disaster. The first section of this book, particularly the first three chapters, establishes an important foundation for understanding stress, crisis, and trauma, what I am referring to as a *trauma scaffold*—such a scaffolding process builds upon basic knowledge about trauma, in order to prepare for understanding increasingly more complex issues that are presented throughout the book. This foundation also provides the groundwork for understanding human responses to disaster and larger scale violence, issues that are discussed in later sections of the book. This first chapter offers an introduction to counseling survivors of trauma as well as a beginning reference point for a professional understanding of the historical and psychosocial implications of trauma; theories that ground the practice of trauma counseling are presented in the next chapter, along with important foundational information drawn from recent neuroscience regarding how trauma affects the brain. Stress management and crisis intervention are discussed in Chapter 3.

The purpose of this chapter is to provide a basic professional understanding of psychosocial trauma and associated issues. This is accomplished in discussions in the following sections: Basic Understanding of Trauma, Historical Implications of Trauma, Modernity and the Conceptualization of Trauma, Posttraumatic Stress Disorder and the *Diagnostic and Statistical Manuals*, and Resilience. Following the discussions in these sections, counseling implications are identified, and the content of the chapter is summarized. The chapter concludes by offering helpful resources for instructors, students, and clinicians.

BASIC UNDERSTANDING OF TRAUMA

The Dalai Lama has stated that “pain is inevitable, suffering is optional.” I find this to be a helpful beginning point in understanding trauma. Life can be challenging and difficult; even in ideal circumstances, some painful experiences are a part of human existence, so in this

in ideal circumstances, some painful experiences are a part of human existence, so in this sense, emotional pain is inevitable. However, getting stuck in pain and continuing to suffer is not a necessary consequence of psychosocial pain. In fact, one of the reasons that it is important for mental health professionals to understand the implications of stress, crisis, trauma, and disaster is so that we are able to assist people who are experiencing psychological distress, thus helping them to make meaningful transformations. The purpose of this brief section, then, is to offer operational definitions of key terms, in order to become conversant with more advanced concepts that are detailed and further discussed in chapters throughout this textbook.

A first important part of this conversation is to highlight the role of stress, both as a motivational force and in dealing with uncomfortable situations. A second aspect of this discussion is to make a distinction among the terms “crisis,” “trauma,” and “disaster.” Briefly, not all crisis situations are traumatizing; however, all traumatic events involve some element of crisis. All disaster events involve some element of crisis and may very well be traumatizing, but not necessarily. It is important to establish, early in this textbook, that not every individual exposed to trauma necessarily feels traumatized. In fact, many individuals either are resilient or are able to develop greater resilience, thus mitigating negative effects that may occur under difficult circumstances; many individuals are able to experience interpersonal growth as they make meaning of whatever traumatic event has occurred. These are issues that are discussed, from various angles, later in this chapter and in other chapters throughout the book.

Stress and Crisis

Stress is a natural part of our biological functioning and is a normal part of life; everyone experiences stress (Levers, 2020). In fact, some stress, originally called “eustress” (Selye, 1956), is productive. An example of “eustress” may involve a student who wants to earn a good grade preparing a presentation for class. This small amount of positive stress is enough to motivate the student to conduct the requisite research, in order to construct a PowerPoint and prepare for the presentation. Without a burst of eustress, the person might succumb to the temptation to procrastinate, which would not facilitate the kind of work that the student wants to do for the class. However, the complexities of modern life produce many stressors that, cumulatively, can be harmful. Too much stress can lead to surges of hormones, like adrenaline and cortisol, which in excess then upset the natural balance of the body (Mayo Clinic, 2019). Individuals may experience acute stress, which is short-term stress, or chronic stress, which is long-term stress.

Not all stress leads to trauma, although a particular stressor or set of stressors can become traumatizing. The concept of adverse life experiences helps us to understand that there is a continuum from normal stress to trauma, with varying degrees of adversity occurring at various points between stress and trauma. Prolonged stress eventually can lead to anxiety. Clients may seek help after recognizing that a stressor or adversity has affected them negatively; counselors then can assist with managing the stress in ways that may prevent stressors and adversity from producing anxiety or even becoming traumatizing. The issue of stress is discussed more fully in Chapters 2 and 3 of this textbook, as well as its connections to larger physiological processes in the body and particularly in the brain.

A crisis can precipitate both danger and opportunity. Crisis is defined in a number of ways, and people experience many differing types of crises. Chapter 3 of this textbook provides a full discussion of crisis and crisis intervention. However, as a foundation for beginning to understand crisis in relationship to the broader issue of trauma, a brief definition is offered here. A crisis is an event that a person perceives as threatening or potentially harmful; this leads to distress that may interrupt or impair the individual’s usual coping mechanisms (Kanel, 2019).

Trauma

Stated simply, “trauma is an emotional response to a terrible event” (American Psychological Association, 2018). “Trauma” is a term that is used in many different ways, and it is important to understand the different meanings of the word. Chapter 2 of this textbook provides a detailed discussion of trauma, including the different types of trauma and the different ways that trauma can be experienced.

[APA], 2019, "Trauma," para. 1). However, as detailed in [Chapter 2](#) of this textbook, when we unpack the term "emotional," in reference to the impact of trauma, the matter becomes more complex, because what we call an emotional response to trauma actually entails physiological processes that involve the brain and other major organs in the body. There are many types of traumatic events, and different people experience trauma in different ways. Common trauma events include some of the following examples (this is not intended to be an exhaustive list):

- Sexual assault;
- Physical abuse;
- Domestic or intimate partner violence;
- Community, workplace, and school violence;
- Medical and health-related trauma;
- Mass public health concerns, such as the COVID-19 pandemic;
- Motor vehicle accidents;
- Acts of terrorism;
- War experiences;
- Natural and human-made disasters;
- Anthropogenic climate change and resulting weather disasters;
- Homicides and suicides; and,
- Other traumatic losses.

People typically suffer when they experience these types of events. However, we can mitigate the effects of traumatic experiences through trauma counseling and other types of therapeutic interventions. While individuals may not forget the trauma that they have experienced, trauma survivors can learn to manage the effects and resume productive lives. In this sense, trauma may disrupt—or even severely disrupt—the lives of those affected, but recovery is always possible; it is thereby imperative that traumatized individuals receive some type of clinical intervention sooner rather than later. The longer that treatment is delayed, the possibility increases that a traumatized person may develop posttraumatic stress disorder (PTSD). Mental health professionals help clients to deal with trauma in its early stages as well as to deal with PTSD. Several important dynamics, often associated with psychosocial trauma, are discussed here; the issues are foundational to understanding trauma, and the discussions are intended to be brief, as these facets are examined more fully in later chapters of this textbook.

Attachment

The concept of attachment, originally proposed by [Bowlby \(1958\)](#), is highly relevant to the discussion of early childhood trauma. The term has referenced the emotionally close and important social relationships that people have with each other. [Bowlby's \(1958\)](#) work provided the framework for identifying four basic characteristics of attachment that have assisted professionals in understanding bonding—or the lack thereof—in relationships between children and their caregivers: having a safe haven, having a secure base, engaging in proximity maintenance, and showing separation distress. It is widely thought that if attachment is seriously interrupted, as is often the case with early childhood trauma, significant developmental problems may result, and attachment disruptions can affect people across the life-span. Recent neurobiological research regarding the effects of trauma on the brain has assisted us in understanding more about the integrative effects of a particular individual's attachment and neurobiology (e.g., [Newman et al., 2015](#)).

Loss, Grief, and Suffering

"Loss is at the heart of life and growth," according to [Walter and McCoyd \(2009, p. 1\)](#). A similar sentiment concerns the experience of trauma: loss, grief, and suffering are at the center of experiencing trauma. Not all experiences of loss, grief, and suffering necessarily involve trauma. However, loss, grief, and suffering are implicit aspects of trauma across the varying circumstances that may manifest as traumatic experience ([Levers, 2020](#)). This point underscores the importance of these constructs and illuminates their centrality to the

underscores the importance of these constructs and illuminates their centrality to the experience of trauma.

Kübler-Ross (1969) wrote *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families*, the source of the now widely accepted and reified stages of grief: (a) Denial and Isolation, (b) Anger, (c) Bargaining, (d) Depression, and (e) Acceptance. At the time of the original publication, professional helpers were eager to view these concepts as linear stages through which clients would progress. However, this was never Kübler-Ross's intention. The book was the result of her interviews with clients facing death; the aim was to understand their experiences and to illuminate the phenomena. Eventually, clinicians learned that clients facing loss and grief issues do not necessarily experience any or all of these, and further, individuals may not experience these stages sequentially. Bowlby later (1980/1998) postulated these stages of loss:

- Numbness (defined as being shocked and stunned, not as denial);
- Separation Anxiety (viewed as yearning/searching);
- Despair and Disorganization (as the loss sinks in, the person attempts to recognize the loss and to develop a "new normal" without the object of the loss); and,
- Acquisition of New Roles/Reorganization (the bereaved begins to relinquish efforts aimed at preparing for the deceased's return, like getting rid of the loved one's clothing; this movement toward new aspects of life and relationships with others is seen as moving through reorganization).

More recently, Worden (2008) has offered his task-based grief theory and intervention framework. This theory emerged in response to some of the stage- and phase-based models of the late 1960s through the early 1990s, thereby providing clinicians with a more behavioral and process-oriented perspective to make clinical intervention decisions. Worden's model includes the following steps: (a) accept the reality of the loss; (b) experience the pain of the grief; and (c) adjust to a world without the deceased.

Shame

Although survivors of trauma may experience a myriad of emotions following a traumatic event, a sense of shame can be particularly insidious. Shame is a self-conscious feeling of painfulness and humiliation. It is important to distinguish between shame and guilt (Tull, 2020); shame is a negative judgment or evaluation of one's entire being as less worthy, whereas guilt is the consequence of a negative behavior. One can alleviate guilt by making amends and repairing relationships, but absolving a sense of shame is much more difficult. Studies have shown that trauma survivors' shame can lead to greater self-isolation and other types of avoidance behaviors (Saraiya & Lopez-Castro, 2016) and is linked to a sense of betrayal, based on the emotional proximity of the perpetrator (e.g., proximal family member versus distal stranger) (Platt & Freyd, 2015). Shame can be debilitating for some trauma survivors and can serve as an impediment to recovery, at least until fully processed.

Disaster

A disaster is any catastrophic event that causes or has the potential to cause serious and widespread material damage and loss of life. In the context of mental health services, disaster situations usually are divided into two types: natural disasters and human-made disasters. Natural disasters include events like tornados, hurricanes, floods, earthquakes, and fires and require special response training for intervention; these issues are discussed in detail in Chapter 22 of this textbook. A variety of human-made disasters are examined across several chapters in this book and include the following: accidents (Chapter 11), mass violence (Chapter 20), war (Chapters 23 and 25), and anthropogenic climate change (Chapter 24).

HISTORICAL IMPLICATIONS OF TRAUMA

People long have recognized the profound impact that trauma can have upon the psychological well-being of those who encounter it (Herman, 1992b; Sexton, 1999; van der Kolk, 2014). However, it only has been since 1980 that the formal diagnosis of the trauma

Kolk, 2014). However, it only has been since 1980 that the formal diagnosis of the trauma-related disorder PTSD has been included in the *Diagnostic and Statistical Manual of Mental Disorders*, the diagnostic nosology published by the American Psychiatric Association (APA). PTSD specifically was introduced in the *DSM-III* (APA, 1980). Following that pivotal event, acute stress disorder (ASD) was added to a later revision of the manual, the *DSM-IV* (APA, 1994) in 1994. These inclusions constituted the first criteria-based clinical distinctions between shorter-term responses to trauma, that is, those lasting for less than a month (ASD), and longer-term responses of over 1 month (PTSD).

The presentation of a full history of the evolving perceptions and understandings of psychosocial trauma is not possible here, yet some understanding of the historical context is important, especially for students who are new to the mental health field. Contemporary understandings of trauma are perhaps more relevant than recapitulations of long-ago historical events, so the focus here is primarily on relatively more recent clinical landscapes; however, at least a brief discussion of high-impact past events can be instructional, especially as this might illuminate the often-violent past treatment of those with psychiatric disorders. This discussion also forecasts important information detailed in other chapters in this volume, particularly those chapters that deal with gender and age-related issues (Chapters 7, 8, 9, and 12), scapegoating and “othering” (Chapter 16), racial and ethnic intolerance (Chapters 17 and 19), gender orientation (Chapter 18), and massive ethnic and political violence and genocide (Chapter 23). Discussion of historical events, social injustice, and the role of the scapegoat naturally leads to the discussion of a relatively new concept in traumatology, that of historical trauma, which Chapters 2 and 19 examine more fully. Therefore, the remaining parts of this section deal with these important issues: The Role of Social Scapegoat as Victim and The Abuse of Power.

The Role of Social Scapegoat as Victim

We often may find ourselves wondering, especially in the face of daily catastrophic news coverage, how one human being (or group of humans) can treat another human being (or group of humans—or any other sentient being, for that matter) in such a violent manner. Our perceptions about trauma are culturally and historically determined, and yet inflicting violence is highly personal. The effects of interpersonal violence, social violence, warfare, and natural disaster have marked ancient societies, just as they have modern ones. Although we could learn much from an examination of the Greek and Roman empires, along with non-Western civilizations, such a full historical examination is beyond the scope of this textbook. It suffices to note that the norms of civilization tend to oppose violent practices, while tending to endorse acts that assist others, especially in times of crisis or disaster. It seems that historical events, over at least the last several centuries (spanning the Dark/Middle Ages and the Age of Reason/Enlightenment), have influenced how our contemporary psychiatric paradigm has come to conceptualize the impact of traumatic events on the human psyche.

Psychosocial stressors and their aftermath often have led to the institutionalization and marginalization of those who have mental health problems, and, by extension, those who have experienced trauma. Indeed, the history of institutionalizing people for medical and psychiatric reasons in Western society offers rich illustrations of scapegoating. This information is an important backdrop for trying to make sense of how victims of violence so often have been—and continue to be, even now—cast as scapegoats. Understanding this offers insight regarding how it is that the mental health professions came to take so long to address trauma issues in *helpful* rather than *victim-blaming* ways. Many survivors of sexual assault, as an example, end up being victimized further, not only by mental health and legal systems, but also by other citizens for even reporting the crime. Box 1.1 presents a brief historical account of some particular types of social scapegoating.

BOX 1.1

A Lesson From History: The “Other” as Scapegoat

In his book, *Madness and Civilization: A History of Insanity in the Age of Reason*, Foucault

IN HIS BOOK, *MADNESS AND CIVILIZATION: A HISTORY OF INSANITY IN THE AGE OF REASON*, Foucault (1973) traced the origins of the mental asylum in Western civilization to the leprosy epidemic in the Middle Ages. He illuminated how the number of leprosaria, the asylums in which lepers were institutionalized, grew in proportion to the number of cases of leprosy that were diagnosed. Foucault posited that as the need for the leprosaria declined, the centers originally built for the seclusion of lepers began to be filled with paupers, "incurables," the "mentally ill," and others perceived as socially deviant. Foucault (1973) suggested that although leprosy disappeared, the residential structures remained, and "the formulas of exclusion would be repeated, strangely similar 2 or 3 centuries later. Poor vagabonds, criminals, and 'deranged minds' would take the part played by the leper" (p. 7). The "part" referenced by Foucault was the social role played by groups of people who have been marginalized; these disenfranchised persons have represented the social "other," thereby enabling societal institutions to justify, in far too many cases, brutal treatment.

Foucault outlined the history of the leprosaria, or lazar houses, as they came to be known, through their transformation to asylums for the "insane" throughout Western Europe; he cited this as the birth of the classical experience of "madness." In the introduction to Foucault's book, Jose Barchilon, MD, pointed out that "as leprosy vanished, in part because of segregation, a void was created and the moral values attached to the leper had to find another scapegoat" (Foucault, 1973, p. vi). Cast in a parallel fashion by Berger and Luckmann (1967) is an assertion of the institutional world as being of human construction, one that does not have "ontological status apart from the human activity that produced it" (pp. 60-61). Foucault also noted that, although it was common knowledge that, in the 17th century, large hospitals/houses of confinement were created, it was not commonly known that "more than one out of every hundred inhabitants of Paris found themselves confined there within several months" (p. 38). This legacy continued and gave birth to the "mental asylum"; even well into the 20th century, "insane" people were placed into abhorrent conditions and exposed to horrendous treatments. In an attempt to redress this situation, the clients' rights movement of the 1970s and 1980s led to deinstitutionalizing psychiatric clients and returning them to their "home" communities; unfortunately, communities did not have sufficient resources, and an entire set of additional community-based problems surfaced.

Foucault (1973) offered an astute inquiry of the architectural confinement of the scapegoat. Thomas Szasz (1970/1997) illustrated how the myth of "mental illness," in his view, has been manufactured by a society in need of a scapegoat, thus providing social sanction and cultural legitimacy to the persecution of certain people. In his book, *The Manufacture of Madness*, Szasz examined the powerful metaphoric constructions of "mental illness," suggesting parallels between the Inquisition and some of the consequences of modern psychiatry. Szasz clearly delineated the persecution of witches, the persecution of Jewish people, and ultimately the persecution of people with psychiatric disorders as artifacts of the Inquisition. In doing so, he illuminated the ways in which multiple strands of human behavior, belief, or status can become encoded as violations of the ideology of those in power, thereby assisting the powerful to maintain control. Throughout history, we have seen many instances in which the maintenance of power has involved violence against those without power. According to Szasz, the transformation of the role of social scapegoat to witches, heretics, Jewish people, and "the insane" paralleled the moralistic transformation of dogmas from religion to science: "The metamorphosis of the medieval into the modern mind entailed a vast ideological conversion from the perspective of theology to that of science" (p. 137). He concluded that the evolving construct of mental illness is an artifact of this paradigm shift. This is not intended to cast doubt upon legitimate principles of science, but rather to comment on the misrepresentation of dogma as science. In a public health crisis, science reigns; when socially constructed metaphors are used to castigate the "other" into further marginalization, then such dogma needs to be questioned and analyzed.

As the role of one social scapegoat declined, new scapegoats emerged (Thurston, 2007). The Inquisition, initiated by the politically powerful Roman Catholic Church in the 12th century, was aimed at the persecution of heretics. People were tortured and killed in

gruesome ways during the centuries that spanned the Inquisition. Some groups of people were affected more than others, and this included the persecution of anyone thought to be a witch and anyone thought to be of Jewish ancestry. For the first time in history, in 1215, by decree of Pope Innocent III, Jewish people were ordered to wear yellow badges in order to identify themselves (Szasz, 1970/1997). The roots of anti-Semitism were embedded in European culture long before the expulsion of Jews from Spain in 1492 and long before the 20th century Holocaust; unthinkable, we are witnessing a horrific reemergence of anti-Semitism in the 21st century.

Misfortunes of all sorts were blamed on witches and Jewish people, who were massacred for such events as epidemics and poor crops. During the Inquisition, witches—or at least those accused of witchcraft—also took on the role of societal scapegoat. Thousands, and by some estimates hundreds of thousands, of (mostly) women, were executed throughout Europe from the 14th to the 17th centuries (Ehrenreich & English, 1973; Thurston, 2007). Intended to systematize the persecution of witches, Pope Innocent VIII's papal bull was implemented in 1486, along with the publication of the infamous manual for witch-hunters, the *Malleus Maleficarum* (*The Hammer of Witches*); the manual detailed how to identify the so-called witches and prescribed ensuing treatments of heinous and unspeakable natures. Not surprisingly, the publication of the nosology was followed by an "epidemic" of witchcraft (Szasz, 1970/1997). Szasz explained that

the incidence of witches increased, as the authorities charged with their suppression covertly demanded that it should; and a corresponding increase of interest in methods aimed at combating witchcraft developed. For centuries, the Church struggled to maintain its dominant role in society. For centuries, the witch played her appointed role as society's scapegoat. (p. 7)

Szasz (1970/1997) affirmed that in the 17th century, as the power of the Church and its religious worldview began to decline, an "inquisitor-witch complex disappeared" and was replaced by an "alienist-madman complex" (p. 13). In this new secular and scientific order, parallel conformity was still demanded; Szasz cited this shift in the social order as a move from a worldview, conceptualized in terms of "divine grace," to one cast more in terms of health.

In reference to institutional psychiatry ("forced" psychiatry, in contrast with what he regarded as a less imposing contractual psychiatry), Szasz (1970/1997) asserted that violence always has been, and remains to be, the key problem. This violence dialectic involves, on the one hand, the feared or perceived violence of the "madman," and, on the other hand, what Szasz refers to as the "actual counter-violence of society and the psychiatrist against him" (p. xvii). If we were to cast these dynamics in a more contemporary landscape, we perhaps would be discussing the feared violence of the "other" and the counterviolence of society against the marginalized "other."

The Abuse of Power

One may or may not agree with Szasz's (1970/1997) position regarding institutional psychiatry and its historical implications. However, this type of "official" projective dynamic arguably has been at play in myriad ways across societies and social structures; it unfortunately has been linked with peoples around the world, representing various types of societal needs for scapegoats and also representing the ways in which individuals are willing to act, uncritically, in accordance with institutional demands that equate with evil. For instance, the "good Nazi soldier" has constituted an example of this, as have the results of social psychology experiments in the 1960s and 1970s (e.g., the Milgram experiment and the Stanford Prison experiment), which have served to underscore the dynamics. Such power-related links between Inquisition-era violence and social scapegoats perhaps have become clearer in some of the more recent atrocities spanning the last several centuries. These include the near-extermination of indigenous peoples in the Americas and other parts of the world, the brutal abduction and enslavement of Africans, the Jewish Holocaust, genocides in

Rwanda and Sudan, the high-profile genocide of the Rohingya in Myanmar, and the horrifying treatment of asylum seekers at the southern border of the United States, especially during 2016 to 2020 and especially concerning the separation of children from their families. These examples represent manifestations of a psychology of exclusion or marginalization, of othering, in ways that are marked by an abuse of power and serve as an antecedent lack of morality, and in ways that have had egregious consequences.

The perpetration of violence has presumed the ability to instill fear, and ultimately to control or to take power over others; indeed, it has presumed the role of a more or less passive victim. In many ways, early conceptualizations of trauma were linked to sin, to a fall from grace, or to moral weakness on the part of the victim who somehow “deserved” punishment or persecution. Later conceptualizations of trauma, beginning with the rise of the psychiatric asylum, were subordinate to a diagnosis of mental illness; in fact, some sequelae of PTSD often were misinterpreted, and clients, usually women, were misdiagnosed as having hysteria or schizophrenia and placed in psychiatric hospitals, where they were traumatized further.

These historical examples have indicated as much about the perpetrators of violence—and the abusive power of the institutions that they have represented—as about the cultural assumptions regarding how experiences of trauma have been viewed. The effects of such brutal behaviors do not necessarily go away; they can continue to resonate, for many generations, among the offspring and in the family systems of people who have been brutalized and victimized. This raises the issue of historical trauma and its effects on marginalized groups of people. The field has developed a greater understanding of the effects of historical or racial trauma and consequential epigenetic changes; a fuller discussion of this is presented in [Chapters 2 and 19](#) of this textbook. The field also has identified the impact of adverse childhood experiences (ACEs), which are expounded in [Chapter 2](#). We do not fully understand as yet the social and cultural effects on the people who perpetrate such actions or who allow such conduct to occur in their midst, and this would seem to be an important area for further research.

MODERNITY AND THE CONCEPTUALIZATION OF TRAUMA

The modern study of how trauma affects the human condition is rooted in the genesis of modern psychiatry. In the mid-1800s, Jean-Martin Charcot studied young Parisian women who were hospitalized at the Salpêtrière. In his consideration of “neurosis,” Charcot examined the repercussions of lives filled with sexual assault, poverty, and violence. Charcot recognized that these women were acting out of their subjective realities and that their conditions were psychological in nature ([Herman, 1992b](#)). Charcot’s students, Sigmund Freud, Joseph Breuer, and Pierre Janet, expanded upon his exploration of hysteria and neurosis and further hypothesized that these conditions were caused by exposure to psychological trauma ([Bogousslavsky & Dieguez, 2014](#)). Freud, Janet, and Breuer’s conceptualization of what constituted psychological trauma was initially quite narrow and was constrained to the idea that hysteria and neuroses were caused by psychosexual events. However, by 1917, extensive exploration of the subject of traumatic conditions had created an expanded definition of psychological trauma.

Freud’s classical psychoanalytic approach emphasized the process of repression, replacing earlier notions of dissociation ([Diamond, 2020](#)). His contributions served as a launching pad for various contemporary approaches, which interestingly evolved to re-emphasize the process of dissociation (dissociation is discussed further in [Chapter 2](#) of this book). In his *Introductory Lectures on Psychoanalysis*, Freud proposed a broadened concept of psychological trauma that included “war, railway collisions, and other alarming accidents involving fatal risks” ([Freud & Strachey, 1966/1977](#), p. 274). This more inclusive definition later served as a foundation for delineating and classifying trauma-related disorders within the APA’s *DSMs*. The remaining parts of this section outline the emergent understanding of trauma in World Wars I and II as well as the growing awareness of the impact of trauma in recent decades (the effects of trauma on war veterans are detailed in [Chapter 25](#) of this textbook).

textbook).

World War I and World War II

Initial investigations into the psychological consequences of traumatic exposure were not limited to hysterical women. The advent of World War I, with its proliferation of what were viewed as emotionally disturbed soldiers, brought the psychological devastation that often resulted from combat to the attention of the field of psychology. Charles Myers, a pioneering psychologist in the study of combat-related disturbance, recognized that the soldiers' symptoms appeared to be similar to behaviors that Freud observed in women who suffered from hysteria. Myers originally hypothesized that the behaviors had a physical cause and attributed the behaviors to the intensity of the concussions resulting from explosive weapons (Herman, 1992b). Because of his hypothesis, Myers labeled the syndrome "shell shock." Probably to the dismay of the military, further study showed that many soldiers exhibited the characteristic symptoms of the syndrome, even without exposure to the physical trauma of concussive force (Herman, 1992b). Eventually, the soldiers' neurosis was acknowledged to be the result of the psychological trauma and stress of combat, with its constant state of violence, threats to life, and horrific images (Herman, 1992b; van der Kolk, 1996, 2000, 2014).

By the end of World War I, psychiatric professionals had adopted the position that combat fatigue, or "war hysteria" as it became known, was a disease created by a lack of "will to be well" on the part of the affected soldier (van der Kolk, 1996). This view, especially prevalent among professionals serving in the military or in positions with connection to the armed services, followed a course of development similar to the earlier studies of hysteria in women. Soldiers were expected to be brave, heroic, and stoic in their adaptation to the rigors of their war experiences. Those who succumbed to psychological distress were categorized as being of poor moral character or of weak temperament (Herman, 1992b; van der Kolk, 1996). This view mirrored initial interpretations of women who exhibited neurotic symptoms as being internally weak and flawed.

Some psychiatrists of the time, most notably W. H. R. Rivers, viewed combat neurosis, or war hysteria, as a pathological, traumatic syndrome that was a result of the severity of the stressors of combat and not a weakness of character (Herman, 1992b; van der Kolk, 1996, 2014). Rivers, who based his treatment interventions upon psychoanalytic principles, strongly believed that combat-related hysteria could affect any soldier, regardless of moral character or capacity for bravery (van der Kolk, 1996). After the war ended, veterans' hospitals continued to serve the psychiatric needs of soldiers who experienced persistent disabilities resulting from their combat experiences. However, these veterans garnered little attention from the medical community, which seemingly adopted the view that the horrors of war and the lasting consequences either could be forgotten or erased, if only they were ignored (Herman, 1992b).

During the time of peace between World War I and World War II, there was little scientific interest in the field of traumatic study. However, the issue of traumatic exposure remained of interest to a few professionals within the arena of psychology. After a career in psychoanalysis and anthropology, American psychiatrist Abram Kardiner began to study combat-related disorders and psychological trauma (van der Kolk, 2001, 2014). Kardiner explored past assessments, theoretical frameworks, and studies on combat-related hysteria, synthesizing his findings in his 1941 work, *The Traumatic Neuroses of War*. Kardiner decried the use of the label "hysterical" in reference to suffering soldiers, as he felt that it promulgated the impression that the experienced disturbance was a result of character weakness or internal flaws (Herman, 1992b).

Growing Awareness of the Impact of Trauma

Social awareness of PTSD evolved concomitantly within the psychiatric community and the public (Friedman et al., 2007; Jones & Wessely, 2006). As an example of emerging public awareness, the symptoms of PTSD were portrayed in Hollywood *film noir* in the 1940s, more than 30 years before the diagnosis first was included in the *DSM-III* (Miller, as cited in Levers, 2001). Earlier war-related investigations of trauma eventually piqued the interest of the civilian sector, and conditions born from noncombat-related trauma began to be examined. As televised atrocities routinely aired in living rooms across the globe, the social movements of the 1960s and 1970s spawned an expansion of examining traumatic experiences and their impact. The experiences certainly were traumatic for those involved, but the news-consuming public also experienced the trauma, vicariously, vis-à-vis newspaper accounts and television news footage. Several of these movements relevant to this conversation are discussed in the following text.

Civil Rights Movement

The Tulsa Massacre occurred on May 31 and June 1, 1921, and its 100-year anniversary recently was commemorated, instructing a large swath of the population about a sordid incident in American history that had been covered up. This massacre was an extreme example of the many savage attacks on African American communities post emancipation (*Smithsonian Magazine* offers a vivid account of this atrocity at: www.smithsonianmag.com/history/tulsa-race-massacre-century-later-180977145/). The civil rights movement in the United States, during the 1950s and 1960s, unveiled the violence long associated with racism. Even though slavery had been abolished in the previous century, Jim Crow laws legalized segregation, continuing from after the Civil War through the end of the 1960s (Chapter 17 of this textbook offers more information about this). The fight for civil rights, led mostly by African Americans, but having some allies of other races, had a vicious backlash then, similar to what we are witnessing now (Glickman, 2020). Emmet Till, a 14-year-old African American male, was brutally murdered in Mississippi. Lynching of African Americans still was occurring in the United States through the late 1960s (NAACP, 2021). These types of events were traumatizing, and they were used by certain White Americans to terrorize and attempt to control Black Americans (Lartey & Morris, 2018). These types of events galvanized the civil rights movement.

Federal civil rights legislation was proposed in the early 1960s, first by President John F.

Federal civil rights legislation was proposed in the early 1960s, first by President John F. Kennedy and then by President Lyndon B. Johnson. The response to the proposed legislation was vile and led to many instances of violence against African Americans, including murder. Groups of mostly African American civil rights activists formed, and they were called Freedom Riders ([History.com Editors, 2021](#)); the groups included both Black and White activists, and those who wished to deny the civil rights of African Americans targeted both. The late John R. Lewis, former U.S. Representative, was a youth activist and a Freedom Rider during the civil rights movement of the 1960s, continuing until his death in 2020. Although televised news coverage was not yet available to capture earlier atrocities, such as the Tulsa Race Massacre in 1921, people watched their television news programs in horror in 1965, as Mr. Lewis and other young activists were beaten, savagely, on the Edmund Pettus Bridge. It was on this bridge that state troopers attacked peaceful protesters, who were exercising their rights to free speech and to protest peacefully against racism; this day became etched in the memory of the public as "Bloody Sunday." It is not surprising, then, that racism, along with its tantamount historical trauma, have contributed to and constituted the serious public health problem that we continue to face today ([Cardarelli et al., 2021](#); [Wamsley, 2021](#)).

Vietnam

As the men and women who served in combat in Vietnam returned to the United States, interest arose, again, concerning the effects of combat upon the human psyche. The tensions related to the social discourse surrounding the war brought the issue to the forefront of the national media. Television news programs broadcast images of longhaired, wild-eyed soldiers into the homes of unsuspecting Americans, who were forced to consider the negative psychological results of war upon the nation's sons and daughters. The images of the conquering hero, which had been the theme of the returning World War II soldier, were replaced with a more disturbing reality. American men and women were returning home with trauma-related mental health conditions that seriously affected their ability to function in all of the domains of their lives. This new breed of veteran often felt guilt-ridden, angry, and emotionally volatile, which had serious implications for their spouses and children ([Z. Solomon et al., 1987](#)). The general population was drawn into an emerging awareness of combat-related trauma conditions.

Violence Against Women and the Rape Crisis Movement

Professional and popular conceptualizations of trauma continued to expand through the end of the 20th century. With the advent of the second wave of the women's liberation movement, issues related to the "tyranny of private life" for women began to be examined ([Herman, 1992b](#)). Early exercises of consciousness-raising groups, in the 1960s and 1970s, soon led to open, and heretofore unprecedented, discussions of the psychological impact of rape, sexual assault, incest, and the sexual subjugation of women for political purposes ([Herman, 1992b](#); [Lating & Everly, 1995](#); [Sinha et al., 2017](#)). The field of psychiatry then acknowledged that sexual assault led to psychological distress that substantially mimicked combat neurosis in its symptom presentation. Psychiatric nurses Lynda Holmstrom and Ann Burgess observed a pattern of numbing, increased startle response, nightmares, dissociative symptoms, nausea, and insomnia in rape victims who came to Boston Hospital for treatment ([Burgess & Holmstrom, 1974](#)). They labeled this pattern of symptom presentation as "Rape Trauma Syndrome," thus pushing the field to consider an even broader definition of traumatic victimization that later was incorporated into the formal diagnostic criteria for PTSD.

Violence Against Children and the Child Protective Movement

As traumatic exposure in noncombat-related situations became more widely recognized as a source of emotional distress and disturbance, issues related to children emerged as a particular area of focus. It long had been acknowledged that children are equally susceptible to the stressors of traumatic events as are their adult counterparts, but it was thought that the reactions of children were of a less severe nature and shorter lived than for adults ([Yule, 1998](#)). Prior to 1987, little research existed to define or delineate the differences in stress responses between adults and children. Since the 1990s, differential diagnosis of PTSD in

responses between adults and children. Since the 1990s, differential diagnosis of PTSD in children has included refinements of symptom presentation that may manifest in children. Some significant differences have included developmentally sensitive displays of disorganized or agitated behavior in children, as well as generalized nightmares and traumatic play (APA, 2000, 2013). The *DSM-5* (APA, 2013) has included a new subtype of PTSD that is specific to children under the age of 6 years (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016).

Statistics have suggested that children experience rape, robbery, assault, and physical violence at a greater rate than do adults (Finkelhor et al., 2013). According to a 1990 study by the U.S. Department of Justice, adolescents were 2.5 times more likely to be the victim of a violent crime than adults, although this trend has decreased since the mid-1990s to a little over one-sixth of what it had been (e.g., Child Trends, 2018; Wordes & Nunez, 2002). However, it has been alarming that these experiences often occur within the child's own family system.

One relatively recent development in the study of PTSD in children has been increased research regarding exposure to family and domestic violence as a catalyst for the development of children's stress-related disorders. Further confounding studies of family violence and PTSD, is the disturbing fact that children who experience trauma at home also are more likely to experience violence in their community, with their peers, and in their personal relationships (Margolin & Vickerman, 2007). Often these exposures are of a chronic nature, presenting challenges to accepted definitions of trauma and trauma experience. These challenges, referenced as complex trauma, are addressed later in this chapter and examined more fully in Chapter 9 of this textbook. It is widely accepted that PTSD appears to be one of the most common psychiatric disorders in children and young adults (SAMHSA, 2014).

POSTTRAUMATIC STRESS DISORDER AND THE *DIAGNOSTIC AND STATISTICAL MANUALS*

The construct of psychological trauma has changed over time. Especially pertinent to this discussion is how the construct has changed in relationship to mental health diagnostics, which has not been without controversy (Carvajal, 2018). This section briefly explores the evolution of trauma-related conceptualizations in the *Diagnostic and Statistical Manuals*, the relatively recent discussion of complex trauma, and the interface of trauma with multiple diagnostic categories.

The Articulation of Trauma in the *Diagnostic and Statistical Manuals*

In 1952, the American Psychiatric Association released the first *Diagnostic and Statistical Manual of Mental Disorders* as a means to mitigate some of the limitations found in using nomenclature from the *International Statistical Classification of Diseases, Injuries, and Causes of Death* (ICD-6). The ICD has been the World Health Organization's (WHO) diagnostic nosology, used globally since its inception. In the ICD-6, stress-related reactions were labeled as "acute situational maladjustment" (WHO, 1949). The *DSM-I* labeled stress-related conditions under the heading of "Transient Situational Personality Disturbance" (APA, 1952). The diagnosis of gross stress reaction was included under this heading and defined psychic disturbance related to combat or civilian catastrophe. Under the same heading, other stress-related conditions were given the labels of adult situational reaction as well as adjustment reaction of infancy, of childhood, of adolescence, or of late life (APA, 1952).

A revised edition of the *DSM* was released in 1968; the *DSM-II* (APA, 1968) reclassified traumatic experience into a category called "Adjustment Reaction of Adult Life." There was no longer a description of the diagnosis, and criteria were explained through the provision of three examples of qualifying experiences. These experiences were unwanted pregnancy, military combat, and being sentenced to death (APA, 1968). There was an asterisk next to the category, which directed the reader to the appendices, where additional examples of similarly qualifying stressful events could be found. These events included railway, car, boat, and plane accidents (Wilson, 1995). One might wonder about the lack of explication of the various types

accidents (Wilson, 1995). One might wonder about the lack of explication of the various types of trauma and the resultant psychological manifestations, but clearly, the intent of the authors was to provide an inclusive category within which to place reactions related to all traumatic experiences that resulted in anxiety, fear, and feelings of overwhelming loss of control (van der Kolk et al., 2007; Wilson, 1995).

In 1980, the third edition of the manual, the *DSM-III* (APA, 1980), offered another reclassification of trauma-related syndromes, locating it within the anxiety disorder section of the manual. The manual contained a new diagnosis, PTSD, which encompassed combat neurosis, rape trauma syndrome, and battered women syndrome. Based substantially upon Kardiner's (1941) work, the diagnosis was a compendium of symptoms culled from clinical records, research, and literary explorations of those working with various trauma-related syndromes (van der Kolk, 1996, 2000). The symptoms of PTSD were clustered into three distinct categories, from which an individual needed to exhibit four symptoms in order to meet the criteria for diagnosis. These clusters encompassed symptoms of re-experiencing the trauma, a display of the effects of numbing and detachment, and changes in personality. In order to meet the diagnostic criteria, the manual further specified that a stressor of relatively universal concern or suffering must be present (APA, 1980). The requirement to identify a recognizable stressor replaced the previously provided list of examples of qualifying traumatic events that were present in earlier editions of the manual. Although there appeared to be a tacit understanding that certain types of events would be particularly distressing, there was neither a discussion of etiology nor an examination of how individual perceptions of events as being traumatic can vary from person to person (Everly & Lating, 1995). The notion of the variability of human perception of events as traumatic became a salient feature for the diagnosis of PTSD in future iterations of the *DSM* and is discussed at a later point in this chapter.

In 1987, the *DSM-III-R* (APA, 1987) was published, with further revisions to the diagnosis of PTSD. In an attempt to provide clarification of what constituted a traumatic event or recognizable stressor, the phraseology "outside of the range of normal human experience... that would be markedly distressing to almost anyone" was added to the criteria (APA, 1987, p. 250). Further, a list of examples of qualifying events was provided again. These examples included serious harm or threats of serious harm to self, children, spouse, or other loved ones; seeing another person killed or seriously injured as a result of violence or accident; and experiencing the sudden destruction of one's home (APA, 1987). Of note, traumatic events that were within the realm of normal human experience, such as being the victim of a violent crime or experiencing or witnessing a serious automobile accident, and that we now view as highly traumatic and as potential triggers for PTSD, were *not* included in the description (Spitzer et al., 2007). Additionally, the list of symptoms was expanded to 17, and the number of symptoms necessary for diagnosis was increased to six. The final significant change in the *DSM-III-R* diagnostic criteria for PTSD was the extension of special qualifiers that related to the manifestation of the disorder in children. Prior to this point, the field promulgated an assumption that children experienced, processed, and exhibited symptoms of traumatic exposure in much the same way as adults, if at all. The *DSM-III-R* clarified that children may display disorganized or agitated behavior instead of the fear, helplessness, or horror listed as adult symptoms under criterion A of the diagnostic category (APA, 1987). According to criterion B, children may demonstrate repetitive play with themes related to the trauma instead of having intrusive recollections, and further, children's dreams may be frightening but occur without recognizable content of the trauma, as would be present in adult experiences (APA, 1987). Although the revisions were intended to provide clarity and to refocus on PTSD as a disorder, debate continued well into the preparation of the *DSM-IV*.

The 1994 revision of the manual, *DSM-IV* (APA, 1994), again brought substantial changes to the PTSD diagnosis. The previously noted statements regarding the need for the stressor to cause distress for most people and to be beyond the normal range of human experience were removed from the criteria in an effort to define trauma more explicitly and to address the problem of common, yet clearly traumatic, events being excluded from the criteria. Some clinical experts suggested that the stressor be defined in terms that are more subjective. Among the experts, most notably were S. D. Solomon and Canino (1990), who advocated for

Among the experts, most notably, were S. D. Solomon and Canino (1990), who advocated for defining the qualifying circumstances or traumas in a more general manner, such as an "extremely shocking event," that would speak to the subjective perception of the individual and provide for broad inclusion of experiences. Others advocated for a more objective classification that further would delineate the symptom and response presentation necessary for differential diagnosis (Lasiuk & Hegadoren, 2006; van der Kolk et al., 2007). Eventually, a combination of subjective and objective measures was included within criterion A.

Criterion A1 addressed the subjective nature of traumatic exposure by defining a qualifying event in which the individual "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (APA, 1994, p. 427). The addition of criterion A1 mitigated the previous omission of considering the subjective or perceptual reality of the individual who experienced the event. The external nature of the event sustained the notion that the etiology of the disorder is external to the individual. Criterion A2 addressed the need for an objective component of the definition by describing the individual's response as one that demonstrated "intense fear, helplessness, or horror" (APA, 1994, p. 428). These changes propagated the controversy surrounding the diagnosis, perhaps going too far with the notion of perception by using the words "confronted with" in criterion A1 (APA, 1994, p. 427). As a broad concept, open for significant interpretation, the addition of this wording substantially expanded the number of individuals who met the criteria for the disorder and allowed for conceptual bracket creep, or a stretching of the boundaries of the diagnosis, beyond the categorical limitations of earlier definitions (McNally, 2003). The last substantive change to the diagnostic criteria of PTSD in the *DSM-IV* was the addition of specifications regarding the duration of symptoms. The following delimitations primarily affected time frames: (a) acute, which was defined as duration of symptoms of less than 3 months; (b) chronic, with duration of symptom presentation of 3 months or more; and (c) delayed onset, with a symptom presentation that did not appear until 6 months or more after exposure to the stressor (APA, 1994).

In an attempt to separate what could be viewed as an early, simple reaction to traumatic exposure from the more chronic, debilitating sequelae of PTSD, a new trauma-related disorder was included in the *DSM-IV*. Placed within the anxiety disorder category, ASD had many of the same diagnostic criteria as PTSD but had an onset of occurrence of symptom presentation within 1 month of the traumatic exposure and was described as lasting for at least 2 days and for a maximum of 4 weeks (APA, 1994). Additionally, ASD criteria included the presence of three or more dissociative symptoms from a list of five that was provided (APA, 1994). Some have argued that the high rates of individuals who progress from ASD to PTSD and the shared symptom profile of the two disorders strongly pointed to ASD as an early form of PTSD, not a separate condition (Classen et al., 1996; Marshall et al., 1999).

In 2000, the APA released the *DSM-IV-TR*. There were no substantive changes to the trauma-related diagnostic criteria in this edition. Rather, as the last edition was published some 16 years prior, and the next full revision was not expected until 2012 at the earliest, changes in the descriptive text were made to reflect the current state of research and empirical literature. Debate regarding trauma-related disorders continued, with many changes proposed for the *DSM-5* (with the fifth edition, the American Psychiatric Association switched from using a Roman numeral to using an Arabic numeral in the sequencing of the volumes). A number of dramatic events, in the first decade of the new millennium, compelled a renewed social science examination of human response to extraordinary circumstances. Some of these events of mass violence (further detailed in Chapter 20 of this book) and natural disaster (further detailed in Chapter 22 of this book) included the terrorist attacks of September 11, 2001; the Oklahoma City bombing; the shootings at Columbine High School and Virginia Tech; the shootings and bombing in Norway; the 2010 earthquakes in Haiti and Chile; and the 2011 earthquake/tsunami/nuclear disaster in Japan.

The APA released the much-anticipated *DSM-5* in 2013. In this most recent revision, PTSD was removed from its previous category as an anxiety disorder in *DSM-IV-TR* (APA, 2000), and has been placed in the chapter on Trauma- and Stressor-Related Disorders in the *DSM-5*. However, the very location of the chapter has been significant, in that it immediately follows

However, the very location of the chapter has been significant, in that it immediately follows chapters on Anxiety Disorders and Obsessive-Compulsive and Related Disorders and appears right before the chapter on Dissociative Disorders. The introduction to the Trauma- and Stressor-Related Disorders chapter importantly notes that the sequencing of the chapter indicates a close relationship among these sets of diagnoses (APA, 2013). An understanding of the relationships among these diagnostic categories is essential for ruling out unsuitable diagnoses and for making accurate diagnoses (Tehrani & Levers, 2016). Other changes to the diagnostic criteria, from the *DSM-IV* to *DSM-5*, have included the following modifications: eliminating the subjective component in defining trauma, explaining and narrowing the definitions of trauma and exposure to it, increasing and rearranging the symptoms criteria, and alterations in additional criteria and specifiers (Pai et al., 2017).

Further revisions that are specific to the diagnostic criteria for PTSD in *DSM-5* (APA, 2013) have involved the addition of new items such as experiencing exaggerated negative expectations, having a distorted sense of self-blame, and experiencing persistent negative emotions. In addition, some of the revisions have offered clarification of what constitutes “experiencing a traumatic event” as well as a redefinition of the symptom presentation of dissociative reactions and the concept of avoidance. A number of scholars and clinicians have suggested that perhaps the best and most efficacious approach is to reconceptualize the diagnosis as a spectrum disorder rather than a single entity, with resilience at one end and severe symptomology at the other (e.g., Goodman, 2012; Lasiuk & Hegadoren, 2006; Wolf et al., 2018). The trauma- and stressor-related disorders included in the current *DSM-5* (APA, 2013) comprise the following:

- Reactive Attachment Disorder (RAD)
- Disinhibited Social Engagement Disorder (DSED)
- Posttraumatic Stress Disorder (PTSD)
- Acute Stress Disorder (ASD)
- Adjustment Disorders
- Other Specified Trauma- and Stressor-Related Disorder
- Unspecified Trauma- and Stressor-Related Disorder

The changes in the *DSM-5* (APA, 2013) have not gone without criticisms, which began significantly prior to publication (e.g., Rosen et al., 2008). It goes beyond the scope of this chapter to detail all of the controversies that surround the latest articulation of PTSD, but it is important to highlight some of the more widely discussed areas of concern. First, a number of experts consider criterion A to be too limiting—it requires actual exposure to a traumatic event as a specific benchmark, to the possible exclusion of those who have experienced other trauma-related clusters of symptoms. Second, many experts advocated for the inclusion of a complex posttraumatic stress disorder (CPTSD) diagnosis in *DSM-IV* (e.g., Courtois, 2008; Herman, 1992a) and, subsequently, in *DSM-5*. Other scholars (e.g., Resick et al., 2012; Rosen et al., 2008) have argued, conversely, that while the discussion magnifies the complexity of multiple traumatic events, the actual evidence has not supported the classification of a new diagnostic category. Finally, some experts have expressed concerns about referencing “disorder” as a descriptor for the trauma that people experience in the event of danger and potential or real harm. Ochberg (2012) has suggested the term “posttraumatic stress injury” (PTSI) as a less stigmatizing and more suitable designation. However, similar to the momentum for inducting CPTSD into the new manual, the drive simply did not gain adequate support for inclusion in the *DSM-5* (Tehrani & Levers, 2016). In the face of all of these changes over the decades since PTSD first was included in the *DSM-III*, it is likely that the criteria will remain under scrutiny and that experts will continue to examine the nature of trauma and its effects. Whether CPTSD finds a designation in a future version of the *DSM* is anyone’s guess, but the construct remains a useful one for clinicians (e.g., Ford, 2020; John et al., 2019; Kumar et al., 2019; Yearwood et al., 2019) and warrants a brief discussion here.

Posttraumatic Stress Disorder and the Effects of Complex Trauma

The diagnostic criteria for PTSD have undergone revisions as research regarding the

The diagnostic criteria for PTSD have undergone revisions, as research regarding the phenomena of traumatic experience has continued to elucidate its effect on the human condition. By the early 1990s, clinicians and researchers, who were exploring PTSD in people who had experienced domestic violence, child abuse, and other long-term exposures, began to identify that the symptom pattern produced by these types of exposures was not defined adequately by the prevailing diagnostic criteria (Briere, 1987; Courtois, 2008; Herman, 1992b). At issue seemed to be what were classified as “comorbid” conditions that, arguably, appeared to be a result of traumatic exposures of a more complex nature (Courtois, 2008). For example, children who have been exposed to family violence, child abuse, or other ongoing maltreatment have experienced trauma over extended periods. These experiences have occurred during different phases of the children’s emotional development, and at the hands of their family members or other significant caregivers, which makes their experiences substantially different from those of combat veterans or individuals who experience acute types of trauma like accidents or natural disasters. Although the effects of such exposure were found to be similar in nature to the prevailing understanding of PTSD, there were significant differences (Herman, 1992b; John et al., 2019; Kliethermes et al., 2014; McCormack & Thomson, 2017; Yearwood et al., 2019). These differences seemed especially pronounced in relationship to the developmental trajectories of children experiencing maltreatment early in childhood, at the hands of the very caregivers whom the children *ought* to be able to trust. In evidence were psychological disturbances not incorporated within the *DSM-III* diagnostic criteria for PTSD, such as medical and somatic complaints, depression, anxiety, dissociative disorders, substance abuse issues, and interpersonal relationship problems (Courtois, 2008).

Because of research regarding the experience of complex exposure to trauma, experts in the field proposed that the PTSD committee, which had been empaneled to explore stress disorders for the *DSM-IV*, also conduct field trials regarding complex exposure to trauma. The committee set out to investigate the possibility of including a diagnosis of complex PTSD, as well as a constellation of trauma-related symptoms not under the umbrella of trauma-related conditions at the time, which could be classified as “Disorders of Extreme Stress Not Otherwise Specified (DESNOS)” (Roth et al., 1997). The DESNOS designation was intended to focus primarily on the effects of early interpersonal trauma. The DESNOS category would consist of the following seven additional criteria, which may result from chronic victimization: (a) changes in emotional regulation, including difficulty with modulation of anger and self-destructive behavior; (b) alterations in consciousness, including amnesias and dissociative episodes; (c) alterations in self-perception such as shame, guilt, and stigmatization; (d) changes in relationship to others, including a lack of trust or loss of intimacy; (e) somatic complaints; (f) changes in one’s sense of meaning such as loss of faith or despair; and, (g) changes in perceptions about the perpetrator (Herman, 1992b; Pelcovitz et al., 1997; van der Kolk, 2001).

The *DSM-IV* field trial, conducted between 1991 and 1992, found 92% comorbidity between DESNOS and PTSD and, as such, a separate diagnosis was not included in the revision of the manual; however, the symptom pattern was incorporated as an associated feature of PTSD (APA, 1994). Since those first field trials, interest in the impact of early and repetitive exposure to relational trauma has continued to increase, and based on continuing research, support for a separate diagnosis has continued to grow (e.g., Ford, 2017; John et al., 2019; Kliethermes et al., 2014; McCormack & Thomson, 2017). Ford (1999, 2017, 2020) found that DESNOS could, in fact, occur in the absence of PTSD, despite the substantial overlap. He further found that PTSD and DESNOS were substantially different in terms of symptoms and functional impairment features (Ford, 1999, 2017, 2020). Research continues to examine whether these conditions are, indeed, separate conditions that frequently may be comorbid but are patently unique.

A primary issue has arisen with the growing awareness that treatment interventions between individuals with PTSD and with DESNOS may need to be significantly different in order to intervene, safely and effectively, with those having complex trauma histories (Ford, 1999, 2017, 2020; John et al., 2019; Kliethermes et al., 2014; McCormack & Thomson, 2017; van der Kolk, 2001). Although the case that was made for complex trauma seemingly was not

van der Kolk, 2001). Although the case that was made for complex trauma seemingly was not sufficient for inclusion in the *DSM-5*, the WHO has included complex posttraumatic stress disorder (C-PTSD) in its final draft of the 11th edition of the *International Statistical Classification of Diseases and Related Health Problems (ICD-11)* (Rosenfield et al., 2018). As previously suggested, while complex trauma is not officially recognized in the *DSM-5*, it is nonetheless a useful construct for clinicians in understanding the rippled effect that multiple and complex traumas may have on an individual client. The utility of understanding complex trauma is elaborated more fully in Chapter 9 of this textbook.

The Interface of Trauma With Multiple Diagnostic Categories

As previously discussed, the notion that traumatic exposure and stress can create psychiatric illness in “normal” individuals has had a long and well-researched history. By definition, the diagnosis of PTSD remains unique in that its etiology stems from an outside stressor. Demonstrated in an earlier study, although exposure rates of traumatic events among the general population ranged from 36% to 81%, only 7% to 10% of exposed individuals developed PTSD (Breslau et al., 1998). In a later study, Kilpatrick et al. (2013, p. 537) found that “Traumatic event exposure using *DSM-5* criteria was high (89.7%), and exposure to multiple traumatic event types was the norm.” What has continued to confound those in the field is the prevalence of comorbid conditions, which suggest that, perhaps, there is a combination of factors at work (Yehuda & McFarlane, 1995). Although any real consensus among experts has remained elusive, an existing body of PTSD research seems to describe a spectrum of disorders that often are present in those who have survived traumatic exposure.

An abundance of evidence has suggested that traumatic exposure can lead to a wide array of psychological disturbances that meet the diagnostic criteria within the *DSM*. The disorders vary in severity from adjustment disorders to more lasting and grave manifestations. Traumatic exposure has shown a strong correlation with anxiety disorders (Spinhoven et al., 2014), substance abuse disorders (Killeen et al., 2015), dissociative disorders (McDowell et al., 1999; Swart et al., 2020), major depression (Flory & Yehuda, 2015; Spinhoven et al., 2014), and eating disorders (Brewerton, 2007; Rijkers et al., 2019). Additionally, borderline personality disorder (BPD) displays commonality with the symptom cluster of complex PTSD and shares, at its core, a high frequency of interpersonal trauma (Cloitre et al., 2014; Harned et al., 2018; Yen et al., 2002). When a broad definition of trauma is applied to the life experiences of people seeking treatment for psychological disorders, most are found to have experienced at least one traumatic exposure across the life-span.

Given the statistical probability that individuals will experience traumatic exposure during their lifetimes, it is the expectation rather than the exception that mental health clients will present with trauma histories. Indeed, a significant percentage of clients who are diagnosed with serious mental disorders such as psychotic disorders, schizophrenia, and bipolar disorder detail extensive trauma backgrounds (Goodman et al., 1997; SAMHSA, 2014). Further, individuals with extensive trauma histories often present with complex symptom patterns that involve multiple disorders, making differential diagnosis difficult. Najavits et al. (2009) describe this as a “central paradox,” stating that “comorbidity with PTSD is the norm, yet treatment outcome studies routinely exclude clients with significant comorbid conditions and fail to assess for them” (p. 508).

RESILIENCE

An introductory discussion of trauma would not be complete without emphasizing the courage and resilience shown by survivors of trauma. It is important that mental health professionals bear in mind that not everyone who experiences trauma develops PTSD. For a variety of reasons, many individuals possess or are able to develop greater resilience and then can cope better with the immediate or aftereffects of traumatic experiences. The U.S. Department of Veterans Affairs (USDVA, 2018) has reported that about 60% of men and 50% of women experience a traumatic event in their lifetimes. Epidemiological research (Benjet et al., 2016) has indicated that about 70% of people, worldwide, have been exposed to at least

al., 2010) has indicated that about 70% of people, worldwide, have been exposed to at least one traumatic incident in their lives. About 7% to 8% of the population qualifies for a diagnosis of PTSD at some point in life (USDVA). So, as ubiquitous and terrifying as trauma may be, it appears that human beings have a real capacity for resilience in the face of traumatic events; the human spirit seems to have an innate ability to transcend adversity. In fact, research has suggested that between 30% to 70% of individuals who experience trauma also report positive change and growth emerging from the traumatic experience (Joseph & Butler, 2010).

Calhoun and Tedeschi (1998) have initiated the concept of posttraumatic growth (PTG), although the construct has remained somewhat controversial. PTG may account for the positive psychological change that results from an individual's engagement with a traumatic event. Tedeschi and Calhoun (2004) have defined PTG as representing

the experience of individuals whose development, at least in some areas has surpassed what was present before the struggle with crises occurred. The individual has not only survived, but has experienced changes that are viewed as important, and that go beyond the status quo. Posttraumatic growth is not simply a return to baseline—it is an experience of improvement that for some persons is deeply profound. (p. 4)

Posttraumatic growth has been associated with a number of interrelated constructs, including resilience, hardiness, and a sense of coherence (Almedom, 2005). However, even though PTG has been reported in an array of samples, it remains controversial due to measurement challenges (Park & Lechner, 2006). Typically, PTG is assessed by self-report, through interviews, or in questionnaires, and sceptics question the validity of the construct (e.g., Frazier & Kaler, 2006; Park & Sinnott, 2018; Steger et al., 2006). A web-based study of 1,739 adults concluded that growth, following trauma, might entail the strengthening of character (Peterson et al., 2008). PTG should not be perceived as a consequence of trauma; rather, it is one possible outcome of the process of working through the aftermath of trauma (Levers, 2020). The discussion of growth after trauma does not discount, in any way, the negative effects of trauma. Rather, attention to growth-promoting therapeutic strategies can facilitate a meaning-making process that potentially enhances a survivor's sense of purpose and promotes personal growth and change (Almaier, 2017). It is essential to understand how the various risk factors and protective factors existing in a person's life at the time of a trauma event and immediately after may contribute to the degree to which the trauma has a lesser or greater impact. Clinicians need to consider the resilience and hardiness of their clients and to maintain a growth-oriented and meaning-making perspective when working with clients who have been traumatized.

According to a publication by Harvard University's Center on the Developing Child (n.d., pp. 1-2), the following elements are important considerations regarding resilience:

Resilience requires supportive relationships and opportunities for skillbuilding.

Resilience results from a dynamic interaction between internal predispositions and external experiences.

Learning to cope with manageable threats to our physical and social well-being is critical for the development of resilience.

Some children respond in more extreme ways to both negative and positive experiences.

Individuals never completely lose their ability to improve their coping skills, and they often learn how to adapt to new challenges.

COUNSELING IMPLICATIONS

As suggested by the rates of exposure to traumatic events among the general population, trauma is a factor that clinicians need to consider when they embark upon a course of treatment with any client. Although most mental health agencies and clinicians routinely obtain information regarding medical and psychosocial histories, it is not nearly as routine to ask about a history of trauma. This, in fact, should be a standard line of inquiry that is a part of any routine intake process, and the information should be requested in as normalized a fashion as possible; in other words, it should be read as a simple and nonthreatening

fashion as possible—in other words, it should be posed as a simple and nonthreatening question that is a part of the larger intake protocol.

Diagnoses are not dogma; by reviewing the history of how the effects of traumatic events have been viewed through the ages, we can see that the psychosocial notion of trauma is one that has been constructed by humans, over time, and that is connected to the cultural ethos in which people pay attention to those affected by traumatic events. At the same time, we now understand that a traumatic event triggers a cascade of neurochemical responses that account for many trauma-related reactions (this is discussed further in [Chapters 2, 3, and 4](#)). Clinicians need to *listen* to the narratives of clients describing the effects of traumatic events and to pay attention both to interpersonal and to family dynamics. Statistically speaking, the potential is high that most therapists are likely to counsel clients who have trauma histories. It also is likely that any practicing clinician may see the effects of racial or transgenerational trauma.

One of the most robust implications across the various clinical fields is the need for more preservice training around issues pertaining to the effects of traumatic events. We need to assist students in understanding the evaluation and treatment of persons who have been exposed to trauma as well as to the effects of stress, crises, and disasters. I am hopeful that, by presenting related foundational knowledge as a trauma scaffold, students and clinicians alike can build upon this scaffold, incorporating other foundational practice and treatment information as we continue to understand increasingly more advanced and complex issues regarding trauma. Along these lines, more research is needed regarding assessment, treatment, and pedagogical issues associated with the effects of trauma.

CONCLUSION

In this chapter, we have explored the historical context of the way in which we have come to view the effects of traumatic events and how we have arrived at several trauma-related diagnostic categories. Although trauma has been a part of the human experience, probably since the beginning of time, an awareness of the impact of trauma on the lives of affected people has developed slowly and only within recent history. We have seen how, in certain historical eras, specific groups of people have been marginalized and actually targeted for violence. In these instances, the abuse of institutional power seems to be linked with the willingness of some members of society to perpetrate violence against the targeted groups. We also have seen how an interest in the experience of psychological trauma emerged with the advent of psychoanalysis and continued through the lens of war and particular social movements. A brief discussion regarding resilience has emphasized the importance of growth-oriented and meaning-making recovery processes, especially in an effort to mitigate diagnostic tendencies toward viewing trauma as necessarily psychopathological. Finally, I have identified some of the implications for understanding the historical and psychosocial contexts of trauma. I believe that an awareness of the historical context of certain traumatic events

and an understanding of societal responses can help those mental health professionals working with trauma, stress, crisis, and disaster to be more effective in their practice.

Author's Note

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ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Websites

Blakemore, E. (2020, 17 June). How PTSD went from 'shell-shock' to a recognised medical diagnosis. *National Geographic*. www.nationalgeographic.co.uk/history-and-civilisation/2020/06/how-ptsd-went-from-shell-shock-to-a-recognised-medical-diagnosis

The Institute on Trauma and Trauma-Informed Care. *What is trauma-informed care?* University at Buffalo, Buffalo Center for Social Research. <http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html>

Without Sanctuary <https://withoutsanctuary.org>

Videos

Understanding Trauma (2020; 2:21) www.youtube.com/watch?v=v60Pi87sqhI

What Is Trauma? (2018; 1:33) <https://youtu.be/uraDbhfFvsk>

The Attachment Theory: How Childhood Affects Life (7:36) www.youtube.com/watch?v=WjOowWxOXCg

Center on the Developing Child, Harvard University; Short Videos on Resilience:

In Brief: What Is Resilience? (2015; 2:22) <https://youtu.be/cqO7YoMscU>

In Brief: The Science of Resilience (2015; 2:29) <https://youtu.be/1r8hj72bfGo>

In Brief: How Resilience Is Built (2015; 2:17) <https://youtu.be/xSf7pRpOgu8>

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The Institute on Trauma and Trauma-Informed Care. *What is trauma-informed care?*
University at Buffalo, Buffalo Center for Social Research. <http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html>
Without Sanctuary <https://withoutsanctuary.org>

Videos

Understanding Trauma (2020; 2:21) www.youtube.com/watch?v=v60Pi87sqhI
What Is Trauma? (2018; 1:33) <https://youtu.be/uraDbhfFvsk>
The Attachment Theory: How Childhood Affects Life (7:36) www.youtube.com/watch?v=WjOowWxOXCg

Center on the Developing Child, Harvard University; Short Videos on Resilience:

- *In Brief: What Is Resilience?* (2015; 2:22) <https://youtu.be/cqO7YoMscU>
- *In Brief: The Science of Resilience* (2015; 2:29) <https://youtu.be/1r8hj72bfGo>
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CHAPTER 2

Theoretical Contexts of Trauma Counseling: Understanding the Effects of Trauma, Stress, Crisis, and Disaster

LISA LÓPEZ LEVERS

CHAPTER OVERVIEW

This chapter introduces multiple theoretical contexts for understanding the impact of trauma. Building upon the foundational information presented in [Chapter 1](#), the current chapter examines how the construct of trauma evolved from primarily life-span and psychological understandings, to a more systems and psychosocial perspective, to our current neurobiological realizations about the effects of trauma. The connections among facets of trauma, which are described in [Chapters 1](#) and [2](#), offer a foundational scaffold upon which to understand the profound effects of traumatic experiences.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Begin to identify a larger context for understanding the often interconnected issues of stress, crisis, trauma, and disaster;

2. Begin to understand developmental, bioecological, and neurobiological theories regarding the effects of trauma;
3. Define trauma from clinical, phenomenological, and systemic perspectives; and,
4. Develop perceptions about the scaffold of intersecting constructs related to stress, crisis, disaster, and trauma.

INTRODUCTION

The world can be a violent and dangerous place, thus making people vulnerable to all sorts of traumatic experiences. Emotional trauma has the potential to inflict severe harm to a person's psyche and biological systems; unabated trauma and toxic stress also can cause physiological damage. Traumatic events can have profound effects on the individuals who experience them, and the impact of such stressful events or circumstances often results in people feeling fearful, overwhelmed, vulnerable, confused, angry, betrayed, helpless, frightened, alone, or any combination of these emotions. As already indicated in [Chapter 1](#), the American Psychological Association (APA) briefly defines trauma as "an emotional response to a terrible event" (APA, 2020, p. 1); however, there is a lot to unpack in this succinct statement. The influences of trauma may manifest in many ways; some may be unique to the individual, whereas others appear to be more culture based, and yet others may be relatively universal. Some traumatic experiences are so unspeakable that victims go without verbalizing the cruelty or assault inflicted upon them. The symptoms of trauma, as clinically defined by the psychiatric profession at the current time, represent only one dimension of the lived experience of trauma; people experience and live through traumatic events in a variety of ways.

Traumatic experiences can cause not only physical and psychological wounds, but deep spiritual or existential wounds as well. For many survivors, the notion of reliving the trauma is agonizingly unthinkable; yet, with great courage, many come forward and seek trauma counseling or some means of recovery or meaning making. The request for trauma counseling often also serves as a request to engage in what needs to be a healing journey for the client. By definition, then, for therapists working with traumatized clients, "trauma counseling" inherently involves a focus on the client's healing process, and this necessitates a holistic view of the person. In order to understand the *whole person* who has experienced trauma, clinicians need to grapple with the ubiquity and the ugliness of traumatic events as well as to engage with the complexity of trauma-associated responses. The aftermath of a traumatic event is profoundly personal; at the same time, the lives of individuals intricately intersect with the lives of other people as well as with pets, places, time, social institutions, and cultural systems. Therefore, many clinical and treatment questions emerge that concern the nature of the person's lived experience of a traumatic event, and the answer frequently is, "it depends." It depends on the developmental stage at the time of the trauma event; it depends on whether the trauma event was of a personal nature or a large-scale disaster; if personal, it depends on whether the perpetrator was a trusted family member/friend or a stranger; it depends on the extent of the person's support system; it depends on gender and cultural perspectives; and it depends on numerous variables that are not always evident immediately, including health status and responses by the autonomic nervous system (ANS). For these reasons, and precisely because so much about working with a trauma survivor depends on the person's circumstances, this book offers a comprehensive view of trauma, stress, crisis, and disaster events, one that is situated within a systemic understanding of the whole person and one that incorporates our most recent understandings about what happens in the brain when someone is experiencing a traumatic event.

Of necessity, once a survivor of trauma seeks counseling, this person's support system extends to the therapeutic milieu, thereby including the therapist, clinical supervisors, the treating agency, and any larger arenas of the treatment system. Survivors of trauma need the clinical world to be more aligned and harmonized in this matter. Once we make the decision to work with traumatized clients, we owe them this level of respect. This kind of integrative approach requires a holistic and systemic perspective of trauma; it requires looking at trauma

approach requires a holistic and systemic perspective of trauma; it requires looking at trauma through a particular contextual lens. I intend for this chapter to offer such a lens, one that enables the reader to begin to understand the impact of traumatic experience from multiple personal and systemic perspectives as well as to make important connections with the evolving historical understandings of trauma, as presented in [Chapter 1](#). The purpose of this chapter is to ground the construct of psychosocial trauma within its various phenomenological, clinical, neurobiological, and sociocultural contexts. My aim is to offer a scaffold that enables readers to see readily and to understand clearly the connections between the personal and the systemic impacts of trauma, within historical context. This aim is accomplished by addressing relevant contextual issues in the following major sections of this chapter: (a) Context for Thinking About Trauma, (b) Defining Trauma, and (c) Counseling Implications. These sections are followed by a brief summary of the chapter and relevant resources for instructors, students, and clinicians.

CONTEXT FOR THINKING ABOUT TRAUMA

Since the earliest days of psychoanalysis in the late 19th century, professional discussions about the construct of trauma have been fraught with controversy. Even Sigmund Freud recanted some of the trauma-related parts of his theory in response to the furor that it caused in affluent Viennese society. As seen in [Chapter 1](#) of this text, the historical details and nuances are important, as they relate to how the international psychotherapeutic establishment has come to comprehend and deal with issues of trauma. Having established this historical understanding, it is essential, in this chapter, to address the variety of meanings, controversies, and contexts associated with the discourse on trauma, especially as these forecast fuller discussions of specific constructs in chapters that appear later in this text. In many ways, [Chapters 1, 2, 3, and 4](#) together are intended to offer a scaffold that firmly supports and readies the reader for the nuanced comprehensions of more complex issues of trauma in later chapters of the book.

Clinicians from the various helping disciplines—professional counselors, psychiatric nurses, psychiatrists, psychologists, social workers, and other behavioral scientists, along with religious helpers and other spiritual guides—have recognized the profound impact that traumatic experiences can have on individuals' psyches. This has been ongoing, long before the more or less recent wave of related research and theory building of the last several decades and leading up to the most contemporary neurobiological understandings of trauma. Psychotherapists working with trauma survivors have realized that the resulting effects of trauma range from acute stress disorder (ASD), posttraumatic stress disorder (PTSD), and other serious psychopathological responses, to existential crises, to post-trauma resilience, growth, and development ([McEwen et al., 2015](#)). Those working in the field have learned from clients that the causes of trauma differ widely and include interpersonal violence, sexual assault, physical maltreatment, political- or community-scale violence, war, various crisis situations, large-scale disasters, the effects of anthropogenic climate change, and witnessing or vicariously experiencing any of these. Yet controversies, along with exciting new scientific findings, continue to abound concerning the etiology, diagnosis, and treatment of trauma-related experiences, sequelae, and disorders.

Some of the controversies relate directly to systemic failures that impede rather than assist traumatized people in acquiring access to needed help. In many ways, the controversies may reflect an elementary psychodynamic about helping professionals and about the very nature of trauma. It may be much easier to intellectualize about abstract diagnostic constructs than to grasp and to engage with the perverse reality of a parent raping or sodomizing their child or of a child soldier who has been trained to kill family members and neighbors. Offering counseling to survivors of trauma can be emotionally intense work for the counselor and thus requires a strong self-reflective orientation. Some clinicians may feel that they are bearing witness to the effects of pure evil, whereas others elect to refer traumatized clients elsewhere.

Understanding the effects of traumatic events is a complex endeavor. Trauma affects people on multiple levels, including in the most intimately personal, as well as in relational, social,

on multiple levels, including in the most intimate, personal, as well as in relational, social, and cultural ways. Relatively recent findings in brain science, particularly Polyvagal Theory (PVT; [Porges, 2007, 2011, 2020](#)), have extended, exponentially, our knowledge about the physiological effects of trauma. Examining some of the various theories of human development can offer a base upon which to build understandings concerning the effects of trauma and the potential for attachment interruptions. For this reason, I believe that it is helpful to revisit, briefly, some of the relevant models of human growth and development before moving on to trauma theory. In this section, I focus on relevant issues of life-span development and the importance of a bioecological perspective, thus providing the background for the next sections of this chapter on defining trauma and on examining various systemic perspectives about trauma, including a brief and basic account of recent neurobiological findings about trauma.

Life-Span Development

Numerous theories and models exist to help us in understanding how people grow and develop across the life-span. Several relevant psychological models have influenced our knowledge of human development and motivation, including Maslow's hierarchy of needs and the developmental theories of Freud, Erikson, and Piaget. However, although these theories are necessary to our understanding, they are not sufficient in addressing the concerns of individuals who have been traumatized. They do not lay out an adequate foundation for grappling with some of the fundamental questions of development, especially child development, as these concern traumatic experiences, for example: How does a traumatic event or ongoing trauma interrupt or delay developmental tasks? What developmental trajectories might we expect when abnormal events occur in the lives of ordinary people? How do these alternative developmental trajectories reflect individuals' environmental conditions, especially concerning relative levels of risk, security, and attachment? In spite of their inadequacy to answer questions of trauma fully, these models offer important background information—they contribute to the scaffold of knowledge that is necessary to understand trauma and are discussed briefly in the following text.

Maslow

Although more of a motivational theory, [Maslow's \(1998\)](#) widely recognized model has some utility in considering certain aspects of trauma. The model has posited that the categorical needs of human beings are hierarchical; these needs are represented in the figure of a pyramid (see [Figure 2.1](#)). The base of the pyramid represents *physiological needs*, those involving such basic necessities as food, water, and shelter. The rungs of the pyramid, in ascending order above physiological needs, include the following: *safety needs*, composed of such features as security, law, order, and stability; *love and belonging*, composed of such elements as affiliation and friendships; *esteem*, composed of such attributes as confidence, respect, and status; and, at the very top of the pyramid, *self-actualization*, or the ability to realize one's full potential. It is important to note that each of these need levels can be interrupted and affected by violent or traumatic events. One practice limitation of this model is that it often is engaged by professionals at the esteem level, without much consideration of the important foundational needs at the base of the model. An example of this would be a school counselor or a school psychologist who focuses on a child's self-esteem without understanding that the child might have walked to school from a local domestic violence shelter where their mother sought safety the night before, or that the child might not have had dinner the night before or breakfast that morning. The child potentially would have difficulty focusing on self-esteem issues when more basic and immediate needs have not been addressed. This model is one that offers necessary constructs about basic needs, but it is not sufficient in explaining the needs of at-risk individuals or those who have experienced a traumatic event.

Freud, Erikson, and Piaget

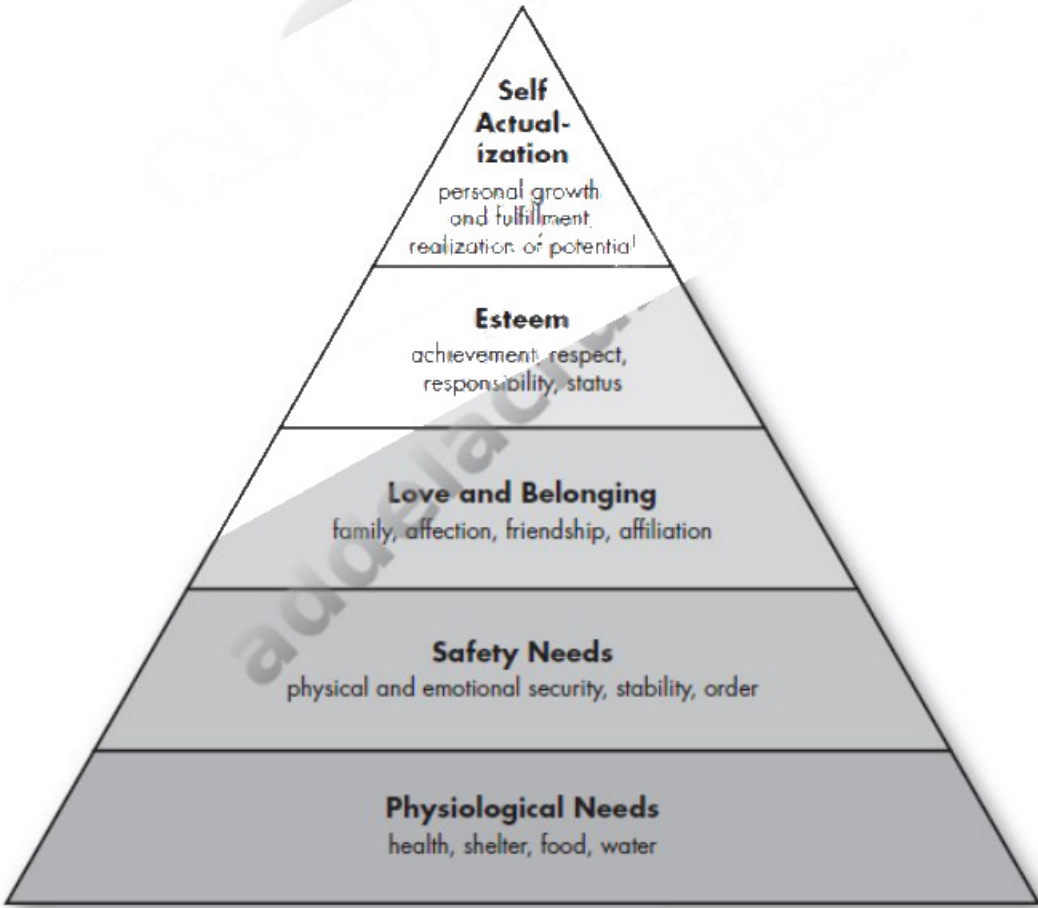
Important pioneers in theories of human development, Freud, Erikson, and Piaget have presented their developmental theories as stage models. A comparison of these stages can be

presented their developmental theories as stage models. A comparison of these stages can be seen in [Table 2.1](#).

Freud's theory of psychosexual development includes five sequential stages: oral, anal, phallic, latency, and genital. However, these stages, like much of Freudian theory, long have been criticized for many reasons, and further elaboration goes beyond the scope of this chapter. For our purposes here, it suffices to say that beyond noting their historical importance, these stages tend to be less relevant to the contemporary discourse on developmental issues, at least outside of a psychoanalytic context.

Influenced by Freud, Erikson's sequential eight-stage developmental theory has involved the completion of stage-specific tasks and resulting alternative consequences or crises when these tasks are not completed in stage-salient ways. Although Erikson's model was designed with the healthy individual in mind, it is helpful to see, especially in the initial stages, how early childhood maltreatment potentially can establish pathways of development that may deviate from a healthy norm and even initiate a developmental trajectory eventually marked by developmental psychopathology. For example, let us consider the case of a child who is so severely abused or neglected during the first year of life that this child is not able to engage in a trusting relationship with a primary caregiver. Instead, the child learns to mistrust the world around them. This has serious implications for the child's developmental pathway, from both psychological and biological perspectives, as well as for attachment issues, at the time and in the future (child and adolescent attachment issues are discussed more fully in [Chapters 7 and 8](#) of this book).

Figure 2.1
Maslow's Hierarchy of Needs



Data for the diagram are based on Hierarchy of Needs from "A Theory of Human Motivation," in *Motivation and Personality* (2nd ed.) by A. H. Maslow. Copyright 1970 by Abraham H. Maslow. Copyright 1991 by Wm. C. Brown Publishers. Adapted with permission.

Piaget's sequential sensorimotor and operational periods have relevance to physical and neurocognitive development. As we have continued to learn more about brain function (Institute of Medicine & National Research Council, 2015; National Research Council and Institute of Medicine, 2000; Thompson, 2016), it becomes clearer how early childhood deprivation and maltreatment can affect the developing child (neurochemical issues related to trauma also are discussed in Chapters 4 and 9 of this book). In fact, recent research has suggested that the effects of such early neglect can persist and be associated with adult brain structure and its functioning (Mackes et al., 2020; Thompson, 2016). However, concerning the developmental theories at hand, some may argue that such age- or stage-dependent theories are somewhat deterministic and reductionist. Far too often, purely psychological approaches may ignore other factors in the environment and may place the onus of developmental deviations on the individual. For these reasons, I argue that these historically important theories allow us to understand necessary information about individuals, but that they are not sufficient in helping us to understand the full needs of trauma survivors.

Table 2.1

Comparison of Freud, Erikson, and Piaget's Stage Theories

Stages (approximate age ranges)	Freud	Erikson	Piaget
Infancy (birth to around 18 months)	Oral	Trust vs. mistrust	Sensorimotor period
18 months to 3 years	Anal	Autonomy vs. shame and doubt	Preoperational thought
3–5 years	Phallic	Initiative vs. guilt	Preoperational thought
6–12 years	Latency	Industry vs. inferiority	Concrete operations
12–18 years	Genital	Identity vs. role confusion	Formal operations
Young adulthood (around 19–40 years)		Intimacy vs. isolation	Formal operations
Middle adulthood (40–65 years)		Generativity vs. stagnation	
Maturity (65 years to death)		Integrity vs. despair	

Other Relevant Models

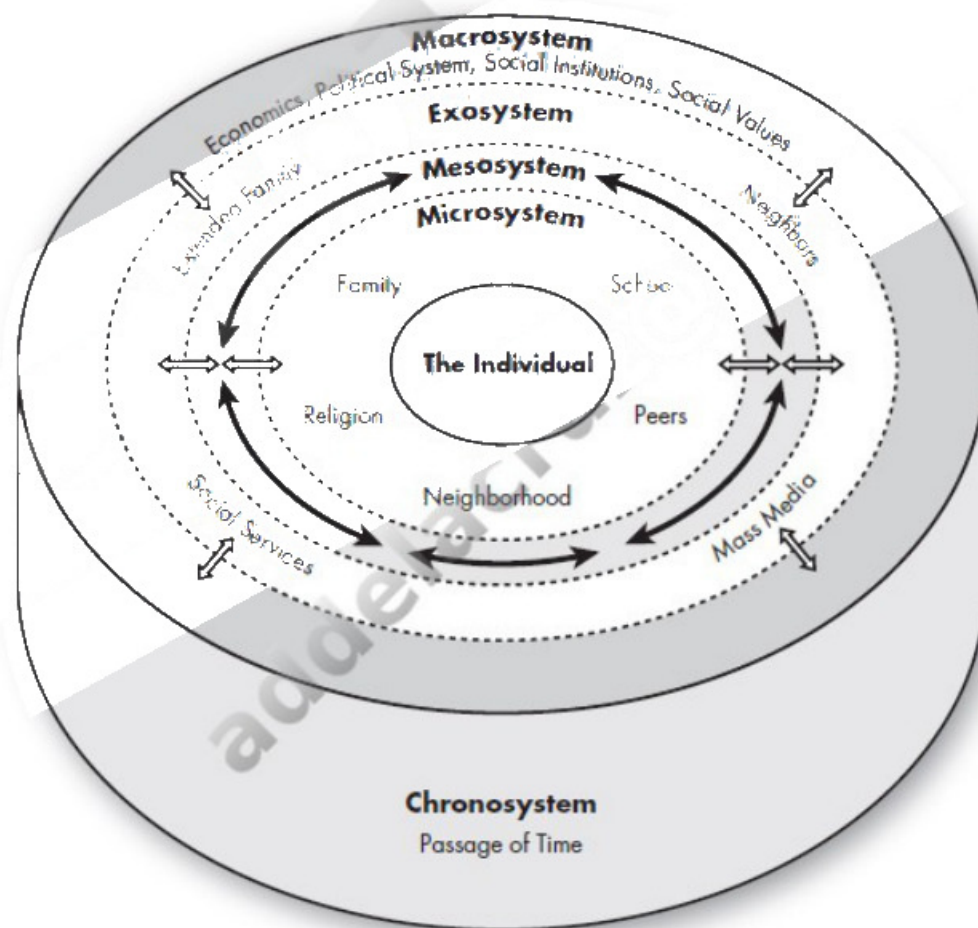
Purely mechanistic models do little to assist our understanding of peoples' lived experiences and worldviews. So in contrast to the aforementioned more linear and more or less purely psychological models, other theoretical models, which also have influenced our understanding, perhaps better account for individuals' worldviews and their interface with social influences. These theories include Bowlby's (1969/1982, 1973, 1980, 1988) attachment theory, Bandura's (1977) social learning theory, Vygotsky's (1978, 1986, 1997) social development theory, and Deci and Ryan's (2012) self-determination theory (SDT). It is not my purpose in this chapter to analyze the corpus of these substantive works. Rather, I raise these pertinent and pervasive theories of human development and social learning to remind us of concepts that are necessary in understanding human development but perhaps are not sufficient for understanding the impact of traumatic experiences on the developing and growing individual. Earlier professional discussions have emphasized the centrality of the nature versus nurture (genetic vs. environmental/contextual influences) discourse, along with the interplay of continuity and discontinuity dynamics throughout the life-span (e.g., Durwin & Reese-Weber, 2020; Lerner, 2002). Thompson (2016, p. 23) has reported that recent research demonstrates that "biology and environment are each important and indissociable." On this note, I turn the conversation to more systemic and biological perspectives.

A Bioecological Perspective

Bronfenbrenner (1979, 1981, 1994) has offered an elegant model for understanding the comprehensive influence of multiple systems on children's development. Simply put, ontogenic (individual) development is nested within larger systems that affect the person's development (see Figure 2.2). From proximal (closer) to distal (at a greater distance), these systemic influences include the *microsystem* (immediate environment, including family), the *mesosystem* (situations in which two or more microsystems come together to have some effect on the individual's life), the *exosystem* (community and neighborhood), the *macrosystem* (broad cultural values and beliefs), and the *chronosystem* (denoting sociohistorical time as well as the real-time personal events and developmental transitions in an individual's life since birth). Environmental factors, along with genetic predispositions, influence the child, and continual reciprocal transactions within the environment, or ecology, determine risk and protective factors. After the initial development of his *ecological model*, Bronfenbrenner later renamed the model, changing it from the former ecological model to the more newly termed *bioecological model*, thus reemphasizing the interactions between heredity and environment. This is significant, particularly in light of the more recent neurobiological research concerning the physiological effects of trauma on the brain and on other systems of the body (the recent neuroscience research is discussed later in this section and detailed more fully in Chapter 4).

Figure 2.2

Bronfenbrenner's Bioecological Model of Human Development



From Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Most contemporary theories of development have acknowledged the roles of both heredity and environment, and many have suggested the importance of a systemic perspective.

and environment, and many have suggested the importance of a systemic perspective. Lerner's (2002, 2006) notion of developmental contextualism, for example, has offered a framework for integrating important developmental theories and for arriving at a developmental systems theory. The literature on developmental psychopathology (e.g., Cicchetti, 2013; Cicchetti & Lynch, 1993, 1995; Toth & Cicchetti, 2013) has provided a developmental-ecological framework for understanding the profound interplay between normal development and abnormal events, especially in the form of child maltreatment. Developmental psychopathology has emphasized the role of attachment in children's lives (Belsky et al., 1996), seeking to assess connections between the quality of attachment and the impact of maltreatment. This perspective has offered a baseline for comprehending the effects of chronic violence on children—and by extension, some of the trauma-related sequelae of adults who experienced severe maltreatment in early childhood.

Drawing from Bronfenbrenner's (1979, 1981, 1994) bioecological model, developmental psychopathology examines the risk factors, as well as the compensatory or protective factors, which exist across the multiple and interactive environments in which we all live. The arrows in Figure 2.2 represent the potential for both risk and protective factors, across and within the systemic levels. The arrows also represent the reciprocity of the model; the environment has an impact on the individual, just as, in reciprocal nature, the individual has an impact on the environment. From this theoretical paradigm, Cicchetti and Lynch (1993) have detailed a related ecological-transactional model that offers an avenue for understanding, in a comprehensive way, the influence of multiple factors—at multiple levels—on children's development. Such an articulation of the transactional nature of development is paramount to understanding the complex, sometimes paradoxical, effects of maltreatment on children at multiple systemic levels.

An understanding of the bioecological model, its transactional and systemic nature, and the role of attachment across the life-span is an essential aspect of understanding the impact of trauma. An ecological-transactional perspective allows us to situate the lived experiences of traumatized persons within the time and space of a relevant ecology in order to understand the trauma event as well as personal meaning making. Lynch and Levers (2007) have suggested the compatibility of ecological, transactional, and motivational perspectives in applying developmental theories to trauma counseling. Also compatible with these perspectives, and as an extension of the biological dimension of the individual, seen as nested within the microsystem and other systemic levels of the bioecological model (represented in Figure 2.2), is Polyvagal Theory (PVT, Porges, 2007, 2011). Introduced by Stephen Porges in 1994, PVT has assisted clinicians in understanding the effects of trauma on the ANS and its interaction with brain activity and the activity of other major organs in the body before, during, and after a traumatic event. In many ways, PVT offers a portal through which mental health clinicians, who may not be brain experts, have an avenue for better understanding the neurobiological perspective of trauma.

A Neurobiological Perspective

Over the last couple of decades, the broader field of mental healthcare has arrived at better understandings of physiological and hormonal responses to stress, crisis, anxiety, and trauma; this, in turn, has led to increased knowledge about how the brain is involved in the physiological effects of trauma (Children's Bureau, 2015; Newman et al., 2015). Trauma affects the brain, and it even has the ability to change the brain. In scans of a healthy brain, shown beside the brain of someone who has experienced traumatic abuse (Perry, 2002), the differences in the scans are readily evident, even to nonneurologists. Neurobiological research also has helped in cultivating a better apprehension of the ways in which the brain affects social relationships (e.g., Cozolino, 2006; Fishbane, 2007; Goleman, 2006; Siegel, 2007). Recent advances in neuroscience have helped us in understanding why some people are more susceptible to developing symptoms of PTSD, while others remain more resilient, in the face of traumatic events (Rattell et al., 2019).

As indicated in the previous subsection, PVT is perhaps one of the most intriguing and promising contributions to the field of traumatology in recent years. PVT relies on an understanding of the vagus nerve, which may be the most important cranial nerve that most people probably do not know that they have. The vagus nerve, actually the tenth pair of the 12 cranial nerves, is like the body's superhighway, carrying sensory information between the brain and various other internal organs (Gould, 2019; Seymour, 2017). Sometimes referred to as the "gut-brain axis," it is key in understanding mind-body connections (Forsythe et al., 2014). The vagus nerve extends from the brain, branching out toward the neck and the torso, to reach the body's organs and tissues. The word "vagus" derives from the Latin term that means "wandering" (Seymour, 2017).

The functions and mechanisms of the vagus nerve have important implications for how we respond to, experience, and process stress, crisis, anxiety, and trauma. As previously indicated, the vagus nerve has important links to the brain, heart, lungs, and other major organs. The auricular branch of the vagus nerve even links to the ear, so that vibrations in the ear ultimately can have a calming effect on the vagus nerve, which accounts for the soothing reaction to certain types of music or the body-calming effect of ancient syllables (e.g., "Om") used in meditation and chanting. The practice of mindfulness, for example, has been successful in its use with anxiety- and trauma-related conditions, and its efficacy can be explained in reference to the functions of the vagus nerve (Forner, 2019).

The Autonomic Nervous System

The vagus nerve is the longest and most complex nerve in the ANS and interacts with two major parts of the ANS: the parasympathetic nervous system (PNS) and the sympathetic nervous system (SNS). According to PVT, these two nervous systems have three circuits or functions that are instrumental in understanding not just the brain's response to trauma, but also the whole body's response to stress, crisis, anxiety, and trauma:

- Social-communicative engagement (ability to interpret facial and social cues)
- Mobilization (fight or flight)
- Immobilization ("shut-down"—inability to fight or flee)

The ANS regulates body functions that generally are beyond conscious awareness, for example, breathing and heartbeat. The PNS is responsible for the *rest and digest* system; it conserves energy by slowing the heart rate, increasing intestinal and gland activity, and relaxing sphincter muscles in the gastrointestinal tract. Conversely, the SNS is responsible for what commonly is referred to as the *fight or flight response*, which is when the body panics, due to a lack of safety or to danger cues in the environment. The SNS *energizes* or *activates* body mechanisms by increasing muscle blood flow and tension, dilating the pupils, accelerating heart rate and respiration, and increasing perspiration and arterial blood pressure.

The ANS essentially scans the environment for safety and for danger. The ANS continually picks up and assesses information in the environment, and the responses to this information are not voluntary (Porges, 2011). In other words, this processing is not conscious or intentional, but rather, it is happening at the neural level. "Perception" is not quite the right word to use, because the process is not a cognitive one; therefore, Porges coined the term "neuroception" (cited in Dana, 2018). Neuroception allows the body to define risk or threat, at the autonomic neural level, in these three essential ways: (a) threat perception, (b) threat sensitivity, and (c) self-image. At the neuroception level, the ANS detects safety or danger, and then engages the PNS or the SNS, depending upon the neurocepted environmental cues. An individual's response to a stressor, to danger, or to a potentially threatening or traumatizing event is beyond conscious control and therefore is not processed at a cognitive level—it is happening at the neuroceptive ANS level.

This explains why two people experiencing the same incident may have very different responses to the incident. It also offers evidence for refuting some of the intense and persistent victim blaming that occurs, even in light of scientific findings (e.g., [Bob, 2019](#); [Gravelin et al., 2018](#)).

Dissociation

Over the decades, the construct of dissociation has returned to an increasingly more dominant point in the discussion of trauma, in general; its prominence in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; [American Psychiatric Association, 2013](#)) discussion of PTSD, specifically, has called greater attention to the significance of dissociation in the trauma-response process. It also is an instrumental concept within the framework of PVT. Dissociation is an altered state of consciousness and actually serves as a biological protection mechanism. While in this state, conscious awareness splits apart from feelings or memories that may be scary or terrifying to the person ([Huntjens et al., 2019](#)). A continuum of symptoms may be experienced, from relatively mild sensations of fogginess, sleepiness, or difficulty concentrating to a feeling of numbness or being separated from others, from the world, or even from parts of oneself ([Levers, 2020](#)). In extreme altered states, a person may even “lose time” or experience amnesia; this is called dissociative amnesia, and it is classified within the dissociative disorders section of the *DSM-5* ([APA, 2013](#)).

Fight, Flight, and More

An understanding of the fight-or-flight response originated in the early 20th century ([Cannon, 1915](#)), and its implications have been examined and better understood since that time. However, PVT accounts for a broader range of responses that actually match the wider scope of trauma experiences ([Porges, 2011](#); [Porges & Dana, 2018](#)). Rather than focusing on only fight or flight, PVT acknowledges a more inclusive continuum of responses to potentially traumatizing experiences, among them dissociative responses. Therefore, it may be helpful to think of the neurobiology of trauma as manifesting in stages, with greater degrees of dissociation occurring in later stages ([Levers, 2020](#)). [Schauer and Elbert \(2010\)](#) refer to these stages as the 6 ‘Fs’ of Trauma Response, and these are:

- Freeze
- Flight
- Fight
- Fright
- Flag
- Faint

Freeze is an orienting response, which involves the initial neuroception of danger—the *deer-in-the-headlights* phenomenon. With hormones shooting throughout the body and the SNS activating, the person under threat prepares either to take flight or to fight. Mild stages of dissociation mediate these first three defensive responses. It is within the activation of the final three responses that dissociation becomes increasingly stronger. According to [Schauer and Elbert \(2010\)](#), fright involves unresponsive immobility; the person is beginning to feel overwhelmed by the threat. In the flag stage, the threat has become so extreme that the SNS’s arousal is beginning to shut down, and the PNS starts to engage. [Schauer and Elbert \(2010, p. 117\)](#) state that this stage “of the defense armament encompasses forms of dissociation and is characterized by reduced sympathetic arousal and passivity or a ‘shut-down’ peripherally dominated by vagal activity.” If the threat or danger continues unabated, a full shutdown may occur in the final, faint stage, and the person literally may faint, experiencing vasovagal syncope ([Schauer & Elbert, 2010](#)). If we think about what happens during a faint, we get a glimpse of how incredibly elegant our body systems are. When a person faints, the person falls to the ground, the floor, or some other surface, usually stretched out; it is being in this prone position, then, that facilitates physiological functions

stretched out; it is being in this prone position, then, that facilitates physiological functions like breathing and heart rate to begin to return to normal. This ability to recalibrate or rebalance, after exposure to fear, is an illustration of our capacity for resilience.

DEFINING TRAUMA

Beginning to define trauma and its encompassing emotional and physiological effects is a daunting task. The effects of traumatic events are complex, reflecting the intricacy of the human beings who are exposed to trauma. Traumatic events involve objective or factual situations, and *DSM*-related criteria attempt to quantify symptoms in an objective fashion. However, the way in which people experience traumatic events is highly subjective, and trauma theories must allow for the reality that people construct personal meanings from their traumatic experiences.

Current theories about trauma offer a framework for understanding the various types of trauma, such as single-event versus complex trauma, and the different ways in which people respond, such as being completely overwhelmed and stuck there, versus making meaning of the trauma in a way that eventually may produce growth and transformation. Although many discussions of PTSD appear in the chapters that follow in this textbook, the diagnostic category of PTSD is only one facet of defining trauma. Laurence J. Kirmayer, MD, James McGill professor and director of the Division of Social and Transcultural Psychiatry at McGill University, offers the following comment regarding PTSD:

Diagnostic constructs also work as metaphors, both in terms of their explicit use as conceptual models and their implicit connotations as labels that affect social relations between people. The construct of PTSD, which has dominated discussions of the treatment of trauma in recent years, emphasizes the enduring effects of fear conditioning on subsequent adjustment and response to later stressors. But PTSD is a limited construct that captures only part of the impact of violence, ignoring issues of loss, injustice, meaning and identity that may be of greater concern to traumatized individuals and their families and children or later generations. (2007, p. vi)

The various discussions in this textbook acknowledge PTSD as an important but limited construct. Indeed, as explicated in [Chapter 1](#), the history of the *DSM* illustrates the extent to which the notion of PTSD is socially constructed and ever changing, even within the psychiatric model.

One powerful tool in understanding the effects of trauma is through interdisciplinary means. For example, during my initial exposure to clinical trauma narratives, early in my career as a young clinician, I recall thinking about the cubist paintings that I had seen in European museums, perceiving the trauma experience through the disciplinary lens of my undergraduate work in literature and art history. Focusing on the deconstructed images in the cubist paintings, like those of Picasso, for example, assisted me to comprehend, even in a limited fashion, the fragmentation that traumatized clients had experienced and tried to share with me. Psychiatry and psychology are not the only professional fields of endeavor that enhance understandings of trauma. Rather, not only do other social and behavioral sciences focus on issues of trauma, for example, professional counseling, sociology, social work, anthropology, nursing, and other allied health professions, but those pursuits involving the arts and humanities and fields such as technology and journalism also contribute to illuminating the effects of trauma. In this section, continuing to build upon the scaffold that we began to construct in [Chapter 1](#), I emphasize some of the multiple facets of how people experience trauma. This is accomplished through the following discussions: Trauma as a Clinical Issue; Phenomenology of Trauma; Trauma as a Systemic Issue; and Intersection of Constructs Related to Stress, Crisis, Disaster, and Trauma.

Trauma as a Clinical Issue

The word “trauma” has been popularized and often is used to indicate almost any stressor experienced by an individual. However, in its clinical sense, trauma refers to events that are

experiences of an individual, however, are extremely difficult and overwhelming for individuals (Briere & Scott, 2006; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Understanding the clinical presentation of trauma can be complex. As discussed in Chapter 1 of this textbook, the definition of trauma has continued to change and evolve across the various iterations of the *DSM* and has reflected our continuing understandings of the effects of trauma. As delineated in Chapter 1, the trauma- and stressor-related disorders articulated in the current *DSM-5* (APA, 2013) span multiple diagnostic categories and include reactive attachment disorder (RAD), disinhibited social engagement disorder (DSED), PTSD, ASD, adjustment disorder, other specified trauma- and stressor-related disorders, and unspecified trauma- and stressor-related disorders. Importantly, the location of the chapter presenting these diagnoses, *Trauma- and Stressor-Related Disorders*, is relevant. The chapters regarding Anxiety Disorders and *Obsessive-Compulsive and Related Disorders* precede that chapter, and the chapter is followed by the chapter on *Dissociative Disorders*. As noted in the introduction to the Trauma- and Stressor-Related Disorders chapter, the sequencing of the chapters indicates a close relationship among these sets of diagnoses (APA, 2013).

A clinical understanding of the separate trauma-related diagnoses, along with an understanding of the relationships among these diagnostic categories, is essential for making accurate diagnoses (Tehrani & Levers, 2016). It also is important for clinicians to be well versed with all of the trauma-related diagnoses, as pertinent client issues, such as life stage or comorbidity with other diagnoses, may have an impact on identifying the most salient and accurate diagnosis. The various chapters in this textbook focus on different types of trauma, crisis, and disaster situations and explore the diagnostic constructs that are most relevant to the situation under examination in the specific chapter. While the current chapter cannot recapitulate the clinical information about trauma that is contained in the *DSM-5* (APA, 2013), discussions in many of the chapters rely on a basic understanding of two of the trauma-specific diagnostic categories, ASD and PTSD. The criteria for these two diagnostic categories are too numerous to list here, but short descriptions are offered as orienting points; interested readers are encouraged to read and study the *Trauma- and Stressor-Related Disorders* chapter in the *DSM-5* (APA, 2013).

A significant difference between ASD and PTSD is based on the duration of symptoms. The ASD diagnosis is used when someone has experienced a traumatic event and demonstrates symptoms within the first month following the event; when symptoms persist beyond 1 month, the diagnosis is PTSD. One prominent feature of the PTSD category is that there are separate sets of diagnostic criteria presented for (a) adults, adolescents, and children older than 6 years of age and for (b) children 6 years of age and under. The introduction to the PTSD section offers the following orienting points:

The essential feature of posttraumatic stress disorder (PTSD) is the development of characteristic symptoms following exposure to one or more traumatic events. ... The clinical presentation of PTSD varies. In some individuals, fear-based re-experiencing, emotional, and behavioral symptoms may predominate. In others, anhedonic or dysphoric mood states and negative cognitions may be most distressing. In some other individuals, arousal and reactive-externalizing symptoms are prominent, while in others, dissociative symptoms predominate. Finally, some individuals exhibit combinations of these symptom patterns. (APA, 2013, p. 274)

The previous text points to the importance of clinicians having a firm understanding of differential diagnosis. Differentiating the diagnostic classifications associated with trauma, particularly PTSD, can be difficult, especially for the new or inexperienced clinician. The importance of accurate clinical assessment, discussed in Chapter 26 of this book, cannot be underscored enough.

The history of the psychiatric and psychological diagnosis and treatment of trauma, as well as its codification in the *DSMs*, has been marked by controversy and by a lack of professional agreement (e.g., Bledsoe, 2019; Echterling et al., 2016; Pai et al., 2017). For example, in a review of research literature, Miao et al. (2018, p. 2) state that "the findings of pertinent studies are difficult to generalize because of heterogeneous patient groups, different traumatic events, diagnostic criteria, and study designs." Criticisms of past and current *DSM*

traumatic events, diagnostic criteria, and study designs." Criticisms of past and current *DSM* codifications have led to increasingly greater discourse surrounding the need for a complex trauma classification (e.g., Briere & Scott, 2006; Courtois, 2004; Herman, 1992/1997; Phillips, 2015). Many have advocated for differentiating between PTSD and complex PTSD (discussions of complex trauma are found in Chapters 1 and 9 of this book), but the architects of the *DSM-5* (APA, 2013) instead elected to implement a separate Trauma- and Stressor-Related Disorders category. While it is essential for mental health professionals to possess requisite diagnostic skills, perhaps of equal concern to most clinicians as the diagnostic categories associated with trauma is the phenomenology of trauma and its clinical manifestation among clients who seek assistance in dealing with the lived aftermath of traumatic events.

Phenomenology of Trauma

People's lived experiences of traumatic events are highly personal and subjective; and at the same time, some of the phenomena associated with trauma are fairly consistent, across cultures and from person to person. Some of the issues related to the core experience of trauma and to trauma as an existential issue of suffering are explored briefly in the following text.

Core Experience of Trauma

In her landmark book, *Trauma and Recovery*, Herman (1992/1997) has identified the core experiences of trauma as terror and disconnection. Stating that "psychological trauma is an affliction of the powerless ... [in which] the victim is rendered helpless by overwhelming force" (p. 33), Herman has qualified the experience of terror as one of disempowerment, helplessness, and abandonment; she has cast disconnection in similar terms as Courtois (1988, 2004), that is, as shattered trust. When an individual has experienced a traumatic event, the person's worldview and the very foundation of their being can be shaken or crushed, what Stolorow et al. (2002) have framed as "the shattering of an experiential world" (p. 123). Herman has noted that "traumatic events call into question basic human relationships" (p. 51); survivors of trauma may experience disconnection from loved ones or other significant people in their lives, as well as a sense of separation from self.

Hyperarousal is an initial major symptom of trauma, what Herman (1992/1997) has described as a "permanent alert, as if the danger might return at any moment" (p. 35). This startle response is relatively easy for most clinicians to recognize. Herman further has described two additional categorical sets of PTSD symptoms: those that are intrusive and those that are constrictive. Symptoms of intrusion include those readily associated with PTSD, such as "reliving" the trauma through flashbacks and nightmares; symptoms of constriction include some that are less likely to be attributed as quickly to PTSD, such as depression, numbing, and a detached state. One of the most important aspects of Herman's work has been her recognition of what she has termed "the dialectic of trauma" (p. 47). In the absence of appropriate intervention, when a survivor of trauma develops PTSD and the condition goes untreated, the person eventually may begin to vacillate between the previously described symptom sets; the dialectic of trauma is represented by this cycling, back and forth, from intrusive symptoms to constrictive symptoms. It is easy to see, especially if a history of trauma has not been documented adequately, how observing a client who is presenting with either set of symptoms could result in an inaccurate diagnosis. At surface, someone exhibiting intrusive symptoms might appear agitated and anxious, and someone exhibiting constrictive symptoms might appear depressed. Therefore, it is extremely important for clinicians who are working with trauma survivors to ask about trauma history and to recognize this dialectic in order to avoid misdiagnosis.

Stolorow (2007) has stated that one theme of trauma is that it "is built into the basic constitution of human existence" (p. xii). Such a phenomenological perspective of trauma is essential in understanding others' lived experiences of trauma as well as in enabling counselors to help survivors in the recovery and healing process. Herman (1992/1997) has articulated a stage-wise recovery process aimed at addressing the core experiences of

articulated a stage-wise recovery process aimed at addressing the core experiences of trauma. She has detailed the clinical work that needs to take place in each of the following phases: (a) establishing safety, (b) reconstructing the trauma story, and (c) reconnecting with ordinary life. This recovery process corresponds to phenomenological aspects of trauma and assumes the potential for an existential transformation from *victim* to *survivor*. The model illuminates the need for therapists to be intentional in their clinical work with survivors of trauma. In addition, Herman's model astutely aligns with the more recent brain research and PVT, discussed earlier in this chapter; once a survivor's ANS is engaged, and fear either mobilizes or immobilizes the person through their SNS or PNS responses, a counselor needs to reestablish a sense of safety so that the survivor is stabilized enough to work constructively with the traumatic experience.

Suffering as an Existential Component of Trauma

When people are subjected to the most adverse of human situations, they naturally experience psychic pain and suffering. Miller (2004) has posited that most people seek psychotherapy to relieve suffering and are therefore not focused on the clinical aspects of symptomatology, asserting that the science of psychology has long ignored this aspect of the therapeutic encounter. Daneault et al. (2004) have suggested that a major mandate of medicine—and by extension, psychiatry and other psychological practices—is the relief of suffering. Yet very little analysis of the construct of suffering has existed in the professional literature (Makselon, 1998) until fairly recently (e.g., Anderson, 2014; Levers, 2020).

A core consequence of all types of trauma, crisis, and disaster events is human suffering. Mental, emotional, existential, and physical suffering can affect people in a variety of negative ways, including personality changes, health status, and the ability to function on multiple levels. The connection between suffering and illness—*illness* defined from an ethnomedical perspective, relative to cultural construction—is profound and calls for existential and multicultural approaches (Levers, 2006a, 2006b). Suffering also can affect people positively, in the long run; the connection between suffering and transformation has been the subject matter of theological and philosophical discourses for centuries. Although a lacuna exists in much of the contemporary scientific literature regarding a psychology of suffering, the theoretical and existential basis for this discourse exists, for example, among such notable scholars as Bruner (1990), Frankl (1959), Fromm (1947), Bakan (1968), and May (1992). Understanding the nature and the phenomenology of human suffering can assist clinicians in defining the subjective meaning making of trauma survivors, thereby guiding the quality of client-informed interventions. This process is central to the transformation from being a *victim* to being a *survivor* and is a profound step toward recovery.

Trauma as a Systemic Issue

Although the clinical features and phenomenological aspects of trauma involve survivors at the individual level, there are at least three areas of potential systemic impact. First, groups of people may simultaneously experience the same racial trauma, gender-based trauma, natural disaster, accident, or human-made catastrophe; many of them may develop trauma-related symptoms. Second, when groups of people are affected by a traumatic event or a disaster, there is usually a coordinated reaction by an official system of responders; such efforts may have trauma-based implications both for those affected and for those who respond. Third, even when a traumatic event only involves an individual, as explained previously in the discussion regarding the bioecological model, the person is nested within and potentially affected by any or all other systems at the microsystemic, mesosystemic, exosystemic, macrosystemic, and chronosystemic levels. The implications for how a victim or survivor of trauma may be able to navigate these various systems and for how systemic responses to crisis, disaster, and trauma events adequately help or fail to help victims are too numerous for a full discussion in this chapter. However, some of the systemic features of trauma are explored briefly in the text that follows, in terms of their cultural, public health, social justice, and pedagogical dimensions.

Cultural Dimensions of Trauma

Just as cultural assumptions have been made across mental health theories and practices, culture profoundly shapes peoples' experiences of trauma, along with molding the rites and rituals of grief and suffering that enable the expression of trauma (Droždek, 2007b). Locating trauma—and by extension, PTSD—in a global context raises transnational issues. As Breslau (2004) has suggested, “problems [are] generated when the process of defining the disorder is viewed simplistically as a matter of scientific technology rather than as a cultural practice in itself” (p. 121). Expressions of suffering and healing vary across cultures and arise from differing world views; for people outside of Western cultures, as well as for non-Western people who have immigrated to a Western country, an ethnomedical perspective may be useful (*ethnomedicine* is a subspecialty area of medical anthropology, focusing on indigenous paradigms of healing and cultural variations of constructs like illness and disease). Culture has informed the ways in which people make meaning of trauma, the rituals for expressing the impact of trauma, and the manner in which people are able to heal. For example, Castillo (1997) has asserted that “cultural schemas affect the subjective experience and expression of dissociation” (p. 219). Dissociation is but one symptomatic manifestation of trauma that offers a good example of cultural nuance. Dissociation has been pathologized within Western biomedicine. Yet when examining non-Western paradigms of indigenous medicine or traditional healing, dissociation actually may play a proactive role in the transactions between client and healer (e.g., Comaroff, 1978, 1980, 1982; Kleinman, 1986; Levers & Maki, 1995; Moodley, 2005; Torrey, 1986; Turner, 1968) and also can offer adaptive mechanisms (Castillo, 1997) such as with the use of yoga, hypnosis, Tai Chi, mindfulness, and other focus-oriented techniques as part of the recovery process.

Public Health Dimensions of Trauma

Professionals working in the arena of traumatology increasingly have cited the effects of trauma on individuals as a public health issue (e.g., Droždek, 2007a; Musisi, 2004). A growing corpus of literature has highlighted the impact of early childhood adversity on later health across the life-span (e.g., Felitti et al., 1998; Felitti, 2002; Lanius et al., 2010). Our knowledge about race-related stressors and the impact of trauma on populations of color has advanced, and we have become increasingly aware of the impact of racial trauma (Williams, 2018; Williams & Cooper, 2019; Williams et al., 2018; Williams et al., 2021; Yehuda & Lehrner, 2018). Breslau (2004) has suggested that “epidemiological surveys have been an important vehicle for bringing PTSD into the global health arena” (p. 117).

The rise of all types of technology has increased the capacity for more violence on broader scales; communication technology has increased the potential for members of the public to witness acts of violence, immediately, even when they are not present. The reality of amplified violence increasingly has become a part of the global discourse on trauma (e.g., Krug et al., 2002; Levers, 2012; Levers et al., 2007). Some analysts even have concluded that the issue of trauma has been exploited for political and economic reasons; in her exploration of associated challenges, James (2004) has introduced the notion of a *trauma portfolio*, a kind of hierarchical cataloging of events that have institutional currency. Noor et al. (2012) have examined adversarial groups involved in violent conflicts and have identified the concept of competitive victimhood to describe the dynamic by which one group tries to establish that they have suffered more than the other group, thus leading to greater incidents of public violence. Many of the chapters throughout this book examine these issues more closely. For the purpose of continuing to construct our scaffold for understanding trauma, two salient issues are outlined briefly in the text that follows: the ACE Study and Racial Trauma.

ACE Study

Felitti et al.'s (1998) landmark study illuminated what many clinicians anecdotally began to realize about clients' trauma histories, long before the evidence was aggregated systematically (Levers, 2020). Fortunately, for the field, Felitti et al. (1998) took the time and initiative to investigate what they also had been observing in clinical settings: Many individuals have endured adverse childhood experiences, and these experiences have had

individuals have endured adverse childhood experiences, and these experiences have had real health consequences. Mirroring Bronfenbrenner's (1979, 1981) bioecological model, adverse childhood experiences are risk factors that exist across an individual's multiple environments, and protective factors can mitigate or even extinguish the impact of such adverse experiences.

The Adverse Childhood Experiences (ACE) Study (Felitti et al., 1998) was undertaken from 1995 to 1997 by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente, the latter being a large managed healthcare consortium. Over 17,000 subjects were involved in the investigation; this constitutes an unusually high number of participants for any research, thus suggesting that the results of the study are quite robust. The number of ACEs experienced by people can have profound influences on future violence, both victimization and perpetration, as well as on health and potential opportunity over the life-span, thereby making adverse childhood experiences an extremely important public health issue. ACEs have been linked to negative outcomes such as risky health behaviors, chronic health conditions, low life potential, and even early death (CDC, 2021). For individuals who have experienced a greater number of ACEs, the risk becomes higher for experiencing these outcomes. Figure 2.3 represents the pyramid of whole-life risks for social impairments and health problems that may result from the core adverse childhood experiences that form the base of the pyramid.

Figure 2.3

Adverse Childhood Experiences Pyramid



From: Centers for Disease Control and Prevention. (2021, April 6). About the CDC-Kaiser ACE study. Violence Prevention. <https://www.cdc.gov/violenceprevention/aces/about.html>

A high ACE score may be an indicator for high risk across a person's life-span. According to "Adverse childhood experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders." The base of the pyramid identifies transgenerational or historical trauma, as well as social conditions and

local context, thus emphasizing the strong impact that racial trauma and living in conditions circumscribed by poverty or community violence may have on a person. Individuals who have experienced a greater number of ACEs are likely to develop a wider range of health and behavioral health problems. The prevalence of health problems typically is higher for those scoring a greater number of ACEs, and this includes problems associated with risky behaviors such as substance misuse. [SAMHSA \(2018\)](#) and the [Village Network \(n.d.\)](#) identify the following most common ACEs:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Intimate partner violence
- Mother treated violently
- Substance misuse within household
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

Clearly, there is a strong association between the health-related effects of ACEs and stress, and this illuminates how stress is implicated in experiences associated with crisis, trauma, and racial trauma.

Racial Trauma

Racial trauma, also referenced as transgenerational trauma and historical trauma, is a source of stress, crisis, and trauma for most, if not all, people of color. Research has established the extent to which race-based stressors can cause serious health and behavioral health issues for people of color ([Williams, 2018](#); [Williams & Cooper, 2019](#); [Williams et al., 2018, 2021](#)). Studies have demonstrated that the extreme effects of racial trauma have caused intergenerational transmissions of trauma that ultimately are responsible for epigenetic changes, affecting the function and expression of genes in subsequent generations ([Shonkoff et al., 2021](#); [Sotero, 2006](#); [Yehuda & Lehrner, 2018](#)). According to [Williams \(2018\)](#), racism that is deeply embedded within the broader culture continues to affect individuals through structural and institutional mechanisms; research that attends to institutional racism and the health effects of racial hostility has the potential for “enhancing our understanding of the complex association between physical and mental health” (p. 466). Issues associated with racial trauma are detailed more extensively in [Chapters 17 and 19](#) of this book. However, it is essential to point to racial trauma as a major public health concern as well as possessing relevant social justice dimensions.

Social Justice Dimensions of Trauma

Geopolitical atrocities continue to occur internationally, even though the phrase “never again” has been repeated over and over in reference to events such as the enslavement of Africans, the near extinction of indigenous peoples in the Americas, the Jewish Holocaust, apartheid in South Africa, the Bosnian genocide, the Rwandan genocide—and now, *again*, in reference to the Democratic Republic of Congo, to Sudan, and to the persecution of the Rohingya people in Myanmar. Circumstances like these have exposed people to such a degree of extreme cruelty and unspeakable horror that the ensuing trauma not only affects the individuals directly involved but can live on as transgenerational trauma. Trauma that continues across generations is called “historical trauma,” and includes racial trauma, as previously mentioned and also discussed at greater length in other chapters of this book.

Both human-made and natural catastrophes can leave the poorest, the youngest, the oldest, and the weakest in highly vulnerable positions. The world has witnessed the devastation of the most vulnerable in recent climate-related disasters as well as in the ongoing effects of the

COVID-19 pandemic. Children (e.g., [Lanius et al., 2010](#); [Sanchez et al., 2019](#)) and older adults (e.g., [Bonnie & Wallace, 2003](#); [DePrince et al., 2020](#)) have been exploited in many ways that can evoke trauma responses (issues associated with child and adolescent trauma are discussed in [Chapters 7 and 8](#), and with elder trauma in [Chapter 12](#) of this textbook). Immigration processes have become fraught with the potential for trauma, in the United States and in various other parts of the world (e.g., [Levers & Hyatt-Burkhart, 2011](#)); these issues are detailed more fully in [Chapter 17](#) of this book.

Trauma-based issues that represent human rights violations need to be examined from a social justice perspective. The effects of a traumatic event can be intensified and worsened when the traumatized person also has cause to feel that they have been betrayed by the very social institutions that should be extending assistance. As an example, this was the palpable pain, witnessed in news feeds across the country and around the world, when victims of Hurricane Katrina were shown, corralled in the most unsanitary conditions and begging for water. Although trauma survivors whose rights have been violated need to be treated individually and to engage in a recovery process, the group aspect of a social justice perspective may require some type of restorative or reparative justice to take place. Restorative justice, which focuses on the needs of the victim rather than legal principles or the punishment of the offender, has been used, as one example, in the *Gacaca* courts in Rwanda, offering a format for reconciliation between victims and perpetrators in a situation where parties need to live together again in the same society (aspects of the Rwandan genocide are discussed in greater detail in [Chapter 23](#) of this book).

Pedagogical Dimensions of Trauma

Opportunities for in-service and professional association trainings concerning all issues related to trauma have swelled during the last several decades. However, preservice clinical instruction, specifically related to the psychosocial impacts of trauma, has been less forthcoming, and the same is true regarding a focus on the clinical supervision of trauma-related cases, although there have been some recent attempts to redress this tremendous training gap. For example, the Council for the Accreditation of Counseling and Related Education Programs ([CACREP, 2016](#)) recently instituted the curricular requirement, for both the master's level and doctoral training of professional counselors, that content related to the areas of crises, disasters, and other trauma-causing events be included in the curriculum of accredited programs. Counseling, psychology, and social work programs gradually have been adding courses that deal with trauma and crisis issues, but little is known about pedagogical best practices and trauma ([Levers, 2020](#)).

Educators have noted the existence of pedagogical problems and difficulties in teaching matters that are associated with trauma (e.g., [Levers, 2020](#); [Simon & Eppert, 1997](#); [Simon et al., 2000](#); [Walcott, 2000](#)). Obviously, care needs to be taken not to overwhelm or traumatize students in the process of helping them to understand the clinical dimensions of trauma. At the same time, educators concerned with trauma issues need to create opportunities for advancing relevant skill sets. Although adding courses that are specific to trauma, especially at the graduate level, is a necessity, embedding trauma-sensitive skills across human services curricula would go a long way in addressing the instructional gap. For example, working with survivors of trauma requires empathic engagement; this skill typically is included in a basic techniques course and so presents an opportunity for illustrating the skill as one related to trauma along with applicability to other mental health issues. In addition to offering an adequate clinical knowledge base within a specialty trauma course, preservice programs could enhance the way they teach basic counseling skills across the curriculum, in order to include issues of trauma. Recent efforts to incorporate trauma-informed educational practices, at P-12 and college levels, appear to be promising (e.g., [Carello & Butler, 2015](#); [Quarmby et al., 2021](#)).

Intersection of Constructs Related to Stress, Crisis, Disaster, and Trauma

Issues associated with trauma constitute a major focus of this book. Stress, crisis theory, and crisis intervention are detailed in [Chapter 3](#), and various types of disaster and mass violence

crisis intervention are detailed in [Chapter 3](#), and various types of disaster and mass violence situations are examined in [Chapters 19 to 25](#) of this book. Of relevance at this juncture is the nexus of constructs regarding stress, trauma, crisis, and disaster experiences and the importance of differentiating their varying characteristics ([Yeager & Roberts, 2015](#)). In some ways, the process of differentiating is paradoxical; the more we look at the differences in these constructs, the more we see the complexity of their intersection, in many human experiences. This is precisely why I have formatted the first four chapters of this book as a scaffold for building upon and understanding these distinct and yet interconnected concepts.

Stress is a common feature of everyday life and has the same psychophysiological effects, whether real or imagined; however, unrelenting stress can be biologically and emotionally harmful. In this instance, a person may need to engage in stress management techniques and prevention activities to alleviate the pressure and tension. A crisis or disaster is usually a time of increased stress or danger. A crisis is an event or situation in which a person perceives a threat to be greater or more intolerable than their ability to cope with or assimilate the circumstances. A disaster is usually a sudden accident or a natural or human-made catastrophe that may or may not be perceived as a crisis or a trauma, depending upon the individual and the context. A traumatic event is typically so overwhelming that the victim experiences a sense of terror or helplessness. Not every stressor constitutes a crisis or a disaster, and not every crisis or disaster is traumatizing. However, a traumatic event typically involves extreme stress and some element of crisis.

It is useful for every mental health professional to be equipped with basic stress management and crisis intervention skills. These skill sets do not rely on long-term counseling as much as assisting clients to regulate their responses to extremely stressful or crisis-oriented situations or disasters; these skills require the counselor to attend to what needs to be done, in the immediate sense. However, survivor responses to traumatic events, especially if the response is enduring enough to qualify as PTSD, usually require longer-term counseling, and this suggests that the mental health professional have clinical preparation in delivering trauma counseling. Determining when a person's sense of intense fear or horror, in response to an overwhelming event, moves from the stress of a crisis to a fully traumatic experience may rely on the clinician's ability to combine two different sets of counseling skills: (a) active and compassionate listening to the client's narrative, and (b) keen assessment and diagnostic skills ([Roberts, 2002](#); [SAMHSA, 2014](#)). Developing all of these skill sets requires professional experience but acquiring as much preservice and ongoing in-service training as possible is also an essential factor.

COUNSELING IMPLICATIONS

Several implications arise from the aforementioned overview of a contextual and systemic perspective of trauma and trauma-related issues. Perhaps a pertinent first implication is that the most effective approach to understanding trauma is one that engages multiple disciplines. Scholars and clinicians point to the importance of interdisciplinarity in the study of trauma, from local to transnational trauma events and responses to these events (e.g., [Droždek, 2007a](#); [Hamburger et al., 2018](#)). As discipline-based professionals, we can learn from our confederate colleagues of all disciplinary persuasions.

A second implication relates to trauma therapists being adequately grounded in their understandings of both the clinical and contextual factors associated with trauma. This is a double-edged issue of professional responsibility: (a) preservice training programs need to offer adequate instruction concerning the ubiquitous mental health issues of stress, crisis, trauma, and disaster and; (b) clinicians working in the arena of traumatology need to ensure that they have an adequate education, whether preservice or in-service training, to support their work with trauma survivors.

Mental health professionals who work with survivors of trauma can provide more effective and culturally sensitive treatment when they conceptualize client concerns through the bioecological, transactional, neuroscience, and public health models described in this chapter. So a third implication is that these models offer an interdisciplinary format for understanding client risk factors, for engaging and enhancing existing protective factors, and for creating mechanisms that facilitate client recovery. A related fourth implication regards a systemic understanding of the impact of trauma. Because of the very personal nature of how traumatic events are experienced, even those involving mass casualties, along with the overwhelming intensity that is typical of any trauma situation, people who experience a traumatic event are affected profoundly in every area of their lives, including physiologically. To ignore the dynamics between individuals and the relevant systems that play essential roles in everyday living is really to ignore central features of the trauma situation.

When clinicians first recognize trauma and begin to treat the client, this constitutes an ecological transition for the therapist, thus providing a strong reason for seeking clinical supervision, a fifth implication. Working with survivors of trauma entails intellectually demanding and emotionally charged scenarios, ones that require clinicians to maintain professionally appropriate boundaries. In addition to the central importance of boundaries, therapists working with traumatized clients need to be keenly aware of the potential for countertransference. The need for self-reflexive skills, for the ability to formulate intentional treatment strategies, and for unwavering attention to boundary and countertransference issues speaks to the essential importance of clinical supervision when working with trauma (see [Chapter 32](#) of this book for a fuller discussion). Even highly experienced trauma counselors find clinical supervision helpful, and for more seasoned therapists, this can be conducted as peer supervision or even in trauma-informed learning groups that are developed by clinicians to support one another in this intense line of work.

Therapeutic intentionality is an important sixth implication for counseling. For a long time, clinicians working in community settings that are not trauma or survivor specific (different from rape crisis centers and domestic violence shelters, for example, that focus on traumatic events) have tended to provide crisis intervention immediately to distressed or traumatized clients, perhaps without even recognizing the trauma, *per se*. They then may refer these clients, so that the trauma issues are likely to be identified so much later that there are additional and more complex sets of problems for the clients. This seems to constitute a therapeutic *default* rather than *intentional* therapy. The mental health field has been defaulting on trauma, in this sense, for far too long. In order to avoid systemic failures and to aspire toward best practices, the delivery of mental health services to trauma survivors needs to be trauma informed (trauma-informed care is discussed more fully in [Chapters 27 and 28](#) of this book), to be offered from a pluralistic professional perspective, and to advance strategies of care that are intentional rather than of a default nature.

CONCLUSION

The construct of trauma has sparked controversies for well over a century, and we have arrived at multiple ways of perceiving trauma. This chapter has emphasized that the effects of a traumatic event are perhaps best understood from multidimensional and multidisciplinary perspectives. I have attempted to amplify how a recognition of the physiological effects of trauma on the brain and other organs of the body, along with an awareness of the bioecological and transactional nature of life-span development, can assist

awareness of the bioecological and transactional nature of life-span development, can assist therapists in dealing with the aftermath of clients' traumatic experiences. The connection between the personal and the systemic has been highlighted and is germane to the trauma scaffold that we have been constructing, with an aim toward supporting heightened understandings of more complex overlays of traumatic experiences.

A clinician's ability to understand the profound effects of a traumatic event on the psyche of a client goes well beyond codified clinical definitions and includes a phenomenological understanding of clients' lived experiences of trauma. This chapter has noted some of the common criticisms of *DSM* categorizations of trauma-based diagnoses, particularly PTSD, especially as these have established the basis for contemporary arguments that favor the consideration of a complex trauma classification, or a trauma spectrum disorders category. Herman's (1992/1997) helpful separation of PTSD symptoms into intrusive and constrictive sets has been offered, and Herman's notion of a dialectic of trauma has been presented.

In addition to defining trauma from clinical and phenomenological perspectives, insight has been derived from a contextual viewpoint, thereby enabling an examination of the cultural, public health, social justice, and pedagogical dimensions of trauma. This chapter also has reviewed constructs associated with stress, crisis, and disaster, exploring their nexus with relevant trauma issues, to begin to frame a scaffold for understanding the complexity and confluence of these lived experiences. The counseling implications of this chapter's contextual orientation toward trauma have been identified, emphasizing the need for adequate training and clinical supervision. Trauma has been viewed here as a complex human issue that requires informed and intentional individual and systemic responses.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is available. Qualifying instructors may request access by emailing textbook@springerpub.com.