

Principles of Trauma Therapy: A Guide to Symptoms, Evaluation, and Treatment
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What Is Trauma?

The term *psychological trauma* has been applied in so many contexts by so many people that it has lost some of its original meaning. Often, *trauma* is used to refer both to negative events that produce distress and to the distress itself. Technically, “trauma” refers only to the event, not the reaction, and should be reserved for major events that are psychologically overwhelming for an individual. The *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revision (*DSM-IV-TR*; American Psychiatric Association [APA], 2000) specifically defines a trauma as

direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person’s response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). (p. 463)

DSM-IV-TR provides a list of potentially traumatic events, including combat, sexual and physical assault, robbery, being kidnapped, being taken hostage, terrorist attacks, torture, disasters, severe automobile accidents, and life-threatening illnesses, as well as witnessing death or serious injury by violent assault, accidents, war, or disaster. Childhood sexual abuse is included even if it does not involve threatened or actual violence or injury.

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Although the *DSM-IV-TR* definition is useful, some have criticized the requirement that trauma be limited to “threatened death or serious injury, or other threat to one’s physical integrity,” since many events may be traumatic even if life threat or injury is not an issue (Briere, 2004). The earlier *DSM-III-R* (APA, 1987) definition also included threats to *psychological* integrity as valid forms of trauma. Because *DSM-IV-TR* does not consider events to be traumatic if they are merely highly upsetting but not life threatening—for example, extreme emotional abuse, major losses or separations, degradation or humiliation, and coerced (but not physically threatened or forced) sexual experiences—it undoubtedly underestimates the extent of actual trauma in the general population. It also reduces the availability of a stress disorder diagnosis in some individuals who experience significant posttraumatic distress—since Criterion A is a prerequisite for the diagnosis of posttraumatic stress disorder (PTSD) or acute stress disorder (ASD).

The issue of whether an event has to satisfy current diagnostic definitions of trauma in order to be, in fact, “traumatic,” is an ongoing source of discussion in the field. Our own conclusion is that an event is traumatic if it is extremely upsetting and at least temporarily overwhelms the individual’s internal resources. This broader definition is used throughout this book, since people who experience major threats to psychological integrity can suffer as much as those traumatized by physical injury or life threat, and can respond equally well, we believe, to trauma-focused therapies. This is solely a treatment issue, however; the *DSM-IV-TR* version of trauma should be strictly adhered to when making a formal stress disorder diagnosis.

Major Types of Trauma

Surveys of the general population suggest that at least half of all adults in the United States have experienced at least one major traumatic stressor (Elliott, 1997; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Although such stressors are common, their ability to produce significant psychological disturbance varies as a function of a wide variety of other variables, as is discussed in Chapter 2. The following pages detail most of the major types of traumatic events potentially experienced by those seeking mental health services. There are myriad ways in which an individual can be traumatized, not all of which are easily expressed in an initial clinical interview. This is important to keep in mind—frequently, clients will not report events they have experienced unless they are specifically asked about those events in a non-judgmental, supportive context (see Chapter 3). Each type of trauma is

described only briefly; the reader is referred to the Suggested Reading section at the end of the chapter for references to more detailed information.

Natural Disasters

Natural disasters can be defined as large-scale, not directly human-caused, injury- or death-producing environmental events that adversely affect a significant number of people. Disasters are relatively common in the United States; surveys suggest that between 13 and 30 percent of individuals have been exposed to one or more natural disasters in their lifetimes (Briere & Elliott, 2000; Green & Solomon, 1995). Typical disasters include earthquakes, large fires, floods, avalanches, hurricanes, tornados, and volcanic eruptions. The extent of physical injury, fear of death, and property loss during disasters appear to be the most traumatizing aspects of these events (Briere & Elliott, 2000; Maida, Gordon, Steinberg, & Gordon, 1989; Ursano, Fullerton, & McCaughey, 1994). When mental health workers are involved in assisting disaster victims, it is usually within the context of governmental or quasi-governmental agencies (for example, the Red Cross) that have been mobilized relatively soon after the event. At such times, as described in Chapter 10, the clinician's initial job usually involves triage and providing support, comfort, and psychological "first aid," as opposed to trauma therapy, *per se*.

Mass Interpersonal Violence

Intentional violence that involves high numbers of injuries or casualties—but does not occur in the context of war—is a newer category in the trauma field. The Oklahoma City bombing on April 19, 1995 (North et al., 1999), the terrorist attacks on the World Trade Center and the Pentagon on September 11, 2001 (Galea et al., 2002), and the July 7, 2005, attacks on the London mass transit system are obvious cases of mass trauma. There is an unfortunately large number of other examples, however, including terrorist attacks throughout the world and mass human rights abuses by totalitarian regimes (Alexander & Brenner, 2001; Pfefferbaum et al., 2001). The September 11 attacks stimulated a dramatic increase in North American research on the effective short-term treatment of mass trauma, as described in Chapter 10. As noted later, this research suggests that it is as important to know what *not* to do as it is to know what *to* do when working acutely with victims of mass trauma. It is a goal of international groups like the International Society for Traumatic Stress Studies (ISTSS; <http://www.istss.org>) to disseminate this information worldwide, since there is little reason to believe that terrorist attacks or other mass traumas will decrease in the foreseeable future.

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Large-Scale Transportation Accidents

Transportation accidents involve events such as airline crashes, train derailments, and maritime (for example, ship) accidents. These events often involve multiple victims and high fatality rates. Although the incidence of such events is not easily determined, large-scale transportation accidents can be especially traumatic to survivors, since such events frequently occur over a relatively extended period of time during which the victims are exposed to ongoing terror and fear of death. Immediate response to airliner accidents in the United States is controlled primarily by the Federal Aviation Administration (FAA) and the National Transportation Safety Board (NTSB), who work in concert with local emergency services, the relevant airline company, and others in providing assistance to traumatized survivors and their families.

House or Other Domestic Fires

Although fires are often listed as disasters in the trauma literature, a significant number of victims seen by trauma clinicians have experienced smaller-scale fires. These include house fires, often caused by smoking in bed or by electrical short circuits, and gas explosions due to leaking propane tanks, stoves, or heaters. Physical injuries from fire can be particularly traumatic. The lasting effects of serious burns—a long recovery period, reconstructive surgeries, the development of visible and/or painful scars, and sometimes chronic pain and reduced mobility—mean that the traumatic event, in some ways, continues and repeats over time (Gilboa, Friedman, Tsur, & Fauerbach, 1994). This sustained traumatization, in turn, can interfere with posttraumatic recovery.

Motor Vehicle Accidents

Approximately 20 percent of individuals in the United States have experienced a serious motor vehicle accident (MVA) (Blanchard & Hickling, 1997). A substantial number of these people go on to develop significant psychological disturbance, especially if the accident involved major injury or resulted in the death of others. In the latter case, grief and self-blame may increase subsequent psychological effects. In addition, survivors of major MVAs may sustain traumatic brain injury, which can further complicate assessment and treatment (Harvey & Bryant, 2002; Hickling, Gillen, Blanchard, Buckley, & Taylor, 1998). Despite the fact that serious MVAs are more likely than many other noninterpersonal traumas to produce PTSD and other forms of

dysfunction, clinicians often inappropriately overlook such traumas when interviewing clients about negative life events.

Rape and Sexual Assault

Rape can be defined as nonconsensual oral, anal, or vaginal sexual penetration of an adolescent or adult (if the victim is a child, see “Child Abuse”) through the use of threat or physical force, or when the victim is incapable of giving consent (for example, when under the influence of drugs or alcohol, or when he or she is otherwise cognitively impaired). The term *sexual assault* typically denotes any forced sexual contact short of rape, although some authorities consider sexual assault to involve any forced sexual contact, including rape. Using definitions similar to these, the prevalence of rape against women in the United States is reported to be 14–20 percent (Kilpatrick & Resnick, 1993; Koss, 1993; Tjaden & Thoennes, 2000). Rape and sexual assault rates for males are less clear, due in part to only recent social awareness that men can be sexually victimized, but are estimated to range between 2 and 4 percent (Elliott, Mok, & Briere, 2004; Tjaden & Thoennes, 2000). Peer sexual assault against adolescent women is, sadly, quite common as well; Singer, Anglin, Song, and Lunghofer (1995) found that, among students in six geographically and economically diverse high schools, 12–17 percent of adolescent women reported having been made to engage in at least one sexual act against their wishes. Because of the shame and secrecy associated with being a victim of rape or sexual assault in many cultures, it is likely that some victims do not identify themselves as such in research studies. As a result, the prevalence rates quoted are probably underestimates. Sexual assault and rape can be particularly devastating and traumatizing events, and are substantial risk factors for PTSD among women in the general population (Kessler et al., 1995).

Stranger Physical Assault

Stranger assault refers to muggings, beatings, stabbings, shootings, attempted strangulations, and other violent actions against a person not well known to the assailant. The motive for such aggression is often robbery or the (sometimes random) expression of anger, although in gang and “drive-by” situations the intent may also be to define or protect turf or to otherwise assert dominance. Although many acts of violence in relationships are directed more toward women than men, the reverse appears true for stranger physical assaults. In one study of inner-city psychiatric emergency room patients, for example, 64 percent of men reported having experienced at least one

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nonintimate physical assault, as opposed to 14 percent of women (Currier & Briere, 2000). Similarly, Singer et al. (1995) found that, depending on the research site, 3–33 percent of male adolescents described being shot at or shot, and 6–16 percent reported being attacked or stabbed with a knife.

Partner Battery

Partner battery (also known as *wife battering*, *spouse abuse*, or *domestic violence*) is usually defined as physically or sexually assaultive behavior by one adult against another in an intimate, sexual, and usually (but not inevitably) cohabiting relationship. In the majority of cases, there is emotional abuse as well (Straus & Gelles, 1990). There may also be threats toward or violence against children, pets, and/or property. In a large-sample survey of individuals in the United States who were married or living with a partner, 25 percent reported at least one incident of physical aggression in a domestic context, while 11.6 percent reported incidents of severe physical violence such as punching, kicking, or choking (Straus & Gelles, 1990). Rates of sexual assault of women by partners or spouses—irrespective of their history of physical battering—range from 9 to 15 percent (Elliott & Briere, 2003; Finkelhor & Yllo, 1985). Among women who are physically assaulted by a partner, concomitant rates of sexual assault as high as 45 percent have been reported (Campbell & Soeken, 1999).

Torture

Torture has been defined by the United Nations as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him [sic] or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or a third person . . .” (Vesti & Kastrup, 1995, p. 214). Regardless of function or context, methods of torture involve both physical and psychological techniques, including beatings, near strangulation, electrical shock, various forms of sexual abuse and assault, crushing or breaking of bones and joints, sensory deprivation, threats of death or mutilation, mock executions, being made to feel responsible for the death or injury of others, sleep deprivation, and being forced to engage in grotesque or humiliating acts. The incidence of torture is not known, although Amnesty International (2002) estimates that more than 111 nations currently sanction the use of—or at least tacitly allow—torture. Torture victims are dramatically overrepresented among refugees (Baker, 1992), although such individuals are rarely questioned about a potential torture history when they come in contact with North American mental health systems.

War

War is a common and relatively powerful source of enduring psychological disturbance. Posttraumatic difficulties have been described in veterans of the American Civil War and both world wars, as well as in those who fought in Afghanistan, Korea, Vietnam, the Persian Gulf (including Iraq), Israel, Armenia, the Falklands, Somalia, and Bosnia. War involves a very wide range of violent and traumatic experiences, including immediate threat of death and/or disfigurement, physical injury, witnessing injury and/or death of others, and involvement in injuring or killing others (both combatants and civilians) (Kulka et al., 1990; Weathers, Litz, & Keane, 1995). For some, war includes witnessing or participating in atrocities, as well as undergoing rape, capture, and prisoner-of-war experiences such as confinement, torture, and extreme physical deprivation. These traumas, in turn, can produce a variety of symptoms and disorders. Most U.S. war veterans who seek psychological services today were combatants or support personnel in Iraq, Vietnam, or Korea. Although the Veterans' Administration provides care for many war veterans with service-connected injuries or disabilities in the United States, it is not uncommon for veterans to present to non-VA mental health centers and clinicians.

Child Abuse

Childhood sexual and physical abuse, ranging from fondling to rape and from severe spankings to life-threatening beatings, is quite prevalent in North American society. Studies of retrospective child abuse reports in the United States suggest that approximately 25–35 percent of women and 10–20 percent of men, if asked, describe being sexually abused as children, and approximately 10–20 percent of men and women report experiences congruent with definitions of physical abuse (Briere & Elliott, 2003; Finkelhor, Hotaling, Lewis, & Smith, 1990). Several studies suggest that 35–70 percent of female mental health patients self-report, if asked, a childhood history of sexual abuse (Briere, 1992). Many children are psychologically abused and/or neglected, as well, although these forms of maltreatment are harder to quantify in terms of incidence or prevalence (Erickson & Egeland, 2002; Hart, Brassard, Binggeli, & Davidson, 2002). As is described in later chapters, child abuse and neglect not only produces significant, sometimes enduring, psychological dysfunction, it is also associated with a greater likelihood of being sexually or physically assaulted later in life (Classen, Paresh, & Aggarwal, 2005).

Emergency Worker Exposure to Trauma

Because emergency workers often encounter potentially traumatic phenomena, including fatal injury, traumatic amputation, disembowelment, severe

burns, and extreme victim distress, it is not surprising that those who help the traumatized may become traumatized themselves. Among those known to be at risk for such work-related stress are firefighters, rescue workers, paramedics and other emergency medical personnel, individuals involved in the identification and handling of deceased trauma victims, emergency mental health and crisis intervention workers, and law enforcement personnel (Berah, Jones, & Valent, 1984; Fullerton, Ursano, & Wang, 2004; Rivard, Dietz, Martell, & Widawski, 2002). Psychotherapists who treat trauma survivors may also develop a form of vicarious traumatization (Dalenberg, 2000; Goin, 2002; Pearlman & Saakvitne, 1995).

The Problem of Combined and Cumulative Traumas

The listing of separately described traumas presented may give the erroneous impression that such traumas are independent of one another—in other words, that undergoing one trauma does not necessarily increase the likelihood of experiencing another. This is generally true of noninterpersonal traumas such as disasters or house fires. However, a number of studies demonstrate that victims of interpersonal traumas are at statistically greater risk of additional interpersonal traumas. This is especially true in what is known as *revictimization*: those who have experienced childhood abuse are considerably more like to be victimized again as adults (Classen et al., 2002; Tjaden & Thoennes, 2000). In addition, many clinicians have noticed that some clients seem to have more than their normal share of adult traumas: lifestyle, environmental, behavioral, personality, and/or social issues appear to increase the likelihood of the individual being repeatedly victimized.

The relationship among different traumas, and the symptoms and difficulties they cause in a given individual's life history, can be complex. Childhood abuse, for example, may produce various symptoms and maladaptive behaviors in adolescence and adulthood (for example, substance abuse, indiscriminate sexual behavior, and reduced danger awareness via dissociation or denial) that, in turn, increase the likelihood of later interpersonal victimization. These later traumas may then lead to further behaviors and responses that are additional risk factors for further trauma, and subsequent, potentially even more complex mental health outcomes (Briere & Jordan, 2004). Because both childhood and adult traumas can produce psychological difficulties, current symptomatology in adult survivors may represent (1) the effects of childhood trauma that have lasted into adulthood, (2) the effects of more recent sexual or physical assaults, (3) the additive effects of childhood trauma *and* adult assaults (for example, flashbacks to both childhood and

adult victimization experiences), and/or (4) the exacerbating interaction of childhood trauma and adult assault, such as especially severe, regressed, dissociated, or self-destructive responses to the adult trauma.

This complicated mixture of multiple traumas and multiple symptomatic responses is well known to trauma-focused clinicians, who sometimes find it difficult to connect certain symptoms to certain traumas, and other symptoms to other traumas, or, in fact, to discriminate trauma-related symptoms from less trauma-specific symptoms. Although this task is often daunting, the remaining chapters of this book describe assessment and treatment approaches that clarify these various trauma-symptom connections or, in some cases, provide alternative ways of approaching multitrauma-multisymptom presentations.

Suggested Reading

- Breslau, N., Davis, G. C., Andreski, P., & Peterson, E. L. (1991). Traumatic events and post-traumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry*, *48*, 216–222.
- Koss, M. P. (1993). Detecting the scope of rape: A review of prevalence research methods. *Journal of Interpersonal Violence*, *8*, 198–222.
- March, J. S. (1993). What constitutes a stressor? The “criterion A” issue. In J. R. T. Davidson & E. B. Foa (eds.), *Posttraumatic stress disorder: DSM-IV and beyond*. Washington, DC: American Psychiatric Association Press.
- Norris, F. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology*, *60*, 409–418.
- Read, J., & Fraser, A. (1998). Abuse histories of psychiatric inpatients: To ask or not to ask? *Psychiatric Services*, *49*, 355–359.

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The Effects of Trauma

This chapter is divided into two sections. The first discusses those individual, social, and trauma-specific variables that are most associated with the development of posttraumatic symptoms in older adolescents and adults. These various contributors to (and moderators of) posttraumatic outcomes are relevant to clinical practice because, as it turns out, two people exposed to a similar trauma may respond in remarkably different ways—one may present with only mild, transient symptoms, whereas the other may develop a full-blown stress disorder that endures for months or years. Current research indicates that only a minority of those exposed to a Criterion A trauma, as defined by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*; American Psychiatric Association [APA], 2000) go on to develop posttraumatic stress disorder (Breslau, Davis, Andreski, & Peterson, 1991)—the rest are either less affected or respond with other symptoms, such as depression or generalized anxiety. The specific extent and type of symptom expression is associated with a number of variables, often referred to as *risk factors* for traumatic stress. In some cases, intervention aimed at these risk factors may lead to decreased posttraumatic response and less risk for future disorders.

The second section of this chapter describes the major forms that posttraumatic symptomatology can take. Clinical outcomes include not only the three major trauma-specific disorders (acute stress disorder [ASD], posttraumatic stress disorder [PTSD], and brief psychotic disorder with marked stressor [BPDMS]), but also a number of other, more generic responses or disorders that can arise from exposure to trauma.