
1

Overview

History of Trauma Theory

The relationship between trauma and mental illness was first investigated by the neurologist Jean Martin Charcot, a French physician who was working with traumatized women in the Salpetriere hospital. During the late 19th century, a major focus of Charcot's study was hysteria, a disorder commonly diagnosed in women. Hysterical symptoms were characterized by sudden paralysis, amnesia, sensory loss, and convulsions. Women comprised the vast majority of patients with hysteria, and at the time, such symptoms were thought to originate in the uterus. Until Charcot, the common treatment for hysteria was hysterectomy. Charcot was the first to understand that the origin of hysterical symptoms was not physiological but rather psychological in nature, although he was not interested in the inner lives of his female patients. He noted that traumatic events could induce a hypnotic state in his patients and was the first to "describe both the problems of suggestibility in these patients, and the fact that hysterical attacks are dissociative problems—the results of having endured unbearable experiences" (van der Kolk, Weisaeth, & van der Hart, 1996, p. 50). In Salpetriere, young women who suffered violence, rape, and sexual abuse found safety and shelter, and Charcot presented his theory to large audiences through live demonstrations in which patients were hypnotized and then helped to remember their trauma, a process that culminated in the abrogation of their symptoms (Herman, 1992).

Pierre Janet, a student of Charcot, continued to study dissociative phenomena and traumatic memories. Janet investigated the influence of patients' traumatic experiences on personality development and behavior. He recognized that patients' intense affects were reactive to their perceptions of the traumatic events that happened to them, and he found that through hypnosis and abreaction, or reexposure to the traumatic memories, patients' symptoms could be alleviated (van der Kolk, Weisaeth, et al., 1996). In his early studies of hysteria (1893–1895), Freud, too, was initially influenced by Charcot and

adopted some of his ideas. In *Studies on Hysteria* (1893), coauthored with Josef Breuer, Freud suggested that

we must point out that we consider it essential for the explanation of hysterical phenomena to assume the presence of a dissociation, a splitting of the content of consciousness. [T]he regular and essential content of a hysterical attack is the recurrence of a physical state which the patient has experience earlier. (cited in van der Kolk, Weisaeth, et al., 1996, p. 30)

Freud and Breuer termed traumatic dissociation “hypnoid hysteria” and highlighted its relationship to a traumatic antecedent. In 1896, Freud suggested that “a precocious experience of sexual relations . . . resulting from sexual abuse committed by another person . . . is the *specific cause* [italics added] of hysteria . . . not merely an agent provocateur” (1896/1962, p. 195, cited in van der Kolk, Weisaeth, et al., 1996, p. 54). In the 1880s, Freud and Breuer as well as Janet independently concluded that hysteria was caused by psychological trauma. They agreed that unbearable reactions to traumatic experiences produced an altered state of consciousness that Janet called “dissociation.” According to Janet, dissociation manifested in hysterical symptoms (Herman, 1992). Putting the emotions into words and reconstructing the past helped alleviate the patients’ symptoms.

However, Freud eventually moved from what has been termed “seduction theory” to conflict theory (see Chapter 3 for a more detailed discussion of this development), suggesting that it was not memories of external trauma that caused hysterical symptoms but rather the unacceptable nature of sexual and aggressive wishes. What his followers neglected to notice, however, was that whereas Freud privileged intrapsychic theory and fantasy over external trauma, he did suggest that it was possible for external trauma to influence the patient’s state of mind (Diamond, 2004). Ferenczi (1933/1955) was the only one among Freud’s followers who regarded his patients’ stories of childhood sexual abuse as veridical recollections, but he remained somewhat of an outsider in the psychoanalytic movement during his lifetime, his theories gaining favor only in the decades following his untimely death in 1933.

Crisis intervention methods to address traumatic events developed gradually, with the establishment of the first suicide hotline in 1902 in San Francisco. Psychological “first aid” was then further developed in the context of military combat. During World War I, psychiatrists observed that soldiers returned with “shell shock” syndrome. Psychological first aid was first developed to help World War I soldiers overcome their symptoms of uncontrollable weeping and screaming, memory loss, physical paralysis, and lack of responsiveness (Herman, 1992). The goal of psychological first aid was to provide a short intervention that would help the soldiers recover and return to the front as soon as possible. It was observed that by providing intervention close to the front and soon after deployment, traumatized soldiers were able to overcome

their shell shock symptoms and return to active combat duty. In 1923, following World War I, Abram Kardiner started to treat traumatized U.S. war veterans (Kardiner, 1941). Like Janet and Freud, he observed the nature of reenactment, a central construct in modern trauma theory, and noted that “the subject acts as if the original traumatic situation were still in existence and engages in protective devices which failed on the original occasion” (p. 82; also cited in van der Kolk, Weisaeth, et al., 1996, p. 58). Kardiner also foresaw an important controversy that continues to haunt trauma therapists, that is, whether to bring the traumatic memories into the patient’s consciousness or to focus on stabilization (van der Kolk, van der Hart, & Marmar, 1996). Although earlier trauma theorists blamed the soldiers’ symptoms on their poor moral character, Kardiner understood that any man could be affected by the atrocities of war and that the traumatic symptoms were a normal response to an unbearable situation.

Kardiner and his colleague Herbert Spiegel argued that the most powerful intervention against overwhelming terror was “the degree of relatedness between the soldier, his immediate fighting unit, and their leader” (Herman, 1992, p. 25). Consequently, treatment for traumatized soldiers during the Second World War focused on minimizing separation between these soldiers and their comrades and providing brief intervention methods such as hypnosis. Kardiner and Spiegel warned, however, that cathartic experiences and hypnosis by themselves, without consistent follow-up, were not sufficiently helpful and that unless the traumatic memories were integrated in consciousness the improvement would not last (Kardiner & Spiegel, 1947, cited in Herman, 1992). During World War II, psychiatrists reintroduced hypnosis as a treatment for trauma, and the U.S. Army instituted the use of “group stress debriefing” (Shalev & Ursano, 1990, cited in van der Kolk, Weisaeth, et al., 1996, p. 59).

After World War II, studies on the impact of prolonged stress and trauma on concentration camp survivors coincided with observations of combat stress. Henry Krystal (1968, 1978, 1988) was a psychoanalyst who studied outcomes of prolonged traumatization on concentration camp survivors, observing that “traumatized patients come to experience emotional reactions merely as somatic states, without being able to interpret the meaning of what they are feeling” (van der Kolk, Weisaeth, et al., 1996, p. 60). Krystal elaborated on the diagnosis of alexithymia, a typical syndrome in chronically traumatized people. He described the effect of trauma on the capacity to experience, identify, and verbalize feelings as well as physiological needs and these patients’ tendency to somatize affective experiences, express themselves in an overly concrete manner, and their lack of capacity to symbolize and dream. McDougall, who also worked with traumatized patients, suggested that it was not the absence of affect that was the issue. Instead, she stated, her patients “were not suffering from an inability to experience or express emotions, but from an inability to contain and reflect over an excess of affective experiences” (McDougall, 1989, p. 94).

Contemporary trauma theory in civilian contexts developed following the 1942 Cocoanut Grove fire in Boston. During that fire, 493 people perished in a nightclub, many of them trampled to death. Following the tragedy, Dr. Lindemann, who treated a number of the survivors, observed that they displayed common responses. He began to theorize about normal grief reactions, including preoccupation with lost loved ones, identification with the deceased, expressions of guilt and hostility, disorganization, and somatic complaints (Lindemann, 1944). Caplan, who also worked with the survivors of the Cocoanut Grove fire, was the first to systematically describe the components of crisis. He spoke of people's being

in a state of crisis when they face an obstacle to important life goals, . . . an obstacle that is, for a time, insurmountable by the use of customary methods of problem solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at solution are made. (Caplan, 1961, p. 18)

During the same time Parad was interested in examining the impact of particular types of crises and identified five components that affected victims' abilities to cope with overwhelming life events:

- The stressful event poses a problem which is by definition insoluble in the immediate future.
- The problem overtaxes the psychological resources of the family, since it is beyond their traditional problem solving methods.
- The situation is perceived as a threat or danger to the life goals of the family members.
- The crisis period is characterized by tension which mounts to a peak, then falls.
- Perhaps of the greatest importance, the crisis situation awakens unresolved key problems from both the near and distant past. (Parad & Caplan, 1960, pp. 11–12)

During the Vietnam War, soldiers and veterans returned with incapacitating symptoms that often developed into chronic problems affecting their capacity to cope with, and function in, civilian life. Many of them started to abuse drugs and alcohol, behaved violently toward their partners, or became homeless and unemployable. Lifton and Shatan, who worked with Vietnam veterans, conducted “rap groups” for the veterans, during which they could share their experiences with their comrades and receive validation and support. Based on their work, Lifton and Shatan identified 27 common symptoms of “traumatic neurosis” (Lifton, 1973). These symptoms were catalogued based on the authors' observations of veterans as well as on their readings of Kardiner and the literature on Holocaust survivors and victims of accidents, which they compared with clinical records of Vietnam veterans. Many of

these symptoms were later included in the *Diagnostic and Statistical Manual of Mental Disorders* (third edition; *DSM-III*) diagnosis of posttraumatic stress disorder (PTSD) and utilized in panel discussions leading to the inclusion of this diagnosis (van der Kolk, Weisaeth, et al., 1996). Figley (1978) also contributed to the growing treatment literature on Vietnam veterans, and Shay (1994) made theoretical contributions to the understanding of the long-term impact of combat trauma on Vietnam veterans by applying Greek mythological imagery. He used, for example, the story of Achilles to anchor his discussion of Vietnam veterans' experiences and psychological wounds.

Along with combat trauma and the trauma of Holocaust survivors, trauma in the lives of women moved from the private domain of the home to the public arena as a consequence of the women's movement in the 1970s. Women's consciousness-raising groups shared common characteristics with the Vietnam veterans' rap groups in that they were based on open sharing, validation, and support and "helped overcome barriers of denial, secrecy and shame" (Herman, 1992, p. 29). The purpose was not only to provide psychological healing but to bring about social change in policies and institutions. An epidemiological survey by Diana Russell in the 1980s of more than 900 women chosen at random showed that 1 woman in 4 had been raped and 1 woman in 3 had been sexually abused in childhood, statistics that were quite shocking insofar as such problems had been well hidden and denied until that era (Russell, 1984). The first rape crisis center opened in 1971, and a more comprehensive understanding and treatment of domestic violence followed (Herman, 1992). Additional contributions to the understanding of types of trauma and their impact were made by Lenore Terr (1979) through her work with children involved in a school bus kidnapping in Chowchilla, California.

PTSD and the *DSM-III*

Psychological trauma and PTSD were not included in the *DSM* until 1980, when returning Vietnam War veterans presented with severe symptoms and clearly needed prolonged psychological services. Advocates for combat veterans and mental health professionals collaborated in bringing these events and their aftermath to public view (Herman, 1981, 1992; van der Kolk, Weisaeth, et al., 1996). Together with advocates of battered women, rape victims, and abused children, these clinicians brought their influence to bear on the *DSM-III* committees, and all of these groups were included under the diagnosis of PTSD in 1980. Veterans' advocates, mental health professionals, and others working with victims of domestic violence and adult survivors of childhood incest/sexual abuse reported similar symptoms in their traumatized clients. Many had been further victimized owing to social stigmata and a lack of understanding of their behavioral, emotional, and cognitive symptoms. In addition to advocating for the acceptance of PTSD diagnosis, women's

advocates opposed the inclusion of certain personality disorders that they regarded as being sexist and/or culturally biased, such as masochistic and histrionic personality disorders.

The *DSM* diagnosis of PTSD addressed immediate symptoms following combat experiences, rape, domestic violence, and child abuse; symptoms were then categorized along four clusters: intrusive reexperiencing, avoidance, hyperarousal, and hypervigilance, with general symptoms of anxiety and dysphoria in addition (Ford & Courtois, 2009). Although the PTSD diagnosis addresses the symptoms of posttraumatic stress, it does not focus on causes in a patient's early developmental history, which may include childhood abuse and neglect; nor does it offer a more complex and comprehensive view of psychosocial stressors and daily functioning that exert influence over all areas of adult life.

Complex Traumatic Stress Disorder ---

As stated above, although the diagnosis of PTSD included the comprehensive symptoms of trauma, it did not address early antecedents in childhood, the impact on long-term social and professional functioning, and the role of trauma in personality disorders. Herman (1992) was the first to suggest that "Complex PTSD" be included as a new diagnosis that would address the multiple origins of trauma and their impact on all aspects of a person's life. She noted that frequently, women with borderline personality disorder were marginalized by mental health professionals who failed to understand the connection between their early experience of sexual abuse and their present personality structure. More recently, Courtois developed the comprehensive diagnosis of complex trauma (Courtois, 2004, 2009), which she explains as the "inability to self regulate, self organize, or draw upon relationships to regain self integrity" (Ford & Courtois, 2009, p. 17). Complex trauma is "associated with histories of multiple traumatic stressors and exposure experiences, along with severe disturbances in primary care giving relationships" (Ford & Courtois, 2009, p. 18). It can lead to substance abuse, unemployment, and homelessness and affects all psychosocial aspects of living. A diagnosis of complex traumatic stress disorder calls for a treatment model that addresses the immediate posttraumatic symptoms as well as psychosocial counseling, substance abuse treatment, domestic violence interventions, and assistance in improving professional and interpersonal skills as well as in obtaining housing.

Developmental Trauma Disorder ---

Along with the recognition of complex traumatic stress disorder and its impact on all aspects of the person's life, van der Kolk (2005) recommended

the inclusion of a new diagnosis, which he called developmental trauma disorder, for children with complex developmental trauma histories. This diagnosis is distinct from other childhood diagnoses such as ADHD, oppositional defiant, and conduct disorder in that it specifically addresses the consequences of early trauma in relation to abuse and neglect. Van der Kolk noted that a study by Kaiser Permanente of 17,337 members revealed that 11% reported having been emotionally abused as children, 30.1% reported early physical abuse, and 19.9% reported sexual abuse (van der Kolk, 2005). This survey shows that childhood abuse is much more common than previously known and that those children deprived of intervention or treatment of early abuse symptoms will likely suffer from behavioral, emotional, and cognitive disturbances for the rest of their lives. In addition, early trauma affects the neurological development of young children, who may not be able to develop the neuronal structures necessary to process information, regulate emotions, and categorize experiences. This can lead to poor impulse control, aggression, difficulty in interpersonal relationships, and poor academic performance because of their inability to concentrate. In later development, such children may develop self-harming and substance abuse disorders in an effort to regulate their emotional arousal, owing to their difficulty in self-soothing and affect regulation. Van der Kolk suggested that multiple exposures to childhood traumas, including “abandonment, betrayal, physical or sexual assaults, or witnessing domestic violence” (2005, p. 406) can have negative sequelae that continue to reverberate throughout childhood, adolescence, and adulthood.

Trauma in Contemporary Life

Traumatic stress has become more prevalent and complex in contemporary American life as a result of the mass trauma of 9/11, the ongoing war against terrorism, and ongoing wars in Iraq and Afghanistan, which have led to an increased incidence of PTSD in returning military personnel. In the immediate aftermath of 9/11, mental health professionals treated survivors based on the principles of critical incident stress debriefing procedures (Everly & Mitchell, 1999; Mitchell, 1983). This treatment approach is based on the assumption that encouraging expression of one’s thoughts and feelings about the traumatic event soon after it happens will bring about relief and resolution of symptoms (Seery, Silver, Holman, Ence, & Chu, 2008). However, to date there are few data to show that expressing one’s thoughts and feelings immediately after trauma is a good way of coping. Although some studies indicate that trauma expression results in better mental health, research has shown that the mean amount of time between the target event and the participant’s disclosure is 15 months, well beyond the limits of early intervention (Frattaroli, 2006). A meta-analysis by van Emmerik, Kamphuis, Hulsbosch, and Emmelkamp (2002) shows that critical incident stress debriefing does not significantly improve PTSD and other trauma-related

symptoms such as general anxiety and depression. In addition, Sherman, Zanotti, and Jones (2005) found that survivors of 9/11 who chose not to discuss the trauma they experienced showed better mental health outcomes for 2 years after 9/11 than people who chose to express their feelings and discuss their experiences. As a result of these studies, trauma intervention methods have become less intrusive and are now based on stabilization and psychosocial approaches (Basham & Miehl, 2006; Briere & Scott, 2006; Ford & Courtois, 2009).

More recently, as a result of the wars in Iraq and Afghanistan, which have entailed multiple, long deployments for military personnel, the violent death of peers, and the high incidence of physiological and psychological trauma, the rates of complex PTSD have been increasing. Complex PTSD affects both these soldiers and their families and requires new intervention approaches. Prolonged exposure techniques (Foa, 2006; Foa et al., 2005) immediately following the event, although helpful to some patients, have been found to be far too intense for others. Moreover, the treatment dropout rate is quite high (K. Basham, personal communication, 2009). A phase-based approach that would include stabilization techniques, education, and social skills training may be more effective in helping these soldiers integrate their experiences, adapt to civilian life and to their role in their families, and return to productive lives (Ford & Courtois, 2009).

Contemporary Approaches to Trauma ---

In this volume, we have tried to include traumatized groups that are less familiar to professional audiences to contribute to the dissemination of new knowledge. The emphasis in this book is on clinical interventions with a number of specific communities. Although limitations of space have made it impossible to cover all contemporary treatments in this volume, we would like to mention the important role of body-based therapies, including somatic therapy (Levine) and sensorimotor psychotherapy (Fisher & Ogden, 2009). These therapies are particularly significant in trauma work, where experiences are frequently stored in nonverbal parts of the brain such as the amygdala and in sensory organs. Body-based therapies help clients access traumatic experiences that are not yet available for verbal narration and cognitive reflection. Many clients require processes other than talk therapy to make the material available to conscious awareness.

Sensorimotor therapy is influenced by several bodies of literature, including mindfulness practice, attachment theory, and neurobiology, particularly Schore's (2003) work on affect regulation, and also by Peter Levine's somatic therapy model (Levine, 1997). Although no formal research has been done on this model, there is clinical evidence of its usefulness with traumatized clients. The model focuses on both body and mind, but rather than focusing on verbal and analytical skills, the interaction of thought, feeling, bodily

sensation, and movement is emphasized through mindfulness observations of the “here and now.” Sensorimotor therapists help clients

regulate arousal by carefully tracking physical sensations for signs of dysregulation, by asking questions that direct attention to relationships between bodily response and narrative content, by teaching clients to recognize the physical signs that indicate dysregulated or hyperarousal, and by encouraging them to experiment with specific somatic interventions that promote regulation. (Fisher & Ogden, 2009, p. 317)

The therapist encourages the client to express experience through action and arm and bodily movements, which may be either protective or aggressive in nature. The therapeutic process includes phases of stabilization, memory and emotion work, and finally integration.

Another group of treatments showing promise with traumatized clients is mindfulness meditation–based therapies. Although these have not been specifically developed to address trauma, they have been effective in the management of stress, pain, and chronic and terminal illness. There has been much research on mindfulness-based therapy that has entered the health care field and is rapidly becoming part of a treatment protocol in hospitals and health care settings. Mindfulness therapies are inspired by Eastern meditation practices, and all share common elements. In addition to dialectical behavioral therapy, other mindfulness-based therapies have been developed and show promise in the treatment of borderline personality disorder, anxiety, depression, and pain management. To date, these models include dialectical behavioral therapy (Linehan, 1993a, 1993b), developed for borderline personality disorders; acceptance and commitment therapy (Hayes & Strosahl, 2004); mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2002); and mindfulness-based stress reduction (Kabat Zinn, 1990, 2003, 2005).

The principles common to all of these models include the following:

- accepting internal experiences as they are, even when difficult, and observing them with curiosity, openness, and compassion;
- integrating mindfulness skills with change-based strategies, which suggests that although there is an attitude of patience and acceptance, there is also an emphasis on teaching skills for change (e.g., affect regulation and social skills); and
- decentering or defusion: observing experiences as transitory mental states, such that the client learns to recognize that thoughts and feelings pass and change and there is no need to immediately react or identify oneself with what one is thinking and feeling.

The goals of such treatment are increasing awareness of the present-moment experience, including sensations, thoughts, feelings, and environmental stimuli; cultivating an accepting nonjudgmental stance; reducing symptoms; developing

self-exploration and insight; developing wisdom and compassion; and finally, living in accordance with values such as love, compassion, integrity, and honesty (Baer & Huss, 2008). Unlike cognitive-behavioral therapy, mindfulness-based models advocate staying with states of mind, feelings, and physical sensations rather than using distraction strategies or restructuring thoughts and beliefs (cognitive restructuring). States of mind might include traumatic memories, physical pain and discomfort, negative thoughts, and intense feeling states. The client learns to allow, accept, and welcome mental states and bodily sensations without trying to fix them or change them.

Outline of the Book

In this book, we will address contemporary developments in the principal theoretical models that deal with trauma, including cognitive-behavioral, psychodynamic, and attachment theories. Although this volume is not intended to comprehensively address all populations and communities affected by various kinds of traumas, we have tried to select groups that the literature has not yet fully addressed. This book will include discussions of interventions with children who experienced 9/11 through the death of family members, adolescents who have been subjected to bullying, combat trauma, practice with traumatized gay men, and intergenerational trauma among Native Americans. Finally, the impact on the clinician and the implications for teaching and supervision will be discussed.

Although there has been much scholarship devoted to the study of trauma, the field has expanded rapidly during the past decade as a result of several significant developments. From an earlier focus on the interpersonal aspects of trauma, including child abuse and domestic violence, traumatic experiences have taken on political and social dimensions, for example, the events of 9/11, the war on terror, and combat trauma associated with recent wars in Afghanistan and Iraq. Finally, the rash of school shootings in American public schools, increasingly linked to the problem of bullying, has also recently entered the public consciousness. These complex social and political phenomena have added to the magnitude of traumatic experiences in everyday life and created a more challenging task for mental health professionals dealing with trauma and its aftermath. Accordingly, this volume will present new developments in the conceptualization of trauma and trauma-related interventions from diverse theoretical and clinical perspectives, with special attention to emerging clinical groups and populations.

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