Societies have encountered traumatic and devastating events since the dawn of time. Cave drawings, oral histories, art, literature, religious texts, and more recently, academic writings document the ubiquity of traumatic events, their nature and consequences. René Descartes (1649/1989), in his treatise The Passions of the Soul, explained the relationship between disruptive emotions, the resulting fear, and its enduring effect on human interactions and behavior. In contrast to what we believe today, Descartes believed passions, or what we today call emotions, originated from an external stimulus acting on the individual. If understood, these passions could be addressed and controlled. Descartes wrote, “Even those who have the weakest souls could acquire absolute mastery over all their passions if they worked hard enough at training and guiding them” (Bennett, 2017, p. 16). Pivoting slightly from Descartes, the general sentiment that one weakened or made vulnerable by external events could gain mastery over their emotions with understanding, effort, training, and guidance is the central principle of psychotherapy and, particularly, trauma-informed treatment.

It is safe to say most individuals have experienced or witnessed at least one traumatic event in their lifetime. The examination of traumatic events by Benjet et al. (2015) supports this supposition. They reviewed and analyzed 68,894 individual general population surveys drawn from 24 countries. Benjet and colleagues evaluated individuals’ exposure to 29 traumatic events, determined prevalence rates, trauma type clusters, correlations with personal characteristics, and traumatic histories including repeated exposures. They found over 70% of individuals had been exposed to at least one traumatic event and 30.5% had been exposed to four or more. Half of the traumatic events identified by respondents came from one of five...
categories: witnessing death or serious injury, the unexpected death of a loved one, mugging, life-threatening automobile accident, and experiencing a life-threatening illness or injury. The nature, intensity, duration, and scope of tragic and horrific events are traumatizing. In some cases, expected traumatic responding progresses into a more acute or persistent process or psychological disorder. In this chapter, we focus on psychological trauma, differentiate it from crisis and disaster, and explore the historical and theoretical, definitions, and models that inform current conceptual and clinical understandings of trauma.

Learning Objectives

After reading this chapter and participating in the case studies and reflective exercises, you will be able to

- Distinguish trauma from crisis and disaster including the role of perception, proximity, exposure, dose effect, fear, and anxiety
- Understand the historical context, development, and contributions of major theories and theorists of trauma and related concepts including definitions, social/political contexts, and six related controversies
- Articulate key elements related to trauma: clinical presentation, assessments, diagnosis, mechanisms of change, models of treatment
- Differentiate simple and complex trauma and associated prevalence rates
- Apply theoretical and diagnostic knowledge case studies

Lions and Tigers and Bears, Oh My! Differentiating Trauma From Crisis and Disaster

With apologies to Dorothy and the gang from the *Wizard of Oz*, we draw on the above referenced mantra to frame the discussion and distinguish crisis from trauma and disaster. Understandably lions, tigers, and bears are majestic animals that contribute to the ecosystem. Yet, depending on the animal’s location—a sanctuary or the wild; your individual temperament—easy/inflexible or curious/fearful; and your history with, proximity to, and length of exposure to lions, tigers, and bears, you may appraise them to be a threat, an awesome creature, or some combination. Context matters and your appraisal of that context matters more!

Whether evaluating potential threats from lions, tigers, or bears or attempting to distinguish trauma from crises and disaster, most of you begin, whether you know it or not, by exploring the common and unique elements of the animals or constructs. With respect to treating the traumatized, understanding categorical
similarities and differences of crisis, trauma, and disaster (CTD) will help you identify and prepare for clients’ needs and inform your case conceptualization and selection of clinical interventions. For example, CTDs involve the perception of threat or harm, are unwanted experiences, and disrupt and disturb previous ways of coping and functioning in many, if not all, domains. Because the clinician understands it is the individual’s perception of the event, not the event itself, that determines the nature and impact of a CTD, most therapeutic interactions begin with the clinician assessing the clients’ perception or experience of the threat. Crises, traumas, and disaster are distinguished by four factors: proximity or how close one was to the event; how long they were exposed to the event; the magnitude of real and perceived threats; and the worsening of troubling or distressing symptoms. Figure 4.1 represents the Spectrum of CTD presented in Chapter 1. The braided image presupposes a somewhat linear progression from crisis to trauma to disaster. It also visually represents the interconnected nature of these constructs that are highly correlated, mutually influenced, reciprocal in nature, and influenced by time, proximity, event intensity, duration, and complexity.

Let’s apply the concepts presented above to Joe, our hypothetical South Dakotan you met in Chapter 2. Joe and Teri lost their family’s home and businesses to a 100-year flood. Revisit the set of circumstances that describe Joe and his family’s crisis event. Now let’s alter an influencing aspect or two of events and witness the progression and transformation of a crisis into a traumatic event, and subsequently into a disaster. Figure 4.2 presents the essential elements experienced by Joe and Teri as Joe perceived events as a crisis, trauma, and finally a disaster. As you read, reflect on the events and experiences influencing Joe’s appraisal and how you might respond as his clinician.

**FIGURE 4.1 • Spectrum of Crisis Trauma and Disaster**

<table>
<thead>
<tr>
<th>Crisis</th>
<th>Trauma</th>
<th>Disaster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close personal/direct proximity brief to moderate exposure</td>
<td>Very close personal/direct proximity moderate/repeated/prolonged engaging multiple senses moderate to high perceived recurrence</td>
<td>Personal/direct proximity prolonged/severe exposure engaging multiple senses high perceived recurrence</td>
</tr>
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© Can Stock Photo / piai
### FIGURE 4.2  ● Crisis-Trauma-Disaster Event Progression

<table>
<thead>
<tr>
<th>Category</th>
<th>Event/Response/Threat Perception</th>
<th>Time Frame for actions</th>
<th>Proximity</th>
<th>Exposure</th>
<th>Perception event will reoccur</th>
<th>Event complexity</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis</td>
<td>Joe and Teri receive non-mandatory evacuation order; remain in their home despite neighbors evacuating; low-moderate perception of threat; both feel overwhelmed and uncertain</td>
<td>12–24 hr.</td>
<td>Close/personal</td>
<td>Brief/Moderate</td>
<td>Low: the river rises and falls each spring</td>
<td>Low</td>
<td>Joe and Teri are in crisis because they feel terrified, are immobilized, uncertain about how to respond, worried about kid’s safety and business; Joe is short-tempered and agitated; Teri, Max, and Emma withdraw</td>
</tr>
<tr>
<td>Trauma</td>
<td>Night of the flood Joe was moving his family to a shelter in town. Along the way, he attempted to rescue Sara, an elderly neighbor, whose truck was surrounded by rising waters. Joe reached the truck, but as he attempted to move her to his vehicle, she was swept away by rushing waters. He feels responsible for her death, Sara’s body has yet to be recovered</td>
<td>Ongoing</td>
<td>Very close/Personal</td>
<td>Moderate/High</td>
<td>Low perception event will reoccur. Joe is experiencing intrusive thoughts and images</td>
<td>Moderate to high</td>
<td>Joe is distraught most days and struggles to function. He feels deep guilt related to Sara’s death. His attempts to sleep are futile he has frequent nightmares; he re-experiences and relives Sara’s hand slipping out of his, her cries and face as she floated into the darkness. Joe is drinking to the point of getting drunk every day. Teri feels helpless and alone</td>
</tr>
<tr>
<td>Disaster</td>
<td>Flood occurs, wipes out 2 of 3 of Joe’s businesses; destroys the family home; country roads are impassable; Teri cannot return to work; limited state disaster funds are available and there has yet to be a Presidential disaster declaration</td>
<td>1 week to 24 months</td>
<td>Direct/deeply personal</td>
<td>Prolonged/Severe</td>
<td>High: a local dam and several berms were breached; more rain is forecasted</td>
<td>High: Joe and his neighbors experienced devastation; multiple services and systems are inoperable</td>
<td>Joe and Teri are responding to the disaster. Feelings of agitation have transformed into feelings of numbness; Joe is fearful and apathetic about his businesses; they are living, temporarily with Teri’s parents</td>
</tr>
</tbody>
</table>
Defining Trauma

The Cultural Context of Trauma

Trauma comes in many forms. Ask laypersons to describe a traumatic event and most will describe horrific or catastrophic events like rape, mass shootings, or abuse while others describe their reaction to the finale of their beloved television mini-series! Our hypothetical laypersons may also offer that traumatic events cause people to “be haunted by their past” and “need counseling” or they will “act crazy or weird” until they “get over it and move on.” The term trauma is also often used interchangeably with stress. For conceptual clarity, in this text we distinguish the concepts of stress and crisis trauma.

<table>
<thead>
<tr>
<th>TABLE 4.1 • Comparison of Stress and Trauma</th>
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<tbody>
<tr>
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<tr>
<td><strong>Stress</strong></td>
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<tr>
<td>Nature of Event/Situation</td>
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<td></td>
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<tr>
<td>Degree of Control</td>
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<tr>
<td>Relief</td>
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<tr>
<td>Emotional Magnitude</td>
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Scholars and clinicians have long sought to resolve controversies related to psychological trauma, particularly its definitions, origins, and interplay of social, biological, physiological, and psychological factors and relationship, if any, to social political contexts. The task seems daunting when one considers the complex history and development of our understandings of trauma, yet it is quite simple when one looks into the eyes of another who seeks our support and skill; they want relief.

Individuals and cultures define and experience traumatic events in multiple ways; it is important to note the commonalities and patterns of trauma-related responding independent of the source of the trauma. In other words, despite many types of traumatic events, humans tend to respond similarly. Descriptions of trauma are commonplace in American culture; they even show up in 1990 in the monologue by comedian George Carlin where he regales the etymology
TABLE 4.2 — Historical Terms For Psychological Trauma

<table>
<thead>
<tr>
<th>Combat Related</th>
<th>Injury Related</th>
<th>Interpersonal Violence Related</th>
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</thead>
<tbody>
<tr>
<td>Wind confusion</td>
<td>Railway spine</td>
<td>Psychic shock</td>
</tr>
<tr>
<td>Nostalgia</td>
<td>Vertebral neurosis</td>
<td>Traumatic neurosis</td>
</tr>
<tr>
<td>Irritable heart</td>
<td>Wiiplash neurosis</td>
<td>Traumatic shock</td>
</tr>
<tr>
<td>Disordered action of the heart</td>
<td>Accident neurosis</td>
<td>Fright neurosis</td>
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<tr>
<td>Soldier’s heart</td>
<td>Accident victim syndrome</td>
<td>Concentration camp syndrome</td>
</tr>
<tr>
<td>Da Costa’s Syndrome</td>
<td>Compensationitis</td>
<td>Battered wife syndrome</td>
</tr>
<tr>
<td>Old Sergeant’s Syndrome</td>
<td>Erichsen’s diases</td>
<td>Battered child syndrome</td>
</tr>
<tr>
<td>War neurosis</td>
<td>Litigation neurosis</td>
<td>Traumatic stress</td>
</tr>
<tr>
<td>Combat fatigue</td>
<td>Profit neurosis</td>
<td>PTSD</td>
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<tr>
<td>Neurocirculatory asthenia</td>
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<td>Gas hysteria</td>
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<tr>
<td>Combat stress neurosis</td>
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<td>Shell shock</td>
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<tr>
<td>Physioneurosis</td>
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<tr>
<td>Battle shock</td>
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<tr>
<td>Neurasthenia</td>
<td></td>
<td></td>
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<tr>
<td>Effort syndrome</td>
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<tr>
<td>War sailor syndrome</td>
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<tr>
<td>Post-Vietnam syndrome</td>
<td></td>
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<tr>
<td>Effects of Agent Orange</td>
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<td></td>
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<tr>
<td>Gulf War Syndrome</td>
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<td></td>
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<tr>
<td>Desert Storm Syndrome</td>
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</tbody>
</table>

Sources: O’Brien (1998); Jones & Wessely (2005); van der Kolk, McFarlane, & Weisaeth (1996).

and history of terms related to traumatic stress (see https://www.youtube.com/watch?v=hSp8iyaKCs0). Table 4.2 contains historical terms, drawn from the professional literature, used to describe psychological trauma. The list of terms in the table is not exhaustive, is culture bound, and reflects the experiences or perspectives of individuals and groups of European and United States origins, particularly Caucasians.

Defining Psychological Trauma

Within the last half century, a robust body of scientific and clinical research has culminated in a more consistent description of trauma and trauma-related responding. Examples include Figley (1995), an American psychiatrist, and Judith Herman, author of the landmark book *Trauma and Recovery* (1992). Herman wrote,
“Trauma events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptions to life” and because they “overwhelm the ordinary system of care that gives people a sense of control, connection and meaning” (p. 33). Karen Saakvitne and her colleagues, who investigated childhood sexual abuse, described trauma as an individual’s subjective (personal) experience of an objective event or condition which overwhels the individual’s ability to integrate or cope with the experience perceived as a threat to life, bodily integrity, or caregivers (Saakvitne, Gamble, Pearlman, & Tabor Lev, 2000).

Although there is a fair amount of agreement surrounding the definition of trauma, conditions resulting from exposure and diagnostic criteria for post-traumatic stress disorder in the *Diagnostic and Statistical Manual* (American Psychiatric Association [APA; *DSM–5*], 2013), controversies remain. For example, in 2013, the APA introduced the new category, Trauma- and Stressor-Related Disorders and included a sub-type for children ages six and younger. All conditions in this category require exposure to a traumatic or stressful event as a diagnostic criterion. The eight criteria and two specifications include stressors such as intrusion symptoms, avoidance, negative alterations to cognitions and mood, alterations to arousal and reactivity, duration, functional significance or functional impairment, and exclusion of other factors or causes. Defining characteristics are further refined by consideration of two specifications, response to traumatic stimuli and duration.

Descriptions and defining characteristics of psychological trauma emerge over time and are continuously refined. The concepts, features, and assumptions that underlie the multiple definitions of trauma and trauma-related responding depend on a complex interplay of cultural, socio-political, economic, philosophical, medical, technological, and knowledge factors. In the following sections, you will read how researchers and clinicians, like our hypothetical laypersons, define and describe trauma as unexpected and shocking events that are devastating. Compared to crises, traumas last longer and cause more suffering.

**A Brief History of Trauma and Trauma-Informed Counseling**

*He who loves practice without theory is like the sailor who boards ship without a rudder and compass and never knows where he may cast.* —Leonardo da Vinci

**History**

Da Vinci’s words are prophetic, particularly for those of us who study crisis, trauma, and disaster (CTD). Until recently, those developing theories related to trauma and traumatic responding cast about in a seemingly rudderless fashion responding to prevailing winds of public opinion or governmental actions. Being a reflective reader, you might rightly ask, “Why is a theory important?” and, voilà, here’s our response! A theory is a constellation of ideas constructed to explain and account for phenomena *independent* of those phenomena. A sound theory has explanatory power, is succinct, describes the relationship(s) between and among components, is testable, predictive, and provides a set of principles, principles that guide real-world application, or in this case CTD treatment approaches. Theories are products of the time and context in which they are set and as such are
bounded by the knowledge base, beliefs, and cultural influences during the era in which they were promulgated. Theories provide Da Vinci’s rudder and compass to guide researchers and clinicians’ knowledge, skill, and treatment of those affected by trauma.

The history and course of trauma theory development, and in particular, post-traumatic stress disorder, are marked by periods of intense interest and study followed inexplicably by extended periods of inattention and disregard. Bessel van der Kolk (2007) summarized, “Psychiatry has periodically suffered from marked amnesias, in which well-established knowledge was abruptly forgotten” and later “…periodically has been fascinated by trauma” (p.19). Other authors have also chronicled the sharp shifts in (Jones & Wessely, 2006; Weisaeth, 2014) the development trauma theories in psychology (Cahill & Foa, 2007; Roberts, 2018; Monson, Friedman, & La Bash, 2014), psychiatry (van der Kolk, Herran, & Hostetler, 1994; van der Kolk, 2007), and the humanities (Alford, 2016, Radstone, 2007). Researchers and scholars have focused on bio-psycho-physiological, social-relational, and vocational aspects of trauma and its impact on individuals, families, and society. In the past two decades, neurobiological and neurocognitive explanations of trauma and trauma-related responses (van der Kolk, 2014) have emerged. Because theories of trauma developed over time and were subject to the influences and controversies of the eras, in this text, we present our understanding of the development of trauma theories chronologically rather than compartmentalizing them in separate sections or chapters. Readers are directed to the works of Alford (2016) and Radstone (2007) for a discussion of trauma theory in the humanities.

Multiple narratives of traumatic events have been chronicled in the literature, creative works, and scholarly writings in many disciplines across many cultures (Antze & Lambek. 1996; Caruth, 1996; Choi et al., 2017; Kurtz, 2014; Herman, 1992; Freud, 1886; Radstone, 2007). Definitions, descriptions, and interpretations emanating from Western cultures are privileged in the development and understandings of the trauma and in our present work. And we recognize the contribution of knowledge and narratives from non-Western cultures. To understand the human experience and expression of trauma, scholars and clinicians must continue to seek a global, nonculture bound understanding of the precursors, factors, and mechanisms of trauma. Human experiences and processes involved in acute and chronic expressions (post-traumatic stress disorder; PTSD) of simple and complex trauma also inform and transform the knowledge base. Failure to recognize and confirm cultural variations in the nature and course of trauma across time co-signs us to the shifts of intense focus and periodic amnesias described by van der Kolk. Considering this caution, we endeavored to represent trauma in its multicultural context.

**Nineteenth Century Understandings of Trauma**

Much of our early understandings of trauma emerged from the experiences of those who experienced the horrors of war and child sexual abuse during the 19th and early 20th century in Europe and the United States. One of the first documented cases of what is now recognized as trauma was recorded in 1813 by Joseph Frank, a Viennese medical professor, at a hospital in Lithuania (Gailiene, ...
The professor described the acute and repeated dissociative experiences of a 14-year-old girl who witnessed invading soldiers from Napoleon’s forces threaten her father’s life. Frank was so taken by the girl’s account he wrote, “How come no doctor known to me has never before written ex professo (as a professional) about the illnesses that spread after wars?” (p. 5). Frank, called into question the absence of medical and psychological professional literature on the mental illnesses associated with citizens who have survived war-torn areas. In the United States, physicians described the anxious, distressed responses of some Civil War veterans as nostalgia. Calhoun (1864) identified four primary causes of nostalgia in Civil War soldiers—rushed enlistments, expectations of a brief war, service far from home, and delays in communication due to use of a nascent postal service challenged by ever-changing battle lines. Calhoun recommended regular leaves to relieve soldiers’ psychological anguish. Frank and Calhoun, among others, viewed the origins of what we now call traumatic stress as a psychological, not physical concern.

In the same era in the same war, Philadelphia physician Jacob Mendez Da Costa, working as an acting assistant surgeon during the Civil War, studied over 300 active duty soldiers reporting a variety of soldier’s somatic complaints—chest pain, heart palpitations, anxiety, fatigue, tunnel vision, and nightmares. Due to the near universal report of cardiac symptoms, Da Costa informed the Surgeon General’s office (Devine, 2014) of these new, peculiar functional disorder of the heart. These dysfunctions came to be known as soldier’s heart, irritable heart, or Da Costa’s syndrome. Calhoun believed symptoms emanated from soldiers’ psychological longing for home in contrast to Da Costa who believed these conditions were due to physiological or organic causes. At this point in history, few medical professionals acknowledged a holistic or systemic understanding of mind-body relationships. This dichotomous view of human functioning provided the foundation for the first of six controversies related to origins and maintenance of trauma and traumatic responding. Physical or Psychological? Were the constellations of symptoms or disordered behaviors an illness with an organic/physiological cause or were they due to an emotional/characterological/psychological response? Were the symptoms of soldier’s heart and other trauma-related responses of psychological or physiological origins? As you read, make note of how this question reverberates through trauma theories for the next century.

Technological advances of the 19th century exposed humankind to an increasing array of traumatic events like pervasive railroad accidents. The next milestone in our understanding of a theory of trauma and trauma-related responding emerged from the medical field, specifically, the 1866 work of John Eric Erichsen. Erichsen authored On Railway and Other Injuries of the Nervous System and documented the physical injuries and somatic complaints of railway accident survivors—exhaustion, terror, and chronic pain. Erichsen (1886) believed the psychological symptoms originated from the physical injuries and warned against confusing them with the symptoms of hysteria which originated from psychological processes.

Because railway accidents were so frequent and horrific, in 1864, the English parliament passed the Campbell Act extending liability to railway companies for the physical and psychological health and safety of their passengers. For some time, accident survivors with physical injuries were readily compensated, but the
presence of physical complaints in survivors with no or limited physical injuries perplexed physicians, particularly when survivors’ psychological and physical health continued to deteriorate long after the accident. Those seeking compensation for psychic complaints or injuries relied on medical professionals’ explanations, in court, to substantiate their claims. Initial descriptions attributed psychic symptoms to the simulated or microscopic deterioration of the spine, identified post-mortem, in the central nervous systems of deceased accident victims. For approximately two decades (1860–1880), physicians believed the somatic complaints had psychopathologic origins arising out of the survivor’s experience of the shock rather than an actual shock to the spine. Thus, railway companies were compelled to award significant injury-related compensation to accident survivors with few or no apparent physical injuries. Herein lies the roots of the second controversy related to trauma: To Compensate or Not. The primary question was and is “Does compensation represent a just settlement for personal injury and loss or does it encourage malingering among the injured resulting secondary gain like financial, social, emotional support?” By the end of the 1880s, the concept of railway spine had been replaced by that of traumatic neurosis (Schivelbusch, 2014). Traumatic neurosis was a term first coined by Oppenheim (1889) who associated trauma-related symptoms with molecular changes in the brain.

**Toward a More Scientific Explanation of Trauma**

Nineteenth century Europeans heeded societal demands for self-control, emotional restraint, rational thought, and interpersonal diligence. The culture was transitioning away from subjective explanations of phenomena toward the scientific, objective, and rational. In medicine and psychology, this movement is reflected in the words of Sir Francis Galton, “the man of science is deficient in the purely emotional element” (Galton, 1874; p. 207). In contrast, others articulated the necessity for physician to study “mankind as well as medicine,” and when treating the afflicted remember that, “they are possessed with hearts and minds that have strong passions, warm sentiments and vivid imaginations, which sway them powerfully both in health and disease” (De Styrap, 1890; p. B1). Divergent opinions extended to advancements in psychological understanding of trauma-related responding. Physicians, including railroad surgeons, neurologists, and physicians like Charcot, Janet, and Freud, investigated and debated the origins and development of emotional conditions resulting from catastrophic injuries. Van der Hart and Brown (1990) credited Albert Eulenburg, a German neurologist, with the introduction of the term psychic trauma (Eulenburg, 1878). Eulenburg contrasted psychic trauma to psychic shock. Psychic shock described acute, vehement, intense emotions, like terror or horror leading to commotio cerebri or disturbances of the brain, disturbances that resulted from physical shock of railway accidents (Caplan, 1995). Thus, Eulenburg may have been the first to hypothesize a biological etiology for psychological trauma. This perspective prevailed for decades. Figure 4.3 denotes first segment of a four-segment timeline summarizing major medical, cultural, psychological, or neurobiological events of 19th, 20th, and 21st
centuries. The chapter concludes with an image of full timeline and transition to the Counselor’s Toolkit chapter.

The industrial revolution of the 18th and 19th centuries advanced technology and manufacturing and created dangerous and grim conditions for poor and working-class individuals. Exacerbated by physical, sexual, and emotional abuse, women and children were viewed as little more than commodities. Elizabeth Barrett Browning’s poem “The Cry of the Children” (1853) and Dickens’s novel *Hard Times* (1854) depict the appalling conditions and consequent suffering of the economically impoverished children and women.

Incest, physical and sexual abuse, and rape of children was prevalent across all races and economic and social classes in Europe and the United States (Tardieu, 1862; Brouardel, 1909; Sacco, 2009) yet was rarely acknowledged or its consequences addressed. In the rare cases when it was acknowledged, the acknowledgment did little to correct the distorted attitudes toward and knowledge of sexual abuse, particularly in middle-upper class, typically White families. Lynn Sacco (2009) argued elegantly in her book, *Unspeakable*, that as the number of official reports of child sexual abuse by immigrants, Blacks, and those economically impoverished increased, reports of sexual abuse in middle- and upper-class White families decreased even though female children in the household were assaulted at the same rates. Here again, note how a social injustice portrays the privileged as exempt from abusive and destructive behavior while advancing the notion that others (read non-White or those of lesser economic standing) were predisposed to it. Thus, the race, class, status, and gender of the perpetrator and the survivor influenced medical, legal, religious, and public understandings of child sexual abuse until late in the 20th century.

Physicians, social workers, and church groups worked to rescue children from moral danger—starvation, physical abuse, incest, and sexual exploitation. While moralistic and religious dualities of good of the era stimulated sympathy for victims, they also associated child sexual abuse with a perceived flaw in the victim’s character, namely moral corruption. Specifically, to explain how adult males could sexually assault child victims, a cultural myth was invoked. The myth posited that child victims possessed advanced sexual knowledge or skills incongruent with their status as children. Therefore, there must be something different or evil about those children who exhibited what we now know to be trauma-related symptoms. The
male perpetrator was vexed or tricked into sexual interaction with the child and he, not the child, was the victim. Blaming the victim is the third controversy related to trauma theory development. Trauma-related responding was associated with the character or actions of the victim rather than the nature, intensity, duration, and proximity to the event(s). An example of this line of thought is present in the writings of Paul Brouardel (1909): “Girls accuse their fathers of imaginary assaults on them or other children in order to obtain their freedom to give themselves over to debauchery” (p. 512). The paradox of this era, and today, lies in the discrepancy between the pronounced religious rhetoric of the time and the public denouncement of the sexual abuse and astonishingly low conviction rates (Jackson, 2000) despite increasing rates of sexual abuse cases brought before the court.

As noted earlier, Jean-Martin Charcot, a French neurologist and professor of anatomical pathology at the famed Salpêtrière Hospital in Paris, is recognized for his investigations into the relationships among patient's suggestibility—the ability to be hypnotized, hysteria, and emotional disturbances in women and men. Charcot treated patients suffering from unexplained bouts of paralysis, seizures, and bizarre postures and surmised these symptoms were associated with the patients’ response to the physically traumatic event like a railway accident rather than the consequence of the event itself. Charcot's perspectives on the potential of a psychological etiology of trauma stimulated the generation of scholars who followed, including those who focused on one's appraisal of events (Lazarus, 1966; Lazarus & Folkman, 1984).

**Psychological Explanations of Trauma**

Charcot influenced and advanced the inquiries of many of his contemporaries, most notably Pierre Janet and Sigmund Freud. Janet recognized that his patients diagnosed with hysteria at Salpêtrière’s psychological laboratory seemed unable to utilize their personal memories, perceptions, understanding, or knowledge to reduce their symptom reduction or productively engage with their surroundings. According to Herman (1997), historians described the term *hysteria* as a strange disease with incoherent and incomprehensible symptoms. Hysteria was “a dramatic metaphor for everything that men found mysterious or unmanageable in the opposite sex” (p. 10). Janet hypothesized patients’ minds were so overwhelmed with emotions that it rendered them incapable of contextualizing current experiences into their previous understandings of their environment. Janet believed accumulated memories resided in what he termed as the *subconscious*, or the hypothesized template for individual meaning and responding (Janet, 1904). One was considered emotionally healthy if they could label and integrate memories, particularly traumatic memories, into their current functioning. Conversely, those afflicted with hysteria stood in stark contrast because they seemed unable to integrate traumatic memories due to overwhelming emotional arousal. The traces of memory remained unintegrated and fixed in the unconscious and outside an individuals’ personal self-story (Janet, 1919/1925). These memories, disassociated or outside the voluntary control of the individual, remained in the unconscious until integrated into consciousness. Janet believed this disrupted integration
resulted in a *phobia of memory* in which traumatic memories remained inaccessible and disassociated from consciousness despite the intense emotional arousal and related symptoms the patient was unable to resolve. In other words, attempts to avoid or exclude traumatic memories prolongs suffering as these memories interrupt one’s functioning in the form of hypervigilance, avoidance, flashbacks, and intrusive thoughts. Van der Kolk, McFarlane, and Weisaeth (1996) summarized Janet’s perspective, “As long as these memory traces have not been integrated into a personal narrative, they will continue to intrude as terrifying perceptions, obsessional preoccupations and somatic re-experiences” (p. 309).

Janet sought to understand the relationship between the mechanisms and types of memory, suggestibility, disassociation, and treatments for hysteria. His systematic work placed dissociative processes at the center of 19th century understandings of hysteria. According to van der Hart and Horst (1989), Janet’s theory of disassociation built on concepts either introduced or elaborated on by Janet’s like psychological automatism, consciousness, subconscious, amnesia, and emotion. For example, Ellenberger (1969) and Jackson (1994) credit Janet with the development of *cathartic psychotherapy*, a method used to provoke emotional release of traumatic memories or mental disinfection through a process called mental liquidation. Blatner (1985), who wrote on catharsis in groups via psychodrama, identified four categories of catharsis: abreaction, integration, inclusions, and spiritual. Abreaction involves reexperiencing traumatic events and formerly disowned memories and feelings, bringing into awareness that which was formerly excluded from awareness. Integration involves accommodating recently recovered emotions and thoughts through the modification of existing mental schema or mastering a new coping skill. The third category, Inclusion, describes the need of affiliation similar to Adler’s (1938) concept of belonging or *Gemeinschaftsgefühl*. The final form of catharsis, significance or spiritual, focuses on one’s awareness of something greater than themselves like the universe or religious deities may be invoked through mediation, breathing, long distance-running, and prayer.

The hypothesized roles of catharsis and the subconscious ruled the early 20th century. For example, Freud embraced many of early works of Charcot and later Janet’s concepts of the subconscious processes, particularly extreme emotional charged and yet unintegrated aspects of hysterical episodes. Joseph Breuer and Freud noted in their 1893 paper, *Physical Mechanism of Hysterical Phenomena* (1893/1955), “It is essential for the explanation of hysterical phenomena to assume the presence of a dissociation-a splitting of the content of consciousness” (p. 30). Though Freud and Janet became distanced (Fitzgerald, 2017), Janet’s influence on Freud’s theories and concepts was profound, particularly as it relates to the nature and function of memories.

In contrast to Charcot, Freud (1896) initially believed hysteria emanated from repressed memories of early or infantile sexual abuse. The foundation of Freud’s seduction theory was his belief that children knew nothing of sexuality and sexual desire; thus, neurosis occurred only after the onset of puberty. Symptoms of hysteria arose from the repressed memory of the event, not the event itself. Over the course of the next year, Freud urged patients to reproduce and explore repressed memories through psychoanalysis, symbolic interpretation, and abreaction. In
September 1897, Freud documented his growing doubts about the seduction theory in a private letter to Wilhelm Fliess. Freud’s reservations centered on “the absence of complete successes” (p. 20) and the theory’s requirement that the father, “not excluding my own had to be accused of being perverse,” which given the prevalence of hysteria was unlikely. Freud struggled to reconcile the prevalence of childhood sexual trauma with the potentiality that scores of Victorian men, were in his words, *perverse*. Freud came to believe that the unconscious did not represent reality and many of his sexually traumatized patients could not distinguish the truth from fantasy. He went on to write that in “the most deep-reaching psychosis the unconscious memory does not break through,” meaning “… the secret of childhood experiences is not disclosed even in the most confused delirium … if … the unconscious never overcomes the resistance of the conscious, the expectation that in treatment the opposite is bound to happen” (p. 22).

This was Freud’s alternate and, the first author would argue, more convenient explanation. Regrettably, Freud abandoned his belief that children were sexually unaware and now viewed hysteria as an intersubjective experience in which the child’s bouts of hysteria were influenced by their parent. From this point forward, Freud’s theoretical work focused on infantile sexuality and the origins of impulses, fantasies, and conflicts. Neurotic systems like anger, anxiety, and nightmares were no longer associated with childhood sexual abuse; they were attributed to the child’s mind, fantasies, and wishes.

Examinations of trauma associated with childhood sexual abuse seemingly vanished from the professional literature for almost three-quarters of a century, except for Sándor Ferenczi (1949). Ferenczi faced criticism for his sexual abuse trauma theory in which he identified the adult as the aggressor and the child as helpless victim. In his theory, Ferenczi noted the child’s primary defense mechanism against the trauma was identification with the aggressor. Freud specifically asked Ferenczi to delay the reading of his paper at the 1932 International Psychoanalytic Society. Undaunted, Ferenczi read his paper leading to a severe lifelong rupture in their relationship and delayed the publication of this paper by almost two decades. Throughout the 19th and 20th centuries, whether it was the tragic carnage and consequence of wars, the utter devastation of sexual abuse, or the corrosive effects of oppression, those with power silenced those with inconvenient truths, be they a theorist, veterans, or victims of childhood sexual abuse.

Researchers and clinicians did not return to investigations of the etiology of trauma related to sexual abuse, sexual victimization, and domestic abuse until the latter half of the 20th century. At that time, Freud faced criticism for his abandonment or suppression (Schimek, 1987; Rush, 1996, Kitzinger, 1996; Masson, 1984) of the seduction theory, but few if any scholar’s noted Ferenczi’s challenge of Freud. We again witness the *marked amnesia* described by van der Kolk. The role of repressed memories in trauma theories is our fourth controversy. What do you think? Can unintegrated and later reclaimed memories of trauma be trusted as a source of delayed traumatic responding or do the influences of time and subjectivity call these memories into question? Reflect on this question as you read further. Review the timeline in Figure 4.4. Are there other elements you would add?

At the close of the 19th and well into the 20th century, researchers and scholars refined their understanding of the etiology of the trauma neurosis sans the effects
of sexual abuse. Investigating trauma related to sexual abuse and to some degree war-related trauma seemed fraught with political and social taboos. The focus of trauma and underlying theories shifted to examinations of potential predisposing protective and vulnerability factors (Stierlin, 1911) and diagnostic criteria for chronic, rather than acute, psychological suffering. Initial criteria proposed by Jaspers (1913/1997) included an assessment of interplay between one’s previous functioning and predisposing physiological or psychological factors, a significant traumatic event, and the time elapsed between the onset of systems and the traumatic event. Jasper’s diagnostic criteria remained relevant for roughly 30 years.

The 20th Century: A World at War

The 20th century was marked by two devastating and horrific world wars. Although primarily centered in Europe and later Europe and Asia, the consequences of these wars were felt in most countries. The early 20th century heralded technological advances in the arts, sciences, industry, and warfare. Regrettably, humankind found ever more deadly ways to wage war from the trenches, poisonous gases, automatic rifles, and heavy ordnance of World War I (1914–1918) to the mobility and rapid deployment of troops, advanced weaponry—napalm, and the A-bomb—to the unconscionable treatment of concentration camp casualties and survivors of World War II (1939–1945). Advances in trauma theories and trauma-related responding were associated with traumatic battlefield experiences of soldiers in these wars.

Soldiers in World War I (WWI) faced the horrors of trench warfare as they were dug in in squalid conditions for extended periods subjected to relentless shelling. Like their Civil War counterparts, WWI soldiers with no apparent or limited external injuries, presented with fatigue, trembling, paralysis, nightmares, or impairments in hearing and vision had their symptoms attributed to shell shock. Recall Oppenheim’s (1889) organic explanation for the symptoms, resulting from the concussive consequences of exposure to shelling. Treatment for shell shock included removal from the front line into a nonmilitary hospital. After a short respite, soldiers returned to active combat and the camaraderie of their unit. In the early months of WWI, overwhelming numbers of soldiers experienced shell shock and growing numbers did not recover and were discharged from the service due to a poor prognosis. Psychiatrists stationed closest to the frontline sought more effective treatment and modified the treatment protocol. Rather than sending soldiers home, the standard treatment became retaining shell-shocked soldiers in field hospitals,
within proximity to the frontlines, where they could benefit from the order, discipline, and support of military mates, and had the expectation to return to duty with a better long-term prognosis. This treatment protocol, along with Thomas Salmon’s five key principles of immediacy, proximity, expectancy, simplicity, and centrality, improved treatment outcomes (Crocq & Crocq, 2000). Although, shell-shocked soldiers were not seen as defective, they were expected to recover. Those with persistent symptoms or delayed onset faced questions related to their bravery, honor, character, and individual constitution. For soldiers, it was better to receive treatment for an unbearable situation (the hell of war) than to be accused of an unacceptable impulse (retreat, fear, or cowardice) and its resulting stigma. The change in treatment protocol reduced needless pathologizing of individuals. Now those suffering from shell shock were neither morally or constitutionally deficient nor were they cowards. Recovery and a return to the front demonstrated success; failure to recover often meant there was something wrong with the individual. This leads us to the fifth controversy related to theories of trauma and traumatic responding—why do people exposed to an identical event, react, respond, and recover differently? Why do some respond to brief interventions while others find no relief?

Abram Kardiner treated veterans of World War I and chronicled his findings in *The Traumatic Neuroses of War* (1941). He concluded from his meticulous patient histories that those afflicted with traumatic neurosis or what he termed physioneurosis presented with a host of symptoms: extreme physiological arousal, preoccupation with the trauma, anxiety, nightmares, startled responses, fight or flight response, irritability, and persistent environmental vigilance. Kardiner (1941) articulated that soldiers’ memories of wartime trauma were generalized to noncombat events and served as a trigger for the reexperiencing of threat during noncombat experiences. As van der Kolk (2007) synthesized, “Central to Kardiner’s thinking, as in that of Janet and Freud . . . 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. 27). The individual appears fixated on the original traumatic event, unconsciously associates the trigger to the original trauma, and responds to the reexperiencing of thoughts and emotions in a variety of ways—racing heart, difficulty breathing, or aggression. Avoidance, restricted emotions, and emotional numbing serve as defenses against the perceived threat of reexperiencing intense psychophysiological responses. Kardiner is credited for the nascent beginnings of trauma theory integration a setting the stage for the biopsychosocial perspective of PTSD in the *Diagnostic and Statistical Manual of Mental Disorders III* (DSM–III). Regrettably, physicians practicing forward psychiatry in World War II largely ignored his findings, once again engaging the alternating cycle of intellectual amnesia and intense interest in trauma and trauma-informed treatments. Figure 4.5 represents a trauma informed timeline spanning from late 19th to mid-20th century.

While, physical injuries in World War II (WWII) were attributable to a different type of warfare and weaponry, the resulting psychological impact on soldiers was devastating. Few scholars focused on trauma theory development in the early to mid-20th century, instead their intellectual and clinical energy centered on improving treatment approaches, specifically the reemergence of hypnosis and narcosynthesis. Narcosynthesis is an inpatient procedure, which pairs psychoanalytic techniques of free association and dream interpretation the injection of a
narcotic like sodium amytal. These treatments provided patients the opportunity to recall aspects of the trauma while in an altered state of consciousness (ASC), which would be addressed and processed later. Much like Janet before them, post–World War II researchers and clinicians believed patients must access and transform traumatic memories prior to substituting them; all three processes were necessary for successful treatment. Other notable developments during this era include the use of group treatments for trauma-related responding of soldiers in America (Shalev, 1991) and at the Tavistock Clinic in Britain (Main, 1989) and the study of concentration camp survivors. Krystal (1968) studied over 300 concentration camp survivors recognizing their unrelenting exposure to the monstrous traumas of the concentration camps. For these survivors, threats were multifaceted and interactional, originating from physical, emotional, social, and existential domains resulting in hypervigilance, progressive blocking of emotions and inhibited behaviors. Follow up studies documented associations between the trauma and enduring changes to many survivors’ personalities (Eitinger, 1964).

An adequate theory of trauma and traumatic responding would address the variations in response to treatment, particularly dose–effect relationship. To date, researchers and clinicians struggle to demonstrate there is a dose–effect or dose–response relationship in the treatment of trauma. The dose–effect relationship describes the number and intensity of sessions (dose) required to achieve a desired treatment outcome (effect). Effective treatments properly applied, should result in similar levels of recovery for most. Evidenced-based treatment models are presented later in this chapter. In sum, it would be reasonable to believe that once a diagnosis is made, researchers and clinicians could apply the appropriate type of intervention, in the most effective dose over a specified period to reduce distress and improve client’s functioning. Regrettably, the science of trauma treatment is not yet to that point, but advancements in empirically supported treatments and neurobiological and neurocognitive trauma responding hold great promise.

The Emerging Influence of Psychological Theories

**From Behaviorism to Cognition**

Despite previous contributions from theories of learning and conscious thought by scholars like Wundt (1909) and James (1907/1981), behavioral researchers in
the early 20th century focused on observable behaviors and eschewed any notion of the influence of cognition on human behavior. Scientific investigations related to anxiety or phobic responding declined. But by mid-century, cognition and learning principles returned to psychology’s understanding of human behavior. Wilson (1982) noted:

During the 1950s and 1960s, the behavior therapies developed within the framework of classical and operant conditioning principles that had originally served importantly to distinguish behavior therapy from other clinical approaches. Over the course of the 1970s, this conceptual commitment to conditioning theory peaked out—some would say even waned. In part this change reflected the shift to more technological considerations governing the increasingly broad application of behavioral techniques that had been developed and refined during the previous period of growth. (p. 51)

Behaviorism continued to be assailed. Noam Chomsky through his critique of B. F. Skinner sought “a more general critique of behaviorist ... speculation as to the nature of higher mental processes” (1967, p. 142). Tongue in cheek, Chomsky credited Skinner with a “most careful and thoroughgoing presentation” and regarded Skinner’s theory as a “reductio ad absurdum of behaviorist assumptions” (pg. 142). Although Chomsky’s (1967) analysis of Skinner’s Verbal Behavior is often cited as a pivotal moment in the cognitive revolution, cognitive researchers had been investigating schemas (Bartlett, 1958) and content (Heider, 1958; Bruner, Goodnow, & Austin, 1956) of cognitions in the previous decade and foreshadowed investigations in the late 20th century (Beck, Emery, & Greenberg, 1985; Herman, 1981; Herman, 1992; Shapiro, 1995).

Social Influences on Theories of Trauma and Traumatic Responding

Freud’s sense of the social order was profoundly disturbed by the scores of female clients who seemed to suffer effects of sexual abuse perpetrated by perverse Victorian men. His abandonment of the seduction theory and banishment of Ferenczi are two of the most notable examples of how society rather than science influenced, and some would say impeded, understandings of trauma and its treatment. Social influences also shaped Americans’ view of trauma and traumatic responding. Post–WWII America teemed with economic and social mobility in pursuit of the American Dream (Adams, 1931). Returning veterans utilized the GI Bill to purchase homes and advanced their education. Yet, despite serving in WWII, members of historically marginalized groups—Blacks, Latinx, Native Americans, and women—did not share equitably in this prosperity. Their marginalization and oppression led to socio-political movements that influenced theories, research, and treatment of trauma.

The late 1960s and early 1970s were a tumultuous time in America. Daily reports of wartime casualties, anti-war protests, political assassinations, and the fight for women’s, civil, and farm workers’ rights reflected society’s transition and turmoil. In response to societal upheaval, grassroots movements and organizations emerged
to meet the specific needs of marginalized groups like Vietnam veterans, women, and persons of color. For example, in contrast to previous returning veterans who were welcomed home as heroes, Vietnam veterans returned to a culture divided and disturbed by the government’s conduct of the war. Isaacs (1997) eloquently wrote, “Men who fought in World War II or Korea might be just as haunted by what they had personally seen and done in combat. But they did not come home, as the Vietnam vets did, to a country torn and full of doubt about why those wars were fought and whether they had been worthwhile” (p. 12).

Like soldiers before them, many Vietnam veterans experienced the horrors of war and some returned traumatized and in need of support and treatment. Unlike other veterans, those returning from Vietnam were treated with derision and disrespect and were abandoned and ignored by the very politicians that sent them to war. Americans wanted to move on and in effect moved away from the needs and care required for returning soldiers. Psychiatrists stationed at the front lines treated combat stress much as their WWII predecessors and were perplexed by returning Vietnam veterans who reported a delayed onset of symptoms of hypervigilance, nightmares, and extreme emotional responding. Physicians and researchers limited treatment interventions for delayed onset of symptoms and questioned differences in predisposing or characterological factors of individual veterans until the work of Shatan (1972, 1973), Lifton (2005), and Figley (1978) pivoted the research and clinical communities’ attention back to the source of veteran’s dysregulation and dysfunction, the stress of war. Shatan and Lifton began *rap sessions* with Vietnam veterans, a form of self-help groups like those simultaneously occurring in the Women’s Movement.

Social activists in the Women’s Movement of the 1970s redefined gender roles, power differentials, reproductive rights, sexual victimization of, and violence against women and children. The landmark book *Our Bodies Ourselves* (1971) chronicled the myths and impact of rape and self-defense tactics. In 1974, Burgess and Holmstrom published their paper detailing their findings related to *Rape Trauma Syndrome*. Rape victims, they observed, described nightmares, flashbacks, intrusive thoughts, and avoidance. Burgess and Holmstrom connected rape survivors’ sequelae to other theories of traumatology, including combat soldiers’ experiences (see Webster & Dunn, 2005, for a more detailed history of feminism and trauma). These and other social/cultural forces led to an intense and unanticipated focus on features, nature, and course of trauma-related responding (Andreasen, 2004).

The influence of grassroots movements culminated in the formal recognition of posttraumatic stress disorder (PTSD) and diagnostic classification in the *DSM–III* (APA, 1980) with greater precision and refinements in diagnostic criteria in the *DSM–III-R* (APA, 1987) including reexperiencing, avoidance and numbing, and physiological arousal. Despite the prevalence of traumatic experiences across the globe, some authors (Summerfield, 2004; Hinton & Lewis-Fernandéz, 2011) debate the culture-bound descriptions of trauma-related responding like differences in numbing and avoidance symptoms, meanings attributed to traumatic events, and exposure to types of trauma [genocide]. Others acknowledge striking similarities in trauma-related responding across cultures (North et al., 2005). In 1952, the American Psychiatric Association formally recognized gross stress reaction (GSR:}
APA, 1952, p. 40) and subsumed it under the broader category of transient situational personality disorders. The GSR diagnosis required an absence of premorbid psychopathology, was focused on the acute nature of an unusual stressor resulting from “combat or civilian catastrophe” and that, given time, would naturally resolve itself. The periodic professional amnesia related to traumatic responding, described earlier in this chapter, reemerged in the publication of the second edition of the diagnostic manual (APA, 1968). Curiously, but not surprisingly, the GSR diagnosis was replaced with the category of disorders entitled transient emotional or adjustment reactions, specifically adjustment reaction in adult life. This newly classified adjustment reaction was exemplified through one’s reaction to an unwanted pregnancy, fear associated with military combat, or receiving a death sentence (APA, 1968; p. 48), a curious combination of events.

PTSD, as a diagnostic category, continues to be a source of controversy as some view it as a bona fide psychiatric disorder while others see it as an artifact of culture. Acute, delayed, and persistent trauma-related responding is not expressed similarly nor does it take an identical course in individuals exposed to the same trauma. Some question the influence of culture on the prevalence, etiology, diagnosis, intensity, and maintenance of trauma-related symptoms, while others attributed refinement of our understanding of trauma on great cultural acceptance of and attention to trauma-related responding, in particular diagnostic criteria for PTSD. What do you think?

Research and clinical investigations into trauma by scientists, scholars, academics, and clinicians flourished in biology, medicine, psychology, and counseling since the mid-1980s. Some focused on the role of memory (Herman, 1992; Shapiro, 1995), differentiating developmental from simple or complex trauma (van der Kolk, 1996, 2005; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) while others investigated risk factors and longitudinal effects of child abuse and natural disaster (Green, Grace, Lindy, Gleser, & Leonard, 1990; Green et al., 1990; Green, Grace, Vary, Kramer, Gleser, Leonard, 1994) and the neurobiology of trauma (Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Marinova & Maercker, 2015). Advances in our understanding of brain plasticity, (Ericsson et al., 1998) neurogenesis, neuroimaging, neuroendocrinology, and psychopharmacology have contributed to continued refinement of theories of trauma. Whether we examine the supposed contagion effects of war neurosis and railway spine diagnoses or the condemnation and stigma faced by Vietnam veterans and victims of rape,

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**FIGURE 4.6 Time Line Segment 1 Through 4—19th to 21st Century**

| Effects of war & childhood sexual abuse are questioned | Catharsis-viable therapy Hysteria distinguished from trauma responses Subjection/oppression of women & children Importance of traumatic memories & their integration Freud abandons the seduction theory | Research focuses predisposing factors and diagnostic criteria Wars influence treatment protocols of shell shock Pathological view of shell shock decreases Kardiner’s provides foundation for DSM–III PTSD criteria | Social & Cultural Influences Diagnostic criteria established Psychological theories emerge Neurobiological understanding grows |
| Technology increases personal injuries | Physical & psychology responses to trauma are examined Victims compensated for injuries Victorian restricted emotionality Rise of empiricism | Physical & psychology responses to trauma are examined Victims compensated for injuries Victorian restricted emotionality Rise of empiricism | Physical & psychology responses to trauma are examined Victims compensated for injuries Victorian restricted emotionality Rise of empiricism |

*Effects of war & childhood sexual abuse are questioned Technology increases personal injuries Physical & psychology responses to trauma are examined Victims compensated for injuries Victorian restricted emotionality Rise of empiricism

Catharsis-viable therapy Hysteria distinguished from trauma responses Subjection/oppression of women & children Importance of traumatic memories & their integration Freud abandons the seduction theory

Research focuses predisposing factors and diagnostic criteria Wars influence treatment protocols of shell shock Pathological view of shell shock decreases Kardiner’s provides foundation for DSM–III PTSD criteria

Social & Cultural Influences Diagnostic criteria established Psychological theories emerge Neurobiological understanding grows

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domestic violence, or childhood sexual abuse, it is safe to say, attributions related to the potential influence of culture and cultural events influenced and continue to influence our understanding of trauma.

**Theories**

The 21st century seemed to usher in trauma and distress at unprecedented levels. Mass shootings, 9/11, wars in Afghanistan and Iraq, anthrax, genocide, and Ebola affected some directly and many indirectly, through an endless news cycle and social media. History and social influences on trauma and traumatic responding continue to emerge and influence our understanding of trauma and the development and maintenance of associated psychological disorders. In the sections that follow, we present theories that form the foundation for current understandings of trauma.

**Biological**

Biologically based theories of trauma focus on personal and environmental factors, their interactions, and human development to explain the relationships between extreme stress, individual vulnerabilities and predispositions, environmental factors, and psychological distress and disorders. Genetic factors such as neurohormones (oxytocin and vasopressin), neurotransmitters (dopamine, nor-epinephrine, and serotonin), and brain structures (amygdala, hippocampus, and the hypothalamus) are believed to contribute to the experiencing of trauma and perhaps the progression to PTSD. But heritability and genetics present an incomplete picture. Ryan, Chaudieu, Ancelin, and Saffery (2016) note the variation in responses to traumatic exposure, and risk for PTSD “is likely to be influenced by genetic predisposition and specific characteristics of the stress itself (nature, intensity and duration), as well as epigenetic mechanisms” (p. 1553). Epigenetics is the study of changes in gene expression that occur from environmental interaction. Changes in gene expression do not alter one’s genetic code or DNA; it alters the way genes communicate or read each other. For example, you may have been born into a family with a low risk for obesity, but if you fail to exercise, eat poorly, and smoke a pack of cigarettes a day, you will likely end up overweight.

Researchers continue to explore the contribution of specific and constellations of genes believed to contribute to traumatic responding, resiliency, and some psychiatric disorders. Ryan, et al. (2016) summarized studies investigating the contribution of 25 genes to PTSD. While a detailed review of genetic studies is beyond the scope of this chapter, we agree with Klengel (2016) who blogged, “We’re already confident that genetic variations play an instrumental role in determining individual risk. However, we still need to pinpoint which genes are involved, how they may interact to affect risk, and what are the exact molecular mechanisms behind this. Similarly, we also need to isolate genetic factors that may be responsible for increasing one’s resilience to trauma—which is why some individuals do not develop PTSD or other disorders despite considerable exposure to trauma.”

The structures in our brain respond and change because of stress. Typical forms of stress can increase awareness, immunity, and determination. Extreme or traumatic stress can lead to significant changes in how we function. Bremner (2006)
reported, “Findings from animal studies have been extended to patients with post-traumatic stress disorder (PTSD) showing smaller hippocampal and anterior cingulate volumes, increased amygdala function, and decreased medial prefrontal/ anterior cingulate function. These changes influence the regulation of emotion and memory (hippocampus and amygdala) and may disturb empathy, impulse control and decision-making (medial prefrontal anterior cingulate)” (p. 445). Researchers (Ryan et al., 2016; Kendall-Tackett, 2009; Solomon & Heide, 2005) describe our biological response pattern to traumatic stress. A stressor or threat is perceived; in response, the hypothalamus signals the pituitary, which signals the adrenal glands to release hormones—adrenal, epinephrine, and cortisol—which increase glucose levels and heart rate. This is known as the Hypothalamic-Pituitary-Adrenal (HPA) system or axis. Those with a history of prior trauma seemed to be more sensitized to a HPA response and the near immediate release of stress hormones in response to subsequent stressors. This population also has higher rates than the general population for cardiovascular disease, diabetes, cancer, and gastrointestinal disorders (Kendall-Tackett, 2009) and disruptions to their neurologic functioning. Perry et al. (1995) reported as chronic trauma stress persists “there will be ‘use-dependent’ alterations in the key neural systems involved in the stress response. These include the hypothalamic-pituitary-adrenal (HPA) axis. In animal models, chronic activation of the HPA system in response to stress has negative consequences. Chronic activation may ‘wear out’ parts of the body including the hippocampus, a key area involved in memory, cognition and arousal” (p. 49).

Mental health clinicians, treating those exposed to trauma, focus on clients’ experiences and meanings of traumatic events. To that end, a bioecological understanding of mass trauma (Hoffman & Kruczek, 2011) and a model of biologic pathways for historical/intergenerational trauma (Conching & Thayer, 2019) will inform your approach and treatment of traumatized clients.

**Bioecological Model of Mass Trauma**

Hoffman and Kruczek (2011) based their bioecological model of mass trauma on the original work of Bronfenbrenner (1979), and Bronfenbrenner and Ceci (1994) extended the model to biological considerations. (See Chapter 6 for a detailed description of Bronfenbrenner's 1979 ecological model.) Bronfenbrenner's original model consisted of five systems (individual-personal characteristics; micro-family and peers; meso-relationship among micro systems; exo-school, community, government, media; and macro-wider environment and social policies). The chronosystem examines patterns of events over one's development and time. Bronfenbrenner and Ceci’s inclusion of biological factors like genetic predisposition and temperament provide richer context for Hoffman and Kruczek's adaptation of this model to mass trauma. They note the “expanded model provides an integrated conceptual structure for understanding the effects, intervening in the aftermath, addressing prevention, and researching aspects of large-scale disaster and catastrophes” (p. 5). Hoffman and Kruczek evaluated the influence of traumatic events on individuals' agency, optimism, well-being, sense of meaning and ecological systems to “identify the biopsychosocial extent beyond initial injury and mortality” (p. 3). Using this model, clinicians structure their
examination and intervention of clients’ traumatic responding in the context of their ecological systems promoting a greater understanding of individual, family, social, community factors and supports, resources, and cultural perspectives.

**Biologic Pathways for Historical/Intergenerational Trauma**

Historical trauma describes the consequences of oppression, violence, forced incarceration, assimilation, and death experienced by marginalized populations because of colonization, enslavement, subjugation, and genocide. First coined by Maria Yellow Horse Brave Heart in the 1980s, the term *historical trauma* identified the intergenerational transmission of psychological trauma symptom in successive generations of Lakota Sioux (Brave Heart, 2000; Brave Heart and DeBruyn, 1998). Sotero (2006) identified three phases. The first describes the perpetration of mass traumas by the dominant culture resulting in widespread cultural, familial, and economic devastation. Traumatic responding occurring in those originally exposed denotes the second phase. Continued oppression, discrimination, and marginalization of the affected population are the mechanisms that transmit the trauma to successive generations. Brave Heart and DeBruyn examined similarities in the manifestation of historic trauma in Native American and Holocaust survivor populations. They surmised that, independent of type of trauma, marginalized populations’ historic trauma responding impacted individuals and communities similarly.

Conching and Thayer (2019) argued that although theories of historical trauma conceptually explain the negative consequences of intergenerational transmission of historical and repeated losses, there is not a model for how historical trauma responding HTR negatively impacts later generations. To address this void, they devised a cumulative two pathway model to explain the health effects of HTR in present populations. The first pathway posits that historically oppressed populations are chronically and continually subjected to traumatic events and stressors like low socioeconomic status, discrimination, and historical loss which cause epigenetic changes (discussed earlier) and negatively impact individual and community well-being. In the second pathway, the authors indicate that “biological consequences of historical trauma can be inherited across generations through intrauterine environments, changes in breast milk composition and breastfeeding behavior, and patterns of parental care” (p. 78). As noted previously, we note epigenetic changes do not impact the structure of one’s DNA, thus as Conching and Thayer state, the effects are “necessarily permanent and that improvements in environmental conditions could reduce the high prevalence of poor health among historically disadvantaged communities” (p. 72).

**Developmental and Neurobiological**

In Chapter 2, we discussed human development across the lifespan and developmental crisis events. Developmental theories of trauma and traumatic responding build on the concepts of attachment, attachment styles, developmental tasks, and neural plasticity described earlier and is expanded here to include brain development, neurocognitive aspects of prolonged or chronic trauma, state dependent use, and mechanisms of change.
Humans mature through several periods of social, cognitive, and physical development. These periods describe expected social, cognitive, and physical changes influenced by age-related changes in cognitive and social processes, which influence psychological adjustment following exposure to traumatic events. When there is a supportive enough environment, most development tasks are completed and milestones surpassed. In neglectful and abusive environments, development and performance in any or all these domains is influenced and altered. Treating traumatized children requires a different framework than working with traumatic responding that occurs in adolescence and adulthood.

**Brain Development 101**

In numerous publications, Perry (1993, 1996; 2000; 2006) notes the brain develops sequentially from the brainstem to the midbrain or diencephalon cerebellum to the cerebrum, which contains limbic, and finally the cortical regions. At each level of the brain, plasticity and complexity increase. The brain is a heterogeneous organ, meaning each region has a distinct organization, purpose, and function. For example, the brainstem region manages communication between the brain and the body and controls basic autonomic functions like breathing, digestion, body temperature, consciousness, and arousal states. The diencephalon cerebellum transmits sensory data between the regions of the brain and controls the autonomic functions of the peripheral nervous system (PNS), which excludes the brain or spinal cord. The cerebrum is comprised of the limbic and cortical regions. Emotion, learning, memory attachment, affiliation, and motivation reside in the limbic region. The cortical region is responsible for abstract and concrete thought, complex language, and decision making. Because the brain develops in a hierarchical, use-dependent manner, development of the upper regions of the brain is influenced by the development of the lower regions.

Each region of the brain contains billions of neurons and ten billion glial cells. A neuron is a specialized cell that transmits electric impulses to other cells in the body. A glial cell supports neurons by providing nutrients, oxygen, and insulation allowing the neurons to sense, process, store, and act on sensory input. Thus, sensory input received by the brain is converted into neural activity. According to Perry (1996) “All neurons change the molecular function in a use dependent fashion. Therefore, patterned sensory input leads to patterned changes in neuronal systems. Patterned neuronal changes allow the brain to make internal representations of the external world.” In other words, the more a neural pattern is activated the more the brain builds in that pattern. Experience “creates a processing template through which all new input is filtered. (Perry et al., 1995; p. 275). This process allows infants to respond their internal and external environment. For example, consider the infant who is repeatedly exposed to abuse and neglect. They respond to these threats with hyperarousal—crying or agitation; or disassociation—freezing, or chaotic responses to caregivers. Over time, the repeated aversive stimuli or state of hyperarousal becomes a trait of the infant’s personality. Because the brain organizes in a use-dependent pattern, continued reactivation of an aroused state leads to maladaptive traits and impaired attachment. Because adult brains are developed,
exposure to traumatic events results in states or periods of hyperarousal rather than traits. (For a detailed discussion, please see Perry et al., 1995.) Figure 4.7 summarizes the theory.

**FIGURE 4.7  Impact of trauma on brain development**

- Developing Brain
- Repeated Traumatic Events
- Prolonged Alarm Response
- Altered Brain Development

**Behaviorism**

Theories of behaviorism and psychological understandings of trauma rose to prominence during the 20th century, particularly theories of classical and operant conditioning. Ivan Pavlov, the director of the Institute of Experimental Medicine, examined the physiology of digestion in dogs and, in 1904, his research resulted in a Nobel Prize. Pavlov continued his work and in 1927 published the principles of classical conditioning. Proponents of operant conditioning, most notably Thorndike and Skinner, examined the stimulus-response relationship in nonreflexive responding including the law of effect, schedules of reinforcement, shaping, and stimulus discrimination through the use of animal models. For a fuller discussion of these concepts, see, McSweeney and Murphy (2014). The initial phases of theory development related to trauma focused on anxiety reduction through classical or operant conditioning. Orval Hobart Mowrer (1951/1960) explained the development and maintenance of phobias. He purported a two-factor theory combining learning principles from classical and operant conditioning. Mowrer believed phobias developed because of a paired association between a neutral stimulus and feared stimulus (i.e., they were classically conditioned). However, classical conditioning theory did not fully explain the maintenance of the phobic behaviors like fear, avoidance, and the desire to escape or enduring impairments in psychological, relational, and social functioning. Mowrer turned to the concepts in operant conditions to explain the maintenance of the phobia. Consider the two-factor theory in the following example. A woman is mugged during her nightly run. After the attack, she experiences debilitating panic attacks when she is outside after dark. Thus, darkness, formerly a neutral or unconditioned stimulus, is now associated
with being attacked, a conditioned response, which in turn results in fear/panic or a conditioned response. By avoiding going outside after dark she is *rewarded* with less anxiety, thus the avoidance becomes her dependable coping strategy.

Wolpe (1954) also examined potential interventions for anxiety experienced by clients. He believed anger and aggression were discordant with the emotional states required for assertiveness. This led him to develop the techniques of reciprocal inhibition and later systematic desensitization. Systematic desensitization, like reciprocal inhibition, is based on the principles of classical conditioning, specifically counter-conditioning. Over time and in successive steps, the fear response is substituted with a relaxation response. Throughout the mid-20th century, systematic desensitization techniques matured beyond the initial clinical setting are distinguished from the two other types of exposure therapies in vivo and imaginal flooding.

The intersections of operant and classical conditioning theories fueled advancements in our theoretical understandings of trauma-related and post-trauma-related responding. Kilpatrick, Veronen, and Resick (1979) compared fear responses of victims of rape to nonvictims. The results of their longitudinal study revealed a possible relationship between the process of classical conditioning and victims’ stimulus generalization and ensuing attempts to avoid thoughts, feelings, and behaviors related to the event. For example, traumatic responding was believed to result from original traumatic cues like unexpected touching or unexplained noise being generalized to subsequent occurrences of the same cues. The generalized cue stimulates emotions, thoughts, and bodily responses independent of the original trauma. Kolb (1987) hypothesized that the reflexive responding present in classical conditioning may explain the conditioned fear response and proposed the amygdala’s role in the exaggerated reaction to stimuli, connecting psychological and physiological. The amygdala is a structure in the brain that facilitates the experience of emotions and memory functions involved in conditioned fear responses. Specific to the development of theories of trauma, Monson, Friedman and La Bash (2014) cite the contributions of operant conditioning to our understanding avoidant behavior as a negative reinforcer as, “avoidance maintains the originally learned anxiety associations because it prohibits exposure and habituation of conditioned responses” (p. 54).

Using Perry’s framework, therapists can precisely target their work to whatever stage a child was in when trauma took place. Treatment begins with assessment. Traumatized children “need patterned repetitive experiences appropriate to their development needs, needs that reflect the age at which they missed important stimuli or had been traumatized, not their current chronological age” (Perry & Szalavitz, 2007; p. 138). For children and adolescents, treatments target regions of the brain and its functioning impacted by the trauma. The neurosequential model of therapeutics is presented later in this chapter.

**Cognitive**

Cognitive theories hypothesize and describe how humans process information. The process involves our perception, selection, and attention to personal experiences and how we store, organize, and retrieve those memories. Over time,
memories develop into schemas or frameworks that are more efficient at interpreting and organizing external stimuli. Traumatic experiences (TE) are believed to influence schemas and, by extension, one’s cognitive interpretation and organization. Dalgleish (1999) conducted a review of cognitive theories of posttraumatic stress disorder (PTSD) and identified five common features. First, individuals hold sets of beliefs about themselves, others, and the world. Most often this is referred to as the just world belief or good things happen to good people and bad things happen to bad people. The frame of individuals whose beliefs are primarily negative is the world is not safe. I can’t trust anyone. Second, when one experiences a TE, the experience is incompatible with their previous beliefs. Traumatic events alter and disrupt individuals’ core beliefs because the unexpected event alters beliefs about self, others, and their environment in an extreme way (Resick, et al 2007). The incompatible information leads to distress. The third common element describes the individual’s attempt to relieve their distress by integrating the TE into their belief system through assimilation, accommodation, or overaccommodation. The integration is difficult and results in the fourth common element—emergence of PTSD phenomena or symptoms like fear, hypervigilance, irritability, and sleeplessness. The final common element addresses resolution. With successful resolution, distressing symptoms remit; when unsuccessful, distress increases as the traumatic information continues to conflict with the individual belief system. The goals of cognitive theories of trauma are to help traumatized clients activate and correct faulty beliefs in order to view themselves, others, and their environment more realistically and to process and acknowledge the traumatic event and associated emotions. Of the plethora of cognitive and cognitive-behavioral theories of trauma, we detail three that contribute to your understanding of fear networks, threat appraisal, and maintenance of PTSD.

**Integrated Emotion Processing Theory**

Foa and Kozak (1986; EPT) based emotional process theory on Lang’s (1977) bio-information theory and Rachman’s (1980) emotional processing theory. Foa and Kozak (1986) noted fear structures become maladaptive through a process in which formerly neutral elements of traumatic events are subsequently perceived as threatening, activating flight or fight responses, and associated physiological responding (increased heart rate, rapid breathing, dilated pupils). Elements of the traumatic event, traumatic-responding, and their meaning comprise the fear structure. These types of fear responses are incongruent with the context and circumstances, are in excess of what is required to manage the event, and their meaning is mistakenly perceived and encoded into memory as a source of danger. During times of trauma or extreme stress memories are stored in a fragmented, chaotic, and incomplete manner. Thus, when all elements of a traumatic event are associated with permeating fear, individuals walk around in a constant state of readiness (hypervigilance). EPT conceptualizes chronic PTSD as a failure to adequately process the trauma memory due to extensive avoidance of thoughts and situations that are trauma reminders. (Foa, 2011). In sum, emotional processing theory proposes that the intervention involves the emotional process of traumatic memories so that they can be modified or replaced (Foa & Kozak, 1986; Foa, Huppert, & Cahill, 2006).
Emotional Processing Theory was expanded to Integrated Emotional Process Theory by Foa and her colleagues (Foa & Meadows, 1997; Foa & McNally, 1996; Foa & Riggs, 1993; Foa & Rothbaum, 1998). They emphasized the nature of disorganized traumatic memories and detail the role of memories, schemas, and post-traumatic reactions to self, others, and the environment. In essence, a traumatic event results in a fear network which contains all information about the event. These networks are strongly associated with fear and are bolstered by multiple stimuli and responses. Extensive fear structures are associated with signs of danger or fear and subject to overgeneralization of threat—almost anything can pose a threat. Dalgleish (2004) viewed the Foa’s expanded theory as one of the most comprehensive to date.

**Janoff-Bulman’s Cognitive Appraisal Model**

Like other cognitive theories, Janoff-Bulman’s (1992) theory, sometimes referred to as the shattered assumptions theory, describes a mental template or model from which the individual views the world and makes decisions. Three basic assumptions ground Janoff-Bulman’s model—the world is benevolent or I am safe; the world is meaningful or we get what we deserve... good behavior and character lead to good outcomes; poor behavior and character lead to poor outcomes; and finally the third assumption, the self is worthy or I am good and can control events in my life. Thus, traumatic experiences shattered one or more of these assumptions. The world is experienced as senseless, chaotic, and disorganized in the cognitive appraisal model. In this theory, a return to coping means rebuilding assumptions thorough prolonged exposure therapy or cognitive processing therapy—both explained later.

**Ehlers and Clark’s Model of the Maintenance of PTSD**

Ehlers and Clark theorize a model of PTSD in which two core cognitive abnormalities exist. The first is the individual’s appraisal and meanings of the TE are excessively negative and viewed as a serious threat. Because they overgeneralize the threat, the individual engages behaviors like safety seeking, intending to reduce the threat. Regrettably, the behavior is maladaptive and sustains the disorder by preventing change. The second cognitive abnormality involves disturbances in one’s memory of themself and the TE. Those with chronic or persistent PTSD have memories that are poorly elaborated and lack context, are strongly associative (the smell of gunpowder evokes the terror of war), and respond quickly to perceptual priming. Ehlers and Clark (2008) recommend a variety of cognitive therapy approaches to address the concerns of those with persistent PTSD.

**Models of Trauma Treatment**

The history and theories presented in the previous section are the foundation for models of treatment and intervention for those exposed to trauma. Consistent with our focus on development, we present the models of treatment from childhood through older age.
Children

Trauma-Informed Care

Hopefully you have been exposed to trauma-informed care in your graduate program or through professional development. The National Child Trauma Stress Network indicates that trauma-informed systems of service are those in which providers routinely screen for traumatic exposures and its symptoms; use culturally responsive and evidence-based protocols; and provide resources/psychoeducation to children and families about trauma exposure. Clinicians in these comprehensive systems also identify, discuss, and address resilience and protective factors in children and their families; address caregiver/parental trauma and its systemic impact on others; and attend to the wellness of clinical staff and takes steps to reduce secondary traumatic stress. These activities are undertaken in a context of mutuality, respect, and collaboration between service providers and families. Services providers also acknowledge and address issues of intersectionality across all identities.

Neurosequential Model of Therapeutics

Perry and Hambrick (2008) describe the Neurosequential Model of Therapeutics (NMT) as “a developmentally sensitive, neurobiologically informed approach to clinical work” not a set of skills or interventions (p. 38). The NMT rests on three principles, in the form of rhetorical statements that inform one’s clinical practice: “Where the child has been” “Where the child is” and “Where the child should go.” “The brain is a historical organ” (Perry & Hambrick, 2008; p. 40), and as such the NMT Assessment begins by cataloging the nature, severity, and duration of “key insults, stressors, and challenges” and when they occurred in the developmental process. These traumatic events are reviewed and scored to an approximate amount of trauma incurred to determine how and in what manner the brain was compromised (Perry, 2001). Relational health history is a Functional Assessment of attachment, resiliency, and vulnerabilities. Along with the neurodevelopmental history, the functional assessment provides an estimate of which brain areas are associated with which neuropsychiatric symptoms or child’s strengths. An interdisciplinary team synthesizes the data into a functional brain map that is used in treatment with child and caregivers. The brain map is the foundation for the third component, Specific Recommendations. Perry and Hambrick note the functional assessment “helps determine a unique sequence of developmentally appropriate interventions that can help the child reapproximate a more normal developmental trajectory” (p. 42). Neurosequential intervention based on the NMT model requires a engaged and reliable team of individuals to create the needed environment. It is not something the clinician should attempt on their own.

Child–Parent Psychotherapy (CPP)

According to Lieberman, Van Horn, and Ghosh-Ippen (2005), child–parent psychotherapy is an effective evidence-based treatment approach for children under six years of age. The treatment is flexible and allows for incorporation of a discussion of cultural values and culture-related experiences. CPP is based on attachment,
psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. This approach focuses on safety, improving the child–caregiver relationship, joint construction of trauma narrative, affect regulation, and helping the child return to a normal developmental trajectory. CPP has been empirically validated through four randomized controlled trials. These trials included a sample of children who witnessed intimate partner violence (Lieberman, Van Horn, & Ghosh-Ippen, 2005); maltreated preschooler’s attachments (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002); the adjustment of maltreated children’s attachment classification (Cicchetti, Rogosch, & Toth, 2006); and low-income Spanish speaking women and their babies (Lieberman, Ippen, & Van Horn, 2006).

Initial CPP therapy sessions are attended by the parent/caregiver and focus on developing an understanding of the nature and magnitude of the traumatic experience. Following these initial sessions, the parent and child attend together. Subsequent sessions focus on working with the child, in a play therapy format, to create a narrative regarding the traumatic experience. The primary therapeutic goal is to assist the caregivers’ reengagement in the protective role with the traumatized child (Lieberman, Van Horn, & Ghosh-Ippen, 2005) and to aid the understanding of trauma and its effects on the child.

**Parent-Child Interaction Therapy (PCIT)**

Parent–Child interaction therapy (PCIT), developed by Sheila Eyberg (1988) and advanced by McNeil and Hembree-Kigin (2010), incorporates components of behavior therapy, play therapy, family systems, and social learning theory into a time-sensitive (12–20 sessions; average 14) dyadic behavioral intervention. PCIT focuses on improving the quality of the parent-child relationship, particularly attachment; decreasing child behavior problems (defiance, aggression) while increasing prosocial behaviors (helping, caring, comforting); improving parenting/relational skills through the use of praise, reflection, imitation, description, and enthusiasm (PRIDE) and positive discipline; and decreasing parenting stress. Originally created for children ages 2 to 7, some authors restricted the target population (Lenze, Pautsch, & Luby, 2011) to children ages of four and seven while others (Chaffin et al., 2004) have researched PCIT’s application to children as old as 12.

Children and their caregivers are seen together in PCIT. The clinician observes typical interactions between the parent and child, then instructs parents on the above-referenced skills and asks them to use them with their child in a playroom while coached by a therapist. Clinicians coach from an observation room with a one-way mirror into the play or consultation room using a wireless or Bluetooth communication system to support the parent as they play with their child. Coaching provides parents immediate feedback on their use of the new parenting skills enabling them to apply the skills correctly while experiencing success designed to support acquisition and mastery. At the end of each session, the therapist and caregiver, together, decide which skill to focus on during daily five-minute home practice sessions the following week. The caregiver must have regularly daily contact with the child as homework is often assigned as a regular part of treatment.

As the clinician, you will spend most of the session time observing, evaluating, and coaching caregivers in the application of specific therapeutic skills.
addition to the initial clinical interview or intake completed, you may also wish to use a number of inventories to assess, monitor, and document treatment outcomes. Assessments you may wish to consider include:

- Eyberg Child Behavior Inventory™ (ECBI™) along with its companion inventory Sutter-Eyberg Student Behavior Inventory-Revised™ (SESBI-R™) https://www.parinc.com/WebUploads/samplerpts/Fact%20Sheet%20ECBI-SESBI-R.pdf; or the Parenting Stress Index™, Fourth Edition Short Form (PSI™-4-SF) https://www.parinc.com/products/pkey/335;
- Eyberg Child Behavior Inventory™ (ECBI™) and its companion inventory Sutter-Eyberg Student Behavior Inventory-Revised™ (SESBI-R™) https://www.parinc.com/WebUploads/samplerpts/Fact%20Sheet%20ECBI-SESBI-R.pdf; and
- Parenting Stress Index™, Fourth Edition Short Form (PSI™-4-SF) https://www.parinc.com/products/pkey/335

PCIT outcomes have been empirically validated through multiple investigations. Chaffin et al. (2004) found PCIT significantly reduced the amount of negative parent–child interactions with 110 parents who physically abuse their children. Not only did the PCIT group demonstrate a significant reduction in abuse behavior, but long-term follow-up demonstrated clear evidence that the changes were maintained. Similarly, Hood and Eyberg (2003) researched the long-term maintenance of changes following PCIT. They utilized a sample of young children demonstrating behaviors of oppositional defiant disorder. Evidence suggested that the positive changes demonstrated in children and caregivers persisted. Finally, PCIT has demonstrated efficacy in a randomized dismantling field trial. Dismantling designs are used with therapies that have multiple components of treatment and seek to either identify active mechanisms of change or the degree to which additional specific features contribute to the degree of change attributable to those components. Discreet components may be studied in isolation or in combination with other components of the intervention, typically in a sequential manner. For example, Chaffin, Funderburk, Bard, Valle, and Gurwitch (2011) found that a motivation–PCIT package, self-motivation (SM) combined with PCIT, reduced child abuse recidivism compared to a services as usual (SAU) sample of 192 parents whose children had been removed from the home, had six prior child welfare referrals, and were receiving parenting services at a community-based agency in Oklahoma. Cases were followed for a median of 904 days. Results from this study supported a synergistic SM + PCIT benefit and reduced future child welfare reports, particularly when children were returned to the home sooner rather than later.
Play Therapy

According to Erikson (1950), “Play is a function of the ego, an attempt to synchronize the bodily and social processes with self” (p. 214). While many adults may conceptualize play as something children do to pass time, in reality, children use play to express their inner-world symbolically. Kottman (2010) defined play therapy as “an approach to counseling young children in which the clinician uses toys, art supplies, games, and other play media to communicate with clients using the ‘language’ of children—the ‘language’ of play” (p. 4). Play therapy assists children suffering from trauma by offering them a process to symbolically play out their experience and is believed to directly impact the sensory experiences stored in the brain (Green et al., 2010). The Association for Play Therapy (Ray & McCullough, 2015; [APT]) recommends play therapy for children ages 3 to 12.

During play, children have control over the extent to which they come into contact with the traumatic experience. The play therapist utilizes warm and empathic skills to encourage the child to feel a sense of safety and empowerment as they project their emotions, thoughts, and experiences on the various play mediums (toys, paint, sand art, dress-up). Play therapy is offered in different formats (individual, co-joint, familial), however it is typically best suited for children three to nine years of age.

Ray and McCullough (2015) describe the effectiveness of play therapy for children based on Paynter’s (2009) research credibility pyramid for the social sciences. Paynter presents a four-level hierarchy of evidence researchers can use in evaluating mental health interventions. This hierarchy parallels but is not as detailed as the work of Chambless and colleagues (1996, 1998) and the American Psychological Association’s 2006 presidential task force’s statement on evidenced-based practice. The pyramid is comprised of four levels; at the top are systematic reviews and meta-analyses of findings from multiple studies from a narrowly defined treatment approach or intervention. Systematic reviews and meta-analyses and randomized controlled trials discussed in the next section are considered the gold standard of efficacy studies. Next are studies designed as randomized controlled trials (RCTs). RCTs compare two groups whose membership is randomly assigned. One group receives the intervention under study; the other group is a control group whose members receive a placebo or no treatment. RCTs reduce research bias through standardized methods and control over variables of interest, thus findings can be generalized to the population from which the sample was drawn. The third level of the pyramid includes observational studies-quasi-experimental studies (manipulation of the independent variable without random assignment, less control over variables of interest, limited generalization), correlational designs (which cannot attribute causation) and single-case experimental designs. The better evidence comes from cohort studies which identify a variable of interest and associate it with an outcome (prospective) or examine a group exposed to a variable (like exposure to trauma) and determine if they experienced the outcome. Studies at this level of the pyramid may have statistically significant results but do not yet provide sufficient evidence to be considered in the gold standard. Finally, the base of the pyramid describes case reports or case studies, which may include qualitative and anecdotal evidence and can include individual quantitative data, on the use of a particular intervention. Similar to quasi-experimental designs, case studies provide valuable information on
the efficacy of treatments but do not yet rise to the level of gold standard set for cognitive behavior therapy (CBT). For full review of the evidence base for play therapy interventions please see Phillips (2010) and Ray and McCullough (2015).

**Adolescents**

**Cognitive Behavioral Intervention for Trauma in Schools (CBITS)**

According to Feldman (2007) CBITS is a 10-session, school-based group intervention, developed for children (5–11) and adolescents (12–14) to reduce symptoms related to PTSD, complex trauma, depression, and general anxiety. Jaycox, Langley, and Hoover (2018) structure the intervention as follows: two group sessions; introductions in session one, followed by education and relaxation techniques in group session two. Next, the child then completes three individual sessions that focus on processing the trauma memory narrative. Group sessions 5 through 10 focus on an introduction to cognitive therapy, combating negative thoughts, an introduction to real-life exposure, two sessions on exposure to stress or trauma memory, problem solving, social problem solving, and concludes with relapse prevention and graduation. Through this treatment protocol, clinicians help adolescents cope with the trauma symptomology and develop more prosocial and adaptive coping skills. CBITS has been tested in a randomized controlled study with children diagnosed with PTSD (Jaycox, et al., 2002). Research findings indicated that the intervention group had significant improvement in PTSD and symptoms of depression.

**Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**

Trauma-focused cognitive behavioral therapy (TF-CBT) is comprised of four components: exposure, cognitive processing and reframing, stress management, and parental treatment (Cohen, Mannarino, Berliner, & Deblinger, 2000). TF-CBT is a 12-week model developed for children and adolescents (ages 3–18). This model has also been adapted for toddlers and preschoolers (Scheeringa et al., 2007). Children and adolescents are often well suited for TF-CBT due to their ability to clearly recall the traumatic event (the focus of treatment). TF-CBT is a holistic model that integrates interpersonal, behavioral, cognitive, and family therapy theoretical tenets. Co-creating the therapeutic relationship, learning skills to cope and understand trauma, and fostering the parent–child bond are all salient to the TF-CBT model. The acronym PRACTICE refers to the major components of this model: psychoeducation, relaxation skills, affective expression, cognitive coping, trauma narration and processing, in vivo mastery of trauma reminders, conjoint child–parent sessions, and enhancing safety.

Trauma theory focuses on the appraisal and experience of crisis or traumatic events accompanied by devastating or paralyzing fear alter emotional and psychological functioning (Perry, 1993). In a percentage of cases if suffering and anguish persists, posttraumatic stress disorder (PTSD) may develop. Thus, clinical interventions target the realignment of emotional and psychological responses to trauma-related thoughts, memories, and recollections. Interventions, like Trauma
Focused Cognitive Behavioral Therapy (TF-CBT), are based on trauma and social cognitive (Beck, 1985) theories. TF-CBT components include creation of current and future safety plans, psycho-education, relaxation training, identification and regulation of emotions, coping and cognitive processing, and trauma narrative. Like CBITS referenced above, TF-CBT includes parent psychoeducation and skills training, as well as conjoint child-parent sessions. The effectiveness of TF-CBT is well established for victims of sexual abuse (Silverman et al., 2008). The parent–child or caregiver–child relationship and attachment seem critical to positive treatment outcomes. For example, Lieberman et al. (2005) found that a 50-week child/parent therapy program, based on attachment theory, reduced symptoms of traumatic stress and improved behavior when compared to case management and individual psychotherapy. Cohen, Mannarino, and Iyengar (2011) used a randomized controlled design to compare Child Centered Therapy (CCT) with a brief version of TF-CBT and found children in the TF-CBT group demonstrated fewer PTSD symptoms and anxiety when compared to those in the CCT group. Clearly, parental or caregiver involvement in treatment influences children's ongoing risk, capacity for resiliency, and recovery from traumatic or neglectful events. TF-CBT is one of the most well-supported forms of therapy for children and adolescents with severe PTSD symptoms and complex trauma (Stein et al., 2003).

### Adults

Effective clinicians take a holistic approach with traumatized individuals understanding their psychological, social, emotional, and behavioral expressions of trauma as well as their physical and somatic reactions. This includes the use of evidence-based treatments and guidelines that aid your selection and utilization of specific treatment protocols matching your client's specific needs. In addition to what we presented in the section on child treatment, Foa, Keane, Friedman, and Cohen (2009) stated that for CBT treatments, guidelines are based on the systematic and metanalytic reviews to examine and establish the efficacy or grade of each intervention. Grades range from A to D. A grade of A demonstrates the treatment approach is strongly supported by empirical evidence and positive client outcomes, while a grade of D indicates a treatment with little to no empirical support and ineffective or harmful client outcomes.

### Empirically Supported

A number of evidence-based treatments (EBT) have been identified as the gold standard for treatment of trauma, most notably for PTSD and other trauma-related problems (CATS Consortium, 2007; Ebert, Amaya-Jackson, Markiewicz, Kiesel, & Fairbank, 2012; Ebert, Amaya-Jackson, Markiewicz, & Fairbank, 2012; Karlin et al., 2010). The most notable trauma-based treatments include trauma-focused cognitive–behavioral therapy (TF-CBT) discussed earlier, prolonged exposure (PET), cognitive processing therapy (CPT), cognitive behavioral therapy (CBT), psychological debriefing, critical incident stress debriefing (CISD), eye movement desensitization and reprocessing (EMDR), art-assisted therapy, and brainspotting (BSP). TF-CBT and CPT can be offered in a group-counseling context.
Prolonged Exposure Therapy (PET)

Prolonged Exposure therapy (PET) is one of the most well-known empirically based treatments for adults with chronic PTSD arising out of single or multiple traumas. Developed by Edna Foa, this approach is recognized as a Level A treatment and is supported by hundreds of studies demonstrating its efficacy. PET is grounded in emotional processing theory (EPT), which focuses on how fear is organized, structured, and stored in one’s memory. As noted previously in this chapter, fear responses or structures can be adaptive or maladaptive, meaning that when threats are real, the experience of fear moves the individual to react by avoiding danger adapting in a context-congruent manner.

Prolonged exposure therapy is aptly named. The goal of treatment, generally 8 to 15 90-minute sessions, prepares the client for prolonged and sustained exposure to the feared situations through a combination of psychoeducation, retelling, and revisiting the trauma. First, clients are educated about typical reactions to trauma, rationale for and explanation of treatment protocol, including the types of exposure, and PTSD and physiological and emotional management strategies like relaxation techniques and breathing retraining. Clients are asked to practice relaxation techniques between sessions. Next, the client, in collaboration with the clinician, ranks trauma-related stimuli from least feared to most feared. Then the client is intentionally and systematically exposed, at a pace they determine, to trauma-related events, elements, and associations via in vivo (direct experience with feared situations) and imaginal (repeated verbal recounting and revisiting the trauma) exposure. Following each exposure, the client and clinician process the experience to explore the client’s reactions, identify errors in thinking, dispute previous beliefs (“The world is a dangerous place” “I am completely incapable”), and challenge avoidance of triggering situations. Clients are asked to monitor between-session traumatic responding and report back in session. The repeated retelling, revisiting, and discussion of trauma-related memories or experiences are believed to aid in the consolidation and clarification of more accurate memories and associations. Foa (2011) reminds us that encouraging clients “to elaborate on new insights and making them explicit is likely to facilitate emotional processing and modification of the pathological emotional structure” (p. 1045). Prolonged exposure therapy has been contraindicated for clients with PTSD, co-morbid suicidality, psychotic, dissociative, and anxieties disorders (Becker, Zayfert, & Anderson, 2004), and multiple childhood traumas (van Minnen, Hendriks, & Olff, 2010). Yet, van Minnen, Harned, Zöllner, and Mills (2012) found prolonged exposure could safely and effectively be used with these populations and is often correlated with a decrease in PTSD and co-morbid behaviors or disorders. For greater detail on EPT, please see the manual Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences, Therapist Guide (Foa et al., 2007).

Cognitive Processing Therapy (CPT)

Originally developed by Resick and Schnicke (1993), CPT is a version of CBT originally designed for the treatment of those traumatized by rape and subsequently has been expanded to treat members of the military. Like PET, CPT is recognized as a gold-standard treatment by International Society for Traumatic
Crisis, Trauma, and Disaster

Stress Studies (ISTSS) PTSD Treatment Guidelines (Foa et al., 2009) and in the clinical practice guidelines from the Veteran’s Administration and Department of Defense (Management of Post-Traumatic Stress Working Group, 2010). The theoretical foundations for CPT rest upon Lang’s (1977) information processing theory, extended into the treatment of trauma by Foa, Steketee, and Rothbaum, (1989) and social cognitive theory. In essence, for CPT, these theories propose an individual’s view of themselves, others and the world frames their experience and interpretation of each; either positively or negatively. Those with a positive frame see the world as a just place and believe in their ability to influence it; those with a negative frame see the world as unjust and believe they have little agency to change events or outcomes. Traumatic events are believed to disrupt the individual’s core beliefs particularly when they are incongruent with their personal frame. Resick et al. (2008) argued individuals attempt to undermine their experiences through the processes of assimilation (memories or cognitions are altered to fit current beliefs), accommodation (beliefs are altered to fit experience; often consider the most health response), or overaccommodation (belief about self, others, and the world are altered to an extreme extent).

Treatment typically occurs over 12 sessions beginning with psychoeducation about depression and PTSD, a brief description of the most traumatic event, cognitive perspective of PTSD, and expectations and commitment to treatment compliance, treatment rational— including stuck points and written work, and homework in the form of an impact statement. In the impact statement, the client is asked to write why they think this event happened to them and how has it changed their views about themselves, others, and the world. In the second session, the client reads the impact statement and discusses it meaning. The clinician introduces the connection between events, thoughts, and feelings, and concludes the session with an introduction of the A B C Worksheets (Activating Event, Belief and Consequence). Sessions 3 and 4 focus on cognitive restructuring; at the end of Session 3, clients are asked to document their traumatic experience including thoughts, feelings, and sensory inputs. CPT Sessions 5 through 12 use a combination of daily assignments, cognitive restructuring, and domain specific concerns (safety, trust, power, intimacy; sessions 8 through 12). Like PET discussed above, CPT is contraindicated for those individuals experiencing dissociative states. Six empirical studies, four of which were randomized control trials, demonstrated the efficacy of CPT. For more detailed information on CPT, please see the therapist training manual available at https://www.apa.org/ptsd-guideline/treatments/cognitive-processing-therapist.pdf.

Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy (CBT) is a well-known empirically supported treatment for trauma, complex trauma, and PTSD (Adler-Nevo & Manassas, 2005; La Greca & Silverman 2009; Stallard, 2006). CBT targets trauma-related symptoms in 12 to 16 sessions via individual or group counseling. Cognitive behavioral therapy approach is a sophisticated set of procedures aimed at ameliorating cognitive and behavioral trauma symptomology. Cognitive techniques center on restructuring unproductive cognitions through ameliorating faulty schemas, assumptions,
automatic thoughts, and cognitive distortions. Typical techniques include, but are not limited to, Socratic questioning, downward arrow, and psychoeducation. Behavioral interventions are generally aimed at decreasing maladaptive behaviors and increasing adaptive ones through intervention based on learning theory, operant conditioning, and classical conditioning.

**Eye Movement Desensitization and Reprocessing (EMDR)**

EMDR is a comprehensive therapeutic modality, encompassing eight phases of treatment (Shapiro, 2001) based on several theoretical perspectives: cognitive-behavioral, psychodynamic, interactional, and body-based (Shapiro & Maxfield, 2002). EMDR is an adaptive information-processing model of treatment designed to ease the suffering linked with traumatic memories (Shapiro, 1989). EMDR treatment is structured into eight stages; stages three through eight occur throughout treatment. The eight stages begin with *client history and treatment planning* followed by *preparation*—which includes education about the nature of trauma, treatment rationale, and procedures specific to EMDR and coping skills instruction (relaxation training, emotional regulation); *assessment*—where targeted trauma memories and associated negative beliefs, physical sensations, and their location in the body are revealed; desensitization and reprocessing—where the individual simultaneously holds negative beliefs, disruptive trauma memories, and the location and type of any bodily sensations while visually tracking the clinician’s rhythmic movements across the visual field. Shapiro (2001) hypothesized that while client’s work with a clinician on attending to traumatic memories, they should also experience brief alternating bilateral stimulation via eye movement, audio stimulation, hand tapping, or vibrating pads. These two experiences, done simultaneously, create an adaptive resolution to the traumatic experience and new associative links are developed. These new associations, guided by the clinician, result in a variety of healing experiences, including information processing, eliminating emotional distress, new learning, and empowerment. The EMDR therapist will also collaborate with the client on creating imaginal templates of future experiences and the skills needed for adaptive behavior. The fifth stage, *installation of positive thoughts* or cognitions, occurs after the client’s report of a 0 or 1 on the subjective units of distress (SUDs) assessment where 0 = no distress and 10 = very distressing. The client is asked to hold the new positive belief in mind while again tracking the clinician’s rhythmic movements and to scale their perceptions of the new positive belief as not at all valid to completely valid. In the sixth stage, *body scan*, the client surveys their body for problematic physical sensations (rapid heartbeat, sweating, muscle tension, aches of unknown origins), acknowledges them, and repeats the visual tracking (or tactile stimulation-finger tapping) procedure with the clinician. *Closure* marks the seventh stage in which direct coping skill instruction (relaxation, visualization) is provided. Clients are encouraged to practice these skills to combat disruptive memories or images. The final stage, *reevaluation*, provides the client and clinician opportunities to review and assess treatment goals, the degree of their attainment, and the potential emergence of additional concerns.

According to Nardo, Hogberg, Looi, Larsson, and Hallstrom (2010), when someone experiences a traumatic incident, the brain’s limbic system fires off chemicals
that direct our bodies to fight, flee, or freeze. Memories from the traumatic event are kept within the brain’s limbic system and midbrain, and are eventually processed within the prefrontal cortex. However, at times, trauma-based experiences are not processed within the prefrontal cortex. Instead, they are stuck within the neurons of the limbic system and mid-brain. When clients experience EMDR treatment around a traumatic event, the neurons within their limbic system start to become rewired. This rewiring moves the trauma-based information from the limbic system and mid-brain to the prefrontal cortex and experiences are processed. The desensitization and prefrontal processing of the traumatic event ultimately leads to a more cognitive-based response to trauma-related stimuli and reduces common trauma-based symptomology akin to hyperarousal, flashbacks, and memory failure (Ecker, Ticic & Hulley, 2013; Lilienfeld & Arkowitz, 2008).

EMDR has an A-level rating from the International Society for Traumatic Stress Studies (Foà et al., 2009) and the Management of Post-Traumatic Stress Working Group (2010), which means it is as effective as other exposure-based treatments. Despite this rating, the function of eye movements bears further investigation as some (Spates, Koch, Pagoto, Cusack, & Waller 2008) have found that eye movements were not associated with positive treatment outcomes, while others (Schubert, Lee, & Drummond, 2011) found benefits associated with eye movement. Clinicians must become certified in EMDR through a 50-hour EMDR Basic Training (previously titled EMDR 1 and 2). Formal training and supervision include supervised practice, and 10 documented consultation hours. More information is available at https://www.emdr.com/us-basic-training-overview/.

**Psychological Debriefing**

Psychological debriefing is a type of post-traumatic care centered on preventing trauma symptoms directly after a crisis event. Psychological debriefing typically includes a single session, group-format debriefing, thought- and fact-based information and processing, coping skills education, and symptom information, and the dissemination of referral information. One approach to psychological debriefing that has garnered considerable attention is Critical Incident Stress Debriefing (CISD; Mitchell & Everly, 1996; Everly, Lating, & Mitchell, 2000). CISD is a seven-phase structured small-group model that takes approximately one to three hours to conduct. The seven phases are introduction phase—a description of the debriefing process and meeting the facilitators. This first phase is an intentional thoughtful presentation of the process that sets the stage and expectations of the session (individuals can choose to pass on a question), highlights problem areas, and invites active participation from the group members. Second is the Fact phase during which participants share their experiences of the traumatic event. A common opening inquiry may be: “Would you each give us (the team) a brief summary of what occurred from your point of view. Third, the Thought phase, participants share their thoughts about the incident and begin the transition into emotional processing. A typical inquiry might include, “What was your first thought after the event?” Fourth, the Reaction phase includes unstructured group processing of the traumatic event. As a facilitator you may ask, “What is the worst thing about this event, for you?” Fifth, the Symptom phase is where facilitators ask participants to
identify symptoms occurring since the event. The symptom phase facilitates participants’ transition from emotional back to cognitive processes. Sixth, the Teaching phase allows the team to normalize the symptoms identified participants. The team provides psychoeducation related to those symptoms and coping skills are reviewed. Handouts may be distributed. Re-entry is the seventh and final phase where the team provides summary statements and referrals. One-on-one sessions are frequent after the CISD ends.

Critically, it is important to note that CISD is a group intervention and is contraindicated for individuals. Individual applications of CISD have been a source of controversy. Several researchers have demonstrated that CISD did not have empirical support for its efficacy (Foa, et al., 2009) and in some cases has made individuals worse (Bisson, McFarlane, Rose, Ruzek, & Watson, 2009). Mitchell (2003), responding to these criticisms, noted that CISD was “not a stand-alone process” (p. 192) and should only be “employed within a package of crisis intervention procedures under the Critical Incident Stress Management umbrella. Without exception, every negative outcome study on CISD to date has not used trained personnel to provide the service and they have violated the core standards of practice in the CISM field” (p. 191) as some have used the CISD for individuals instead of homogeneous groups. The Cochrane Review (Wessely, Rose, & Bisson, 1998) summarized the negative outcome studies on CISD. In that review, 100% of the studies were performed on individuals. When a group process designed for homogeneous groups is used on individuals, it changes the inherent nature of the process itself and also what is being measured. In addition, the negative outcome studies applied a group process model to individuals for whom the CISD process was never intended.

Art-Assisted Therapy

Art therapy is a trauma-based treatment that is centered on clients utilizing drawing, painting, collage, and sculpting to create awareness of trauma-based experiences and to latent memories and thoughts. Art therapy is often categorized as creative art therapy (along with music, dance, and psychodrama therapies). Clinicians typically augment a traditional, empirically based approach to trauma (EMDR, TF-CBT, CBT) with art-assisted therapy or it is part of a multidisciplinary inpatient or outpatient treatment program (Drozdek, Bolwerk, Tol, & Kleber, 2012). The overarching goal of art therapy is to help client’s process emotions, cognitions, and latent processes to work through, process, and symbolically express trauma symptoms through art mediums (Gantt & Tinnin, 2009). According to Foa, Keane, Friedman, and Cohen (2009), art therapy reduces trauma symptomology (alexithymia [an inability to identify and describe emotions], dissociation, anxiety, nightmares, and insomnia).

Brainspotting (BSP)

Grand (2013) describes BSP as a brain-based dual-attunement model of trauma therapy. While EMDR emphasizes bilateral eye movements, BSP has client’s hold a gaze in an area that causes the eye to wobble. Clinicians initially utilize a pointer and music while having the client follow the pointer until they reach a place where they are stuck. Without being asked to talk about their trauma, clients
are encouraged to initiate activation around a problem issue and work through whatever is getting them stuck in that particular eye position. Repeatedly working through these brain spots facilitates rapid discharge and resolution of traumatic experiences that are embedded in the brainstem. According to Hildebrand, Grand, and Stemmler (2017),

By slow eye tracking, either with one eye or with two eyes, locations for BSP are identified. To find these locations, the techniques of either “Inside Window” or “Outside Window” can be used. The “Inside Window” utilizes the client’s felt sense, the “Outside Window” helps to locate this location by observation of clients’ reflexive response such as blinks, eye twitches or wobbles or quick inhalation, by the therapist. (p. 4)

Scant empirical evidence exists in support of Brainspotting, yet Corrigan and Hull (2015) describe it as an advancement in psychotherapy that works at a deeper level, perhaps the midbrain.

### Summary

History, context, and individual characteristics or perceptions influence our understandings of trauma and traumatic responding in clients and ourselves. They provide a foundation for further advancements in theories, research, interventions, clinician training, and ultimately, client care. Originally, trauma theories focused on the body’s physiologic responses to physical insults. Over time, the number of theories has increased and, as a group, has matured, become more integrated, robust, and culturally relevant. Succinct theories with high explanatory power led to trauma-informed treatment models and interventions which resulted in relief for those who suffer. Dynamic fields of study, like trauma, are rife with controversies and powerful prevailing social or economic influences. Hopefully, this dynamism continues to support intellectual curiosity and rigor that advances the needs of our clients rather than the periodic professional amnesias.

### Extended Learning Exercises

**Questions for Review**

1. List the six controversies related to the development of trauma theories and their effect on diagnosis and treatment.
2. Discuss the concepts of the unbearable situation and unacceptable impulse.
3. Compare and contrast psychiatric and psychological theories of trauma.
4. Describe the contributions of cognitive behavioral understandings of trauma.
5. How does the concept of malingering influence our understanding of trauma and trauma-related responding?
6. Describe the cultural influences refinement of trauma-related responding and diagnosis in the diagnostic manuals (*DSM–I through DSM–V*).
Additional Resources

Helpful Books


Helpful Websites

Adverse Childhood Experiences Study: http://www.acestudy.org/
The Child Trauma Academy: http://www.childtrauma.org/
Community Connections (includes TREM, M-TREM): http://www.communityconnectionsdc.org/

International Society for Traumatic Stress Studies: http://www.istss.org/Home1.htm
Mc Silver Institute for Poverty Policy and Research: http://mcsilver.nyu.edu/search/search_by_page/trauma%20of%20racism
PTSD Alliance: http://www ptsdalliance.org/
SAMHSA National Center for Trauma-Informed Care: http://www.samhsa.gov/nctic/
Seeking Safety: http://www.seekingsafety.org/
Sidran Institute: http://www.sidran.org/t3
Training: think-teach-transform: http://www.center4si.com/training/index.cfm
Trauma Focused Cognitive-Behavioral Therapy (TF-CBT) Training: http://tfcbt.musc.edu/
Trauma-Informed Response: http://www.traumainformedresponse.com/Home.html
Trauma Stewardship: http://traumastewardship.com/
Traumatic Stress Institute: http://traumaticstressinstitute.org/
Veterans Administration: http://www.ptsd.va.gov/