



What Is Psychological Trauma?

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We all use the word "trauma" in everyday language to mean a highly stressful event. But the key to understanding traumatic events is that it refers to extreme stress that overwhelms a person's ability to cope. There are no clear divisions between stress, trauma, and adaptation. Although I am writing about psychological trauma, it is also important to keep in mind that stress reactions are clearly physiological as well. Different experts in the field define psychological trauma in different ways. What I want to emphasize is that it is an individual's *subjective experience* that determines whether an event is or is not traumatic.

Psychological trauma is the unique individual experience of an event or enduring conditions, in which:

- The individual's ability to integrate his/her emotional experience is overwhelmed, or
- The individual experiences (subjectively) a threat to life, bodily integrity, or sanity. (Pearlman & Saakvitne, 1995, p. 60)

Thus, a traumatic event or situation creates psychological trauma when it overwhelms the individual's ability to cope, and leaves that person fearing death, annihilation, mutilation, or psychosis. The individual may feel emotionally, cognitively, and physically overwhelmed. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss.

This definition of trauma is fairly broad. It includes responses to powerful one-time incidents like accidents, natural disasters, crimes, surgeries, deaths, and other violent events. It also includes responses to chronic or repetitive experiences such as child abuse, neglect, combat, urban violence, concentration camps, battering relationships, and enduring deprivation. This definition intentionally does not allow *us* to determine whether a particular event is traumatic; that is up to each survivor. This definition provides a guideline for our understanding of a survivor's experience of the events and conditions of his/her life.

Jon Allen, a psychologist at the Menninger Clinic in Houston, Texas and author of *Coping with Trauma: A Guide to Self-Understanding* (1995) reminds us that there are two components to a traumatic experience: the objective and the subjective:

“It is the subjective experience of the objective events that constitutes the trauma...The more you believe you are endangered, the more traumatized you will be...Psychologically, the bottom line of trauma is overwhelming emotion and a feeling of utter helplessness. There may or may not be bodily injury, but psychological trauma is coupled with physiological upheaval that plays a leading role in the long-range effects” (p.14).

In other words, trauma is defined by the *experience of the survivor*. Two people could undergo the same noxious event and one person might be traumatized while the other person remained relatively unscathed. It is not possible to make blanket generalizations such that “X is traumatic for all who go through it” or “event Y was not traumatic because no one was physically injured.” In addition, the specific aspects of an event that are traumatic will be different from one individual to the next. You cannot assume that the details or meaning of an event, such as a violent assault or rape, that are most distressing for one person will be same for another person.

Trauma comes in many forms, and there are vast differences among people who experience trauma. But the similarities and patterns of response cut across the variety of stressors and victims, so it is very useful to think broadly about trauma.

Single Blow vs. Repeated Trauma

Lenore Terr, in her studies of traumatized children, has made the distinction between single blow and repeated traumas. Single shocking events can certainly produce trauma reactions in some people:

- *Natural disasters* such as earthquakes, hurricanes, floods, volcanoes, etc.
- Closely related are *technological disasters* such as auto and plane crashes, chemical spills, nuclear failures, etc. Technological disasters are more socially divisive because there is always energy given towards finding fault and blaming.
- *Criminal violence* often involves single blow traumas such as robbery, rape and homicide, which not only have a great impact on the victims, but also on witnesses, loved ones of victims, etc. (Interestingly, there is often overlap between single blow and repeated trauma, because a substantial majority of victimized women have experienced more than one crime.) Unfortunately, traumatic effects are often cumulative.

As traumatic as single-blow traumas are, the traumatic experiences that result in the most serious mental health problems are prolonged and repeated, sometimes extending over years of a person’s life.

Natural vs. Human Made

Prolonged stressors, deliberately inflicted by people, are far harder to bear than accidents or

natural disasters. Most people who seek mental health treatment for trauma have been victims of violently inflicted wounds dealt by a person. If this was done deliberately, in the context of an ongoing relationship, the problems are increased. The worst situation is when the injury is caused deliberately in a relationship with a person on whom the victim is dependent—most specifically a parent-child relationship.

Varieties of Man-Made Violence

- *War/political violence* – Massive in scale, severe, repeated, prolonged and unpredictable. Also multiple: witnessing, life threatening, but also doing violence to others. Embracing the identity of a killer.
- *Human rights abuses* – kidnapping, torture, etc.
- *Criminal violence* – discussed above.
- *Rape* – The largest group of people with posttraumatic stress disorder in this country. A national survey of 4000 women found that 1 in 8 reported being the victim of a forcible rape. Nearly half had been raped more than once. Nearly 1/3 was younger than 11 and over 60% were under 18. Diana Russell's research showed that women with a history of incest were at significantly higher risk for rape in later life (68% incest history, 38% no incest).
- *Domestic Violence* – recent studies show that between 21% and 34% of women will be assaulted by an intimate male partner. Deborah Rose's study found that 20-30% of adults in the US, approved of hitting a spouse.
- *Child Abuse* – the scope of childhood trauma is staggering. Everyday children are beaten, burned, slapped, whipped, thrown, shaken, kicked and raped. According to Dr. Bruce Perry, a conservative estimate of children at risk for PTSD exceeds 15 million.
- *Sexual abuse* – According to Dr. Frank Putnam of NIMH, at least 40% of all psychiatric inpatients have histories of sexual abuse in childhood. Sexual abuse doesn't occur in a vacuum: is most often accompanied by other forms of stress and trauma-generally within a family.

We must be careful about generalizations about child sexual abuse: research shows that about 1/3 of sexually abused children have no symptoms, and a large proportion that do become symptomatic, are able to recover. Fewer than 1/5 of adults who were abused in childhood show serious psychological disturbance.

More disturbance is associated with more severe abuse: longer duration, forced penetration, helplessness, fear of injury or death, perpetration by a close relative or caregiver, coupled with lack of support or negative consequences from disclosure.

- Physical abuse often results in violence toward others, abuse of one's own children, substance abuse, self-injurious behavior, suicide attempts, and a variety of emotional problems.
- *Emotional/verbal abuse*

- *Witnessing*. Seeing anyone beaten is stressful; the greater your attachment to the victim, the greater the stress. Especially painful is watching violence directed towards a caregiver, leaving the child to fear losing the primary source of security in the family.
- *Sadistic abuse* – we generally think about interpersonal violence as an eruption of passions, but the severest forms are those inflicted deliberately. Calculated cruelty can be far more terrifying than impulsive violence. Coercive control is used in settings like concentration camps, prostitution and pornography rings, and in some families.

One of the best-documented research findings in the field of trauma is the DOSE-RESPONSE relationship –the higher the dose of trauma, the more potentially damaging the effects; the greater the stressor, the more likely the development of PTSD.

The most personally and clinically challenging clients are those who have experienced repeated *intentional* violence, abuse, and neglect from childhood onward. These clients have experienced tremendous loss, the absence of control, violations of safety, and betrayal of trust. The resulting emotions are overwhelming: grief, terror, horror, rage, and anguish.

Their whole experience of identity and of the world is based upon expectations of harm and abuse. When betrayal and damage is done by a loved one who says that what he or she is doing is good and is for the child’s good, the seeds of lifelong mistrust and fear are planted. Thus, the survivor of repetitive childhood abuse and neglect *expects* to be harmed in any helping relationship and may interact with us as though we have already harmed him or her.

Summary

Psychological effects are likely to be most severe if the trauma is:

- Human caused
- Repeated
- Unpredictable
- Multifaceted
- Sadistic
- Undergone in childhood
- And perpetrated by a caregiver

Who Are Trauma Survivors?

Because violence is everywhere in our culture and because the effects of violence and neglect are often dramatic and pervasive,

- *most clients/patients/recipients of services in the mental health system are trauma survivors.*

Because coping responses to abuse and neglect are varied and complex,

- *trauma survivors may carry any psychiatric diagnosis and frequently trauma survivors carry many diagnoses.*

And, because interpersonal trauma does not discriminate,

- *survivors are both genders, all ages, all races, all classes, all sizes, all sexual orientations, all religions, and all nationalities.* Although the larger number of our clients are female, many men and boys are survivors of childhood abuse and trauma. Under-recognition of male survivors, combined with cultural gender bias has made it especially difficult for these men to get help.

What are the Lasting Effects of Trauma?

There is no one diagnosis that contains all abuse survivor clients; rather individuals carrying any diagnosis can be survivors. Often survivors carry *many* diagnoses.

Abuse survivors may meet criteria for diagnoses of:

- substance dependence and abuse,
- personality disorders (especially borderline personality disorder),
- depression,
- anxiety (including post-traumatic stress disorder),
- dissociative disorders, and
- eating disorders, to name a few.

PTSD is based on etiology. In order for a person to be diagnosed with PTSD, there had to be a traumatic event. Because most diagnoses are descriptive and not explanatory, they focus on symptoms or behaviors without a context: they do not explain how or why a person may have developed those behaviors (e.g., to cope with traumatic stress).

For purposes of identifying trauma and its adaptive symptoms, it is much more useful to ask “What HAPPENED to this person” rather than “what is WRONG with this person.”

Symptoms as Adaptations

The traumatic event is over, but the person’s reaction to it is not. The intrusion of the past into the present is one of the main problems confronting the trauma survivor. Often referred to as *re-experiencing*, this is the key to many of the psychological symptoms and psychiatric disorders that result from traumatic experiences. This intrusion may present as distressing intrusive memories, flashbacks, nightmares, or overwhelming emotional states.

The Use of Adaptive Coping Strategies

Survivors of repetitive early trauma are likely to instinctively continue to use the same self-protective coping strategies that they employed to shield themselves from psychic harm at the time of the traumatic experience. *Hypervigilance, dissociation, avoidance and numbing* are examples of coping strategies that may have been effective at some time, but later interfere with the person’s ability to live the life s/he wants.

It is useful to think of all trauma “symptoms” as adaptations. Symptoms represent the client’s attempt to cope *the best way they can* with overwhelming feelings. When we see “symptoms” in a trauma survivor, it is always significant to ask ourselves: what purpose does this behavior serve? Every symptom helped a survivor cope at some point in the past and is still in the present — in some way. We humans are incredibly adaptive creatures. Often, if we help the survivor explore how behaviors are an adaptation, we can help them learn to substitute a less problematic behavior.

Developmental Factors

Chronic early trauma — starting when the individual’s personality is forming — shapes a child’s (and later adult’s) perceptions and beliefs about everything.

Severe trauma can have a major impact on the course of life. Childhood trauma can cause the disruption of basic developmental tasks. The developmental tasks being learned at the time the trauma happens can help determine what the impact will be. For example, survivors of childhood trauma can have mild to severe deficits in abilities such as:

- self-soothing
- seeing the world as a safe place
- trusting others
- organized thinking for decision-making
- avoiding exploitation

Disruption of these tasks in childhood can result in adaptive behavior, which may be interpreted in the mental health system as “symptoms.” For example :

- disrupted self-soothing can be labeled as agitation
- the disrupted ability to see the world as a safe place looks like paranoia
- distrust of others can be interpreted as paranoia (even when based on experience)
- disruptions in organized thinking for decision-making appears as psychosis
- avoiding/preempting exploitation is called self-sabotage

Physiologic Changes

The normal physiological responses to extreme stress lead to states of physiologic hyperarousal and anxiety. When our fight-or-flight instincts take over, the wash of cortisol and other hormones signal us to watch out! We humans are incredibly adaptive. When this happens repeatedly, our bodies learn to live in a constant state of “readiness for combat,” with all the behaviors-scanning, distrust, aggression, sleeplessness, etc. that entails.

Cutting edge neurological research is beginning to show to what extent trauma affects us on a biological and hormonal basis as well as psychologically and behaviorally. Research suggests that in trauma, interruptions of childhood development and hypervigilance of our autonomic systems are compounded and reinforced by significant changes in the hard-wiring of the brain.

This may make it even more challenging (but not impossible) for survivors of childhood trauma to learn to do things differently. But it may also hold the promise of pharmaceutical interventions to address the biological/chemical effects of child abuse.

So, as scientists learn more about what trauma is, we are seeing see that it is truly a complex mixture of biological, psychological, and social phenomena.

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