CHAPTER 10 TRAUMA

"Trauma is the public health crisis of our time" - Bruce Perry

Finally, trauma has been getting the attention it deserves over the past decade. Historically this has not been the case. It was not until 1968 that PTSD, the diagnosis most synonymous with trauma, was officially designated a diagnosis. Prior to that it was called to as "shell shock," a military term used in World Wars I and II. We now how much PTSD and other forms of trauma affect people in profound and beguiling ways.

Trauma is closely affiliated with anxiety, as anxiety is a primary manifestation of trauma. Severe anxiety can be traumatic, like when someone has a panic attack. PTSD was officially an anxiety disorder until DSM V; now, trauma disorders have their own chapter in the DSM 5. I used to think that PTSD needed to remain an anxiety disorder, but after reading much more extensively about trauma, it makes sense that the two are separate. While trauma has numerous variations, anxiety has more comprehensive sources and can be a creator, magnifier and reinforcer of traumatic events.

TRAUMA AND STRESS

Trauma is directly correlated with stress, and the following are the different types of pronounced stress:

- POSITIVE STRESS, or EUSTRESS, is healthy and necessary and results from age-appropriate challenges from toddlerhood onward when we begin exploring the world, walking and talking, and trying to get our wants and needs met. Normal challenges like these provide opportunities to accomplish important milestones in life

and usually lead to success and of mastery that is important for a good sense of self-esteem.

- TOLERABLE STRESS, or DISTRESS, may result from more significant stressors such as a major health issue, death of a loved one, or other jarring emotional experiences like eviction or divorce. When these stressful experiences are managed well, they can result in successful outcomes and culminate in "stress-induced resilience" that helps prepare people for more serious and complex difficulties. People need to draw on their past successes when facing the continual challenges that life supplies.
- TOXIC STRESS develops from more intense, consistent and/or prolonged major stressors such as emotional or physical neglect, physical or sexual abuse, poverty, death of a loved one, manmade or natural disasters, or other high-stress experiences.
- TRAUMATIC STRESS consists of extreme types of toxic stressors resulting form of either a horrendous singular incident that is psychologically upending, life-threatening or severe ongoing psychological and physical stressors that have a profoundly negative cumulative effect.

Listed below are the specific types of stress "exposure" that help clarify the different categories of effects one has experienced:

- DIRECT is when a stressful incident happens to you.
- SECONDARY is when the stressful incident happens to someone else, you witness it, or are somehow indirectly affected by the incident in some meaningful way.
- ACUTE is a one-time event that is severe and correlated mostly with toxic or traumatic stress.
- CHRONIC is ongoing and representative of either tolerable or toxic stress, although it can occur with traumatic stress too.

Acute and chronic are often regarded as opposite types of stressors in terms of time span and intensity. Direct and secondary can occur independently or in concert with one another.

Both stress and trauma share the same language, as evidenced most vividly in the term traumatic stress. However, a stressor is an actual event, and stress is what one experiences during the event, which often means a triggering of the sympathetic nervous system. Trauma is the residual effects of significantly stressful or outright traumatic events. The full fallout after a traumatic event can take weeks, months, years, or decades to play out. When I talk to patients about trauma, I share with them how *The Iliad* is actually a metaphor for PTSD; when people are in crisis, they are in survival mode in order to get through the crisis (the war), and only after one has had enough distance from the event does one have a chance to process it (the trials and tribulations the crew had to deal with on the way home).

People experience events differently for numerous reasons, temperament and experience being primary factors. What happens to a person matters, but what happens after an event can matter even more. The evidence for this statement seems clear; if a traumatic stressful event occurs and the "victim" receives enough physical, emotional, legal and financial support, they may only experience minimal residual trauma, whereas if a milder event occurs and a "victim" gets no support, or worse, is disregarded or denigrated, they may experience compounded residual trauma. (FYI: I put the word victim in quotes due to different perspectives and implications of the word.) Part of this dynamic reflects how critical human connection is to each of us; empathy and compassion can minimize the fallout of major events and keep seemingly minor events in life from dominoing into an unnecessarily worse outcome.

FORMAL TRAUMA DIAGNOSES

Below are the official trauma diagnoses listed in the DSM 5:

POST-TRAUMATIC STRESS DISORDER (PTSD) - Defined in the DSM V through the following criteria:

A. Directly experiencing, witnessing, learning of a loved one experiencing, or indirect exposure to death, threatened death, actual or threatened serious injury or actual or threatened sexual assault.
B. Intrusive symptoms of emotionally painful memories, flashbacks, nightmares, emotional or physical reactivity to triggers associated with the original stressor (e.g., watching something on TV, hearing a similar sound or spoken phrase).
C. Avoidance of thoughts, feelings or direct or indirect external associations with the original stressor.
D. Negative changes in thoughts or moods: repressed memories of the event; overly negative thoughts or beliefs about oneself, other people or life in general; excessive blame of oneself or others for causing the trauma; negative affect (depression being a prime example); anhedonia; feeling isolated; difficulty experiencing positive emotions.
E. Changes in arousal and reactivity: increased hyper-vigilance, startled reaction, irritability or aggression, risky or destructive behavior, poor concentration, or trouble sleeping. One of each criterion is required (except two for D and E is optional). Symptoms must last a month and result in impaired functioning in relationships, at work, or normal enjoyment of life. (Please see the formal DSM listing for complete details.)

- Dissociative Subtype of PTSD is diagnosed when an individual meets all diagnostic criteria for PTSD and also exhibits depersonalization or derealization.
- PTSD with Delayed Expression is diagnosed if full diagnostic criteria are not met until at least six months after exposure to the traumatic event.

ADJUSTMENT DISORDER is when someone experiences a change in their life that typically results in some anxiety such as a new job, move, or relationship ending. Symptoms usually includes insomnia, perseverating on the problem, etc. to a normal degree under the circumstances for most people. Adjustment Disorder include the

qualifiers "with anxiety," "with depressed mood," "with mixed anxiety and depressed mood," "with conduct," "with mixed emotions and conduct," "unspecified." Adjustment Disorder with Anxiety is characteristic of normal anxiety to one's changing circumstances. Most significant changes in life take three months to a basic sense of a new situation, six to feel settled to a good degree, and twelve months to fully acclimate to. One interesting, sometimes powerful, and not uncommon version of this diagnosis that falls under "with anxiety" is "Imposter Syndrome" a non-diagnosable condition whereby someone is hired at a new job or given a promotion and the person feels as though they are not competent enough for the position. This results in significant self-doubt about one's abilities to do the job properly and thoughts of oneself being a fraud or having conned others into believing in them run rampant. It is quite challenging to contend with this negative mindset while one is acclimating to new coworkers, protocol and environment. It is related to performance anxiety, and, unfortunately, a lot of people are unaware of how common and normal it is.

ACUTE STRESS DISORDER (ASD) shares the majority of symptomology as PTSD but the onset is usually much quicker for ASD (within a month) versus PTSD (within a month to several months or years after) and duration, at least 3 days to no more than a month for ASD versus at least a month and potentially limitless for PTSD. ASD can officially change into PTSD after a month, and they oftentimes do follow one another in this succession but not always. ASR, as noted by Tobias Nolte and colleagues in their article "Anxiety Disorders and Developmental Attachment,""is defined as a transient normal reaction to traumatic stress and is not a DSM-5 diagnosis, although symptoms may be temporarily debilitating…In most cases, symptoms will resolve rapidly with simple measures, such as reassurance, rest, and ensuring safety…Combat and operational stress reaction (COSR) is the military analog of ASR."

REACTIVE ATTACHMENT DISORDER (RAD) is a distinct disorder caused when a child is physically or emotionally abused or severely neglected. This diagnosis is based

on attachment theory and represents Anxious-Avoidant attachment. A classic example is children in orphanages who were technically cared for with food and shelter but not emotionally attended to. Children from multiple foster homes or refugees are also prone to developing the condition. The child does not come to expect care or comfort form a stable attachment to caregivers, and problematic behaviors can include defiance, impulsivity, manipulative behaviors, self-harm, and physical aggression, sometimes serious, within the home. RAD and Borderline Personality Disorder (BPD) are similar. RAD is considered the child/teen diagnosis while BPD is the adult version since a personality disorder cannot be diagnosed until age 18.

DISINHIBITED SOCIAL ENGAGEMENT DISORDER (DSED) - A rare and distinct disorder in early childhood related to problematic attachment. It is considered the opposite of RAD in that children with DSED exhibit disinhibition or complete lack of caution where it is natural and advised to be cautious.

OTHER SPECIFIED TRAUMA AND STRESS-RELATED DISORDER also known as Subthreshold PTSD, Partial PTSD or Subsyndromal PTSD is a diagnosis used by clinicians to characterize individuals with clinically significant post-traumatic reactions who fail to meet full PTSD criteria (often for lack of one or two symptoms).

UNSPECIFIED TRAUMA AND STRESSOR-RELATED DISORDER is used when none of the above diagnoses applies but there are still significant symptoms warranting a formal diagnosis.

INFORMAL TRAUMA DESIGNATIONS

Below are trauma designations not listed in the DSM 5:

COMPLEX TRAUMA aka COMPLEX PTSD is defined by The National Child Traumatic Stress Network as "both children's exposure to multiple traumatic events - often of an invasive, interpersonal nature - and the wide-ranging, long-term effects of this exposure. These events are severe and pervasive, such as abuse or profound neglect. They usually occur early in life and can disrupt many aspects of the child's

development and the formation of a sense of self" (Complex Trauma). I think of complex trauma as having several layers of factors with multiple forms of trauma (e.g., child sexual abuse with the home has different trust, safety, role and physical issues along with PTSD, institutional and developmental trauma, with possible generational and secondary trauma). Complex Trauma is not limited to childhood, and adults can be just as prone to it depending on factors of temperament, history and support. In addition to meeting full PTSD diagnostic criteria, those suffering from Complex Trauma exhibit a unique range of prominent emotional, cognitive, behavioral or interpersonal difficulties (as with RAD) and possibly even somatization (psychological problems that manifest in physical terms, such as chronic fatigue after the death of a loved one).

DEVELOPMENTAL TRAUMA is a relatively new term devised by Bessel van der Kolk, which shares many of the same characteristics as Complex PTSD, creating some confusion about these two terms. Developmental Trauma is gaining traction in psychology and should be included in the DSM. In her article "Developmental Trauma: How Useful is This Framework?", Catherine Frogley noted that "individuals exposed to multiple traumas in childhood frequently do not meet the criteria for a PTSD diagnosis…[so,] Developmental Trauma was introduced and intended to specify the impact of multiple childhood traumas…[and] for greater understanding, reduced stigma and better access to support." The main purported difference between Developmental Trauma and Complex PTSD is Developmental Trauma is the domain of children while Complex PTSD should primarily be assigned to teens and adults. Children are very different creatures than teenagers and adults as children have less developed abilities, agency, and access to resources, all of which make them much more vulnerable to trauma. Due to the cumulative ramifications of these very factors and the implications in treatment, the behavioral health field needs to continue to review and redefine trauma, one of the most demanding factors people have to contend with in life. Frogley noted there is criticism that Developmental Trauma would "overlap with

existing disorders such as Borderline Personality Disorder and Attachment Disorder, and thus undermine the existing structure" of diagnosing patients. However, I see Developmental Trauma as an umbrella category for more involved diagnoses such as eating disorders, OCD, perfectionism, RAD and BPD. In treating these disorders, one is primarily helping the present-day teen or adult reconcile with the wounded child from the past.

GENERATIONAL TRAUMA, also called Intergenerational Trauma or Transgenerational Trauma is trauma directly or indirectly passed from one generation to the next. In Claire Gillespie's article "What Is Generational Trauma? Here's How Experts Explain It," licensed clinical psychologist and parenting evaluator Melanie English explained, it "'can be silent, covert, and undefined, surfacing through nuances and inadvertently taught or implied throughout someone's life from an early age onward.'" Brutalities like war, domestic violence, abuse, racism and poverty contribute to generational trauma. A cruel insight in Gillespie's article was shared by Dr. Gayni DeSilva, who said, "'incest is often a traumatic experience which is repeated generation after generation" due to learned helplessness. The tragic outcome of repeating abusive behaviors from one generation to the next also fall under Complex PTSD or Developmental Trauma depending on the circumstances. Generally, people who have experienced trauma growing up either go in the opposite direction (e.g., the child of alcoholic parents who never touches alcohol) or mimic the same behaviors as an adult (e.g., girls witnessing their mothers being physically abused ending up in abusive relationships themselves). It is for all these reasons that teenage rebellion can be such a good thing, within reason. Adolescence is a time and accepted phase for young people to question the relevance of their parents direct or inadvertent influences in relation to who the teen is.

INSTITUTIONAL TRAUMA is when institutions, especially those established to be helpful, are abusive (e.g., systematic racism, abuse within the family or foster homes, the military providing inadequate services to scarred veterans, police brutality, Catholic

Church child sexual abuse, corrupt government entities). Abuse by supposedly good people, especially those one has trusted, embraced, supported or championed, can lead to an extreme sense of betrayal and crush one's worldview. Institutional Trauma has lead to untold amounts of Complex Trauma and Generational Trauma. Too many people, businesses, religions and government institutions still propagate racist, homophobic, misogynistic, and socio-economic biased agendas and policies. I believe that equal rights are the foundation to any good society.

SECONDARY TRAUMA is a common phrase used to characterize the immediate aftereffects of witnessing traumatic events or the cumulative effects of witnessing the aftermath of multiple traumatic events. While allowed for within the criteria of PTSD, Secondary Trauma is a necessary term and distinction in and of itself because the term allows for proper recognition of the issue, a greater understanding of the residual effects of trauma, and an appropriate approach to treatment. Military personnel, police officers, firefighters, EMTs, ER personnel, corrections officers and others regularly exposed to the aftermath of physical and emotional carnage without realizing the incredible toll it may take on them on deep psychological levels. Unbeknownst to the individual, the accumulation of disturbing experiences results in severe distress that play out in poor behaviors. Unhealthy attempts to cope, like relying on alcohol to self-medicate, only exacerbate matters and alcohol then becomes a comorbid problem for the first responders and their families.

Complicating matters, first responders have a camaraderie that demands a certain bravado, thus making it challenging to express unease about witnessing horrifying events without betraying the unwritten code of toughness. Luckily, this is now being addressed more directly in these professional departments around the country. I worked with a firefighter who was mandated for treatment due to a domestic violence charge involving alcohol. His department supported him as he addressed his

AODA issues and better ways to cope with his secondary trauma, which he recognized as the underlying reason he drank and was hostile towards his family.

Secondary trauma can also be indirect. During 911, people in NYC were inundated with powerful burning odors, witnessed live events on TV, and saw posters of missing people plastered near hospitals afterward. Stimuli surrounding a major catastrophe like these grab people's attention and affect people's mood and general sense of the world. Our nation annually recognizes the tragedy of 911, and anyone who was an adult at the time can tell you where they were and what they were doing when they first heard the news.

MORAL INJURY is a new concept that is taking hold that is comprised of three distinct versions of trauma associated with crimes against humanity: "Moral Witness" in which one has witnessed an atrocity; "Moral Trauma" is when one is the actual victim; "Moral Offense" means one is the perpetrator. Of course, one can experience two or more of these aspects. This issue is taking hold with veterans in books like *Odysseus in America: Combat Trauma and the Trials of Homecoming* by Jonathan Shay. Unfortunately, there are so many complicating factors for veterans contending with PTSD that treatment necessitates an experienced specialist who understands the implications of military indoctrination and protocol. The bonds developed with peers under extreme stressors (e.g., monotony, unpredictability, danger), and the major disconnect between war-zone and civilian life are also complicating factors.

COMPASSION FATIGUE is the emotional equivalent of secondary trauma and is something therapists and other empathic professionals need to be aware of and guard against. Compassion fatigue is less threatening subconsciously, as one isn't witnessing violence, mutilation or death, but hearing brutal stories of abuse while absorbing the stirring outpouring of the emotional upheaval from a patient is both challenging and draining. This dynamic is exacerbated when mirror neurons in the brain of an empathic professional mimic the feelings of the patient/client sharing their emotional pain, which

is even more relevant for highly-sensitive individuals, as was the case for me. As an outpatient therapist working for a demanding and apathetic corporate healthcare behemoth, I lived on the edge of burnout for five years straight, and it finally took a toll on me physically despite utilizing multiple healthy coping skills regularly.

QUALIFYING AND EVALUATING TRAUMA

Clarifying different types of trauma is necessary given the history of people, especially children, being misdiagnosed with a wide range of disorders, including anxiety, depression, ADHD, oppositional defiant disorder, and mood disorders, when, in fact, the underlying issue is trauma. It makes sense that such a pattern would occur given our still-evolving integration of trauma-informed care and how the cognitive, emotional and behavioral manifestations (e.g., anxiety, depression, impulsivity, emotional dysregulation, and dissociation) of trauma mimic these disorders.

As a clinician, I look back on my work with people over the years and recognize patients who struggled with misdiagnosed trauma, such as the adopted teenager diagnosed with bipolar. At the time, her behaviors didn't seem to make sense, and the multiple mood disorder medications seemed utterly ineffective. However, after gaining more insight into attachment, trauma and adoption (especially when race is also a factor), I see how her trauma was announcing itself.

One needs to be clear which form of trauma one is contending with, overt (primarily physical) or covert (emotional). Even though overt trauma may be more brutal in the severity of physical pain or damage, covert trauma can be more insidious and difficult to reconcile. An overt traumatic event, such as assault, rape, kidnapping or war, is concrete in terms of being “bad” or “wrong.” Since overt trauma is an obvious negative external event, it is ego-dystonic, which is in opposition to one's self-concept - “I am a good person and did not deserve to be robbed at gunpoint,” except when others pointedly blame a child for deserving the mistreatment. Being clearly grounded as

undeserving of abuse limits or precludes "victims" from blaming themselves, making it much easier for people to seek and receive support or treatment.

Covert trauma can play out in a variety of incredibly subtle ways:

- Body language (e.g., disbelieving eye rolls)
- Other non-verbals (e.g., exasperating sighs)
- Non-action (e.g., a parent not taking an active interest in who their child is as a person, what their strengths are, or what is happening in their life)
- Even well-intentioned acts that disregard a child's sense of ability or potential (e.g., telling a girl that girls shouldn't try talking about football because it's a guys sport) can be the equivalent of minimizing her voice, intelligence, confidence and sense of agency

The psychological damage from these types of incidents and can not only be real but vexing as noted in Traci Pedersen's article "Witnessing Parental Psychological Abuse May Do More Harm Than Physical Abuse" which quoted Dr. Catherine Naughton of The University of Limerick's Department of Psychology, "Psychological domestic abuse when it occurred alone seems to be the most damaging, perhaps because people are unable to recognize and speak out about it." Secondary trauma of witnessing physical or emotional abuse, especially to a primary caregiver, can result in similar outcomes as direct trauma, and to a greater degree the younger the child. When the perpetrator is also a primary caregiver, the child's internalizers mixed messages can become confusing, conflicted and destabilizing.

Because covert trauma is more subtle and, consequently, less consciously recognizable as a valid problem, more easily minimized or outright dismissed as typical, people often don't consider receiving support or seeking treatment. With covert trauma, people accept and integrate the self-deceptive narrative of minimizing and dismissing, thus making it ego-syntonic. Ego-syntonic problems sync with one's self-concept, making a negative perspective about oneself easier to infiltrate one's

insecurities and reinforce poor self-esteem. Not only are younger children especially vulnerable to these dynamics as they are less apt to be consciously aware of the context of a given problem, but they are also ego-centric meaning they think they're responsible for everything that happens to themselves and, oftentimes, to other people too. So, children can feel doubly responsible for negative events within the home, especially to a primary caregiver they are closely attached to. And, if the child has other risk factors like a highly-sensitive personality or a depressed or otherwise unavailable caregiver, it can contribute to the child being even more prone to internalizing guilt or shame. From there, it's just a hop skip and a jump from self-blaming to self-shaming to an entrenched inferiority complex, which is the cruelest mindset in life.

Covert trauma is like an invisible assassin as it does not usually announce itself consciously until adulthood. Without treatment, direct and indirect signals like emotional dysregulation, relationship problems and compulsive behavior get louder and louder as one ages. The trauma flies under the radar until the poor coping or desperate avoidant techniques people unconsciously use finally cause enough problems to necessitate a person recognizing a definitive need to change. Unfortunately, by then, the poor mindset and habitual tendencies of the residual trauma are defining parts of one's persona; one is so used to it, because one has been this way seemingly forever and there has not been enough to dissuade residual trauma from perpetuating outdated defense mechanisms. These neural pathways get reinforced, making the predisposition towards reflexive negative self-regard more habitual.

Having a general idea of who might be contending with trauma and to what degree is critical in treatment. The Adverse Childhood Experience (ACE) Questionnaire is utilized in treatment to better capture the extent and severity of trauma that people have experienced. However, I find the ACE questionnaire too "quick and dirty" to understand the degree someone is contending with trauma. Following is a more thorough accounting of the mitigating circumstances of trauma:

- Is your culture a factor? If so, in what ways and how should this inform treatment?
- Was the event accidental or intentional?
- Was it random or something that is a regular or common-enough life event, like a car crash in snowy conditions?
- Was it physical or emotional? And, to what degree?
- If both, which aspects were and have been difficult to contend with?
- One-time occurrence or prolonged series of traumas?
- Was the perpetrator a stranger, acquaintance, authority figure, friend, family member or parent?
- Did it happen in public, private or the family home?
- What had this place meant to you prior and then afterward?
- If in public, were there witnesses? If so, how did they respond?
- Were they people you know, and, if so, what did their reactions mean to you?
- If other people did not know, did you tell them?
- If not, what was the reason you chose not to tell them? If yes, how did they respond?
- Do your parents and other close people know what happened to you?
- If other people knew without you telling them, how did they respond?
- Did this change the way you think about people in general?
- How did this change the way you think about life and yourself in general?
- Are there past events this recent event triggered?
- How much does your temperament influence the way you experienced the event?
- How do you relate to what happened to you from your current position in life?
- Which of the following do you experience due to your trauma: sadness, anger, anxiety, blame, grieving, guilt, shame?
- Did you have treatment? If so, how soon afterward, and what was treatment like for you?
- How have you grown as a person from this challenging experience?

- What would you like to accomplish in treatment regarding this challenging experience?
- How will reconciling with this challenging experience help you now and in the future?

While all of these questions don't necessarily need to be asked in treatment, they are a resource to review how and why traumatic events are always so uniquely personal.

The good news is there is a Resilience Questionnaire that helps people examine their psychological resources they have to counterbalance the effects of trauma, which is essential because when people are in crisis or working through their trauma they tend to focus on the problem and not their strengths, experience and resources. Resilience factors such as core beliefs, values, mindset, personality, expectations, and even physical appearance contribute to how well people can cope with trauma over the long-term. "Cope" is the operative word because trauma is never "healed" or "goes away." People can only learn how to live with, reconcile or integrate trauma in ways that minimize the after-effects, which, in turn, allows them to embrace life as much as possible.

To put the experience and aftermath of trauma in proper perspective, I tell my patients, "What happened to you or how you handled it at the time does not define you. Nor is how it affected you or the problematic attempts to cope with it since indicative of your true character or potential." It's a long and hard road out of the dark tunnel of trauma, but people can and do make it out and into the sunshine. As someone who has made that journey, I can tell you the process wasn't fun or easy. However, I will testify that it was definitely worth all the determination, honesty, effort, money, frustration and creativity it took. The feeling of liberation was intoxicating and enlivening, and the sense of ongoing peace is reassuring and powerful. I can finally focus the majority of my energy on what I believe is meaningful without background hyper-vigilance and energy drain. The day-to-day benefits are amazing as I feel like a new person, and life

is a much better and even experience. And the best part is knowing that I accomplished this Herculean task and get to own it forever.

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