There are two basic categories of trauma:

- **natural disasters** ("caused by nature"): hurricanes, floods, tornadoes, earthquakes . . .
- **human-induced** (humans cause or are associated with a trauma, i.e., sexual assault, incest, war, traumatic accident, traumatic disabling injury, technological disaster, terrorist acts . . .

There are two major differences between survivors of natural disasters vs. human-induced trauma. Natural disaster survivors, in contrast to human-induced trauma survivors):

- rarely are blamed by others for having been in the trauma in the first place
- rarely blame themselves for having been in the trauma. (unless, for example, they ignored order to evacuate and then something bad happened)

Historically, survivors of human-induced trauma have been plagued by denial, silence, isolation, self-blame and scapegoating (e.g., "victim bashing"). At the core of the problem:

- the long-standing denial of the extent of the prevalence and incidence of human-induced trauma (i.e., child abuse and domestic violence, sexual assault)
- the "collusion of sanitization and silence" about the longer-term impact of human-induced trauma (i.e., war, adult survivors of childhood incest) (Scurfield, 1992), and
- the historic argument in mental health: was post-trauma symptomatology explained primarily by:
  - (a) etiological (individual) factors, such as early childhood conflicts, pre-existing personality vs.
  - (b) environmental factors (nature/severity of the trauma exposure rather than pre-disposing factors.

Not until the Diagnostic and Statistical Manual of Mental Disorders, Volume III (1980) was it officially recognized that anyone could be impacted shorter- or longer-term following exposure to a severe enough stressor----regardless of his or her (pre-morbid) background.

- This recognition culminated decades of controversy re the inadequacy of existing diagnostic categories and prevailing personality theory to explain the psychiatric sequelae manifested by large numbers of survivors exposed to war (among both military and civilian personnel) and railroad/industrial accidents.
- Viewpoints converged, heightened by large numbers of "delayed stress" Vietnam veterans, and greater awareness of the extent and impact of sexual and physical abuse and assault.

**Post Traumatic Stress Disorder diagnostic criteria** (DSM-IV-TR, 2000):

- The person is exposed to a traumatic event in which both of the following are present
  - (a) The person has experienced, witnessed, or been confronted with an event/events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others;
  - (b) The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.
- The inclusionary symptoms are persistent & occur sometime following exposure to the trauma (note that only re-experiencing symptoms are unique to PTSD:
  - (a) re-experiencing of the trauma in some way: intrusive recollections, thoughts, dreams, reactivity to external or internal cues that symbolize or resemble the event....
  - (b) avoidance of stimuli associated with the trauma; numbing of general responsiveness, denial. .
  - (c ) increased arousal: hyper-vigilance, startle response, sleep disturbance, anger outbursts . . .
NOTE: *DSM-IV-TR*, pp. 465-66) identifies *distinctive symptom clusters* for two populations—in children, and *in such chronic interpersonal stressors as childhood sexual or physical abuse & domestic battering* [This is in contrast to single-event or more shorter-lasting trauma]: impaired affect modulation; self-destructive & impulsive behavior; dissociation; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; hostility; impaired relationships, change in personality characteristics . . . I would contend that *prolonged combat exposure* fits these criteria.]

**“Associated Features of PTSD”:**
[It is important to note that critics contend that several of the symptoms listed in the expanded “Associated Features” should be part of the required inclusionary criteria.] *DSM-IV-TR* has 24 lines of text describing various associated features, such as (p. 465):

“Individuals with PTSD may describe guilt features about surviving when others did not survive or about things they had to do to survive. Avoidance patterns may interfere with interpersonal relationships and lead to marital conflict, divorce or loss of job. Auditory hallucinations and paranoid ideation can be present in some severe and chronic cases.”

“PTSD is associated with increased rates of Major Depressive Disorder Substance-Related Disorders, Panic Disorder Agoraphobia, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Social Phobia, Specific Phobia and Bipolar Disorder. These disorders can either precede, follow or emerge concurrently with the onset of Posttraumatic Stress Disorder.”

Finally, additional associated laboratory findings, physical examination findings and general medical conditions have been added to the PTSD section, to include: increased arousal of autonomic functioning, e.g., heart rate, electromyography, sweat gland activity; that physical injuries may occur as a direct consequence of the trauma; and that chronic PTSD may be associated with increased somatic complaints and, possibly, general medical conditions.”

[Note: *Chronic PTSD almost never exists as the only mental health condition* in a trauma survivor. Rather, if you see someone who has had significant PTSD for a considerable period of time, it is the rule rather than the exception that the survivor has psychiatric symptoms and/or conditions in addition to those of PTSD. The key issue is: what is the “core disturbance” for such persons that should be the focus of interventions versus what are associated or secondary conditions . . .]

**Common Factors That May Trigger Re-Experiencing of the Original Trauma (see Scurfield & Platoni, “Warning Signs, Triggers, Survival Strategies & Coping From War”).**

In this handout I want to emphasize one set of powerful triggers: *dynamics related to earlier life trauma that may interact with subsequent reactions to a current, additional or recurring trauma* (ex: cult survivor in Hawaii). Let’s take the example of our reactions or non-reactions to 9/11. Dynamics related to pain and loss from trauma experienced *prior* to 9/11 might have interacted with our reactions to the trauma of 9/11 and/or with subsequent post-9/11 trauma, i.e.:

- A preoccupation with past hurt may have *totally or partially eclipsed* reacting to 9/11
- An *alternating preoccupation* between reactions to pre-9/11 and current 9/11 reactions
- A *convergence* of feelings and thoughts from both pre-9/11, 9/11 and post-9/11 trauma
- A *heightened “anniversary reaction”* to a trauma prior to 9/11 that happened at the time of 9/11
There are at least ten categories of exposure to trauma (Scurfield, 1994)
Please note that: (1) each of the following categories of exposure tends to elicit specific sets of symptoms and (2) it is not unusual for the survivor to have experienced combinations of two or more categories of trauma exposure within the same traumatic event (and to require therapeutic attention to each)

- Bereavement: (traumatically-induced) loss of significant other (typically elicits symptoms of grief and loss, and of rage/anger)
- Physical injury or disability: traumatically-induced (typically elicits symptoms of fear of repetition of the event, and feeling responsible for having been injured in the first place, and of rage/anger)
- Agent or perpetrator of trauma onto others: duty-related (i.e., law enforcement, military); other (i.e., driver in a fatal vehicular accident)
- Self-inflicted: accidental or purposeful (to include substance abuse)
- Witness, observer or by-stander: "watching from a distance" as trauma is happening to others and either unable or unwilling to assist or prevent it (i.e., Katrina and September 11th resulted in millions of people witnessing the terrorist acts and carnage via repeated and prolonged television and other media accounts)

[Film clip, part 1]: Vietnamese woman exposed to both witnessing and responsibility-based trauma

- Exposure to death and dying: merely" being around" death and dying, i.e., emergency medical techs, body handlers, relief workers & survivors at technological or natural disasters
- Responsibility-based: indirect or sense of responsibility for trauma having occurred to others
- Prolonged and severe trauma: sustained childhood sexual abuse, family violence, hostage or prisoner-of-war, torture conditions, recurring combat conditions [Psychological sequelae of exposure to such trauma is inadequately addressed in the DSM & a new diagnostic category has been proposed----Disorders of Extreme Stress Not Otherwise Specified or DESNOS]
- Pervasive exposure to "insidious" cumulative & repetitive stressors; while threatening, discriminatory or violent, such exposure might not result in a discrete catastrophic traumatic event per DSM-IV. Such cumulative and repetitive exposure may be:
  (a) race-, gender-, disability-, nationality-, politically-, sexual preference-, or religion-based, or
  (b) infused in the milieu of a threatening, violent or randomly violent family/home or community
- Secondary or "vicarious" traumatization (a.k.a. "compassion fatigue")----through intimate or repeated exposure (by clinicians, care-givers) to others who had been directly exposed to trauma.

Problematic Aspects of PTSD Diagnostic Criteria in the DSM-IV-TR

- DSM-IV-TR diagnostic criteria tend to label normal post-trauma reactions as “disordered”; i.e., is the impact of war being described as PTSD oftentimes really a disordered—or a natural and understandable--reaction to being immersed in war-trauma for months or years?
- Core inclusionary PTSD diagnostic criteria also are fundamental, functional modes of coping with trauma and its aftermath, i.e., detachment, minimization, denial, hyper-alertness/arousal, experiencing the environment as surreal/distrust of environment.
- It is inherently artificial and arbitrary to have a categorical (versus a continuum or dimensional) mode of diagnosis for PTSD, e.g., how and where does one draw the line between what is within a “normal and expectable” range of reactions versus a “disordered” reaction?!
- The very definition of what is a trauma was dramatically expanded in DSM-IV to include many ordinary events that can precipitate stress reactions; are characteristic reactions to death of a loved
one, assault, family violence, abuse and harassment necessarily symptoms of a mental disorder? (Kutchins & Kirk, 1997).

Critical symptoms are missing from the DSM-IV-TR (Scurfield, 1993; 1994; 2006b):
- **Damaged self**: denigrated, disordered & fragmented identity, self-hatred, affective instability
- **Existential malaise**: the "broken connection" (R.J. Lifton, 1979), one’s life is out of orbit . . .
- **Disconnections** between cognitions, affect, physiological responses and environmental cues
- Pre-occupation with blame: externally and/or internally directed
- Pre-occupation with fear of *loss of control* over affect and behavior (for a very small minority of trauma survivors, there has been a history of *actual* loss of control)
- The central role of *rage, grief, and terror/fear* (Scurfield, 1993)

The Difference B/W PTS and PTSD (my opinion): It must be based on *functional impairment*, not the presence or absence of DSM symptoms: symptoms are “out of control”, significant daily dysfunction.

Phases of trauma survival (symptoms from each phase may persist into subsequent phases):
- **Immediate**: shock, overwhelmed, panic, dissociation, exhaustion, numbness, fear, confusion, denial; possibly becoming very task-oriented and busy, staying on an emergency survival mode
- **One week to several months**: The survivor manifests post-trauma changes in behaviors and/or emotions/cognitions that are *in contrast* to the survivor’s status *before* the identified trauma:
  a. **physiological** indicators (changes in appetite, digestive problems, headache, other bodily pains, sleeping problems; depression/apathy)
  b. **intrusive** symptoms (recurring painful memories, nightmares, inability to forget, helplessness, anger, suspicion/fear of the environment, irritability; continuing confusion;)
  c. **denial/isolation** (isolation, withdrawal from friends/family/activities that previously were pleasurable; anxiety or preoccupation about the future)
  d. **maladaptive avoidances**: emotionally unavailable, suicidal ideations, substance abuse, phobias, physically exhaustive behaviors, marked over-involvement in work/other activities.
- **Months-to-years**: strong feelings of disappointment, resentment, bitterness if aid and resolution not fulfilled; self-absorption to solve one’s individual problems and losing a sense of shared community. Sometimes assuming a primarily denial/detached mode as a characteristic life-style
- **Months, years or decades (if ever): reconstruction**: reaffirming belief in one’s own abilities and in community, learning how to *more peacefully co-exist* with unforgettable trauma experiences.

Emergency survival modes during actual trauma exposure. So as to *not* be overwhelmed psychologically and physically, the survivor engages in one or more of several survival tactics:
- Fighting or active survival actions (to eliminate or repulse the environmental threat)*
- Flight or escape (to remove oneself from the environmental threat)*
- Detachment and numbing (of feelings and responsiveness); dissociation*
- Cognitive reframing/redefinition
- Tunnel vision and rigid attention to task-completion
- Discharge emotions externally (rage, "gallows humor," sexual or substance abuse binging)
- Thrill/excessive-risk behaviors: the adrenaline rush addiction

[*Typical acute survival actions when exposed to trauma----versus protracted reactions.*]

Survival modes sometime following exposure to the trauma. The trauma is over, but the survivor makes a powerful, anguished discovery----"escape" from the original trauma is not entirely
accomplished. There is the emergence of painful and intrusive re-experiencing and accompanying arousal phenomena that provoke a "reliving" of the trauma in some way. This, in turn, provokes numbing and detachment (I call this the “push-pull” dynamic in trauma reactions.)

- Re-experiencing and arousal symptoms occur along a frequency, duration and severity continuum.
  *The mildest end: symptoms are very infrequent, momentary (split-second) and minimally intrusive;
  *The most severe: symptoms are frequent, last for seconds/minutes/hours, and/or are markedly intrusive----to include dissociative episodes. [Also, severe trauma may engender or be associated with borderline personality features or multiple personality disorder.]
- The emergence of re-experiencing and arousal symptoms results in the "push-pull" that is the central dynamic of PTSD: the survivor engages in numbing, detachment, denial and avoidance, alternating with re-experiencing and arousal (Scurfield, 1994, 2004):
- The dominant post-trauma survival mode typically is similar to survival tactics utilized during exposure to the original trauma----oftentimes primarily detachment, or detachment alternating primarily with rage, re-enactment, grief or chronic anxiety; on others—acting out behaviors.

[Film clip, part 2]: Demonstrates numbing as a defense, what happens when the numbing starts to "thaw" and the issue of forgiving the perpetrator--and no, it is not necessary to forgive a perpetrator to be able to heal from the trauma----but it is necessary not to be consumed with hatred.

Oftentimes in contrast to the treatment goals of clinicians or family members, trauma survivors can become very resistant or ambivalent to “giving up” some longer-term survival modes that they have been engaging in, i.e., hyper-vigilance, detachment/emotional numbing and isolative life styles. Such survival modes may have “become trusted companions” that the survivor has become familiar and comfortable with, and/or are perceived as necessary to (1) survival in what continues to be seen as an unpredictable, cruel or dangerous world or (2) keep disturbing trauma-related memories from re-emerging.

The Two Central Post-traumatic stress treatment principles:
Intervention strategies are fundamentally affected by whether the trauma survivor is more in the (1) intrusive, hyperarousal and/or dissociative phase of symptom presentation--intervention strategies focus on helping to stabilize and “ground” the survivor in the present, reduce acutely exacerbated and painful emotions and memories, and minimize acting out or self-destructive behaviors; or is more in the (2) denial, numbing, avoidance phase of symptom presentation--intervention strategies focus on helping to foster the survivor to recognize detachment and numbing dynamics, the pros and cons of such dynamics, and how or if he/she might choose to get in touch with underlying emotions and thinking that are being suppressed or avoided.

Secondly, almost all accepted PTSD treatment approaches involve: therapeutic re-experiencing of an aspect of the original trauma in some way (Fairbank & Nicholson, 1987).