

**TRAUMA COUNSELLING: A COMPREHENSIVE OVERVIEW  
FOR UNDERGRADUATE AND GRADUATE STUDENTS**

by

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## ABSTRACT

Throughout the literature on trauma, various researchers have pointed out the necessity of incorporating trauma education into academic settings. The purpose of this project is to present a comprehensive overview of trauma counselling to undergraduate and graduate students. The twelve sections encompassing this project are the following: (1) What is trauma? (2) Posttraumatic Stress Disorder (PTSD) and symptomatology; (3) Complex Trauma in adults and symptomatology; (4) Complex Trauma in adolescents and children; (5) Assessment of PTSD and Complex Trauma in adults, adolescents, and children; (6) PTSD modes of treatments; (7) Phases of treatment for PTSD and Complex Trauma; (8) Culture and trauma; (9) Historical Trauma; (10) Intergenerational Trauma; (11) Secondary Traumatic Stress, Vicarious Traumatization, and clinician self-care; and (12) Coping strategies and Posttraumatic Growth. This project ideally will prepare future clinicians to effectively deal with trauma issues in their clinical work and, ultimately, to provide quality services to trauma survivors.

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## DEDICATION

I wish to dedicate this project to my mother, father, son, and partner.

To my mother, who has relentlessly promoted education as one of the most important values to pursue in life. My mother gave me the courage to embark on a Master's degree at 40 years-old.

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## **Introduction**

The prevalence of trauma in human's lives brings a necessity for mental health professionals to be adequately prepared to effectively work with clients presenting trauma history. The purpose of this project is to present a comprehensive overview of trauma counselling to undergraduate and graduate students on the route to becoming future clinicians.

As noted by Courtois (2004), "a large number of individuals seeking mental health treatment do so for the direct or indirect consequences of traumatization at some point in their history" (p. 415). In their study involving a national survey of 500 randomly selected American psychologists, all of whom were members of the American Psychological Association (APA), Pope and Feldman-Summers (1992) reported low scores when participants were asked to rate their training in graduate programs relative to their readiness in dealing with issues of abuse. Correspondingly, these participants felt poorly prepared to address cases of abuse and rated themselves as only "moderately competent" to give services to survivors of abuse (Pope & Feldman-Summers, 1992, p. 355). What seems to emerge from this study is that not only is there a lack of training in trauma related issues, but also a lack of preparedness to effectively address clients' needs in service delivery. This raises the following question: Had these participants been enrolled in a trauma course, would they have been better prepared to address trauma cases?

The importance of incorporating trauma education into academic settings, at the undergraduate or graduate levels, is paramount and has been recognized throughout the field of traumatology (Alpert & Paulson, 1990; Courtois and Gold, 2009; Figley, 1995;

Graziano, 2001; McKenzie-Mohr, 2004; O'Halloran & O'Halloran, 2001). It is in the context of this highlighted need for trauma theory and practice in professional curriculum that my project originates, aiming at helping future mental health professionals to become not only knowledgeably competent about trauma but also better prepared to address trauma issues in their daily work.

This comprehensive overview of trauma counselling includes twelve sections surrounding the phenomenon of traumatization. The fundamental concept of trauma is first explored, with an emphasis on its definition in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000). Next, Posttraumatic Stress Disorder (PTSD), a set of symptoms experienced by some individuals in the aftermath of psychological trauma, is examined as well as its characteristic clusters of symptoms. Because the symptoms of PTSD are mostly related to a single traumatic event, they do not represent the complexity of symptoms experienced by trauma survivors due to ongoing acts of traumatization happening over a long period of time and generally within the sphere of specific relationships (Briere & Spinazzola, 2005; Courtois, 2004; Herman, 1997). Therefore, Complex Trauma or Disorder of Extreme Stress Not Otherwise Specified (DESNOS; APA, 2000) has been attributed a specific section. During the completion of this comprehensive overview, I realized how incomplete this work would be without a special consideration given to Complex Trauma in children and adolescents. As such, the fourth section aims at developing a better understanding of the various domains of impairment resulting from repeated acts of traumatization to those who most deserve adults' protection, understanding, and love.

The first four sections of this handbook represent the foundation for the investigation of the various modes of assessment and treatment for both PTSD and Complex Trauma. The subsequent sections of this work present various modes of assessment and treatment available for clinicians in their therapeutic encounters with trauma survivors.

In the following part of this journey on trauma counselling, I invite readers to view trauma from a collective stance, by widening their knowledge relative to the consequences of trauma on a huge number of people across the globe. As such, it is first imperative to learn the influence of our Western culture on our current conception of trauma and the necessity for clinicians to develop effective cross-cultural competencies in the modes of assessment and treatment they use in their service delivery to trauma survivors from different backgrounds. Furthermore, the concept of Historical Trauma, a form of chronic and cumulative trauma passed on across generations by means of daily reminders of losses, is overviewed. Throughout the trauma literature, the concept of Historical Trauma and its underlying theory are mostly associated with the collective traumatic events experienced by First Nations, Métis, and Inuit in Canada as well as Native Americans and the Alaska Natives in the U.S. Because of the subtle ways by which trauma can invade people's lives, the concept of Intergenerational Trauma which refers to "the cumulative emotional and psychological wounding that is transmitted from one generation to the next" (Dass-Brailsford, 2007, p. 5) deserves mental health professionals' attention. Rooted in clinicians' observations of children of Nazi Holocaust survivors (Danieli, 1998), the transmission of the intergenerational consequences of

trauma are experienced by descendants of other massive traumas, including the African American enslavement and the Japanese American Internment (Dass-Brailsford, 2007).

Finally, the last two sections relate to the dangers and rewards for clinicians from working in trauma counselling. Making reference to the APA (1994) code of conduct, Munroe (1995) speaks about a “duty to warn” (p. 213) trauma professionals about the possibility of being harmed as a result of working with traumatized individuals. As such, the concepts of Secondary Traumatic Stress and Vicarious Traumatization are explained and the importance of self-care strategies for trauma counsellors is highlighted. As the consequences of Secondary Traumatic Stress and Vicarious Traumatization are destructive not only for clinicians, but also for the clients they treat, these concepts are paramount in trauma counselling. One of the newest additions to the field of traumatology is the exploration of Posttraumatic Growth. Defined as the profoundly transformative experience that trauma can be for some individuals, Posttraumatic Growth is explained in the last section of this handbook.

Before we embark on our learning process about trauma counselling, I wish to utter some words of caution. Various authors teaching trauma-related classes have pointed out the prevalence of trauma in their students’ lives (Alpert & Paulson, 1990; Graziano, 2001; McCammon, 1995; O’Halloran & O’Halloran, 2001; Pope & Feldman-Summers, 1992). For instance, O’Halloran and O’Halloran (2001) state: “We estimate that approximately 40% to 50% of our students mention their experience as survivors of trauma while relating how the lectures impact them” (p. 94). It is worthwhile to think about the many ways by which therapeutic encounters with trauma survivors can adversely be affected when mental health professionals are trauma survivors themselves.

More fundamentally, what if trauma survivors' clinicians are not offered an opportunity to deepen their understanding about trauma or to come to terms with the impacts of their own trauma in their personal lives? Therefore, it is my deep wish that an important contribution of this project will be to help students who are trauma survivors themselves not only to develop a better understanding about the effects of traumatization in their personal lives, but also to prevent their personal trauma from negatively impacting their future counselling practice. To conclude, I wish this comprehensive overview to be a template for students to build their confidence in their professional abilities to effectively deal with trauma issues when delivering services to trauma survivors.

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### Section 1: What is trauma?

This section explores the following topics: 1. Current definition of trauma in the DSM-IV-TR; 2. Major types of trauma; 3. Prevalence of trauma exposure in the general population; 4. Limitations of the trauma definition in the DSM-IV-TR; 5. Risk factors in the development of symptoms of PTSD following trauma; 6. Concluding comments.

#### 1. Current definition of trauma in Diagnostic and Statistical Manual of Mental Disorders

What is psychological trauma? This concept was first investigated in the mid-1890s by the French neurologist Charcot, followed by Pierre Janet in France and Sigmund Freud in Vienna, in the context of their clinical work with “hysterical” women (Herman, 1997). As noted by Herman (1997), hysteria, initially considered a “strange disease” thought to originate in the uterus, was later found to be the result of childhood traumatic experiences such as abuse, incest, and sexual assault. This primary encounter with psychological trauma and some of the symptoms of what is called today the Posttraumatic Stress Disorder (PTSD) diagnosis – a set of symptoms experienced by some individuals in the aftermath of psychological trauma – seems to have been a fundamental step in the recognition of the tremendous effects of traumatic events on human beings.

In her book *Trauma and Recovery*, Herman (1997) highlights the paramount importance of the political context in the emergence of psychological trauma into public awareness. She emphasizes “three separate lines of investigation” (p. 9), responsible for our current understanding of psychological trauma. First, she talks about the study of hysteria in the late nineteenth century in the republican political movement in France,

giving birth to the traumatic conceptualization of the causes of hysteria also called by Charcot “The Great Neurosis”. She then examines the prolonged exposure of soldiers to war atrocities, after the First World War and culminating after the Vietnam War, giving rise to the development of an antiwar movement in England and the United States. Finally, she recognizes the tragic presence of sexual and domestic violence in the daily lives of an outrageous number of individuals, in the context of the feminist movement spreading in North America and Western Europe.

As the definition of trauma is part of PTSD, it is of importance to briefly introduce this diagnosis. The first inclusion of the PTSD diagnosis into the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980 was guided by the work of Kardiner, an American psychiatrist working with trauma veterans during the second wave of the psychological trauma investigation previously discussed (Herman, 1997). In the 1940s, Kardiner developed the clinical profile of what we now understand as PTSD. As stated by Brett (2007):

The extreme complexity and subtlety of posttraumatic responses have been noted since Kardiner’s (1941) postulation of a two-stage response to trauma. In Kardiner’s description, the first stage is the core traumatic neurosis (what we now call PTSD). The second stage can have any diagnostic manifestation and is the personality’s adaptation to and reorganization in the face of its compromised functioning caused by the traumatic neurosis. (p. 125)

Noteworthy for our discussion, this primary inclusion of PTSD into the DSM as an independent diagnosis stemmed from the collection of various traumatic syndromes

already acknowledged in our contemporary society including the rape trauma syndrome, the battered woman syndrome, the Vietnam veteran's syndrome, and the abused child syndrome (van der Kolk, Weisaeth, & van der Hart, 2007). Even though these syndromes had been described quite differently from the resulting PTSD definition (van der Kolk et al., 2007), they had fundamentally the same features (Herman, 1997) and have consequently been subsumed into a unique syndrome: the Posttraumatic Stress Disorder. The growing acknowledgement of PTSD within American society gave rise to the recognition of this disorder in the world by the means of humanitarian and medical institutions (Breslau, 2004).

The most recent Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> edition, Text Revision (DSM-IV-TR; American Psychiatric Association [APA], 2000) presents PTSD as an anxiety disorder which can be developed when someone is exposed to:

- (1) a direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; (2) or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; (3) or learning about unexpected or violent death, serious harm, or threat of death or injury to a family member or other close associate (Criterion A1). (p. 463)

Furthermore, the individual's response to the traumatic experience must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (criterion A2; p. 463).

As can be seen, Criterion A of the DSM-IV-TR definition for PTSD involves two distinctive parts; the first referring to the type of trauma exposure (Criterion A1) while the second to the individual's response following exposure to traumatization (Criterion A2). In fact, even though a necessary prerequisite for one to be traumatized is to encounter a catastrophic event, the critical component is the emotional response to such an event (Herman, 1997; van der Kolk & McFarlane, 2007). As reactions to stressors differ from one person to another, a traumatic experience does not necessarily result in traumatization. From a cognitive framework, Janoff-Bulman (1992) states:

Those events that seem most overwhelming do not produce a traumatic response in every survivor, and other life events that may not be considered very threatening may, in fact, produce a traumatic response in some survivors. It always comes down to a question of interpretation and meaning. What does this event mean to the victim? (p. 52)

As such, future clinicians should avoid making generalizations in regard to expected responses of individuals in the aftermath of a traumatic experience.

The assessment of Criterion A lies on the identification of at least one event that qualifies for Criterion A1 and A2, this event representing the index event from which symptom inquiry can proceed (Weathers, Keane, & Foa, 2009). As noted by Weathers et al.(2009), when the stressor is not a single, distinct event (e.g., an earthquake or a motor vehicle accident), which is the case for many kinds of traumas (e.g., childhood sexual abuse or domestic violence), assessing Criterion A is a more difficult task. In such cases, Weathers et al. propose different approaches such as “to ensure that at least one aspect of the stressor meets Criterion A, then ask the respondent to consider the stressor as a whole

and link symptoms to the most traumatic aspects” (p. 29). Another option is to inquire traumatized individuals to identify the present most distressing event, among numerous traumatic experiences, based on the higher frequency and severity of symptoms it creates, and then use that experience as the starting point for symptom exploration.

Criterion A has been the source of considerable controversies throughout the trauma literature, because of the key role of trauma exposure as the expected fundamental etiological component for the diagnosis of PTSD. As noted by Weathers and Keane (2007), stressors differ along various dimensions including magnitude, frequency, complexity, duration, controllability, and predictability. Furthermore, because an event is perceived as stressful on the basis of a subjective appraisal, defining stressors objectively becomes a challenging task. Some researchers such as Kilpatrick, Resnick, and Acierno (2009) recommend retaining Criterion A, explaining that PTSD always results from exposure to one or many events qualifying as stressors. On the other hand, Weathers et al. (2009) pinpoint that others researchers have questioned whether or not it is a possible task to adequately define trauma and to differentiate it from ordinary stressors. Finally, other scholars such as Maier (2007) have even proposed the elimination of Criterion A, therefore defining PTSD solely in relation to its typical symptoms. Even though the chief criticism of Criterion A in DSM-IV-TR (2000) relates to the overly general trauma definition, allowing plenty of stressors to be classified as trauma (Weathers et al., 2009), researchers have emphasized the necessity to reach an agreement concerning the trauma definition in order for advances to be made in the field of traumatology (Weathers & Keane, 2007).

## 2. Major types of trauma

Many events have the potential to be traumatic and very distressing for human beings. The DSM-IV-TR (2000) categorizes traumatic events into three different categories. First, they can be directly experienced (e.g., violent personal assault, torture, natural and manmade disasters, incarceration, or being diagnosed with a life-threatening illness). Alternatively, traumatic events may be witnessed, for instance, “observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts” (p. 464). Finally, these events may be learned, including learning about a serious accident, a violent personal assault endured by a family member or a close friend, or learning about the sudden, unexpected death of a member of one’s family or close friend.

In their book titled *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation and Treatment*, Briere and Scott (2006) present the eleven major groups of trauma most commonly presented by clients seeking therapy. These groups are: (1) natural disasters; (2) mass interpersonal violence or mass trauma which is not war-related but implies intentional violence resulting in numerous injuries, suffering or death; (3) large-scale transportation accidents; (4) house or other domestic fires; (5) motor vehicle accidents; (6) rape and sexual assault; (7) physical assault by a stranger; (8) domestic violence; (9) torture; (10) war; and (11) child sexual and physical abuse. In addition to being not exhaustive, these separate categories of trauma types do not intend to mean that experiencing one type of trauma prevents someone from experiencing other types (Briere & Scott, 2006). As noted by Briere and Scott, even though this is generally true for non-

interpersonal trauma such as natural disasters and house fires, victims of interpersonal trauma are more likely to experience additional interpersonal traumas.

Other ways of categorizing traumatic events have been proposed throughout the trauma literature. For instance, Terr (1991) differentiates between the Type I single-incident traumas, mostly characterized by their unpredictability such as in cases of natural disaster, and the Type II traumas also named Complex Trauma (which is discussed in a subsequent section of this handbook), distinguished by their repetitiveness and cumulative effects, and resulting in various detrimental effects at different levels of human functioning. On the other hand, McFarlane and de Girolamo (2007) divides traumatic stressors into three categories: (1) time-limited stressors (e.g. car accident, rape), characterized by the victim's unpreparedness and the high intensity of the event; (2) sequential stressors, which can have a cumulative effect such as in the case of emergency service workers, and (3) long-lasting stressors, qualified by prolonged exposure to danger such as in the context of family violence and combat.

A question worth investigating is whether or not some types of trauma are more commonly experienced than others. In their review of the literature on the epidemiology of trauma, Solomon and Davidson (1997) explored this question by inquiring into four studies of adults conducted in the general population. They found the most common traumatic experiences, impacting approximately 15% to 35% of the individuals surveyed, as being the following: (1) witnessing someone killed or badly injured; (2) experiencing a natural disaster; and (3) experiencing a life-threatening accident. Less common, but nonetheless highly traumatic were experiences, such as molestation, rape, physical attack, combat, and physical abuse, which affected less than 15% of individuals surveyed.

Taking into account gender differences, research indicates that generally, men are more likely to report traumatic experiences such as witnessing violence, accidents, and physical assault. In contrast, women are significantly more represented in other types of traumatic events including rape, sexual molestation, and childhood sexual and physical abuse (Breslau, 1998; Kessler et al., 1995; Norris, 1992).

### 3. Prevalence of trauma exposure in the general population

As evidenced by many research findings (Hidalgo & Davidson, 2000; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995; Norris, 1992), exposure to traumatic events is, unfortunately, a common experience in our modern society. In a national study in the United States, Kessler and his colleagues (1995) surveyed almost 6,000 people ranging from 15 to 54 years old using face-to-face interviews. They found a lifetime rate of exposure to one or more traumatic experiences of 50% in women and 60% in men, in comparison to rates of 74% and 65%, respectively, found by Norris (1992); and 92% and 87%, respectively, found by Breslau (1998). As can be seen, there is higher lifetime prevalence of traumatic experiences in men than in women, as confirmed in the general trauma literature. Of interest, among all individuals with some type of lifetime trauma, Kessler et al. (1995) found that almost 13% of women and 17% of men had experienced more than three traumatic experiences. Despite methodological variations accounting for differences in findings, these results highlight the common presence of trauma in people's life.

One question worth investigating is whether or not there is a relationship between the experience of some type of trauma and the likelihood of developing the symptoms characteristic of PTSD. While Kessler and his colleagues (1995) reported that rape and

sexual assault were the types of trauma most likely to lead to PTSD for men as well as women, Hidalgo and Davidson (2000) reported the event to be the sudden unexpected death of a loved one. Of interest, gender differences in the types of trauma experienced and their probability to lead to PTSD has also been researched. According Kessler et al., a greater proportion of women reported their most upsetting trauma as being exposed to sexual molestation, physical attack and being threatened with a weapon, whereas those reported by men included combat exposure and childhood neglect. Both genders identified childhood physical abuse as one of their most upsetting trauma. Similarly, Hidalgo and Davidson (2000) found that the types of trauma most closely related to the development of PTSD were sexual assault and rape in women and combat and childhood physical abuse and neglect in men. Of interest, Resnick, Kilpatrick, Dansky, Saunders, and Best (1993) highlighted a greater percentage of lifetime PTSD among women exposed to completed rape and these reported greater percentages of PTSD among individuals traumatized in the context of crimes versus non-crime (25.8% vs. 9.4%) events.

#### 4. Limitations of the trauma definition in the DSM-IV-TR

Controversies around the trauma definition extend well beyond the previously discussed problems about Criterion A. In fact, various researchers have identified what they qualified as limitations of the current trauma definition. These limitations deserve future clinicians' attention as they can influence modes of assessment as well as choice of treatments and, ultimately, the delivery of effective services to traumatized individuals. As noted by Briere and Scott (2006),

Because DSM-IV-TR does not consider events to be traumatic if they are merely highly upsetting but not life threatening- for example, extreme emotional abuse, major losses or separations, degradation or humiliation, and coerced (but not physically threatened or forced) sexual experiences- it undoubtedly underestimates the extend of actual trauma in the general population. (p. 4)

In the same vein, radical feminist psychotherapist Burstow (2003) argues that linking trauma to a physically dangerous situation does not account for the daily “insidious” (p. 1296) traumas endured by oppressed people in our society when they face detrimental societal components such as, among others, sexism, racism and homophobic manifestations. For instance, Allen (1996) qualifies African American life as being “traumatogenic” (p. 216) because of the omnipresence and persistence of racism in America in addition to its manifestations in the political and social spheres. This results in a life context continuously permeated by trauma in such forms as: unemployment and underpayment; social and medical problems; racial discrimination and health care; racial discrimination in schools; and racial discrimination in financial activities. As such, Allen (1996) qualifies “racism as traumatic stress” (p. 221).

Another limitation takes root in the concept of intergenerational trauma, defined as the transmission of the effects of trauma across generations, such as in the cases of Nazi camp survivors and the enslavement of Africans (Dass-Brailsford, 2007; Evans-Campbell, 2008; Goodman & West-Olatunji, 2008). As noted by Dass-Brailsford (2007), “violent historical events, discrimination, and oppression experienced by prior generations can potentially affect the lives of future generations in the form of unresolved

grief and ongoing trauma” (p. 5). Even though the DSM-IV-TR (2000) states that “there is evidence of a heritable component to the transmission of Posttraumatic Stress Disorder” (p. 466), the concept of intergenerational trauma which is discussed in a subsequent section is not mentioned in the current trauma definition. A consequence of this omission has been identified by Danieli (1998) who notes that mental health professionals often overlook intergenerational trauma, leaving many clients to experience symptoms such as depression, anxiety, low self-esteem and substance abuse, which they can not relate to trauma.

Finally, the concept of Historical Trauma experienced by certain communities such as, First Nations, Métis, and Inuit in Canada and Native Americans and Alaska Natives in the U.S., who dealt with numerous traumatic experiences resulting in lasting consequences not only for families but also for entire communities, is also absent in the trauma definition. Referring to our present knowledge of the transfer of trauma on subsequent generations, Goodman and West-Olatunji (2008) warn counsellors of the necessity “to become educated about the significance of historical and contextual factors in case conceptualization” (p. 128). Section 9 discusses the massive and collective traumatic experiences endured by Aboriginal populations through colonization.

These examples of limitations give rise to a fundamental issue related to Criterion A identified by Weathers and Keane (2007): “How broadly or narrowly should trauma be defined” (p. 107). What is more, they highlight the necessity for future counsellors to understand other means by which trauma can be experienced in order to effectively treat traumatized individuals.

## 5. Risk factors in the development of symptoms of PTSD following trauma exposure

Before beginning our exploration of the PTSD symptomatology, one area worth investigating concerns the factors most likely to influence the development of symptoms after a traumatic encounter. Building upon abundant research findings, Briere and Scott (2006) report three groups of variables strongly supported by research findings which account for the amount and type of PTSD symptoms after a traumatic event: (a) victim variables; (b) characteristics of the stressor; and (c) social response, support, and resources. While attempting to predict posttraumatic stress in a person, these authors warn us about the inaccuracy of making assumptions as to one of these variables being solely responsible for the manifestation of symptoms.

According to Briere and Scott (2006), victim variables include gender, with women more at risk than men; age, with younger and older more at risk than middle-aged individuals; and race, with African Americans and Hispanics more at risk compared to Caucasians. Other variables include lower socioeconomic status; previous psychological dysfunction or disorders; family dysfunction and/or a past history of psychopathology, genetic predispositions, past history of trauma exposure, and more distress at the time of the trauma or immediately after.

Various characteristics associated with the nature of the stressors have the potential to lead to symptomatology. The DSM-IV-TR (2000) asserts that the severity, proximity, and duration of an individual's exposure to the traumatic experience represent the paramount elements determining the likelihood of developing PTSD. For instance, traumatic events involving death or injury as well as long lasting trauma are associated with heightened levels of related stress (Evans-Campbell, 2008). As stated by Breslau

(1998), “the evidence that the likelihood of PTSD varies across types of traumas, and that assaultive violence confers a higher PTSD risk than, say, disaster, supports the notion that the nature of the stressor influences the risk of PTSD” (p. 19). Other researchers such as Wilson, Smith, and Johnson (1985) have discussed characteristics of stressor events and their hypothesized relationship to the development of PTSD. Wilson et al., highlighted the level of life-threat, the loss of significant others, the individual’s role in the traumatic event, and the degree of exposure to death, dying, and destruction as being important characteristics of stressors. Of note, other stressor characteristics highlighted by Briere and Scott (2007) refer to the presence of sexual versus nonsexual victimization, and whether the traumatic experience is an intentional act of violence versus non-interpersonal traumatic events.

Regarding the last group of variables encompassing social response, support, and resources, literature findings generally indicate a relationship between the presence of psychological support by the means of friends, family members, and others, and the decrease of the severity of PTSD symptoms (Green, Wilson, & Lindy, 1985; Janoff-Bulman, 1985). As stated by Janoff-Bulman (1992), “Our fundamentally social nature is evident in the aftermath of victimization, for the reactions of others are extremely important in understanding victims’ post-traumatic adjustment” (p. 144). Similarly, Harris, Putnam, and Fairbank (2004) pinpoint that support from caregivers can frequently resolve the symptoms of PTSD after a severe episode of accidental trauma. Figley (1986) suggested the four following ways by which the family and the social support system in general, act as an antidote to PTSD: (1) detection of the symptoms by family members;

(2) confrontation of the problem; (3) reconsideration of the traumatic event, and (4) helping traumatized individuals engage in a process of trauma resolution.

As noted by Koenen (2007), a paramount question in trauma research is “why some individuals develop PTSD following exposure to potentially traumatic events when others appear to experience few negative effects” (p. 737). New paths of research in the field of traumatology attempt to answer this question. Building upon evidence from family, twin, and molecular genetic studies, Koenen (2007) posits the existence of genetic factors influencing individuals’ susceptibility to develop this disorder. However, as mentioned by this author, only scarce progress has been made in the genetics of PTSD, more specifically in the identification of variants in specific genes mediating risk for PTSD. As genetic studies have already shed light on the development of better pharmacological modes of treatment in other disorders, this author highlights the potential of these studies in treating PTSD.

Furthermore, the interaction between genetics and the environment also accounts for the various responses in individuals exposed to a potentially traumatic event. As pointed out by Yehuda and Bierer (2009) epigenetic modifications – a change in the DNA caused by an environmental perturbation and resulting in the alteration of the function, but not the structure, of a gene – have the potential to be transmitted across generations, as these changes are stable as well as long lasting. Even though these authors noted the lack of research findings suggesting epigenetic modifications specifically related to PTSD, numerous new observations are compatible with explanations of epigenetic modifications in this disorder. These include “recent findings of stress-related gene expression, in utero contributions to infant biology, the association of PTSD risk

with maternal PTSD, and the relevance of childhood adversity to the development of PTSD” (Yehuda & Bierer, 2009, p. 427). Similarly, Koenen, Amstadter, and Nugent (2009) highlight the possibility to significantly improve our comprehension of the specific genetic variants related to PTSD, in addition to the environmental circumstances influencing these effects, by the means of the gene-environment interaction. As they explained, this understanding of genetic as well as environmental impacts and their reciprocal interactions on PTSD will ultimately inform treatment efforts.

## 6. Concluding comments

In this section, we have seen that encounters with trauma, even though horrific and devastating, are a frequent phenomenon affecting human beings. Knowing the DSM definition of trauma, the major types of trauma experienced by individuals, the prevalence of PTSD in the general population and what the risk factors are for this disorder is paramount for future counsellors in their clinical work with a wide array of people. Despite numerous controversies and limitations inherent in the current definition of trauma in the DSM-IV-TR, the foundation for both the elaboration of the most appropriate definition of trauma and the understanding of the risk factors associated with the future development of PTSD symptoms are well underway.

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## Section 2: Posttraumatic Stress Disorder (PTSD) and symptomatology

This section explores the following topics: 1. Risk factors in the development of PTSD following trauma exposure; 2. *Acute, chronic and with delay onset* response to trauma; 3. DSM-IV-TR diagnostic criteria for PTSD; 4. Comorbid symptoms associated with PTSD; 5. What is still to come? PTSD and the fifth edition of the DSM; 6. Concluding comments.

### 1. Risks factors in the development of PTSD following trauma exposure

As previously noted, experiencing a traumatic event does not necessarily result in the development of symptoms. In fact, despite a high rate of lifetime exposure to one or more trauma evaluated at 50% in women and 60% in men (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), these authors found a lifetime prevalence of PTSD estimated at 7.8% in their national sample. Furthermore, Kessler et al.(1995), reported that women were twice as likely overall, in comparison to men, to have lifetime posttraumatic symptoms. Similar findings have been found by Hidalgo and Davidson (2000) and the DSM-IV-TR (2000) reports a rate of approximately 8% of lifetime prevalence of PTSD in the adult population of the United States. Unfortunately, information concerning the prevalence of PTSD in the general population in other countries is not presently available (APA, 2000).

As can be seen, the majority of people exposed to a traumatic experience proceed with their lives without developing the symptoms characteristic of Posttraumatic Stress Disorder (PTSD). McFarlane and Yehuda (2007) state:

To be distressed is a normal reaction to the horror, helplessness, and fear that are the critical elements of a traumatic experience. The typical pattern for even the most catastrophic experience, however, is resolution of symptoms and not the development of PTSD. (p. 156)

This does not mean, however, that individuals are not affected by the traumatic experience (van der Kolk & McFarlane, 2007). Generally, in the aftermath of a traumatic encounter, most people become “preoccupied” with the painful experience, suffering from intrusive thoughts related to the trauma (van der Kolk, 2007a). Furthermore, a wide range of responses experienced in the aftermath of a traumatic event have been classified by Dass-Brailsford (2007) into four clusters: (1) emotional, such as hopelessness, depression, irritability, grief, and guilt; (2) cognitive, such as confusion, trouble making decisions, and a reduced span of attention; (3) behavioral, such as withdrawal, exaggerated startle response, and impulsivity; and (4) physiological, such as an increase in heart rate and blood pressure, hyperventilation, fatigue, headaches, and muscle tension.. According to Dass-Brailsford, rather than being maladaptive or unhealthy, these reactions are common and expected responses to extreme life events. Furthermore, these reactions may vary in intensity over time, be experienced several at a time and be triggered by significant life stressors. Of note, when these reactions persist and interfere with areas of human functioning, seeking help from a mental health professional is advisable.

## 2. *Acute, chronic and with delay onset* response to trauma

In the aftermath of an individual exposure to trauma, two distinct psychopathologies are presented, not only in the American classification (APA, 2000),

but also in the World Health Organization (WHO)'s *International Classification of Mental and Behavioral Disorders* (WHO, 1992): the acute stress reaction, also called Acute Stress Disorder (ASD; APA, 2000), and the Posttraumatic Stress Disorder (PTSD). Of importance, some sources of literature link the presence of ASD to the future development of PTS (e.g., Bryant & Harvey 1998; Classen, Koopman, Hales, & Spiegel, 1998), and others (e.g., Briere & Scott, 2006).

Even though ASD and PTSD have similar attributes such as reexperiencing, avoidance and hyperarousal symptoms, the most distinctive feature of ASD is the inclusion of more dissociative symptoms in the diagnostic criteria. Defined as “a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment” (APA, 2000 p. 519), dissociative symptoms can also be experienced as symptoms of PTSD in the form of dissociative flashbacks episodes and amnesia for certain aspects of the traumatic experience (Zucker, Spinazzola, Blaustein, & van der Kolk, 2006). However, for a diagnosis of ASD to be made, an individual has to experience at least three dissociative symptoms out of the five specified in the DSM-IV-TR (APA, 2000) which are: (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness; (2) a reduction in awareness of his or her surrounding; (3) derealization; (4) depersonalization; and (5) dissociative amnesia.

Research suggests that through detachment from the traumatic event, dissociation represents an ego's defense against complete disorganization and, ultimately, a process of adaptation of human nature. As pinpointed by van der Kolk and Kadish (1987), dissociation “allows relatively normal functioning for the duration of the traumatic event and leaves a large part of the personality unaffected by the trauma” (p. 186).

Unfortunately, prolonged use of this defense mechanism in posttraumatic stress, as a way to avoid re-experiencing the feelings related to the traumatic experience, may result in a diminished capacity in the realm of feeling, thinking, remembering, or being (Varvin, 1998).

Because dissociative symptoms are part of many diagnoses in the DSM-IV including PTSD, borderline personality disorder, somatization, eating disorders, and panic disorder, this may result in overlooking specific PTSD symptoms and misdiagnosing traumatized clients. As reported by Herman (1997) survivors of childhood abuse have often been diagnosed with three especially challenging diagnoses: somatization disorder, borderline personality disorder, and multiple personality disorder. Correspondingly, she suggests that “the therapist’s first task is to conduct a thorough and informed diagnostic evaluation, with full awareness of the many disguises in which a traumatic disorder may appear” (p. 156). As such, knowing and understanding the diagnostic criteria of ASD and PTSD is paramount for future clinicians.

Acute Stress Disorder (ASD) can be diagnosed if the posttraumatic stress symptoms are exhibited in the first month after trauma exposure, including the time of the traumatic event, and experienced for at least two days. As pointed out in the DSM-IV-TR (APA, 2000), symptoms of ASD “should cause clinically significant distress, significantly interfere with the individual’s functioning or impair the individual’s ability to pursue necessary tasks (Criterion F)” (p. 469). The DSM-IV-TR (APA, 2000) estimates the range of ASD diagnoses in the general population as ranging from 14% to 33% in survivors of severe trauma.

In cases where the symptoms persist after a period of one month, a diagnosis of PTSD may be appropriate. After this length of time, PTSD symptoms do not have to occur within a specific time frame in order for PTSD to be diagnosed (Briere & Scott, 2006). It should be noted that PTSD is most commonly observed in the aftermath of a one-time trauma event (Faust, & Katchen, 2004), in contrast to complex trauma, also named Diagnosis of Extreme Stress Not Otherwise Specified (DESNOS), which results from the enduring of repeated and prolonged traumatic experiences and which will be described in a further section of this handbook.

Finally, the Posttraumatic Stress Disorder (PTSD) can either be called “acute” PTSD, if symptoms persist less than three months (not to be confounded with ASD), “chronic” PTSD if they are experienced for three months or longer, and “with delay onset”, when symptoms happen at least six months after the occurrence of the traumatic event, or even years after (APA, 2000).

### 3. DSM-IV-TR diagnostic criteria for PTSD

The distinctive characteristic between individuals who develop PTSD symptoms, compared to those who do not, is the revolving of their lives around the trauma. As emphasized by van der Kolk and McFarlane (2007), the traumatic experience becomes the focus from which they organize their existence. Unable to assimilate the traumatic event, to fit this experience with other parts of their lives, they commence to develop the characteristic symptoms of PTSD. As such, “the core issue is the inability to integrate the reality of particular experiences, and the resulting repetitive replaying of the trauma in images, feelings, physiological states, and interpersonal relationships” (van der Kolk & McFarlane, 2007, p. 7).

In order to be diagnosed with PTSD, someone must be in contact with an “extreme stressor” which complies with the definition of “trauma” as defined in Criterion A of the DSM-IV-TR (APA, 2000). More specifically, as previously discussed, an experience is traumatic when there is a threat or actual damage to the life, physical safety, or physical integrity of the individual or another person (Luxenberg, Spinazzola, & van der Kolk, 2001, p. 374). As a result, traumatized individuals must have experienced intense feelings of fear, helplessness or horror and have continued to endure a set of symptoms typical of PTSD that have severely impacted the course of their daily lives. According the DSM-IV- TR (APA,2000, p.467), there are 17 symptoms characteristic of PTSD divided in three main categories: (1) reexperiencing of the traumatic experience after its occurrence (e.g., intrusive memories, recurrent distressing dreams, flashbacks, nightmares, hallucinations, and feelings of intense psychological distress when faced with reminders of the trauma); (2) persistent avoidance of reminders of the trauma (e.g., avoidance of the feelings, thoughts, or conversations associated with the traumatic event; avoidance of the places, activities, or people triggering remembrance of the trauma; difficulty remembering parts of, or the totality of the traumatic situation; feelings of detachment from others; and a sense of a foreshortened future), or numbing of general responsiveness; and (3) persistent signs of continual arousal (e.g., poor sleep, irritability, anxiety, difficulty to concentrate, hypervigilance, and exaggerated startle response). Of interest, in order to be diagnosed with PTSD, individuals must exhibit at least one re-experiencing symptoms, a minimum of three avoidance or numbing symptoms and at least two persistent symptoms of increased arousal (APA, 2000). To better understand

the trauma too often results in a narrowing of consciousness, a withdrawal from engagement with others, and an impoverished life. (p. 42)

As such, intrusive symptoms are an important part of trauma survivor's therapeutic treatment.

#### (b) Avoidance symptoms

Mental avoidance of the distress associated with the trauma may be achieved by traumatized individuals through the process of dissociation. Noteworthy, current research support Janet's finding that dissociation is a fundamental component of PTSD (van der Kolk, 2007a). As further emphasized by van der Kolk (2007a), the process of dissociation allows traumatized individuals to split between the role of the "experiencing self" (p. 192) and that of a "spectator" of the traumatic experience, observing what is happening from a distance, therefore enabling individuals to feel none or only limited pain or distress. Despite being an effective protective mechanism, helping traumatized individuals to go on with their daily lives while the trauma continues to interfere with their happiness, dissociation comes to impede with human functioning as well as to translate into an inherent feeling of "deadness" and isolation from others.

Traumatic experiences may result in memory disturbances (e.g., van der Kolk, 2007; van der Kolk, Hopper, & Osterman, 2001) which can be displayed as an inability to remember some important aspect of the trauma. This form of dissociation called "amnesia" can be extended to its most extreme manifestation referred to as "generalized amnesia", exhibited as a failure to remember one's complete life (Dass-Brailsford, 2007). Building upon research findings, van der Kolk (1994) notes that traumatic events do not impede the implicit or non-declarative memory which is responsible for conditioned

emotional responses and sensorimotor sensations, as well as skills and habits. However, van der Kolk highlights that trauma inhibits the explicit or declarative memory allowing the conscious remembrance of the event. As van der Kolk posits, because traumatic experiences are so overwhelming, traumatized individuals can not translate what happened into words or what could be called a verbal narrative. Rather, these memories are stored in a sensori-motor form or, fundamentally, they are kept “in mind and brain as images, sounds, smells, physical sensations, and enactments” (van der Kolk, 2009). Forever remembered as bodily sensations, implicit or sensori-motor memory may acts as a feed-back loop when triggers of the trauma are present in traumatized individuals’ lives, resulting in re-traumatization. As will be seen in a subsequent section of this handbook, some therapeutic approaches in the treatment of PTSD directly target these traumatic memories, helping clients to cautiously construct a narrative out of these horrific experiences therefore diminishing their interference with daily life.

Another explanation for memory impairment in PTSD such as amnesia resides in the secretion of an excessive amount of stress hormones including endogenous opioids, oxytocin, and vasopressin during the occurrence of the traumatic event, impacting memory consolidation (van der Kolk, 1994). According to van der Kolk (1994), these neurohormones intervene in “the long-term potentiation (and thus, the overconsolidation) of traumatic memories” (p. 259). As stated by Kreidler et al. (2000),

Trauma affects the brain, especially in the key regulatory processes that control memory, aggression, attachment, emotion, and sexuality. When trauma occurs, the neurohormonal system is activated. Alterations occur in memory systems, and immobilization and dissociation can result. (p. 18)

The impact of psychological trauma on the brain is well evidenced throughout the literature (e.g., van der Kolk, 2007a; Kreidler, Zupanic, Bell, & Longo, 2000) and will be overviewed in a subsequent section of this handbook.

Alexithymia is another form of dissociation which may be found in individuals with PTSD, as reported by Frewen, Dozois, Neufeld & Lanius (2008) through their meta-analysis exploring the prevalence of alexithymia in 12 studies involving 1,095 individuals with PTSD. Alexithymia manifests as an individual's difficulty in accessing emotional experiences (Dass-Brailsford, 2007) and can be exhibited by challenges in the identification and labeling of feelings. This lack of ability to identify particular emotions may contribute to the altered impulse control observed in traumatized children and the likelihood of individuals to act on their feelings before taking the time to understand what makes them so distressed (van der Kolk, 2007a). It is important to note that unacceptable memories can translate into somatic symptoms which have no medical explanation, such as in the case of somatoform dissociation (Dass-Brailsford, 2007). As emphasized by van der Kolk, (2007a), since the first inclusion of the PTSD into the DSM-III (1980), a close link between somatization and dissociation as well as between somatization and PTSD have repeatedly been supported by research findings. The Dissociative Experiences Scale (DES), a 28-item self-report questionnaire with clinical validity, adequate test-retest reliability, and good internal consistency (Dass-Brailsford, 2007), is a mode of assessment which can be used by mental health professionals in order to assess psychological dissociation.

### (c) Hyperarousal symptoms

According to Herman (1997), hyperarousal is the main symptom of posttraumatic stress and represents the continual expectation of danger. As stated by Herman: “After a traumatic experience, the human system of self-preservation seems to go onto a permanent alert, as if the danger might return at any moment” (p. 35). Van der Kolk (1994) reports that abnormal psychophysiological reactions may be displayed in traumatized individuals in two different forms. First, as conditioned autonomic reactions to specific reminders of the traumatic experience, such as when traumatized individuals are afflicted by an increase in physiological arousal in response to stimuli such as images, sounds, and thoughts of the trauma (e.g., increase in heart rate, skin conductance, and blood pressure; van der Kolk, 2007). Second, as reactions to intense but neutral stimuli (e.g. loud sounds), implying a loss of stimulus discrimination in traumatized individuals as triggers not directly connected with the traumatic experience may provoke extreme responses. In what seems to be a venture to offset their chronic hyperarousal, traumatized individuals may “shut down” at two different levels of their beings: behaviorally, through their avoidance of stimuli acting as trauma triggers, and psychologically, through emotional numbing to trauma-related as well as daily experience (van der Kolk, 2007).

Before ending our discussion regarding PTSD symptoms, one intriguing question is whether or not there are gender differences in the manifestation of symptoms relative to this disorder. According to Perry and Pollard (1998), “Women tend to dissociate much more frequently than men. This is likely due to multiple factors, but it is a persistent observation across all ages and culture” (p. 44). Perry and Pollard also note a similar pattern of gender distribution in children. While the tendency for boys is to use

hyperarousal responses in reaction to stress, girls are much more incline to use dissociation.

By exploring the symptoms of PTSD, it is easier to understand the power of traumatic experiences on human beings and their intrinsic potential to completely change one's world from being a safe, enjoyable, predictable and controllable place to a place where one feels unsafe, continually consumed by trauma-related psychological and physical distress, a place that is not predictable anymore or controllable (Bergner, 2005). As such, it appears that, for traumatized individuals, there is life "before" and "after" the trauma; two separate entities almost impossible to unify. This passage from Janoff-Bulman (1992) helps us to comprehend the distress of trauma survivors:

The essence of trauma is the abrupt disintegration of one's inner world. Overwhelming life experiences split open the interior world of victims and shatter their most fundamental assumptions. Survivors experience "cornered horror", for internal and external worlds are suddenly unfamiliar and threatening. Their basic trust in the world is ruptured. Rather than feel safe, they feel intensely vulnerable. (p. 63)

Despite being devastative in so many ways, traumatic experiences are also seen by some survivors as profoundly transformative, giving birth to a new phenomenon in the trauma literature called the "Posttraumatic Growth". The positive psychological changes reported by some individuals in the aftermath of highly challenging circumstances (Tedeschi and Calhoun, 2004) will be discussed in a further section of this handbook.

#### 4. Comorbid symptoms associated with PTSD

Various studies have revealed that, rather than occurring on their own, there is a frequent association between PTSD symptoms and other disorders (e.g., Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; McFarlane & de Girolamo, 2007; McFarlane & Papay, 1992; van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). In the National Comorbidity Study, Kessler et al. (1995) reported the presence of at least one disorder connected with lifetime PTSD in 88.3% of the men and 79% of the women surveyed. Posttraumatic symptoms not included in the PTSD criteria are referred to as “comorbid conditions” and they may include various disorders. As pinpointed by Ford and Courtois (2009), PTSD occurs comorbidly with other DSM Axis 1 disorders expressed as chronic (episodic or continuous) problems with anxiety (e.g., phobias, generalized anxiety, panic, obsessions, or compulsions), mood (e.g., major depression, mania) or self-regulation (e.g., schizophrenia, dissociative disorders, eating disorders, substance use disorders).

In reference to the Kessler et al. study (1995), disorders frequently found to be associated with PTSD were affective disorders (e.g., major depression, mania), alcohol or substance disorder, conduct disorder, and anxiety disorders (e.g., generalized anxiety disorder, phobia, and social phobia). According to Solomon and Davidson (1997), somatization afflictions (e.g., medically unexplained gastrointestinal, neurological, or sexual pain) are overrepresented in PTSD individuals who are 90 times more affected than those without PTSD. The DSM-IV-TR (APA, 2000) also highlights an association between chronic PTSD and an augmentation in rates of physical or somatic complaints.

Noteworthy, impairments in social and occupational daily functioning (Solomon et al., 1997) are also important detrimental outcome of PTSD.

Throughout the literature, many researchers have noted the close relationship between PTSD and other ailments in specific populations. For instance, in his work with African Americans, Allen (1996) argues that PTSD, substance abuse and alcoholism treatments are inherently related, as excessive consumption of alcohol may rapidly develop in the aftermath of traumatic experiences. In their book titled *Trauma and Substance Abuse*, Ouimette and Brown (2003) present the multiple facets (e.g., epidemiology, etiological issues, assessment and treatment) of substance use disorder in specific PTSD populations such as veterans, incarcerated women, and adolescents.

Herman (1997) reminds us that, because of the wide range and complexity of their symptoms, traumatized people are often mistakenly diagnosed and not well treated. Furthermore, van der Kolk and McFarlane (2007) state that “focusing solely on PTSD to describe what victims suffer from does not do justice to the complexity of what actually ails them” (p. 16). Consequently, clinicians are strongly encouraged to ask patients presenting with anxiety/mood symptoms, substance/alcohol abuse, dysfunctional personal relationships, and somatic complaints not medically explained about past and current trauma history (Ballenger et al., 2004). Therefore, it appears paramount for future counsellors to know the many subtle ways by which trauma can express itself in client’s lives for efficient service delivery.

##### 5. What is still to come? PTSD and the fifth edition of the DSM

The next edition of the DSM is planned for completion in 2012 (Schnurr, 2009). In the meantime, some questions are revisited by researchers. For instance, Resick and

Miller (2009) debate whether PTSD is “best classified as an anxiety disorder and, if not, where it might be better located in the DSM-V” (p. 384). As reported by Resick et al., concerns about the location of PTSD among the anxiety disorders have existed since the text revision of the first DSM edition in 1987, and are based on the fact that the chief symptom of this disorder is the reexperiencing of the trauma rather than anxiety or avoidance behavior. Resick et al. (2009) suggest the placement of PTSD in its own class of traumatic stress disorders caused by the exposure to severe detrimental life experiences.

Because abnormalities in some areas of the brain (i.e. amygdala, hippocampus, and medial prefrontal cortex) specifically involved in fear conditioning, emotion regulation, and extinction have been reported by various neuroimaging studies of PTSD, a potential new category proposed for PTSD is “Stress-Induced Fear Circuitry Disorder”, (Shin & Handwerger, 2009, p. 409). According to these authors, these brain abnormalities are linked, among others, with PTSD symptom severity. Although Shin and Handwerger believe that PTSD can be described as a stress-induced fear circuitry disorder, these authors acknowledge the necessity to take into consideration numerous different issues before this disorder should be nominated as a new diagnosis category in the DSM. However, they state that “the move toward forming diagnostic categories based on validated biological markers is a useful endeavor that deserves attention in future research” (p. 412).

Pynoos, Streinberg, Layne, Briggs, Ostrowski, and Fairbank (2009) suggest expanding upon the current PTSD symptoms criteria by including a developmental perspective which would promote specific attention to age-related symptom

manifestations of PTSD among children and adolescents. What is more, Pynoos et al., (2009) highlight the importance to also consider an expansion of the impairment criterion (Criterion F) in order to incorporate developmental disturbance/ impairment such as regressions.

Finally, recent advances in the field of epigenetic modifications have motivated some researchers (Yehuda & Bierer, 2009) to question the implication of epigenetic mechanisms for the next edition of the DSM. As these authors point out, if epigenetic contributions influence PTSD susceptibility in individuals, this will impact on two controversial issues in the current DSM-IV-TR edition (APA, 2000), the Criterion A definition and whether or not PTSD would be best categorized as an anxiety disorder or a stress disorder.

## 6. Concluding comments

As can be concluded, the field of traumatology is continually growing. Important questions wait to be answered and recent observations build the foundation for a more solid understanding of the Posttraumatic Stress Disorder. Future clinicians are encouraged to follow the new developments in this field in order to keep their practice in line with current knowledge and better treat traumatized individuals seeking their professional services.

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### Section 3: Complex Trauma in adults and symptomatology

This section explores the following topics: 1. What is complex trauma? 2. Precursors to Complex Trauma; 3. DESNOS diagnostic criteria: (a) Alterations in the domain of affect and impulses regulation, (b) Alterations in the domain of attention or consciousness, (c) Alterations in self-perception, (d) Alterations in relationships with others, (e) Somatization problem, (f) Alterations in systems of meaning; and 4. Concluding comments.

#### 1. What is Complex Trauma?

A new understanding of the numerous consequences of traumatization in the last two decades has given birth to a new construct: Complex Trauma, also called Complex Posttraumatic Stress Disorder or Disorder of Extreme Stress Not Otherwise Specified (DESNOS; APA, 2000). Initially proposed by Herman (1997), Complex Trauma is the result of repeated acts of traumatization happening over a long period of time and generally taking place within the sphere of specific relationships (Briere & Spinazzola, 2005; Courtois, 2004; Herman, 1997). As pinpointed by Luxenberg, Spinazzola, and van der Kolk (2001): “Often these individuals have histories of a large variety of traumatic events, spanning years and even decades. Such individuals may not have had discrete traumatic experiences so much as ongoing, chronic exposure to untenable environments” (p. 375).

Primarily rooted in empirical research on childhood abuse and neglect (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2001), Complex Trauma can also be the outcome of traumatic experiences occurring in other contexts such as domestic violence,

war imprisonment, concentration-camp, and torture. Even though chronic traumatization does not necessarily results in the development of a complex group of symptoms called the DESNOS symptomatology, the exposure to repeated and prolonged trauma generally cause a wide range of symptoms (Briere & Spinazzola, 2005; Courtois, Ford, & Cloitre 2009; Herman, 1997; van der Kolk, 2007), expanding well beyond the scope of the PTSD symptoms. Referring to Complex Trauma, Scaer (2007) notes that “PTSD represents only the tip of the trauma iceberg” (p. 195). In fact, while the PTSD diagnoses represents relatively well the range of symptoms experienced for a single traumatic experience, survivors of interpersonal trauma display a more complex symptomatology (Luxenberg et al., 2001) resulting in unfavorable outcomes in the areas of mind, emotion, body, and relationships (Ford, & Courtois, 2009). As reported by Briere and Spinazzola (2009), however, the complexity of DESNOS symptomatology is influenced not only by the nature, number, and timing of specific traumas experienced by an individual, but also by significant biological, social and psychological components present at the time of traumatization.

## 2. Precursors to Complex Trauma

Some factors seem to be paramount in playing the role of precursors to Complex Trauma. In their DSM-IV field trial research, composed of 400 traumatized individuals seeking treatment and 128 community residents, van der Kolk, et al. (2005) identified the following precursors of DESNOS: (1) the developmental level at which the trauma occurred; interpersonal traumatization earlier in life causing more complex symptoms than later interpersonal traumatization; (2) the context in which the trauma happened; interpersonal traumatization (e.g., related to a caregiver or in intimate relationships)

causing more complex symptoms than non-interpersonal traumatization; and (3) the age at which the traumatic experiences happened; the younger an individual at the occurrence of the trauma, the more likely she/he is to experience both DESNOS and PTSD symptoms. More specifically, van der Kolk et al. (2005) study suggest that “trauma has its most pervasive impact during the first decade of life and becomes more circumscribed, i.e., more like “pure” PTSD, with age” (p. 395). Furthermore, van der Kolk et al. highlight a relationship between the length of time of exposure to traumatic experiences and the likelihood of experiencing both PTSD and DESNOS. As such, symptoms of Complex Trauma do not necessarily manifest as a distinct group, apart from PTSD, as both sets of symptoms can happen conjointly (van der Kolk et al., 2005). Of interest, in some studies (Ford, 1999), DESNOS patients (25 to 45%) did not meet PTSD criteria.

As the PTSD symptoms formulation presented in the DSM-IV (1994) was not fully embracing the wide spectrum of symptoms associated with DESNOS, a heading titled “Associated descriptive features and mental disorders” of PTSD was added in the DSM-IV-TR (APA, 2000, p. 465), listing the categories representative of the DESNOS manifestation of symptoms (van der Kolk et al., 2005). Despite not currently presented as a separate diagnosis, the complex symptoms of DESNOS has been recognized in the clinical and research field of traumatology (Luxenberg et al., 2001). Interestingly, van der Kolk (2009) refers to DESNOS as “a psychiatric condition that officially does not exist, but which possibly constitutes the most common set of psychological problems to drive human beings into psychiatric care” (p. 455).

Throughout the trauma literature, the diagnostic criterions for DESNOS consist of alterations present in the six following areas of functioning (Luxenburg, et al., 2001;

Zucker, Spinazzola, Blaustein, & van der Kolk, 2006): (a) alterations in the domain of affect and impulses regulation (e.g., affect regulation, excessive risk-taking, regulation of affect, self-destructiveness, modulation of anger); (b) alterations in the domain of attention or consciousness (e.g., amnesia, episodes of transitory dissociation and depersonalization); (c) alterations in the domain of self-perception (e.g., shame, guilt and responsibility, sense of permanent damage, ineffectiveness); (d) alterations in the domain of relationships with others (e.g., revictimization, incapacity to trust, victimization of others); (e) somatization problems (e.g., chronic pain, digestive system disturbances, sexual symptoms) and; (f) alterations in the domain of systems of meaning (e.g., anguish and hopelessness, loss of past fundamental beliefs). In an attempt to foster a better understanding of these categories and help clinicians to better recognize the complex symptomatology of DESNOS, these categories are partially detailed below. For additional details regarding the DESNOS criteria and the required subscale items for endorsement of the proposed main categories of symptoms, readers are encourage to refer to Luxenburg et al. (2001, p. 375).

### 3. DESNOS diagnostic criteria

#### (a) Alterations in the domain of affect and impulses regulation

Affect regulation is related to both affect tolerance and affect modulation. While the former refers to our ability to tolerate strong internal emotions, the latter apply to our capacity to inherently decrease intense emotional states without having to use either avoidance strategies or dissociation (Briere & Scott, 2006). As pointed out by Zucker et al. (2006), DESNOS is fundamentally conceptualized as a self-regulation disorder. These authors further state that “dysregulation occurs across *multiple* systems (i.e., affective,

behavioral, somatic, dissociative, relational, and self-attributional) and is expressed through a wide and varying range of associated clinical impairments and behavioral disturbances” (p. 27). For instance, affect dysregulation may be exhibited in DESNOS individuals by an overreaction to neutral or mild stimuli, great difficulties in the expression or modulation of anger, and the manifestation of sexual as well as suicidal preoccupation (Luxenberg et al., 2001). Of importance, because DESNOS individuals have trouble managing their emotions and calming themselves, they may choose to use self-destructive strategies including self-injury, eating disorders, substance abuse, or compulsive sexual behaviors (Luxenberg et al., 2001). As emphasized by Luxenberg et al. (2001), affect dysregulation is one of the most troublesome feature of working with DESNOS patients and should be a paramount focus of treatment.

According to Briere and Scott (2006): “One of the most important component of successful affect regulation is the ability to correctly perceive and label emotions as they are experienced” (p. 101). These authors posit that DESNOS survivors experience great difficulties to specifically name what they feel and accurately distinguish different kinds of feelings (e.g., anger from anxiety and sadness). Therefore, naming emotional states becomes a very important treatment component (van der Kolk, McFarlane, & van der Hart, 2007).

#### (b) Alterations in the domain of attention or consciousness

One mechanism used by individuals to cope with traumatic experiences is to dissociate, or separate, traumatic experiences from day-to-day consciousness. As previously explained, due their intense inherent attributes, information about traumatic events is most often not integrated into a coherent whole easily accessible (Luxenberg et

al., 2001) but is rather registered as sensory information or bodily sensations. Therefore, chronically traumatized persons can experience physical sensations which seem to have no origin and can not be described by the means of words. These somatic problems are briefly discussed below.

As noted in the previous section, PTSD symptoms may include dissociative experiences such as dissociative flashbacks episodes and amnesia for certain aspects of the trauma. Alterations in the area of attention and consciousness are not, however, a requisite in the diagnosis of PTSD (Zucker et al., 2006). In contrast, amnesia, transient dissociative episodes, and/ or depersonalization represent essential elements of DESNOS (Zucker et al., 2006). In their study on dissociative symptomatology in PTSD and DESNOS, Zucker et al. (2006) found that participants in the group meeting criteria for both PTSD and DESNOS scored significantly higher on the DES (Dissociative Experiences Scale), in comparison to participants with only PTSD. As noted by Zucker et al., this finding brings evidence to the validity of DESNOS by establishing a difference between PTSD with DESNOS from PTSD without DESNOS, in relation to the dissociative element of DESNOS. For instance, DESNOS individuals' superior use of depersonalization/derealization suggests a higher level of clinical impairment in these individuals than in those with PTSD alone.

Of importance, van der Hart, Nijenhuis, and Steele (2005) bring our attention to the confusion surrounding the present use of the term "dissociation". As these authors note, "it is difficult to determine whether "dissociation" is a central feature in complex PTSD and other trauma-related disorders because there is not uniform agreement on what constitutes the construct" (p. 414). As such, van der Hart et al. (2005) point out that a few

PTSD intrusive symptoms are referred to as “dissociative flashback episodes” (APA, 2000, p. 468), and at the same time the flashbacks are not referred to as dissociative in ASD. Furthermore, these authors note that avoidant or numbing symptoms are not considered to be dissociative in PTSD, whereas these symptoms are considered dissociative in ASD (APA, 1994, p. 432; APA, 2000, p. 471). According to van der Hart et al. (2005), traumatization fundamentally involves some degree of dissociation of the psychobiological systems composing an individual’s personality. More specifically, there is avoidance of traumatic recollections of one or more dissociative parts of the personality, allowing an individual to function on a daily basis, whereas there is fixation on the trauma and defensive actions by one or more other parts. According to van der Hart et al. (2005), the manifestation of dissociative parts can be exhibited by negative as well as positive dissociative symptoms which should be differentiated from alterations of consciousness.

#### (c) Alterations in self-perception

Trauma deeply affects people sense of dignity, power, and personal value. As noted by van der Kolk (2007) traumatized people “tend to perceive themselves as being unlovable, despicable, and weak” (p. 198). Similarly, Briere and Spinazzola (2005) report an association between interpersonal victimization, such as in the cases of childhood and adult abuse, and the development of feelings of low self-esteem, self-blame, hopelessness, helplessness, and an anticipation of being rejected.

When traumatic events happen during the preoperational cognitive stage, infants tend to believe that they are responsible for being mistreated, causing the establishment of an inherent negative view of self (Luxenberg, et al., 2001). Alteration in self-perception

can also manifest as the frequent belief in trauma survivors that no one can truly comprehend what happened to them. Furthermore, trauma survivors may intensely diminish the effects of their experience as not having strongly affected them or as being unrelated to their present difficulties.

(d) Alterations in relationships with others

The type of attachment infants have with their caregivers greatly influence the establishment of healthy patterns of relationships with others. As pinpointed by van der Kolk (2005), numerous critical developmental impairments may result when the source of trauma is the child-caregiver relationship itself or when the exposure to other traumas deeply affects this fundamental relationship. Luxenberg et al. (2001) point out the consistent association, in the trauma literature, between childhood abuse and difficulty trusting others, revictimization, and the victimization of others, which are all manifestations of alterations in relationship with others. According to Pearlman and Courtois (2005), alterations in relationship with others include the “individual’s ability to connect with other people in ways that foster relational security and stability” (p. 449). As such, these alterations may hamper the building of healthy relationships.

The compulsive reexposure to situations similar to the trauma can be observed in traumatized individuals from a broad range of traumatized populations (van der Kolk, 2007). The understanding of trauma reenactment or what seems to be a “paradoxical phenomenon” (van der Kolk & McFarlane, 2007, p. 11) is, according these authors, of paramount importance, as it may offer a means of understanding for numerous kinds of antisocial behavior and interpersonal difficulties. Luxenburg et al. (2001) highlight the common occurrence of trauma survivors to reenact their interpersonal trauma in the

therapeutic relationship and other contexts of their lives. As such, the establishment of a trusting alliance between trauma survivors and clinicians can be a slow and arduous process (Luxenburg et al., 2001). Victimization of others, self-destructiveness, and revictimization are the three means by which traumatized individuals can reenact trauma (van der Kolk and McFarlane, 2007). As pointed out by van der Kolk and McFarlane (2007), research findings have extensively acknowledged the relationship between subsequent victimization of others and past histories of childhood abuse. Furthermore, studies constantly found a very strong correlation between childhood sexual abuse and numerous forms of self-harm behaviors later in life, especially, cutting, self-starving, and suicide attempts. Finally, van der Kolk and McFarlane note that individuals who have been traumatized are more likely to be revictimized on future occasions. This is well exemplified by women with past histories of physical and sexual abuses who are more at risk to be abused later in life (Herman, 1997).

As noted by Herman (1997), however, survivors of childhood abuse are much more likely to be victimized – through self-harming behaviors and revictimization - than to harm others. More specifically, Herman reports the existence of a strong relationship between childhood abuse and self-mutilation, whereas the link between childhood abuse and adult social deviance is fairly weak. Of importance, Herman invites us to be very cautious in the interpretation we make of the phenomenon of repeated victimization. She states:

For too long psychiatric opinion has simply reflected the crude social judgment that survivors “ask for” abuse. The earlier concepts of masochism and the more recent formulations of addiction to trauma imply

that the victims seek and derive gratification from repeated abuse. This is rarely true. (p. 112)

In fact, Herman emphasizes the deep deficiencies in many trauma survivors in the realm of self-protection. As such, trauma survivors can hardly view themselves as having the power of making choices, drawing personal boundaries, and saying “no” to the demands of a spouse, parent, lover, or a person in a position of authority. Furthermore, Herman highlights a dissociative coping strategy used by many trauma survivors which consists to overlook or diminish the importance of social cues. Importantly, these cues would normally alert trauma survivors of the presence of danger. These deficiencies in the domain of self-protection lead chronically traumatized individuals to experience the consequences of revictimization.

#### (e) Somatization problems

As pointed out by Luxenberg et al. (2001), numerous chronically traumatized individuals suffer from continual physical complaints which most frequently have no evident physical cause or medical explanation. Cardiopulmonary, chronic pain, digestive system, sexual and conversion symptoms are among the symptoms cited by trauma survivors. Luxenberg et al. (2001) point out the various impacts of exposure to repeated traumatic experiences on the biological system such as neurohormonal dysregulation, neuroanatomical impacts, and overresponsive nervous system to neutral stimuli. Courtois (2004) notes that somatic responses and medical conditions may either be directly related to the type of abuse experienced and any corporal injuries that were caused or they may be more disperse. Furthermore, Courtois notes that somatic complaints have been found to encompass every important body systems.

#### (f) Alterations in systems of meaning

The shattering of basic assumptions, as proposed by Janoff-Bulman (1992), is inherently related to traumatic experiences. As she explained, our core beliefs - those assumptions believed by most of us - about the benevolence and meaningfulness of our world and the worthiness of our self are challenged forever by a traumatic experience. This passage from Kinsler, Courtois, & Frankel (2009) illustrate this fact very well:

In general, persons who experience severe abuse *come to believe, at a very deep level, that the world is unsafe, that other people are not trustworthy.*

By virtue of their repeated experiences of abuse and neglect, they come to “know”, *in the deepest sense of internal knowing, that they are somehow to blame and deserving of the abuse.* They feel “in their bones” that they are bad, that it is fruitless to hope, that they will never be safe, and that they must keep their pain a secret from others. (p. 184)

Janoff-Bulman speaks about the necessity for traumatized individuals to rebuild their assumptive world, to create a world in which the trauma experience is accepted and integrated into a new frame of reference.

#### 4. Concluding Comments

The symptom presentation of DESNOS is more complex than that exhibited in PTSD. Consequently, the assessment and treatment of complexly traumatized individuals is more difficult. For instance, Luxenberg et al. (2001) point out the importance to assess as well as address the biological, interpersonal, emotional, and social aspects of DESNOS in the treatment of chronically traumatized individuals. Furthermore, Ford and Courtois (2009) state that due to “the multiplicity of traumatic

antecedents and the range of traumatic stress reactions, symptoms, and impairments that follow, individuals with complex traumatic stress disorders have proven very difficult to assess accurately, diagnose, and effectively treat” (p. 442). As such, it is imperative for mental health professionals to continue to perfect their knowledge regarding both the subtle manifestations of DESNOS symptoms as well as the best modes of assessment and treatment for complexly traumatized individuals.

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#### WEEK # 4: Complex Trauma in Children and Adolescents

This section explores the following topics: 1. Impact of trauma in children and adolescents; 2. Secure attachment to caregivers, a defense against the effects of trauma; 3. Domains of impairment in children with Complex Trauma; 4. Developmental Trauma Disorder (DTD); 5. Childhood trauma in the school context; and 6. Concluding comments.

##### 1. Impact of trauma in children and adolescents

The impact of trauma on children warrants increased attention as traumatic experiences are the precursors of impairment in various domains of functioning (Cook, Blaustein, Spinazzola, & van der Kolk, 2003). Posttraumatic stress reactions in children are similar to those experienced by adults. As such, children and adolescents also experience symptoms of re-experiencing, avoidance or emotional constriction, and hyperarousal, (Pynoos & Nader, 1993; Pynoos, Steinberg, Layne, Briggs, Ostrowski, & Fairbank, 2009). As noted by Pynoos and Nader (1993), reexperiencing of the trauma in children can be manifested in different ways including behavioral reenactments, traumatic play, intrusive thoughts and frightening dreams. In contrast, avoidance symptoms can be displayed by means of the avoidance of places, specific thoughts, and concrete items acting as reminders of the trauma. Finally, hyperarousal symptoms may include irritability, anger, hypervigilance, sleep disturbances, trouble concentrating, exaggerated startle response, and physiological responses to trauma reminders.

Of note for clinicians, Pynoos et al. (2009) have proposed a developmental reframing of the PTSD symptoms in children and adolescents to be incorporated in the

fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V).

These developmental modifications are based on “scientific and clinical advances in the etiology and nature of PTSD among children and adolescents, along with increased knowledge of child and adolescents development” (Pynoos, 2009, p. 391). Clinicians are encouraged to refer to the Pynoos et al. article (2009, see p. 396) for a detailed review of the proposed modifications of the PTSD criteria for children and adolescents.

Usually occurring in a context characterized by a substantial lack of support or positive caregiving from grownups, complex trauma in children involves chronic traumatization either in the form of continuous or repeated traumatic experiences (Harris, Putnam, & Fairbank, 2004). Of importance, complex trauma in children represents a major public health concern in the United States, affecting millions of children (Harris et al., 2004; van der Kolk, 2005a). As stated by Harris et al.(2004),

For many children, the unaddressed consequences of trauma will adversely affect their entire lives and the lives of those around them - and even the lives of their unborn children. The effects of trauma can be pervasive, impacting on school readiness and performance, diminishing cognitive abilities, and leading to substance abuse, crippling mental disorders and costly physical health problems. (p. 2)

Even though there are currently no reliable national statistics across Canada on both the nature and magnitude of childhood abuse and neglect, it is estimated that 76,000 children are under the care of Child and Family Services in this country (O'Neill, Guenette, & Kitchenham, 2010). As pointed out by O'Neill and colleagues, these children are

considered to be survivors of childhood abuse and neglect and, therefore, at significant risk for developing complex trauma reactions.

Despite the high prevalence of trauma in children, it is of importance to note its uneven distribution (Harris et al., 2004). In fact, Harris et al. (2004) note that some groups of children are considered at high-risk for trauma and violence exposure. More specifically, these groups of children are: 1) known abused and neglected children, the majority presently receiving little or no trauma interventions at all; 2) foster care children, 70-80% of which are placed in foster care because they and/or their siblings were victims of abuse and neglect; 3) children witnessing domestic violence or the death of a close one (parent, sibling, or friend); 4) child victims of tragic accidents or massive trauma, such as school violence, natural disasters or different types of terrorism; 5) children who are part of the juvenile justice system; 6) refugee children coming from countries enduring civil disruptions and armed conflicts; and 7) children in need of psychiatric hospitalization due to certain symptoms or behavioral disturbances such as suicide or running away. According to Harris et al., these groups of children would be particularly advantaged by a quick process of detection and intervention.

Briere, Kaltman and Green (2008) have examined the relationship between childhood cumulative trauma and symptoms complexity. They found a linear relationship between the types of trauma experienced by participants (2,453 female university students) aged 18 and the variety of symptoms reported. As pointed out by Briere et al., (2008), there is growing evidence in trauma literature that the lifetime number of various types of trauma exposure predicts the severity of an individual's symptomatology in

diverse areas, including depression, somatic complaints, anxiety, dissociation, and posttraumatic stress symptoms.

## 2. Secure attachment to caregivers, a defense against the effects of trauma

Early attachment to primary caregivers is of paramount importance in trauma psychopathology. According to van der Kolk (2003),

The security of attachment bonds seems to be the most important mitigating factor against trauma-induced disorganization. In contrast, trauma that affects the safety of attachment bonds interferes with the capacity to integrate sensory, emotional, and cognitive information into a cohesive whole and sets the stage for unfocused and irrelevant responses to subsequent stress. (p. 295)

Ainsworth (1978) and Bowlby (1988), who uncovered the significance of early attachment styles between caregiver and infants, shed the light on the significance of attachment styles for human development. Using the strange-situation test, Ainsworth (1978) found two primary types of early attachment: secure attachment, in which a strong emotional child-caregiver relationship exists, as a result of responsive caregiving, and insecure attachment, resulting from inconsistent or unresponsive caregiving. Insecure attachment style can manifest in three different forms: (1) resistant attachment, typified by infants' anger and avoidance toward their caregiver; (2) avoidant attachment, characterized by infants' ambivalence toward their caregiver; and (3) disorganized or disoriented attachment, in which infants display contradictory behavior and uncertainty toward their caregiver (Craig & Dunn, 2007).

While a secure attachment style develops by means of caregivers who give consistent attention to their infant and interact with them with an attitude of care, sensitivity, and warmth, an insecure attachment bond may be a consequence of inattentive or emotionally rejecting caregivers (Craig, & Dunn, 2007). Building upon recent research findings, van der Kolk (2005a) emphasizes the existence of a disorganized/disoriented attachment style in as much as 90% of maltreated children. Van der Kolk (2005a) further notes that the principal attributes displayed by infants having a disorganized attachment style include an “increased susceptibility to stress (e.g., difficulty focusing attention and modulating arousal), inability to regulate emotions without external assistance (e.g., feeling and acting overwhelmed by intense or numbed emotions), and an altered help-seeking (e.g., excessive help-seeking and dependency or social isolation and disengagement)” (p. 376). Understandably, caregivers who are dealing with personal issues of addiction and past traumatic experiences are much more challenged when it comes to establishing secure bonds with their infants (O’Neill et al., 2010). As noted by O’Neill and colleagues (2010), in the personal context of some caregivers, disrupted attachment can be outside of their own control.

Another area affected by hostile caregivers is brain development in children (Davis, 2002; Ford, 2009; Nemeroff, 2004; Solomon and Heide, 2005; van der Kolk, 2003; van der Kolk, 2009). More specifically, Solomon and Heide (2005) explain that the relationship between infants and primary caregivers directly impact “on the hard wiring of neural circuits in the developing brain” (p. 55). As such, many of these affected neural circuits connect regions of the brain which are crucial for physiological, psychological, emotional, and social development. Building upon extensive research findings, Teicher,

Polcari, Andersen, Anderson, and Navalta (2003), conclude that severe stress in early childhood interferes with the sequential development of the brain. This results in detrimental and enduring alterations in brain function, therefore producing brain impairment. According to Teicher et al. (2003), the sequence of alterations likely to happen are the following: (1) the activation of stress-response systems following childhood exposure to intense stress results in an alteration of their molecular organization as a means to modify their sensitivity; (2) when the developing brain is exposed to stress hormones, this interferes with the neurotransmitters and synaptic connections' normal growth and development to stress; (3) the enduring functional outcomes that occur include "reduced left-hemisphere development, decreased left-right hemisphere integration, increased electrical irritability within limbic-system circuits, and diminished functional activity of the cerebellar vermis." (p. 213); and (4) there are related neuropsychiatric detrimental effects and vulnerabilities, causing an increased risk for the development of posttraumatic stress disorder (PTSD), borderline personality disorder (BPD), dissociative identity disorder (DID), depression, and substance abuse. Consequently, brain alterations, both at a structural and physiological level, are hypothesized to impact various aspects of functioning such as memory, affect regulation, learning as well as social and moral development (Solomon & Heide, 2005).

### 3. Domains of impairment in children with Complex Trauma

Children's exposure to complex trauma is linked to a set of lasting sequelae incorporating the PTSD symptoms but also extending beyond these symptoms (Cook et al., 2003). Speaking of complex trauma, Ford and Courtois (2009) state:

The timing of its occurrence - in critical windows of development during childhood, when self-definition and self-regulation are being formed and consolidated - and its very nature - the disruption or distortion of fundamental attachment due to betrayal of the developing child's security and trust in core relationships - distinguish complex trauma from all other forms of psychological trauma. (p. 16)

From a developmental framework perspective, the occurrence of repeated acts of traumatization in childhood deeply interferes with developmental tasks of that period, such as the crucial development of self-regulation and interpersonal relatedness (Cloitre, 1998; Cook et al., 2005). For instance, the key role of caregivers in the modulation of infants' physiological arousal is well established throughout the literature (e.g., van der Kolk, 2007; Cloitre 1998). By giving assistance to infants in modulating their arousal, effective caregivers provide equilibrium between soothing and stimulation, therefore helping infants to learn how to effectively take care of themselves and get help in distressing situations (Cloitre, 1998). In contrast, "unresponsive or abusive parents may promote chronic hyperarousal which may have enduring effects on the ability to modulate strong emotions" (van der Kolk, 2007a, p. 186). Making reference to the DSM-IV field trials for PTSD, van der Kolk (2007a) reports that the younger the age of the trauma occurrence, and the longer its span, the most likely individuals were to experience long-term problems related to the modulation of anger, anxiety, and sexual impulses.

Furthermore, by being repeatedly exposed to traumatic experiences, children, like adults, may suffer from alterations in states of consciousness. More specifically, van der Kolk (2007a) speaks of a "separate state of mind" (p. 192) or a "separate ego state" (p.

193), encompassing features of the traumatic experience, and reemerging only when specific aspects of the traumatic experience are activated. As stated by van der Kolk (2007): “Very complex forms of such secondary dissociations can be found in dissociative identity disorder (formerly called multiple personality disorder), which has also been described as a complex form of PTSD with origins in severe childhood traumatization” (p. 192). Children may come to use these separate ego states, or alternative identities, when attempting to escape intolerable experiences.

In the same vein, Perry and Pollard (1998) report the use of dissociative adaptations by infants who are facing threatening situations, such as distraction, numbing, avoidance, fugue, derealization, daydreaming, fantasy, depersonalization and, in extreme cases, catatonia and fainting. As noted in a previous section, dissociation serves as a defense mechanism against the overwhelming feelings (e.g., fear, pain, helplessness, panic) associated with the traumatic experiences, offering a feeling of detachment from the physical as well as the emotional reality inherent to the traumatic reality (Kreidler, Zupanis, Bell, & Longo, 2000).

Based on a comprehensive review of the trauma literature, Cook et al. (2003) report seven domains of impairment observed in children exposed to chronic or repeated acts of traumatization. These domains of Complex Trauma are: (1) attachment (e.g., trouble with boundaries, social isolation, problems with perspective taking); (2) biology (e.g., somatization, analgesia, more medical problems across a broad span); (3) affect regulation ( problems with naming and expressing feelings, difficulty with emotional self-regulation); (4) dissociation (e.g., amnesia, depersonalization and derealization); (5) behavioral control (e.g., aggression toward others, eating disorders, sleep disturbances);

(6) cognition (e.g., problems planning and anticipating, learning difficulties, language development difficulty); and (7) self-concept (e.g., low self-esteem, shame and guilt, body image disturbances). For additional information regarding these domains of impairment, readers are invited to refer to Cook et al. (2003, see p. 392).

#### 4. Developmental Trauma Disorder

Even though DESNOS is currently the formal diagnosis used to depict complex trauma in children, a possible new diagnostic has been proposed by the National Child Traumatic Stress Network (NCTSN): Developmental Trauma Disorder (DTD) (van der Kolk, 2005). Standing specifically for children experiencing complex trauma, DTD complements a group of childhood disorders (anxiety, affective, attachment, and behavioral) already included in the next (fifth) edition of the DSM (Ford & Courtois, 2009). As described by van der Kolk (2005); “Research has shown that traumatic childhood experiences not only are extremely common but also have a profound impact on many different areas of functioning” (p. 402). Mostly related to childhood abuse (emotional, sexual, physical abuse and neglect), as well as witnessing domestic violence, childhood trauma can also be experienced by other means. For instance, traumatization in children can occur through community violence and war (Cook et al., 2005), or the loss of a primary caregiver during early childhood (van der Kolk, 2005a). Of interest, surveys of childhood trauma exposure reveal a significantly low prevalence of childhood exposure to trauma that are non-interpersonal in nature, such as accidents, disasters, or severe illness (van der Kolk, 2005a).

The proposed diagnosis of DTD is based on the notion that several exposures to interpersonal traumatic experiences such as betrayal, physical assaults, abandonment, or

sexual assaults, result in consistent and expected detrimental effects, which negatively influence various domains of functioning such as familial, educational, relationship with peers (van der Kolk, 2005). More specifically, when children are in the presence of trauma reminders, a pattern of recurring dysregulation (affective, somatic, behavioral, cognitive, relational, self-attribution) is triggered. Of importance, dysregulation in the presence of cues can be either high or low, the changes are enduring and do not come back to previous levels and are not diminished in intensity by consciously attempting to do so (van der Kolk, 2005). Van der Kolk (2007a) states:

After exposure to trauma, children tend either to be excessively shy and withdrawn, or to bully and frighten other children. Their inability to regulate their arousal, to articulate their feelings in words, or to attend to appropriate stimuli, and the ease with which they are triggered to reexperience feelings and sensations related to the trauma, make it difficult for them to be attuned to their environment. (p. 198)

In addition to repeated dysregulation, the diagnosis of DTD incorporates the observation that children with complex trauma construct a world view including the betrayal and pain created by the trauma, giving rise to persistent altered attributions about self and others. As pointed out by van der Kolk (2007a), the internalization of the trauma deeply impacts children in various ways. This is exemplified by their impaired capacity to trust others, their trauma-related feelings of guilt, shame and self-blame, their lack of success in reaching an inner sense of competency, significance, and worth; their altered capacity to play and find comfort in the presence of others, and their intense interpersonal sensitivity. Finally, the proposed diagnosis of DTD stipulates that when children suffer from

complex trauma, their relationships are deeply influenced by their expectations of a return of the trauma (2005). Consequently, these children's interactions with others are immersed with the anticipation or prevention of rejection or victimization. For instance, they may lose hope of being protected by others, including caregivers, or lose trust in the protection of social agencies.

Of note, van der Kolk (2005) reports that detrimental childhood experiences can have a powerful influence on adult health as much as fifty years later. According to this author, the Adverse Childhood Experiences (ACE) study highlights a strong connection between trauma in children and future depression, suicide attempts, drug abuse, alcoholism, sexual promiscuity, cigarette smoking, obesity, domestic violence, physical inactivity, and sexually transmitted diseases. Furthermore, childhood traumatic experiences are thought to be the foundation for the future development of numerous psychiatric disorders including borderline personality disorder (BPD), somatization disorder, dissociative disorders, self-mutilation, eating disorders, and substance abuse (van der Kolk, 2007). In fact, the estimated prevalence of childhood past histories of trauma varies from 40 to 70% in the general populations of psychiatric patients (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). These tragic revelations call attention to the necessity of preventing trauma in children. Even though not incorporated in the DSM as a distinct diagnosis, DTD deserves to be known and recognized by clinicians.

## 5. Childhood trauma in the school context

Even though the detrimental effects of childhood abuse on children's adaptation to the school context has not been exhaustively investigated, research findings indicate a

relationship between difficulties in the realm of academic performance and childhood physical abuse and neglect (O'Neill et al., 2010). As described by O'Neill and colleagues in addition to learning challenges, a wide variety of complex trauma symptoms can be observed in classrooms ranging from somatic problems, hyperactivity, fear and aggression in younger children, as well as depression and self-harming behavior in adolescents. Similarly, van der Kolk (1987) reports on the learning difficulties frequently experienced by abused children and he further states that "many abused children with learning disabilities are now treated in remedial reading classes, often unsuccessfully, because no attention is paid to the traumatic elements that interfere with perception and cognition" (p. 18).

Harris et al. (2004) state that the problems related to mood modulation and anger regulation experienced by abused children can seriously jeopardize their school performance as well as their ability to establish healthy relationship with their peers, which can ultimately lead to circumstances inflicting pain to self and others. These authors further assert that attention regulation is often undermined in traumatized children and these problems, sometimes resulting from PTSD symptoms, negatively affect school performance.

Reviewing research findings, O'Neill and colleagues (2010) highlight sexual abused children as being the group of students who are most highly diagnosed with learning disabilities. They also emphasize a correlation between children with a major disruptive style of attachment with caregivers and their enrollment with special education as well as Serious Emotional Disturbance (SED) classes. Despite the necessity to both recognize the complex and unique features of each child's development as well as the

broad variability in abused children's reactions to their deviant caregivers (van der Kolk, 1987), these findings may provide valuable information for school counsellors.

#### 6. Concluding comments

To provide effective treatment of Complex Trauma in children, the first step is to have a diagnostic category representing the clinical presentations of children experiencing Complex Trauma, instead of continuously relying on the adult diagnosis of PTSD, which does not capture the developmental components of adjustment to trauma exposure (van der Kolk, 2005a). More fundamentally, van der Kolk (2005) pinpoints the necessity to comprehend the relationship between a wide range of symptoms, currently captured by various and apparently disconnected diagnoses addressing "affect regulation (e.g., bipolar illness), chronic distrust of authority (e.g., oppositional defiant disorder), inability to focus and concentrate (e.g., attention-deficit/hyperactivity disorder), and others" (p. 377). According to this author, none of these separated diagnoses offer a complete framework from which to understand the tremendous suffering endured by traumatized children. As such, mental health professionals are encouraged to become knowledgeable about the various manifestations of Complex Trauma in order to recognize the presence of psychological trauma behind the wide panoply of symptoms displayed by children and adolescents.

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### WEEK 5: Assessment of PTSD and Complex Trauma

This section explores the following topics: 1. The clinical interview, (a) Assessing PTSD, (b) Assessing Complex Trauma in adults, (c) Assessing Complex Trauma in children and adolescents, 2. Qualities of screening measures, 3. Measures for Posttraumatic Stress and Complex Trauma in adults, (a) Self-report measures for adults, (b) Interview-based measures for adults, (c) Measures for children and adolescents, (d) Other types of measures, 4. Concluding comments.

The role of assessment is paramount as a prerequisite for case conceptualization and treatment plans (Cook et al., 2005). As pointed out by Herman (1997), symptoms resulting from occurrences of traumatization cannot be accurately treated if they are not first diagnosed. Therefore, according to Herman, “the therapist’s first task is to conduct a thorough and informed diagnosis evaluation, with full awareness of the many disguises in which a traumatic disorder may appear” (p. 157). On a long term basis, assessment approaches enable clinicians to be confident that implemented interventions are reflecting what is best for addressing each individual’s specific needs (Briere and Scott, 2006).

#### 1. The clinical interview

Even though research findings strongly encourage the use of standardized methodologies (Briere & Scott, 2006; Briere & Spinazzola, 2009), it is of importance to mention the value of the intake session, which, despite its more informal context, offers precious information that may influence future treatment plans (Briere & Scott, 2006).

According to Courtois (2004) and Courtois, Ford and Cloitre (2009), the inclusion of the trauma assessment within a formal psychosocial assessment is the recommended

approach in trauma counselling. More specifically, questions regarding both past and/or present trauma history and the presence of posttraumatic (PTSD) and/or dissociative disorder (DD) symptoms should be included in the intake session. As pointed out by Courtois (2004), the motivation for this recommendation resides in the fact

...that a large number of individuals seeking mental health treatment do so for the direct or indirect consequences of traumatization at some point in their history and that individuals who meet diagnosis criteria for PTSD and for DDs are high end users of mental health services and thus are very likely to be presenting for treatment. (p. 415)

According to Briere and Scott (2006), the focus of the clinical interview, in trauma-related situations, should be directed toward three main areas of evaluation, the (a) client's imminent level of safety; (b) client's psychological stability, and (c) client's level of readiness regarding future assessment and treatment.

The first concern in all trauma-related assessment is "whether the client is in imminent danger of loss of life or bodily integrity, or is at risk for hurting others" (Briere & Scott, 2004, p. 38). Noteworthy for future clinicians, these authors propose, in a hierarchical way, some general guidelines to follow:

1. Is there risk of immediate death (for instance by internal wounds, bleeding, toxic or infectious ways), or serious physical functioning?
2. Is the survivor in a state of incapacitation (for instance because of intoxication, brain injury or serious psychosis) resulting in him/her being unable to assure his/her own safety (for instance, unable to reach accessible food or shelter)?
3. Is the survivor acutely suicidal?

4. Is the survivor representing a danger to others (for instance, homicidal, or uttering plausible threats to hurt someone), particularly when means are obtainable (for instance, a gun)?

(Briere and Scott caution that #3 and #4 are equally important)

5. Is the survivor's imminent psychosocial surrounding unsafe (for instance, is he/she imminently exposed to mistreatment or abuse by others)?

The most important intervention, in the presence of any of these issues, is to provide physical safety to trauma survivors or others, often by referring them to different resources such as emergency medical, psychiatric, social and law enforcement services. Additionally, as much as possible, the involvement of supportive persons such as family members, friends and others can be an important asset for trauma survivors.

The second concern refers to psychological safety. Briere and Scott (2006) warn us of a frequent clinical error consisting of first evaluating psychological symptoms or disorders before assessing the trauma survivor's general level of psychological stability. They remind us of the fragile state of being of individuals who were recently exposed to a traumatic event. More fundamentally, during the assessment, traumatized individuals may still experience a state of crisis or even be so psychologically unstable that they are incapable of fully understanding their present situation. Consequently, responding to clinician's probes or interventions may not only be overly challenging to trauma survivors, they may also result in misleading assessment outcomes. In the same vein, Courtois et al. (2009) remind clinicians of the importance, while addressing the subject of trauma, to approach trauma survivors with the respect, dignity, and the openness they deserve. These authors also encourage clinicians to try to deeply understand how painful,

challenging, and overwhelming it can be for trauma survivors to be asked questions about their traumatic experience(s) as well as to engage themselves in the disclosure of personal trauma details.

The first procedure, in the mental health assessment of trauma survivors, is the evaluation of the relative degree of psychological homeostasis. In such cases in which survivors are overwhelmed or cognitively unstable, interventions leading to clients' stabilization (for instance, reassurance and psychological support) should be attempted as a primary course of action (Briere and Scott, 2006).

It is of importance to note that some clients, even though appearing superficially stable after a traumatic encounter, may unexpectedly exhibit reactions such as heightened anxiety, extreme distress, intrusive symptoms, or abrupt eruption of anger when confronted with questions of the trauma. Named "activation response" (Briere and Scott, 2006, p. 39), these reactions may lead to psychological instability in cases when survivors can not regulate internal distress. Ultimately, these reactions may result in unwanted "retraumatization" in trauma survivors. As such, Courtois (2004) invite clinicians to be aware of and prepared to respond preventively to the spontaneous incidence of symptoms displayed by some clients while discussing trauma information. Therefore, Courtois highlights the importance for clinicians to pay very close attention to clients' conditions both during the session and after (e.g., delayed reactions), as well as to give foremost importance to clients' safety and well-being over the story.

In cases of excessive activation, it is suggested to delay questions and discussion relative to traumatic material (Briere & Scott, 2006; Courtois, 2004). However, the decision to postpone discussions about the trauma must be made diligently, as the need

for assessment is sometimes pressing and talking about the trauma can be helpful (Briere & Scott, 2006).

The third concern refers to the assessment of trauma exposure and effects. When the patient is safe and fairly stable, details about the traumatic experience(s) and reactions can be discussed (for instance, duration, severity, frequency, degree of life threat) followed by the assessment of trauma effects. One word of caution is to avoid assuming that trauma survivors will easily reveal the traumatic event(s) even if it is the specific reason bringing them into therapy. Briere and Scott recommend the assessment of trauma history for every client, whatever the presenting problem. Referring to Complex Trauma, Herman (1997) states that

...explicit questioning is often required to determine whether the patient is presently living in fear of someone's violence or has lived in fear at some time in the past. Traditionally these questions have not been asked. They should be a routine part of every diagnostic evaluation. (p. 157)

#### (a) Assessing PTSD

Because PTSD involves dysfunction in many areas of human functioning, Weathers, Keane, and Foa (2009) pinpoint the "significant conceptual and practical challenges with regard to accurate assessment and diagnosis" (p. 26). These authors propose to closely follow the diagnosis criteria submitted in the DSM-IV-TR (APA, 2000), as this manual presents the modern official construct of PTSD. The Posttraumatic Stress Disorder syndrome, as previously explained, is composed of 17 symptoms divided in three main categories: reexperiencing the trauma, avoidance and numbing of general responsiveness, and hyperarousal. Readers interested in having a complete description of

the assessment of each of the seventeen PTSD symptoms are invited to consult Weathers et al (2004). As a reminder, to be diagnosed with PTSD, an individual must experience at least one of the 5 reexperiencing symptoms (B1-B5), at least three avoidance or numbing symptoms (C1-C7) and at least two hyperarousal symptoms (D1-D5). The assessment of the PTSD clusters of symptoms is essential as a prerequisite to determine the best treatment plan for each individual. This is well exemplified by van der kolk, McFarlane, and van der Hart (2007), who point out the inappropriateness of using flooding therapy with clients experiencing heighten levels of avoidance whereas clients who dissociate need to learn to master 'spacing out' while faced with stressful situations before working on trauma memories.

Weathers et al. (2009) report the complexity surrounding the clinical presentation of PTSD individuals as this syndrome is generally affiliated to comorbid disorders (e.g., anxiety, depression, and substance abuse), somatic complaints and other attributes (e.g., dissociation, affect dysregulation, guilt, and alterations in intimacy and personality). Consequently, a complete PTSD assessment, according to Weathers et al. would "evaluate all the diagnostic criteria, and would also evaluate associated features and comorbid disorders, establish differential diagnosis, and measure and identify the effects of response bias" (p. 27). Similarly, Newman, Kaloupek, and Keane (2007) propose a multimethod assessment which combines suitable measures in order to differentiate individuals who have developed PTSD in the aftermath of trauma exposure. As such, multiple measures are recommended as a means to rise above the psychometric restrictions imbedded in any kind of instruments. More specifically, Newman et al. state that "batteries of tests can be combined to maximize the predictive power of the entire

assessment by incorporating measures with varying levels of specificity and overall efficiency” (2007, p. 246).

An essential task in accurately assessing PTSD is to differentiate this disorder from others, more specifically in the case of PTSD, from adjustment disorder. According to the DSM-IV-TR, a diagnosis of adjustment disorder can be made in the two following situations. First, when the symptoms developing after being exposed to a Criterion A stressor are not fully meeting the PTSD criteria. Second, when the kind of stressor from which symptoms developed does not meet the definition for Criterion A. As a reminder, PTSD can be easily distinguished from Acute Stress Disorder as PTSD symptoms continue to be experienced following the first month after the trauma occurrence (Weathers et al., 2009).

Finally, a paramount task in the assessment of PTSD is also to rigorously evaluate response biases, such as symptoms exaggeration or malingering, as PTSD is highly compensated. Weathers et al. (2009) propose different approaches to detect response biases such as seeking trauma-related information from other sources than the respondent (e.g., medical records, public records, friends, family) and administering a specific malingering instrument (e.g., Structured Interview of Reported Symptoms (SIRS; Rogers, Bagby, & Dickens, 1992).

#### (b) Assessing Complex Trauma in adults

The assessment of the standard form of posttraumatic stress symptoms does not capture the repertoire of symptoms typical to Complex Trauma. Speaking about childhood abuse survivors, Herman (1997) voices how frequently they are misdiagnosed as well as mistreated, because of the variety and complexity of their symptomatology.

More specifically, Herman states that “the patient may not have full record of the traumatic history, even with careful, direct questioning” (p. 157). Furthermore, Herman posits that, even though childhood trauma survivors usually have some recollections of the traumatic history, they do not establish any associations between their past abuse and their current psychological problems.

Taking into account the variety of possible symptoms for each chronically traumatized client, Briere and Spinazzola (2009) caution that a structured assessment may prevent clinicians from unwittingly missing crucial intervention goals, which could result in a defective or incomplete treatment plan. According to these authors, during the initial session, the clinician must “make an educated guess” (p. 108) as to what are the possible areas of dysfunction, related to the client’s presenting problems and trauma history. However, Briere and Spinazzola (2009) state: “This process may be assisted by the early use of broad-spectrum screening instruments that assess a number of different areas of symptomatology simultaneously” (p. 108). In these authors’ view, psychometrically valid psychological tests measuring conditions such as anxiety, psychosis, and depression as well as instruments assessing a variety of posttraumatic symptoms may be used and even re-used in the course of treatment. In fact, repeating tests may present the advantage of informing clinicians about the need to modify a treatment plan. Some tools specifically designed for the assessment of complexly traumatized survivors are presented in a subsequent part of this section.

### (c) Assessing Complex Trauma in children and adolescents

Symptoms of posttraumatic stress disorder are found in children and adolescents as a result of various kinds of events including war, family violence, illness, community

violence, and natural disasters (Balaban, 2009). However, Balaban notes that, basically, the DSM-IV criteria for the diagnosis of PTSD are formulated for adults, not for children. As a matter of fact, the PTSD designation is frequently employed for traumatized children, even though the criteria for this diagnosis are not met for most traumatized children because of the wide array of developmental effects of childhood traumatization (van der Kolk, 2005). As it has been previously discussed, van der Kolk has proposed a new diagnosis, Developmental Trauma Disorder (DTD), which better captures the complexity of trauma symptoms in children (van der Kolk, 2005).

According to Cook et al. (2005), a comprehensive assessment of complexly traumatized children and adolescents involves drawing information from many sources such as the child's/adolescent's personal disclosures, reports from various providers such as caregivers, clinician's observations, and standardized assessment measures. As numerous traumatized children may be involved with court procedures, these authors suggest conducting the evaluation "in a forensically sound and clinically rigorous manner" (Cook et al., 2005, p. 396). Consequently, they mention the necessity to evaluate both complex trauma exposures and complex posttraumatic consequences during the assessment. Additionally, Cook et al. pinpoint numerous other areas worthy of investigation such as: "developmental history, family history, trauma history for child and family, primary attachment relationships, child protective services involvement and placement history, parental/family mental illness, substance abuse, legal history, coping skills, strengths of child/adolescent and family, and environmental stressors" (p. 396). In the same vein, Putman (2009) proposes the use of a wide range of resources accessible to

clinicians for the assessment of traumatized children, including resources from outside authorities such as teachers, physicians, family, social workers, clergy, and legal services.

Of interest, Balaban (2009) reminds clinicians about the importance, when using assessment instruments with young children, to consider children's restricted verbal abilities as well as their various ways of responding to stress. As such, young children may be unable not only to verbalize their symptoms but also to communicate signs of how they experience symptoms such as numbing and withdrawal. Furthermore, instead of displaying reexperiencing symptoms in the forms of flashbacks or intrusive thoughts, young children may exhibit them as play reenactment. As pointed out by Pynoos and Nader (1993), particular techniques of interview may be of necessity to both facilitate a rigorous exploration of childrens' inherent traumatic experience(s) and help them comprehend the meaning of their reactions. More specifically, Pynoos and Nader (1993) state: "Encouraging children's expression through drawing, play, dramatization, and metaphor, the therapist attempts to understand the traumatic links and looks for ways to recruit children's fantasy and play actively into communication about their experience" (p. 541).

## 2. Qualities of screening measures

It is paramount for future clinicians to understand the inherent qualities a screening measure or a diagnosis instrument must possess if it is to be considered a valid instrument to be used in clinical settings. In Harris, Putnam, and Fairbank's (2004) words, "...the validity of a screening measure is measured by how well it does what it is supposed to do, that is, to accurately categorize individuals as to whether they are positive or negative for a particular disorder" (p. 15). Thus, the effectiveness of a

measure can be quantified, according to these authors, by the calculation of some inherent attributes such as its specificity, sensitivity, and positive and negative predictive value. Harris et al. link the sensitivity of a test to its probability to test “positive” when, indeed, tested subjects have the disorder, which determines the positive predictive value of the test. In contrast its specificity involves the probability to test negative if the disorder is really absent in tested subjects, which determines the negative predictive value of the given instrument. Even though very high sensitivity and specificity are the ‘ideal’ to achieve for a test, in practice it is necessary to weigh the probability of an instrument to have false positive and false negative for numerous cut-off scores of the test. A false positive screen is the result of a false detection: a person is identified as having the disorder when, in fact, the condition is absent. In comparison, a false negative “miss” the detection of a person who truly has the disorder.

Briere and Spinazzola (2009) remind clinicians that some trauma-related instruments “were developed in research contexts and do not meet current standards for clinical psychological tests” (p. 107), because of a variety of reasons including unknown clinical applicability, absence of normative data, and unknown utility. Consequently, their advice for clinicians is to avoid, as much as possible, the use of nonstandardized measures in trauma-related assessments. Building upon research findings, Briere and Spinazzola (2009) propose the assessment measures described below for PTSD and Complex Trauma in children and adolescents as well as adults. Of importance, these measures are evidence-based, meaning that they have adequate levels of sensitivity and specificity in controlled studies and they are standardized or normalized on the general population. Readers interested in obtaining more detailed information on evidenced-

based trauma measure instruments than that provided below are encouraged to refer to Briere and Spinazzola's article titled *Assessment of the sequelae of complex trauma* (2009). Of note, some psychological tests cited below are followed by a bracket indicating the name of the researcher(s) responsible for its conception. Therefore, references for these tests are added in the reference list.

### 3. Measures for PTSD and Complex Trauma

Briere and Spinazzola (2009) point out the existence of two types of psychological tests related to posttraumatic stress. First, there are tests measuring symptoms of posttraumatic stress without reference to a specific trauma. These tests give a general measure of the "quantity" of posttraumatic symptoms endured by a person in a range of various areas. Second, there are tests exploring responses in reference to a specific traumatic experience. These tests offer a temporary diagnosis of PTSD. Similarly, Briere and Scott report that psychological tests for Complex Trauma are also divided in two categories. First, there are tests measuring a broad range of non-trauma-specific psychological symptoms and, second, there are tests which directly target different types of posttraumatic symptoms.

#### (a) Self-report measures for adults

##### *Trauma Symptom Inventory (TSI)*

This test explores the general level of posttraumatic symptoms endured by trauma survivors in the previous 6 months. It is composed of three validity scales (Response Level, Atypical Response, and Inconsistent Response) as well as 10 clinical scales (Anxious Arousal, Depression, Anger/Irritability, Intrusive Experiences, Defensive

Avoidance, Dissociation, Sexual Concerns, Dysfunctional Sexual Behaviors, Impaired Self-Reference, and Tension Reduction Behavior).

*Posttraumatic Stress Diagnostic Scale (PDS)*

The PDS (Foa, 1995) assesses four areas: exposure to potentially traumatic experiences, features of the most traumatic event, 17 symptoms related to DSM-IV PTSD criteria, and the range of symptoms interference in trauma survivors day-to-day life.

*Detailed Assessment of Posttraumatic Stress (DAPS)*

The DAPS (Briere, 2001) possess two validity scales and 10 scales assessing lifetime exposure to traumatic experiences, immediate trauma-specific responses in the cognitive, emotional, and dissociative domains, the following symptoms of PTSD as well as Acute Stress Disorder (ASD), and three related components of posttraumatic stress: trauma-specific dissociation, suicidality, and substance abuse.

(b) Interview-based measures for adults

*Clinician-Administered PTSD Scale (CAPS)*

The CAPS (Blake et al., 1995) is a structured diagnostic interview providing two kinds of scores (dichotomous and continuous) for the current and lifetime PTSD. Furthermore, this interview succinctly explores phenomena related to complex posttraumatic disruption, such as dissociation, homicidality, guilt, disillusionment with authority, memory impairment, hopelessness, depression, and feelings of being overwhelmed.

*Structured Interview for Disorders of Extreme Stress (SIDES)*

The SIDES (Pelcovitz et al., 1997) is composed of 45 items scoring the present and lifetime presence of the DESNOS criteria, not only for the whole construct but also

for each of the six symptoms categories: affect dysregulation, somatization, self-perception, alterations in attention or consciousness, relationships with others, and systems of meaning.

*Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D)*

The SCID-D (Steinberg, 1994) explores the existence and severity of five symptoms of dissociation: depersonalization, amnesia, identity confusion, derealization, and identity alteration. In addition, this interview gives diagnosis for the five foremost DSM-IV dissociative disorders, in conjunction with ASD. Finally, this interview provides “intrainterview dissociative cues” (Briere and Scott, 2009, p. 116), such as spontaneous age regression, alterations in demeanor, and trance-like appearance.

(c) Measures for children and adolescents

*Child Behavior Checklist (CBCL)*

The CBCL (Achenbach, 1991; revised version of this test can be found in Achenbach, 2002) measures various problems which may result from abuse of other forms of trauma, such as somatic problems, withdrawal, delinquent behavior, and thought problems. This test also explores competencies which may change or diminish these problems.

*Trauma Symptom Checklist for Children (TSCC)*

The TSCC (Briere, 1996) assesses self-reported trauma symptomatology in 8-16 aged children, with small normative corrections for 17-years-olds. It is composed of two validity scales (underresponse and hyperresponse) as well as six clinical scales: depression, anxiety, posttraumatic stress, anger, dissociation (with two subscales) and sexual concerns (with two subscales).

### *Trauma Symptom Checklist for Young Children (TSCYC)*

The TSCYC (Briere, 2005) serves to evaluate various trauma-related symptoms in children aged 3-12. It is composed of two caretaker report validity scales (Response level-RL; and Atypical response-ATR) in addition to a norm-referenced item scoring the number of hours per week the caretaker and the child spend together. This instrument comprises nine clinical scales: Posttraumatic stress-avoidance, posttraumatic stress-intrusion, posttraumatic stress-arousal, posttraumatic stress-total, anxiety, depression, sexual concerns, anger/aggression, and dissociation.

### *Child Sexual Behavior Inventory (CSBI)*

The CSBI (Friedrich, 1998) explores the sexual behaviors displayed by children aged 2-12, in the previous 6 months. Nine areas often linked to childhood sexual abuse are monitored by this instrument: exhibitionism, self-mutilation, sexual anxiety, boundary problems, gender role behavior, sexual interest, sexual intrusiveness, sexual knowledge, and voyeuristic behavior. This instrument provides a total score as well as a two scale score: (1) developmentally related sexual behaviors, which represents the level of age and sexual behaviors that are gender-appropriate; and (2) sexual abuse-specific items including items which have been empirically linked to a sexual abuse history.

### *Trauma Symptom Inventory (TSI)*

The TSI (Briere, 1996), which has already been presented under the interview-based measures for adults, is frequently used for older adolescents, aged 18-21. Some attributes of the TSI are particularly pertinent to traumatized adolescents who are inclined to externalize their distress, such as dysfunctional sexual behavior, affect dysregulation, identity disturbance, and anger/aggression.

#### (d) Other types of measures

Of note, Briere and Scott (2009) point out other psychological tests that can be very useful in trauma assessment such as (1) generic measures designed to assess non-trauma-specific symptoms in chronically traumatized individuals. Of note, many of these tests evaluate syndromes related to Axis I and Axis II of DSM-IV, as well as self-capacity difficulties frequently linked to Complex Trauma repercussions; (2) self-capacity measures addressing Complex Trauma difficulties such as affect regulation, boundary awareness, identity, and interpersonal relationships; (3) cognitive disturbance measures, assessing chronic cognitive symptoms frequently present in individuals with Complex Trauma such as cognitive distortions and negative interpersonal schemas; (4) dissociation measures, evaluating dissociative symptoms; and (5) measures of dysfunctional behavior, assessing externalization and tension reduction behaviors. Readers are invited to consult Briere and Scott (2009) for more details regarding these tests.

#### 4. Concluding comments

The role of assessment is paramount in trauma counselling. As such, a meticulous clinical interview and the use of multiple evidence-based modes of assessment are the foundation of a valuable assessment. More specifically, psychometric tests detecting not only specific symptoms of PTSD and Complex Trauma but also associated comorbid dysfunctions, as well as psychological tests are of necessity in order to get a more complete picture of trauma survivors impairments in various areas of functioning. By building a solid groundwork in the realm of assessment, mental health professionals are better prepared to competently treat trauma survivors.

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### Section 6: PTSD Modes of treatment

This section explores the following topics: 1. Clinical considerations for PTSD treatment, (a) Treatment goals, (b) PTSD treatment, (c) Comorbidity, (d) Suicidality, (e) Chemical abuse/dependence, (f) Concurrent general medical conditions, (g) Disability and functional impairment, (h) Indications for hospitalization; 2. Overview of some PTSD Treatment, (a) Psychoeducation, (b) Cognitive therapy, (c) Cognitive Processing Therapy, (d) Stress-anxiety Management, (e) Stress Inoculation Training, (f) Exposure Therapies, (g) Dialectical Behavior Therapy, (h) Acceptance and Commitment Therapy; 3. The emergence of new treatments for PTSD; 4. Concluding comments.

The treatment of trauma survivors is at the core of counsellors' clinical work. However, "part of ethical practice involves being informed as to which interventions and therapies are effective, which are not effective, as well as those that could potentially cause harm" (Black, 2004, p. 1). Therefore, this section presents an overview of some modes of therapies utilized in the treatment of trauma survivors experiencing the symptoms of PTSD, in addition to providing some clinical considerations underlying the treatment of PTSD. Due to the extensive literature in this subject, and the consequent impossibility to incorporate a detailed explanation of all approaches and interventions in the context of this work, readers are referred to other sources of literature throughout the unfolding of this section.

#### 1. Clinical considerations for PTSD treatment

At the outset of this section, the following question is worth addressing: Are there clinical considerations, imperative for clinicians to think about, when making decisions

about the best treatment plan for PTSD individuals? Building upon clinical practice, Foa, Keane, Friedman, and Cohen (2009) have identified eight clinical considerations influencing treatment decisions.

(a) Treatment goals

Foa et al.(2009) highlight the variation of therapeutic goals depending upon the modes of treatment used for treating PTSD. For instance, some PTSD treatments such as Eye Movement Desensitization and Reprocessing (EMDR), pharmacotherapy, and cognitive-behavioral therapy aim at reducing PTSD symptoms. In contrast, others forms of treatment such as art therapy and hypnosis focus more on the capacity to enhance the process of therapy, rather than directly targeting PTSD symptoms. Additionally, some treatments including psychosocial rehabilitation focus on improving daily functionality, with or without lessening PTSD symptoms. In comparison, some kinds of interventions such as substance abuse treatment and hospitalization center essentially on comorbid disorders needing to be addressed before the beginning of PTSD treatment. The current view about PTSD treatment, however, highlights a treatment goal which is threefold, encompassing a diminution of PTSD symptoms severity, a reduction of comorbid symptoms (e.g., depression, anger, shame, general anxiety, and guilt), and an emphasis on a better lifestyle (Foa et al., 2009).

(b) PTSD treatment

According to Foa et al. (2009), PTSD modes of treatments are effective if interventions result in a diminution of “symptom frequency, intensity, or severity” (p. 9). While some modes of treatment seem to diminish the three categories of PTSD symptoms, others appear to be effective in diminishing only one category of symptoms

(either intrusion, avoidant/numbing, or arousal symptoms), but not others. According to Foa et al., however, some experts in trauma treatment claim that clinical efficacy of a certain treatment depends upon a general improvement in PTSD, instead of a reduction in specific PTSD symptoms.

#### (c) Comorbidity

Due to the high percentage of comorbidity associated with lifetime PTSD, as much as 80% according to U.S. epidemiological findings, effective clinical practice involves therapeutic interventions targeting the amelioration of both PTSD and comorbid symptoms (Foa et al., 2009). The cognitive-behavioral therapy (CBT) is an example of therapy reducing these two sets of symptoms conjointly. Other researchers such as Wilson, Friedman, and Lindy (2001) suggest combining different modes of treatments (e.g., pharmacotherapy and individual or group therapy; Friedman, 2000) for the treatment of comorbidity and PTSD. However, when trauma survivors experience overwhelming symptoms of depression or anxiety, McFarlane (2001) points out the necessity for them to develop control over these primary symptoms before they can accept to work on the underlying symptoms of PTSD.

#### (d) Suicidality

A necessary procedure, when assessing PTSD patients, is to include a conscientious evaluation of current suicidal ideation as well as past occurrences of suicidal attempts (Foa et al., 2009). Foa et al. highlight the importance of evaluating risk factors for suicidality, including current depression and substance abuse. When client's safety as an outpatient is of concern, immediate actions such as hospitalization must be the focus of treatment. Furthermore, in cases in which suicidality results from current

depression and/or substance dependency, Foa et al. emphasize the importance of directing the therapeutic focus on either or both of these afflictions before implementing PTSD treatment.

(e) Chemical abuse/dependence

In most cases, when there is serious substance abuse/dependency in an individual, this condition should be treated first and brought under control before initiating PTSD treatment (Foa et al., 2009). Even though Najavits et al. (2009) acknowledge the extensive use of a sequential approach to PTSD treatment - treating successfully Substance Use Dependency (SUD) first, followed by PTSD - they state that “research on integrated treatment consistently indicates that it is helpful for this comorbid population” (p. 517). Najavits et al., direct our attention toward an integrated model of therapy for both PTSD and SUD called Seeking Safety (SS; 1998, p. 517), which is a CBT-based mode of treatment incorporating psychoeducation as well as coping skills. This model aims at helping trauma survivors achieving a higher level of safety in their daily lives. Of note, this “model has been rigorously tested and shown to be effective” (Friedman, Cohen, Foa, & Keane, 2009, p. 630). According to Najavits et al. (2009), this model has been conceived for individuals and group contexts; can be used in various settings (outpatient, inpatient residential); as much with men than women; and with all kinds of trauma and types of substances. Furthermore, Najavits et al. (2009) highlight the SS model as being the most studied model for any comorbid condition with PTSD. For more information concerning this model of therapy, readers are invited to consult Najavits’s (2002) book titled *Seeking Safety*.

(f) Concurrent general medical conditions

As stated by Foa et al. (2009): “Compared to nontraumatized individuals, trauma survivors report more medical symptoms, use more medical services, have more medical illnesses detected during a physical examination, and display higher mortality” (p. 10). More specifically, these authors highlight the growing evidence that trauma survivors seem to be more at risk of developing medical conditions. Even though only a small number of studies have suggested that PTSD may act as a mediator to detrimental medical conditions, there are currently no studies exploring the effects of PTSD treatment among patients with medical conditions (Foa et al., 2009).

(g) Disability and functional impairment

Foa et al. (2009) remind mental health professionals of the wide variation between PTSD survivors in regard to symptom severity, comorbidity, complexity, chronicity, functional impairment and associated symptoms. Consequently, these disparities may influence not only the kind of treatment chosen but also the targeted clinical goals.

(h) Indications for hospitalization

Situations necessitating inpatient treatment should be examined in the following cases:

... when the individual is in imminent danger of harming self or others, has experienced functional or psychological destabilization, exhibits a significant loss of functioning, is in the throes of major psychological stressors, and/or is in need of specialized

observation/evaluation in a secure environment. (Foa et al., 2009, p. 11)

As specified by Foa et al. (2009), a broad recommendation would be that hospitalization must be done in association with outpatient providers and be incorporated into the entire long-term developed treatment plan.

## 2. Overview of some PTSD Treatments

A wide variety of treatments have been employed in the treatment of posttraumatic stress disorder including hypnosis (see: Cardeña, Maldonado, van der Hart, & Spiegel, 2009), creative art therapies such as art, music, dance/movement, and psychodrama (see: Johnson, Lahad, & Gray, 2009; Spring, 1994; Vogel, 1994), writing (see: Feldman, Read Johnson, & Ollayos, 1994), action therapies (see: Scurfield, 1994; Stuhlmiller, 1994), psychodynamic therapy (see: Kudler, Krupnick, Blank, Herman, & Horowitz, 2009; Lieberman, Ghosh Ippen, & Marans, 2009), and group therapy (see: Herman & Lawrence, 1994; Kaplan, 1994; Shea, McDevitt-Murphy, Ready & Schnurr, 2009). However, throughout the trauma literature, the cognitive-behavioral therapies (CBT) are considered as some of the most effective kinds of therapy for the treatment of PTSD, because of their effectiveness in addressing many of the symptoms resulting from trauma exposure (Cahill, Rothbaum, Resick, & Follette, 2009; Friedman, Cohen, Foa, Keane, 2009). As stated by Friedman et al. (2009), “this conclusion [concerning CBT effectiveness] is shared by all other clinical practice guidelines for PTSD” (p. 622).

CBT aims at improving emotional well-being and daily functioning by identifying emotions, thoughts, and behaviors linked to psychological turmoil. These feelings, beliefs, and behaviors are then revised by means of critical analysis and experiential

investigation in order to be consistent with positive outcomes and desire future life goals (Jackson, Nissenson, & Cloitre, 2009). According to Blake and Sonnenberg (1998), two different approaches have been utilized in cognitive-behavioral therapy with traumatized individuals. The first approach assists traumatized individuals in the identification of cognitive distortions or irrational beliefs with the goal of challenging and replacing these inaccurate thoughts by more beneficial ones. The second approach helps individuals to recognize the themes, stories, or narrative memories associated with the trauma, with the goal of helping individuals to endorse more flexible and more rewarding ones (e.g. Meichenbaum, 1994). As noted by Blake and Sonnenberg (1998), the practice of cognitive-behavioral therapy with trauma individuals involves most frequently a mixture of treatment interventions, with roots both in the cognitive and constructivist approaches.

In their book titled *Treating survivors of childhood abuse: Psychotherapy for the interrupted life*, Cloitre, Cohen and Koenen (2006) point out their utilization of techniques of intervention mostly derived from CBT in their therapeutic work with adults survivors of childhood abuse. As they state: "These include, for example, strategies for evaluating beliefs about oneself and the world, and use of role playing to facilitate new learning and behavioral changes" (p. xi). These authors further emphasize the inherent philosophy in CBT which entails practice of new ways of behaving, feeling, and thinking.

There are a number of CBT techniques commonly employed in the treatment of chronic PTSD (duration of symptoms more than 3 months) which have been found to improve PTSD symptomatology (Cahill, Rothbaum, Resick, & Follette, 2009; Litz and Bryant, 2009; Zoellner, Fitzgibbons, & Foa, 2001). The various interventions identified throughout the literature include psychoeducation, cognitive therapy (CT), cognitive

processing therapy (CPT), stress management skills training, stress inoculation training (SIT), exposure therapy (ET), dialectical behavior therapy (DBT) and acceptance and commitment therapy (ACT). According to Litz and Bryant (2009), “all of the CBT is collaborative, action-oriented and experiential, and utilizes homework and *in vivo* application of strategies learned in face-to-face therapy” (p. 119). A brief overview of these interventions is provided below.

#### a) Psychoeducation

According to Litz and Bryant (2009), there is not a definite delivery process relative to psychoeducation. However, clinicians generally provide information that (1) help trauma survivors understand how traumatic experiences impact their functional competencies as well as their mental well-being; (2) assist trauma survivors in explaining what cause their symptoms, typically by using a conditioning and learning framework of reference; (3) furnish realistic expectations regarding treatment requirements and procedures as well as positive exigencies about its efficiency. In addition, trauma education has a special importance in treatment, as it may yield some relief to trauma survivors. Building upon their clinical experience with war-zone-related PTSD, Flack, Litz, and Keane (2001) state:

PTSD is explained as a normal, natural adaptation to the extreme stress of warfare and its sequelae. Clients are taught that recovery is facilitated by the effective handling of daily stressors, the telling (and retelling) of their story, and the gradual reestablishment of interpersonal ties at home and at work. (p. 84)

## b) Cognitive therapy

The goal of cognitive therapy (CT) is to replace automatic thoughts by more helpful, accurate, and logical ones. Taking roots in Beck's CT for the treatment of depression (Meadows and Foa, 1998), this approach emphasizes that emotional states evolve from one's interpretation of an event, rather than from the event itself (Cahill, Rothbaum, Resick, & Follette, 2009). What all CT have in common is that

...they provide experiential opportunities for patients to monitor, to examine critically, and to change the way they think about various trauma-related challenges and modify beliefs about the meaning and implication of the trauma as manifested in generalized expectations about the self and various outcomes. (Litz and Bryant, 2009, p. 119)

The specific alterations in core schemas, resulting from traumatic experiences, can be targeted and cognitively restructured in counselling sessions in order to be replaced by more beneficial thoughts about self and the world (Meadows & Foa, 1998).

## c) Cognitive Processing Therapy

Initially developed by Resick and Schnicke (1993) for the treatment of rape survivors (Meadows & Foa, 1998), Cognitive Processing Therapy (CPT) encompasses three components: education regarding PTSD symptomatology and information processing theory; exposure; and cognitive therapy (Zoellner et al., 2001). Of interest, information processing theory refers to the way we encode and recall information in memory (Resick & Schnicke, 1993). More specifically, this theory posits that one way by which humans organize and process incoming information is through the elaboration of schemata. As stated by Resick and Schnicke, "a *schema* is a generic stored body of

knowledge that interacts with the incoming information such that it influences how the information is encoded, comprehended, and retrieved” (1993, p. 10). As such, schema influence the attention we give to events, how we interpret them, the expectations we have of ourselves and the world, and our ability to cognitively integrate experiences happening in our lives. In their book titled *Cognitive processing therapy for rape victims*, Resick and Schnicke (1993) present the content of each of the twelve session programs they use in their work with rape survivors.

#### d) Stress-anxiety Management

Fundamentally, the goal of stress management training is the help trauma survivors to cope more positively with the wide range of responses (behavioral, cognitive, and emotional) they are prone to have to the usual annoyances and stressors of daily life (Flack, Litz, & Keane, 2001). Numerous strategies are employed as coping mechanisms with stress, including cognitive interventions, relaxation techniques (e.g., diaphragmatic breathing and progressive muscle relaxation), social skills strategies, biofeedback, and other stress management techniques such as stress inoculation training (SIT; Meichenbaum, 1985). Even though there is not a specific process for stress management, Litz and Bryant (2009) point out the usual teaching of skills related to arousal modulation and affect dysregulation.

The rationale behind the teaching of stress management techniques to trauma survivors encompasses multiple advantages. Making reference to their personal clinical experience with veterans, Flack, Litz and Keane (1998) report that, theoretically, as arousal symptoms and detrimental emotions are important causes of memory activation, a diminution of stress responses in an individual should provoke a diminution in

reexperiencing symptoms. Furthermore, learning skills to control the effects of stress empower trauma survivors with coping skills they can use in a broad range of stressful situations, thus reducing avoidance behaviors. Advantageously, this lessening of avoidance implies the exposure to various situations frequently associated with the trauma, situations acting as “corrective information” (Flack et al., 1998, p. 85) of the trauma experience. Finally, according to Flack et al., the possibility of relapse is diminished when trauma survivors possess positive coping strategies against daily stressors.

#### e) Stress Inoculation Training

Stress Inoculation Training (SIT) is an anxiety or stress- management program which has been extensively studied in PTSD survivors and encompasses various components such as education, breathing control, relaxation, cognitive restructuring, thought stopping, and covert modeling (Meadows and Foa, 1998; Zoellner, Fitzgibbons, & Foa, 2001).

In their use of SIT with war-zone- related PTSD, Flack, Litz, and Keane (1998) describe the sequence of three stages which consist to (1) help survivors understand the causes of stress, the stress response, and substitute ways of coping; (2) teach survivors stress management skills (e.g., problem solving), encourage them to practice these skills, and inform them about their performance; and (3) encourage survivors to employ these skills in real-life context and to continue using these skills in different contexts. Flack et al. (1998) emphasize the importance for veterans to experience at least some success while learning how to deal with stress, as a means to reinforce the use of these techniques and sustain an optimistic attitude as when encountering more challenging situations.

#### f) Exposure therapies

Many authors highlight the importance of using graduated and controlled exposure in the treatment of PTSD (Cahill, Rothbaum, Resick, Follette, 2009; Zoellner, Fitzgibbons, & Foa, 2001). Various effective modes of treatment, such as Prolonged Exposure, SIT, and CPT, which are all rooted in the cognitive-behavioral approach, have the common characteristic of purposefully exposing trauma survivors to their own trauma memories (Luxenberg, Spinazzola, Hidalgo, Hunt, and van der Kolk, 2001). More specifically, the therapeutic goal behind the activation of traumatic memory, conjointly with any related affect, is to modify these memories and therefore diminish or release any negative affect connected to them. Consequently, traumatic memories lost their rigid and disturbing attributes and resemble more non-traumatic experiences.

Prolonged exposure treatment was developed by Foa and her colleagues (1994; Meadows and Foa, 1998). The treatment program includes the gathering of information related to both the traumatic experience and the trauma survivor's reactions to it, psychoeducation, the teaching of breathing retraining techniques (how to breathe in a calming way), the reliving of the trauma in imagination (imaginal exposure), and the *in vivo* exposure or confrontation with trauma memories. For more information concerning Prolonged Exposure therapy for PTSD, readers are invited to refer to Foa, Hembree, and Rothbaum (2007).

Another exposure-based mode of treatment is Eye Movement Desensitization and Reprocessing (EMDR). This mode of treatment has been introduced by Shapiro in 1989 and consists of a sequence of eight stages (Spates, Koch, Cusack, Pagoto, & Waller, 2009). EMDR involves engaging clients in bilateral stimulation (e.g., eyes stimulation by

means of following in a cadence objects in motion; hand taps; or alternating audible tones) while remembering traumatic memories, along with the associated emotions and faulty beliefs. Importantly, the processing of traumatic memories, through EMDR, has been found to be highly effective in dealing with traumatic experiences (Blake & Sonnenberg, 1998; Foa, Keane, Friedman, & Cohen, 2009; Spates, Koch, Cusack, Pagoto, & Waller, 2009) and frequently faster improvement compared to verbally based modes of treatments (Luxenberg et al. 2001).

#### g) Dialectical Behavior Therapy

As noted by Welch and Rothbaum (2007), "...although exposure therapy has demonstrated efficacy and is one of the best treatments for PTSD, there has been some concern that clients with poor emotion regulation skills may have trouble with the treatment" (p. 485). To address some problems relative to the use of exposure therapy, two treatments, Dialectical Behavior Therapy (DBT) and acceptance and commitment therapy have been proposed (Welch and Rothbaum, 2007). According to these authors, DBT is a behavioral treatment elaborated by Linehan (1993) based on the premise that dysfunction in individuals relates to a lack of emotion regulation. Therefore, the teaching of skills thought to be essential to regulate intense affect such as emotion regulation, interpersonal effectiveness, mindfulness, and distress tolerance, have a central importance. Throughout the treatment, a balance between acceptance and change is emphasized and various acceptance and change-based strategies are used in order to increase clients' motivation as well as commitment. Of interest for trauma clinicians, Welch and Rothbaum (2007) highlight the mounting interest in the application of this mode of treatment "because of the pattern of emotion dysregulation, treatment

noncompliance, dropout, and avoidance in patients with PTSD, areas specifically targeted in DBT” (p. 486).

#### h) Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) is based on the assumption that psychopathology results from one’s efforts to avoid or change personal experiences (e.g., distressing emotions, thoughts, memories) related to an experience, rather than from the experiences themselves (Welch & Rothbaum, 2007). Therefore, the main goal of ACT is to “help clients become more accepting and willing to experience painful private experiences” (Welch & Rothbaum, 2007, p. 488). As such, symptoms of avoidance of distressing internal stimuli, such as thoughts about the trauma, are directly targeted by ACT. This mode of treatment might be more gradual than that of prolonged exposure and it promotes a systematic elaboration of clients’ goals, related to their personal value system, instead of a reduction in symptoms. (Welch & Rothbaum, 2007). Consequently, clients are encouraged to engage in behavioral change in order to achieve these goals, even in circumstances when the behavior is emotionally challenging and results in past avoided experiences. Building upon research findings, Welch and Rothbaum (2007) point out the limited direct evidence regarding the efficacy of ACT for PTSD, despite its documented effectiveness with numerous other disorders. The theoretical background underlying ACT is described in Hayes, Strosahl, and Wilson (1999) for readers interested to expand their knowledge regarding this approach of therapy.

### 3. The emergence of new treatments for PTSD

In addition to DBT and ACT which have just been presented, there are other new forms of treatment for PTSD. Treatment using novel technology such as Internet-

delivered approaches and virtual reality exposure therapy as well as treatments highlighting social support such as group therapy, and family or couple therapy are some examples of new types of therapies to treat trauma survivors (Welch and Rothbaum, 2007). Furthermore, imagery-based treatment, such as imagery rescripting and dream/imagery rehearsal for nightmares as well as 'power therapies' are other examples of emerging treatments for PTSD described by Welch and Rothbaum (2007).

As stated by Benight, Ruzek, and Waldrep (2008), "the World Wide Web offers the best of worlds and the worst of worlds for trauma survivors" (p. 513). Offering interactive information as well as support to people anytime, Web delivery has the possible advantage of diminishing the social stigmatization frequently linked with seeking mental health help, support clinicians' education, enhance the delivery of superior intervention practices by means of better quality supplies, and make research easier (Benight et al. 2008). According to Benight et al. (2008), however, the Internet "also provides an unfiltered vehicle for inaccurate, misleading, possibly harmful information to unsuspecting consumers" (p. 513). Of interest, the Internet is shifting the way by which individuals find help when the need arises. For general information concerning the use of the Internet for psychological treatment, including traumatic stress, as well as the pros and cons of various types of interventions, readers are referred to Benight et al., 2008, Marks et al., 2007, Newman, 2004, and Tate and Zabinski, 2004.

Virtual reality exposure (VRE) has been used with Vietnam veterans with PTSD (Welch and Rothbaum, 2007). As noted by these authors, "during VRE therapy sessions, patients wear a head-mounted display device that contains two television screens and stereo speakers that expose patients to both sights and sounds consistent with the

Vietnam experience” (p. 481). According to Welch and Rothbaum (2007), the primary limitations to VRE include the (1) drawbacks of the technologies; (2) current limited acceptance of the technology by clients, clinicians, and institutions; and (3) cost.

However, primary evaluation of VRE points out the success of this treatment mode for PTSD. For more information regarding studies related to VRE, readers are invited to consult Rothbaum et al., 1999 and Rothbaum, Hodges, Ready, Graap, & Alarcon, 2001.

Due to the strong influence of social support on both the development of PTSD in the aftermath of trauma and the recovery of this disorder by survivors, some clinicians have emphasized the utilization of treatments centering more on social support, such as family therapy, at least in addition to CBT (Welch and Rothbaum, 2007). Shea, McDevitt-Murphy, Ready, and Schnurr (2009) posit that group therapy is one of the most common modes of treatment used for PTSD. Shea et al. note the numerous dimensions by which group approaches vary from one another, including objectives and goals, theoretical foundation and strategies, organization of the group (open or closed), number and length of sessions, and length of treatment. However, according to Welch and Rothbaum (2007) “the problem is that group therapies for PTSD remain a woefully understudied phenomenon” and, consequently, there is a need for more research (p. 484). For an updated revision of the three main applications of group therapy for PTSD – psychodynamic group therapy, supportive group therapy, and cognitive-behavioral group therapy – as well as the supporting data for each treatment, readers are referred to Shea, McDevitt-Murphy, Ready, and Schnurr (2009). In addition, others sources of information on the use of group therapy for PTSD include Brand, 1996, Foy, Ruzek, Glynn, Riney,

and Gusman, 2002, McMackin, Leisen, Sattler, Krinsley, & Riggs, 2003, and Schnurr et al., 2003.

Imagery-based treatments include imagery rescripting (IR) and imagery rehearsal therapy (IRT). IR includes asking clients to “manipulate recurrent, distressing images mentally through “rescripting”, which is intended to modify the images and challenge trauma-based beliefs, particularly those containing themes of powerlessness and helplessness” (Welch and Rothbaum, 2007, p. 475). The new images produced through this process are clients-generated and the therapist support the method by means of Socratic questioning (i.e., “If you could now change that part of your image in any way to make it less threatening or frightening, what change or changes would you introduce?” (Welch & Rothbaum, 2007, p. 475). As such, clients are encouraged to replace imagery of victimization by imagery of mastery. In comparison, IRT is a brief, group-based mode of treatment developed specifically to treat nightmares but which may also be useful for PTSD symptoms (Welch & Rothbaum, 2007). However, not all studies involving this approach have confirmed a diminution of PTSD symptoms. Of note, IR and IRT both utilize exposure to trauma material, with a decreased intensity, as well as a modified form of cognitive restructuring. For more information on these two forms of treatments, readers are referred to Krakow, Hollifield, et al., 2000, Krakow, Hollifield, et al., 2001, Krakow, Haynes, et al., 2004, and Krakow, Germain, et al., 2002.

Finally “power therapies”, such as trauma incident reduction (TIR), visual kinesthetic disassociation, eye movement desensitization and reprocessing (EMDR), and thought field therapy (TFT), are professed to be more powerful than the traditional CBT (Welch and Rothbaum, 2007). Power therapies allege to drastically improve PTSD

symptoms in a short period of time, sometimes in only one session. TIR consists of having trauma survivors repeatedly imagine their traumatic experience while the clinician provides only basic imagery directions during this process as well as unconditional positive regard. This process increases trauma survivors' positive emotions, instead of increasing negative emotions, and aid them to develop deeper insight about the traumatic experience. Visual kinesthetic dissociation momentarily induces dissociation from negatives feelings linked with the trauma by means of visually reviewing the event from a different point of view. The goal of this process is to encourage the resolution and diminution of negative emotions associated with the traumatic experience. After the process of dissociation, trauma survivors are "reassociated" (Welch and Rothbaum, 2007, p.478) and aided to retain the learning which took place during the dissociation period. TFT includes imagining the traumatic experience, evaluating personal discomfort, and tapping oneself on different parts of the body as instructed by clinicians. If clients do not experience a diminution in personal anxiety, the tapping is repeated. The alleged efficacy of this treatment resides in the use of circulatory fields or "meridians" within the body, which supposedly direct numerous "thought fields" in such a way that clients' symptoms are eliminated. Finally, for EMDR which has been previously discussed in this section, readers are invited to consult Resick, Monson, and Gutner (2009) for a review of this mode of treatment. Of importance, Welch and Rothbaum (2007) note that data for TIR are limited to unpublished dissertation, uncontrolled case studies and a controlled trial; research for visual kinesthetic dissociation is limited to a small, multiple baseline study; and there is no "convincing evidence for the theory of TFT" (p. 479). For additional information readers are referred to Gerbode, 1985, Figley and Carbonell, 1999,

and Valentine and Smith, 2001, for trauma incident reduction therapy; Commons, 2001, Gallo, 1996, and Hossack and Bentall, 1996, for visual kinesthetic dissociation; and Callahan and Callahan, 1997 for thought field therapy.

#### 4. Concluding comments

Even though some modes of treatment for PTSD have proved their effectiveness, others represent new paths in the treatment of this disorder and still need more clinical and empirical research before they can be confidently and extensively accepted and used for treating trauma survivors. Future clinicians are encouraged to use their professional judgment, based on a strong foundation of reliable knowledge as well as adequate training, before deciding of the best modes of treatment for PTSD trauma survivors.

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### Section 7: Phases of treatment for PTSD and Complex Trauma

This section explores the following topics: 1. Trauma Treatment Model: Some differences between PTSD and DESNOS; 2. Description of the three phases of treatment: (a) Phase one: Safety/ Symptoms reduction/Stabilization; (b) Phase two: Remembrance and mourning/ Exploration of traumatic memories/ Integration/ Creation of a new narrative; (c) Phase three: Reconnection with others/ Transforming systems of meaning/ Enhancing daily life / Building a better future; 3. Treatment principles underlying the recovery process; 4. Concluding comments.

#### 1. Trauma Treatment Model: Some differences between PTSD and DESNOS

Throughout the literature, clinicians and experts in the domain of traumatology extensively acquiesce upon the application of a phase-oriented treatment for PTSD (van der Kolk, van der Hart, & Marmar, 2007; van der Kolk, McFarlane, & van der Hart, 2007) and DESNOS individuals (Courtois, 2004; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Herman, 1997; Luxenberg, Spinazzola, Hidalgo, Hunt, & van der Kolk, 2001). With each phase working on particular issues and skills, the phase-oriented model of treatment and recovery underlines a holistic philosophy of human nature (Courtois, 2004). This model does not give precedent to the traumatic past of individuals over everything else, and yet this matter receives the emphasis and importance it deserves (Courtois, 2004).

Despite different recovery frameworks proposed throughout the trauma literature, most researchers currently agree on the use of a three-phase treatment model, initially used by Janet in his work with hysterical women (Steele & van der Hart, 2009). The three

delineated phases, termed slightly differently by scholars, revolve around three different areas: (phase 1) safety/ symptoms reduction/stabilization; (phase 2) exploration of traumatic memories/ integration/ creation of a new narrative; and (phase 3) reconnection with others/ transforming systems of meaning/ enhancing daily life by various means including enjoyable activities, meaningful work, and bodily care/building a better future (Ford et al., 2005; Herman, 1997; Luxenberg et al., 2001; van der Kolk, van der Hart, & Marmar, 2007).

Even though Herman (1997) reports on the possibility of detecting the presence of gradual and discernable shifts indicative of the passage from one phase to the other in the process of a successful therapy, she states that “no single course of recovery follows these stages through a straightforward linear sequence. Oscillating and dialectical in nature, the traumatic syndromes defy any attempt to impose such simpleminded order” (p. 155). Consequently, issues needing to be addressed in one phase of treatment may have to be re-addressed in another phase or, as mentioned by Luxenburg et al. (2001), the phase-oriented recovery process implies moving back and forth between the three treatment stages. For instance, according to Ford et al., (2005)

...the shame, guilt, and disgust associated with a sense of being damaged or a terror of rejection, betrayal, and abandonment tend to emerge anew in each treatment phase even after apparently having been dealt with in earlier phases of treatment. (p. 438)

Of importance, each of these treatment phases necessitates different modes of treatment and kinds of techniques (van der Kolk, van der Hart, & Marmar, 2007). In fact, Herman (1997) states that “a form of treatment that may be useful for a patient at one stage may

be of little use or even harmful to the same patient at another stage” (p. 156). Therefore, this author suggests a comprehensive treatment for each recovery stage which must address the typical biological, psychological and social aspects of the disorder.

Importantly for future clinicians, this phase-oriented treatment involves some differences in its application depending upon the type of symptoms - PTSD or Complex Trauma – exhibited by traumatized individuals. More specifically, different treatment approaches have to be used for the standard form of PTSD in comparison to the Complex Trauma syndrome (Luxenburg et al., 2001). What is more, PTSD and DESNOS treatment vary in the time frame required for each phase: the first treatment phase (safety), for instance, may be short for acutely traumatized patients while quite long, sometimes extending for years in treatment, for DESNOS individuals. (Luxenburg et al., 2001). Finally, the focus of treatment is different for PTSD and Complex Trauma patients. While PTSD treatment focuses on the memory imprint of traumatic experiences as well as the processing of these memories, the treatment of chronically traumatized individuals may have to deal with other problems first (e.g., affect dysregulation, dissociation, and interpersonal issues), because these problems generate more dysfunction than the PTSD symptoms (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

Before beginning our investigation of the three phase-oriented model, it should be noted that other models have been proposed for the treatment of Complex Trauma. For instance, Pearlman and Courtois (2005) propose a model that is consistent with other existing interpersonal and affect treatment models presently used in the context of childhood abuse, but is based on a different theoretical model: the constructivist self-

development theory. The essential component of this model (see also Pearlman, 2001) is the integration of attachment theory and complex developmental trauma in the therapy of complex trauma. As noted by Pearlman and Courtois (2005): “The underlying assumption is that the therapeutic relationship provides an opportunity to rework attachment difficulties, or, per Bowlby’s model, revising inner working models” (p. 453). Therefore, a fundamental aspect of this treatment framework is the development of a therapeutic alliance characterized by four core components: respect, information, connection, and hope (RICH).

## 2. Description of the three phases of treatment

In the rest of this section, treatment phases for PTSD and DESNOS individuals are conjointly discussed. It is of interest to note the use of some PTSD therapeutic interventions in the treatment of Complex Trauma. For instance, psychoeducation and the use of Exposure techniques for the integration of trauma material, which have been previously discussed in the section on PTSD modes of treatment, may also be employed in the treatment of Complex Trauma. Despite the more complex nature of Complex Trauma treatment, what has been learned in PTSD treatment is useful to better understand the treatment of DESNOS individuals.

### a) Phase one: Safety/Symptoms reduction/Stabilization

Possibly the longest stage and the most decisive to successful treatment, this first stage involves the development of a therapeutic alliance and encompasses pretreatment issues including informed consent, psychoeducation, and the modalities of the therapeutic model which will be used in the recovery process (Courtois, 2004).

More specifically related to DESNOS individuals, a wide range of concerns surrounding bodily integrity need attention at the beginning of the recovery process. These are: (1) the establishment of basic health necessities; (2) the modulation of bodily functions such as sleep, eating, and exercising; (3) the management of posttraumatic symptoms, which may include medication; and (4) the establishment of authority over self-destructive behaviors (Luxenberg et al., 2001).

According to Ford et al. (2005), safety necessitates the management of maladaptive coping behaviors such as self-harm, unhealthy risk taking, suicidality, eating disorders, substance abuse, and tolerating or inflicting relational aggression. Therapeutically, these dysfunctional behaviors are understood as strategies aimed at reducing distress and one therapy goal is to replace them by healthier coping strategies (Jackson, Nissenson, & Cloitre, 2009). Courtois (2004) notes that numerous trauma survivors are chronically revictimized because of their engagement in unsafe circumstances or relationships. Additionally, many traumatized individuals reenact their original trauma, consciously or unconsciously, therefore placing themselves in risky and dangerous situations. It is paramount to address these safety issues in treatment.

Establishing safety, however, extends well beyond developing control of the body, including managing the environment as well (Herman, 1997). Environmental issues needing to be addressed mostly cover the instauration of a self-protection plan incorporating a social support component, financial security, reliable means of transportation, and a safe housing. For instance, Jackson et al. (2009) posit that clients should decide with the clinician what action plan should be taken if he/she is in an emergency situation (e.g., reach the closest emergency room, call 911, phone the

therapist if available). Furthermore, “clients should commit to not acting on suicidal or homicidal urges and to trying their best to avoid other destructive behaviors” (Jackson et al., 2009, p. 248). Importantly, traumatized individuals also need clinician assistance in the task of identifying and utilizing a broad range of supportive persons who can act as a reliable support network in times of distress (Courtois et al., 2009; Luxenburg et al., 2001).

As previously noted in the Section on Complex Trauma, issues with relationships and self-perception disturbances are two realms of difficulties experienced by complexly traumatized individuals. Having past histories imprinted with repeated traumatization taking place by means of others, complexly traumatized individuals are prone to believe that similar experiences will continue to occur in their present and future life (Luxenburg et al., 2001). Therefore, establishing a “working alliance” (Kinsler, Courtois, & Frankel, 2009, p. 187) in the context of therapy is of utmost importance while working with chronically traumatized individuals. Kinsler et al. (2009) highlight some specific and essential components found in a working alliance with complex trauma clients such as the development of trust, the clinician’s humility and empathy, the clinician’s sensitivity toward clients’ negative view of themselves, and the clinician’s awareness about one’s personal issues as well as countertransference reactions. As noted by Luxenburg et al., (2001), issues of trust are especially important in the initial phase of therapy - and can extend the process of relationship building in therapy - as clients are encouraged to be involved in a powerful interpersonal relationship with a clinician while, at the same time, recognizing how much they have been hurt by others. As noted by Van der Kolk (2007a), mental health professionals working with DESNOS individuals become acquainted with

“the patients’ compulsion to repeat the trauma in the therapeutic relationship, and with their skill in enlisting therapists’ help in recreating the context in which their trauma happened, whether it be their families of origin or some other traumatic situations” (p. 204). By being aware of this compulsion to recreate the trauma, clinicians can best address this situation in their therapeutic encounters with trauma survivors.

An important part of the first treatment phase, as much for PTSD as for DESNOS’ individuals, is psychoeducation. Van der Kolk, Mcfarlane, and van der Hart (2007) state that “patients are often confused by their symptoms and believe that they are ‘going crazy’” (p. 426). Involving a wide range of interventions, psychoeducation includes providing clients with primary information about the short and long-term effects of trauma, offering the rational explanation behind trauma symptoms (e.g., affect dysregulation, flashbacks, dissociation, and hyperarousal), as well as helping clients to recognize environmental triggers acting as trauma reminders (consciously or not) leading to distress (Luxenberg et al., 2001). For instance, Luxenburg et al. (2001) propose the use of ‘mood logs’ to support clients in identifying the causes (e.g., thoughts, behaviors, bodily feelings, environmental cues) of their distress. The identification of the origin of their distress helps clients to exercise a realistic evaluation about the actual degree of danger in their present environment, instead of constantly enduring a state of hyperarousal. As noted by Courtois (2004), another crucial role of psychoeducation is to teach particular skills related to various areas of functioning such as self-care, the identification and modulation of affects, personal mindfulness, social and coping skills, and decision making.

As pointed out by Chu (1998), stabilization of symptoms related to severe PTSD is essential during this initial phase because “as long as symptoms such as abrupt state changes (including personality switching), amnesia, and reexperiencing of the trauma occur frequently, the patient is likely to remain in crisis” (p. 80). Consequently, managing symptoms of reexperiencing and modulating change states are paramount in the beginning of treatment. Throughout the trauma literature, behavioral and cognitive techniques are suggested in order to encourage symptom management in clients (Chu, 1998; Williams & Sommer, 1994). For instance, Williams and Sommer (1994) propose numerous arousal management techniques (e.g., thought stopping, anger management, relaxation) as well as stress management skills that clients can be introduced to and encouraged to use. Referring to adult survivors of prolonged child abuse, Gold (2009) emphasizes that the most important treatment goal is “to teach the client how to self-soothe” (p. 233), as a fundamental component of trauma-based difficulties is chronic arousal. Because DESNOS individuals have been cut-off from their own body for so long, they often do not yet have the opportunity to develop sufficient awareness to know what self-soothing strategies are helpful to them in order to tolerate and overcome their distressing emotions (Luxenburg, 2001). Consequently, Luxenburg et al. (2001) suggest presenting clients with various self-soothing options to try as a means of discovering what is helpful or unhelpful to them.

A key component of this first treatment phase is to help PTSD individuals name their emotional states (van der Kolk, McFarlane, & van der Hart, 2007). Unable to stabilize their emotions by taking appropriate action, PTSD individuals tend to either accumulate their emotions in their bodies, through somatization, or frequently release

them by being aggressive towards self and others. According to van der kolk, McFarlane, and van der Hart (2007), the process of learning to name their feelings “give patients a subjective sense of mastery and a mental flexibility that facilitate comparison with other emotions and other situations” (p. 427).

Luxenberg et al. (2001) caution about the necessity for clinicians to set clear boundaries, which may differ from one case to another with clients, especially surrounding formalities such as clinician availability during evenings and week-ends as well as out of session contacts, “due to the crisis-oriented nature of this phase of treatment” (p. 398). According to these authors, the role endorsed by clinicians in therapy should be active and direct, including the development of a well structured ‘safety-plan’ explaining the course of action patients will take in situations when they feel overwhelmed and incapable to cope. Clinicians should expect clients to take responsibility for their affect regulation, meaning that clinicians who constantly ‘rescue’ clients intensify their feelings of helplessness and powerlessness, instead of helping them to take control over their inherent state of being in times of distress (Luxenberg et al., 2001).

Overall, this initial phase of treatment is concerned with patient safety and stabilization (physical well-being, safety, trust, self-soothing strategies, and the establishment of a support network), in contrast to working on the trauma itself. As stated by Luxenberg et al. (2001): “Therapy during this stage of treatment should be reparative, not explorative” (p. 400), as patients do not possess the needed tools, in this initial treatment phase, to work on the trauma specificities.

b) Phase two: Remembrance and mourning/ Exploration of traumatic memories/  
Integration/ Creation of a new narrative

The second phase of treatment is mostly concerned with the deep exploration of traumatic experiences, involving not only the creation of a new life narrative in which traumatic memories are coherently integrated, but also desensitization of the highly negative affect attached to these memories (Luxenberg et al., 2001). As van der kolk, McFarlane and van der Hart, (2007) note, “traumatic memories tend to be stored as perceptual and affective states, with little verbal representation” (p. 429). Consequently, many trauma survivors are haunted by these unintegrated memories from trauma experiences.

As such, in this second phase of treatment, patients are encouraged to accept, explore, and normalize both bodily emotions and cognitions linked to the trauma, in a secure and controllable way. The fundamental reasons underlying trauma processing are threefold: (1) lessening of symptoms, (2) integrating separated parts of the self and the trauma experience, and (3) allowing traumatized individuals to embrace non-traumatic components of their lives instead of focusing on the trauma (Luxenburg et al., 2001). As noted by van der kolk, McFarlane, and van der Hart, (2007):

Traumatic memories need to become like memories of everyday experience; that is, they need to be modified and transformed by being placed in their proper context and reconstructed into a meaningful narrative. Only if all residual fragments are integrated can full resolution occur. (p. 429)

Importantly, the processing of traumatic memories leads to inherent changes in traumatized individuals including alteration of their systems of meaning, change in their self-perception as well as in their ability to participate in relationships (Luxenberg et al., 2001). As pointed out by Luxenberg et al. (2001), the best time to begin the work of trauma processing depends upon the exigencies of each case and the patient's desire to embark into this intense therapeutic work. These two factors should be carefully considered as the premature utilization of trauma processing techniques such as exposure-based interventions - before the basic treatment components representative of phase one have been fully addressed (safety/ symptoms reduction/ stabilization) - can unfortunately result in the reactivation of deeply seated traumatic memories, leading to the retraumatization of clients. Consequently, "the importance of timing, sequencing, and titration of phase two intervention with DESNOS cannot be underestimated" (Luxenberg et al., 2001, p. 404).

According to van der Kolk (2009), trauma processing can be realized through verbal as well as nonverbal means of expression. Verbalization of traumatic experiences allows individuals to transform their experiences into words, instead of constantly experiencing them in the form of bodily emotions, which may ultimately translate into somatic and kinesthetic disturbances. However, talking about traumatic experiences does not necessarily result in a coherent integration of the fragmented images and sensations associated with the trauma (van der Kolk, 2009). Consequently, nonverbal means of processing can be used "such as body-oriented therapies, self-defense training, and other physically based means of moving through emotions, discovering resources, and seeking empowerment" (Luxenberg et al., 2001).

As much for PTSD than DESNOS clients, a main goal of therapy, during this second phase of treatment, is the integration of progressive exposure of traumatic memory within a supportive therapeutic relationship. The activation of traumatic memory along with any related affect becomes the target of therapy with the intention of both modifying traumatic memory and diminishing or releasing the array of negative affect linked with these memories (Luxenburg et al., 2001). As a result, traumatic memory may lose rigidity and distressing components and become more like non-traumatic memories.

Due to the possible occurrence of intense emotions and behaviors following the exploration of traumatic memories, some words of caution for future clinicians relate to the necessity of being qualified to work through traumatic memories, by means of specific training in trauma counselling, before attempting to guide clients towards trauma exploration. Moreover, even though abundant empirical evidence advocates the necessity of trauma processing in the treatment of the simple form of PTSD, the relationship between trauma exploration and clinical improvement is not so clear in the case of chronically traumatized, DESNOS individuals and still needs additional empirical research (Luxenberg et al., 2001). Accordingly, depending upon clients' circumstances, trauma processing may not be appropriate in some cases.

c) Phase three: Reconnection with others/ Transforming systems of meaning/ Enhancing daily life / Building a better future

Finally, the third stage of treatment focuses on reconnecting with others and developing constructive relationships, changing systems of meaning, building a better present and future, and reconciling with oneself (Herman, 1997; Luxenberg et al., 2001).

As noted by Herman (1997): “This simple statement – ‘I know I have myself’ – could stand as the emblem of the third and final stage of recovery. The survivor no longer feels possessed by her traumatic past; she is in possession of herself” (p. 202). For Herman, the paramount task of therapy is for the survivor to become who she/he wants to be. Thus, the development of desire and initiative represents an important focus of the therapeutic work during the third phase of treatment. This author notes that, frequently, acquiring possession of oneself goes hand in hand with repudiating attributes of the self which were inflicted by the traumatic experience(s). In the process of “letting go” (Herman, 1997, p. 203) of what has been inflicted by the trauma on aspects of the self, Herman posits that trauma survivors become not only more forgiving toward themselves but also more willing to recognize the damage done by the trauma to their character.

“Enhancing daily living”, as stated by Ford et al. (2005, p. 440), is another focus of this healing phase. More specifically, the quality and balance of the survivor’s life, involving various areas such as work, relationships, play and rest become a focus of treatment. Another centre of attention is to continue working on the use of skills (e.g., regulatory skills) learned in phase one, as well as the understanding of trauma developed in phase 2 in order to address residual issues and enhance life satisfaction. Finally, Ford et al., (2005) emphasize that a paramount goal of this last treatment phase is to guide individuals through the reexamination of the various changes made in the two previous phases of treatment regarding their ability to stretch their limits in numerous personal realms such as emotion, beliefs, activities, awareness, and interpersonal relationships. Including the actual (vs. anticipated) risks, cost and benefits of each change, this reexamination should also centre on the individual’s decision to either accept, pull back

or refrain from changing, as a means to underscore the individual's perception of self-control. As stated by Ford et al. (2005): "The goal is to enhance the client's capacity to simultaneously feel in control of her or his own perceptions, emotions, thoughts, goals, decisions, and actions, while recognizing and managing intense dysregulated feelings, impulses, and thoughts" (p. 441).

During this last phase of the recovery process, appropriate trust has been developed by survivors (Herman, 1997). Consequently, issues of identity and intimacy may surface at this stage and, more specifically for sexual trauma survivors, issues of intimacy and sexuality (Herman, 1997; Luxenberg et al., 2001). This time of recovery is highlighted by connections with others and the process of reconnecting may take various forms such as taking lessons, getting involved with old friends, joining clubs and becoming involved in group activities in the workplace (Luxenburg et al., 2001).

Even though the resolution of a traumatic experience is worked through by most trauma survivors in the context of their personal lives, some engage themselves in a "survivor mission" (Herman, 1997, p. 207). Herman (1997) states that "these survivors recognize a political or religious dimension in their misfortune and discover that they can transform the meaning of their personal tragedy by making it the basis for social action" (p. 207). Social, political or religious actions can take many forms such as helping others who underwent similar trauma, deploying political efforts in the prevention of traumatization in others, volunteering in a shelter for battered women, or simply speaking to others about one's personal trauma experience.

### 3. Treatment principles underlying the recovery process

Noteworthy for future clinicians, some basic principles underlying the recovery process, or technical precautions, are widely advocated in order to ensure safety, processing of trauma, and reintegration. Ford et al. (2005) have highlighted five basic treatment principles which are described below. They represent a synthesis of a variety of literature findings in the field of traumatology. As noted by Ford et al., these technical precautions may require some adaptations when there is a need to address specific issues such as in the case of complex posttraumatic self-dysregulation.

The first treatment principle relates to the necessity of helping clients increase their ability to control intense arousal states. Scurfield (1994) states that “trauma survivors must be given practical, concrete behavioral and cognitive strategies to promote self-control over powerful emotions and physical arousal” (p. 188).

The second treatment principle highlights the importance of enhancing trauma survivors’ sense of self-control and self-efficacy. The concept of empowerment has been emphasized by Herman (1997) who posits that trauma causes disempowerment. According to Ford et al. (2005), increasing self-control and self-efficacy can be accomplished by adequately timing and structuring both the processing of trauma memories and the reconstruction of a narrative during the second phase of the recovery model. As noted by Rothschild (2005):

I never help clients call forth traumatic memories unless I and my clients are confident that the flow of their anxiety, emotion, memories and body sensations can be contained at will. In other words, I never teach a client to hit the accelerator before I know that he can find the brake. (p. 13)

As such, the pacing and structuring of trauma processing supports trauma survivors' ability to tolerate traumatic memories and to acquire a sense of personal efficacy. Furthermore, it helps them to develop a coherent narrative incorporating not only trauma and decline but also success and growth.

The third treatment principle, as pointed out by Ford et al. (2005), centers on helping trauma survivors to maintain an acceptable degree of functioning, in conformity with their past and present lifestyle and conditions. Importantly, functionality may be diminished temporarily at significant times in therapy such as when survivors are struggling with personal safety in phase one, trauma memories and associated symptoms in phase two, and relationships and life activities in phase three. However, one role of therapy is to foster trauma survivors' growth and strengthen functionality by increasing their internal and external resourcefulness.

The fourth treatment principle relates to enhancing trauma survivors' ability to approach and master rather than avoid experiences (bodily affects and external occurrences) leading to trauma symptoms (e.g., intrusive re-experiencing, hyperarousal and hypoarousal, and emotional numbing). According Ford et al. (2005), a paramount challenge throughout all the recovery treatment is to assist survivors becoming gradually more competent at recognizing the circumstances when they use avoidance strategies in order to cope with current and expected danger or distress. Following this acknowledgment, clinicians can propose safety measures which can help survivors regulate anxiety and utilize more successful coping strategies.

Finally, the fifth treatment principle cautions clinicians about the necessity to recognize and effectively work through survivors' transference responses and

countertransference. As stated by Courtois, Ford, and Cloitre (2009), transference and countertransference can be "...understood as related to past experiences enacted within or projected onto the therapeutic relationship" (p. 96). As such, clinicians' self-care as well as professional development are paramount in order to recognize and deal with transference and countertransference reactions in a productive way (Courtois, 2009).

#### 4. Concluding comments

Treatment phases in the recovery of PTSD and Complex Trauma are especially relevant for clinicians as they represent the foundation of their daily work with trauma survivors. In our desire to provide responsible caring, which is one of the four basic principles derived from the Canadian Code of Ethics for Psychologists, we should be, among others, eagerly aware of our own competencies and limitations, as well as performing only those interventions for which we have competence (Daniels & Ferguson, 1999). Particularly in the context of counselling trauma survivors, this principle has a foremost importance. More specifically, responsible caring reminds clinicians of the necessity to build and maintain clinical expertise encompassing five ethical values: competence, humility, professional growth, self-awareness, and openness to complexity and ambiguity (Jennings, Sovereign, Bottorff, Pederson-Mussell, & Vye, 2005). Clinicians are encouraged to persistently pursue these ethical values in their attempts to provide the best therapeutic services to survivors of trauma.

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### WEEK 8: Culture and Trauma

This section explores the following topics: 1. Multicultural counselling; 2. Foundation of trauma and PTSD conceptualization; 3. Posttraumatic and DESNOS responses in Non-Western cultures; 4. Adaptation of method of assessment; 5. Effective cross-cultural competencies, 6. Concluding comments

#### 1. Multicultural counselling

One reason underlying the historical reluctance of many refugees to seek help, despite severe mental health problem, relates to a lack of cultural responsiveness on the part of mainstream services (Bemak & Chung, 2002). Of importance, competence guidelines have been provided by the American Psychological Association for its members (APA, 2002). More specifically, these guidelines require practitioners to be mindful of significant research regarding the cultural background of clients, to ascertain the validity of assessment instruments used with this clientele, to take into account cultural beliefs and values, to respect religious and spiritual values, and to identify personal biases or racism as clinicians (Garcia, Cartwright, Winston, and Borzuchowska, 2003). Additionally, contained in the section on professional competence of the American Psychological Association (APA, 2002), counsellors are required to demonstrate dedication to acquire skills, awareness, and experience associated with the provision of services to a diverse population. In the APA Code (2002) diversity is defined in terms of “age, culture, disability, ethnic group, gender, race, religion, sexual orientation, marital status, and socioeconomic status” (APA, 2002, p. 1).

## 2. Foundation of trauma and PTSD conceptualization

Taking roots in our Western psychological orientation, our conception of trauma is therefore instilled by the cultural components of our society. Wessells (1999) brings our attention to the mechanistic worldview of Western societies and the promotion of a set of values including individualism, freedom, pragmatism, and material wealth. According to Wessells, when trauma is primarily conceptualized as an individual phenomenon, it may divert us from attending to the wider societal context of the situation. This is particularly unfortunate as, in many traumatic cases, the distressing impacts of trauma on individuals, as well as on the surrounding family system, community, and society at large, go hand in hand.

Chung and Bemak (2002) assert that culture:

...is a tool that defines reality for those who belong to the culture. Within this reality or worldview, the individual's purpose in life is defined, and properly sanctioned behavior within the culture is prescribed. The beliefs, values, and behaviors of a culture (its norms) provide its members with some degree of personal and social meaning for human existence and are learned through tradition and transmitted from generation to generation.

(p. 154)

The tight connection between our trauma conceptualization and the culture in which we live is accounted for by many authors. For instance, some researchers highlight the influence of cultural values on how a traumatic event such as rape impacts a person's sense of identity and sense of violation (McFarlane & de Girolama, 2007). More fundamentally, Kleber, Figley, & Gersons (1995) state: "We interpret war, loss, violence,

and disasters in ways shaped by our culture, by our society, and by its values and norms. We cope with serious life events in ways provided and approved by our surroundings” (p. 1). In their survey of 297 Aboriginal adolescents ranging from Grade 9 to 12, Manson et al. (1996) noted that even though some people would argue whether death by natural causes, sickness, or surgical procedure of someone close or a family member represents a sufficient stressor, a number of adolescents surveyed personally felt traumatized by such events. According to Dragnus (1996), apart from natural disasters, culture permeates every step of a traumatic experience: stressors, experience, response, explanation, residues, coping, help seeking, and outcomes.

Throughout the literature some researchers direct our attention to the basic assumptions underlying our current conception of PTSD. Brom and Witztum (1995) point out that our basic conception of PTSD is rooted in the medical model and, consequently, is portrayed as being a *disorder* stemming from psychological and biological dysfunctions, and needing to be cured. Individually rooted, this model does not view societal connections to the disorder, leaving the individual as the basic component of study. In the same light, McFarlane and de Girolama (2007) report an assumptive “universal” response to traumatic experiences. They state, “the notion behind PTSD is that there is a generalized reaction pattern to traumatic events, which is predetermined by the limited range of affective, cognitive, and behavioral responses that humans can have to overwhelming stress” (p. 130). Building upon the traumatic stress literature, Shalev (1996) posits that PTSD is conceptualized “as a normal response that continues over an extended time period, beyond its usefulness” (p. 78). Shalev notes that psychodynamic and behavioral approaches are based on the same hypothesis: in the former, PTSD is

viewed as an unfinished mental processing while, in the latter, it is conceptualized as a set of normal learned responses continuously exhibited over time. Viewing PTSD through a cognitive lens, Janoff-Bulman (1992) conceptualizes a traumatic event as shattering an individual's core assumptions, resulting in an inability to integrate the traumatic experience into one's internal world. Therefore, rebuilding a trauma survivor's assumptive world becomes a paramount goal and, in a sense, this view could also be conceptualized as an unfinished cognitive processing.

What appears to emerge in our conceptualizations of both the trauma construct and the PTSD syndrome is the predominance of our Western culture and, more fundamentally, its basic assumption of individualism, among others. Viewing trauma from a cultural stance, the predominance of a Western trauma framework can be harmful as it "marginalizes local voices and cultural traditions, disempowers communities, and limits healings" (Wessells, 1999, p. 269). Furthermore, the impregnation of a Western cultural stance in our conceptualization of both trauma and PTSD is especially important to consider when these two concepts are used in cross-cultural settings. More fundamentally, the characteristic set of learned values, beliefs, and norms specific to our Western culture are reflected in various areas related to PTSD including its own theoretical conceptualization, modes of assessment, treatment orientations and service delivery.

### 3. Posttraumatic and DESNOS responses in Non-Western cultures

Understanding trauma in different cultural settings means expanding our vision of trauma within a societal perspective. As such, we reach a deeper understanding of

survivors of various types of trauma including war, disaster, and violence. As stated by Kleber, Figley, and Gersons (1995):

Traumatic stress does not occur in a vacuum. Victims of traumatic stress live in specific situations in specific societies. The characteristics of these circumstances determine the intensity and severity of the consequences of extreme life events, such as combat, disaster, sudden bereavement, and violence. They even determine the occurrence of the events themselves: Such diverse situations as political repression and technological disasters are human-made and create intense feelings of helplessness, disruption, and despair. (p. 1)

Defined by Marsella, Friedman, and Spain (1996) as “the tendency to view one’s own ways of thinking or behaving as the right, correct, or moral way, and to reject all others as incorrect or of limited accuracy or value” (p. 116), ethnocentricity, and its inherent risk - ethnocentric bias - represents key concerns in cross-cultural studies. Marsella et al. caution that ethnocentric bias may notably jeopardize the relevancy and usefulness of the PTSD concepts and modes of measurement in cross-cultural settings.

Osterman and de Jong (2007) bring our attention to the etic-emic dichotomy in cross-cultural studies. Conceptualizing culture as a general entity, and consequently running the risk of being ethnocentric, the etic approach to cross-cultural studies fails to make adaptations to the cultural context. In contrast, the emic framework and its specific orientation towards culture, necessitates clinicians or researchers to adapt their modes of assessment and/or their therapeutic interventions to suit the cultural context, generally working within the culture in an attempt to learn these concepts. The etic-emic dichotomy

deserves researchers' attention when a disorder such as PTSD is used in other cultural contexts.

As such, one question worth investigating is: How efficient is the diagnosis of PTSD when used in a non-Western context? According to Osterman and de Jong (2007), the epidemiological literature gives support to the PTSD diagnosis in survivors of violence, war, and natural disorders across various cultures. However, these authors caution that very few studies were directed towards populations in non-Western regions. In his study of twenty-two Salvadoran women refugees who experienced daily conditions of terror under the political context of El Salvador, Jenkins (1996) used the PTSD symptoms criteria to verify the presence of PTSD in these women. He concluded that the PTSD diagnostic was not fully applicable in the cultural context of his sample. Even though some PTSD symptoms were experienced by the Salvadoran women (e.g., intrusive reexperiencing of the traumatic event and increased arousal), other symptoms not included in the PTSD list were also part of their experience. Essentially, somatic reactions - in the form of bodily pains, shaking, and trembling; affect dysregulation such as anxiety, fear and anger and, often, a sensation of intense heat suddenly submerging the entire body - rather than psychological responses were more steadily reported by these women. Making reference to the wide diversity in the expression and experience of emotion in different cultures, Jenkins argue that variation can be expected not only in the parameters but even in the validity of the PTSD syndrome when used cross-culturally.

In the same vein, Allen (1996) notes the problem of the PTSD diagnosis in his work with African Americans. He states that "considerable thought ought to be given to an expanded application of adjustment disorder and PTSD diagnosis categories as these

can be applied to African American clients” (Allen, 1996, p. 227). Of interest, Marsella et al. (1996) research findings suggest that even though intrusive thoughts and memories of a traumatic experience seem to be universally expressed in the aftermath of a traumatic event, the avoidance/numbing and hyperarousal symptoms, also characteristic of PTSD, may be significantly influenced by ethnocultural components. Similarly, using the Structured Interview for Disorders of Extreme Stress (SIDES) to assess symptoms of DESNOS in three cultural settings (Algeria, Ethiopia, and Gaza), de Jong, Komproe, Spinazzola, van der Kolk, & Van Ommeren (2005) claim that some DESNOS symptoms were rarely acknowledged by surveyed individuals, when compared to the endorsed symptoms in the DSM field trial, even though a conscientious procedure for translating the DESNOS had been undertaken. As stated by Manson et al. (1996): “...culture may place differential emphasis on particular symptoms, assign unique attributions to the intensity of their experience as well as expression, and shape the general tone of emotional life to which a person should aspire” (p. 267).

#### 4. Adaptation of method of assessments

Acknowledged throughout the literature, there seems to be a profound need for culturally sensitive empirical research regarding the usefulness of the current PTSD parameters in various cultural settings as a means to highlight ethnocultural variations in the expression of both the PTSD and DESNOS symptomatology. In order to achieve this goal, valid and reliable modes of assessment need to be implemented which require, according to Marsella et al. (1996), “equivalency in language, concepts, scales, and norms” (p. 118), or the use of ethnosemantic methods in which the subjective experience of the individual is the foundation, rather than the researcher’s assumptions. In this

regard, the emic framework seems to be warranted, giving priority to the cultural context and asking researchers to make the necessary adaptations of assessment and/or modes of therapeutic interventions. Various researchers have discussed the adaptations needed to be made when method of assessments are used cross-culturally. For more information, readers are encouraged to refer to Manson (1997), Flaherty and colleagues (1988), and Brislin (1986).

For instance, in assessing the cross-cultural construct equivalence of the SIDES, De Jong et al. (2005) concluded that the construct validity of the SIDES was not stable across the three samples surveyed, because of a lack of content, semantic, and/or technical equivalence. As stated by the authors: "The panel of researchers who decided which items were included in the SIDES captured the experience of their predominantly Western patients in a Western setting" (DeJong et al., 2005, p. 19). Consequently, even though the DESNOS has a construct validity strongly supported in Western samples, especially in individuals with a childhood history of intrafamilial abuse, modifications may have to be implemented if used in other cultural contexts.

In our drive to better understand PTSD cross-culturally, Marsella et al. (1996) pinpointed ethnocultural identity as the most important independent variable in cross-cultural settings. These authors caution about the striking and profound differences in behavior within a specific ethnocultural group, given birth to exorbitant error variance in research design, when people are grouped on the basis of very general ethnocultural characteristics (e.g., Black, Arab, Hispanic).

## 5. Effective cross-cultural competencies

Our Western society and the values it embeds create a system of thoughts that can subtly instill into our counselling practice. As stated by Wessells (1999):

These values find expression in the myth of the self-made person who, despite a difficult background, rises above his or her circumstances and succeeds through hard work and a can-do attitude. Since US psychology embodies these values and beliefs, it seems natural for American psychologists to seek scientific explanations, to focus on individual healing, to empower individuals to rise above the limits imposed by their material circumstances, and to encourage healing through free exploration and expression of emotions and ideas. (p. 271)

In their cross-cultural work with traumatized children and their families, Fernandez (2003) reported that counsellors socialized in the context of European American values may be (1) more future, instead of past or present, oriented; (2) expecting clients to actively work on therapeutic goals (doing) within a reasonable time frame (future) and to engage themselves in a process of change (mastery); and (3) hoping that client will develop autonomy (individuality) over connection within the family system. Fernandez warns us about the necessity for counsellors to be aware of their client's cultural values in order to avoid making the therapeutic process an "oppressive" practice.

In contrast, Wessells (1999) bring our attention to spiritually oriented cultures such as Angola, Sierra Leone, and most of the sub-Saharan Africa. Wessells states:

There, the visible world and the spiritual realm are united, and the living community is viewed as an extension of the ancestral community. Since

people attribute events in the visible world to spiritual causes, it is the spiritual meanings and dimensions of their life experiences that are most important and that have greatest psychological impact. (p. 272)

As noted in the Diagnostic and Statistical Manual of Mental Disorders [DSM-IV-TR; American Psychiatric Association [APA], 2000), when the DSM-IV classification is used by a clinician from one ethnic or cultural group to evaluate an individual from another ethnic or cultural group, diagnostic assessment can be particularly difficult. More importantly, “a clinician who is unfamiliar with the nuances of an individual’s cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual’s culture” (APA, 2000, p. xxxiv). As such, developing awareness regarding our own set of values as clinicians and the cultural background of our clients are paramount in order to achieve the best standard of practice.

Kinzie (2001) reminds us that cross-cultural therapy involves particular approaches. He highlights the needs for clinicians to be flexible, welcome the patient’s cultural background, investigate the patient’s expectations, and overtly discuss the goals of therapy. Building upon his work with refugees, Kinzie claims that PTSD symptoms (numbing, amnesia, and avoidance) can stop many trauma survivors from searching help, since talking about the trauma seems too challenging for them. For other refugees, their belief systems, religious orientations or, generally, their cultural frameworks may prevent them from disclosing traumatic experiences. This is well exemplified by the traumas of rape and domestic violence which are perceived as so shameful in some cultural contexts that they may not be discussed at all.

More fundamentally, Brown (2009) directs our attention to *emic* epistemologies for culturally competent practice. She states: "Emic models assume, not a stance of expertise on the part of the clinician, but a stance of curiosity and ignorance, an important foundation for culturally competent practice" (Brown, 2009, p. 170). She cautions us about the presence of biases in everyone, simply as a result of being humans. In this regard, the discourse about clinicians being nonjudgmental and unbiased prevents the growth of cultural competence as it assumes a state virtually impossible to achieve for most of us. Brown also alerts us about *aversive bias*, referring to unconscious biases owned by people who consciously work at not showing overt utterances of bias. She states: "Given the sensitivity of complex trauma survivors to a therapist's own unexplored or denied feelings, it stands to reason that aversive bias can play a large part in undermining the therapeutic relationship, thus reducing treatment effectiveness" (Brown, 2009, p. 173). Sustained by denial and undoing, aversive bias brings shame and discomfort to its realm, ultimately, distancing ourselves from our clients. As reminded by Brown, efficient cultural competence is not only a matter of knowing about aversive bias; it is much more a willingness to openly accept our personal aversive bias with compassion, in our sincere attempts to become more congruent and authentic human beings.

As pointed out by Osterman and De Jong (2007), the wide variety of cultures and subcultural groups render almost impossible the task of being knowledgeable of all existing cultures and subcultures. However, these authors inform us of the possibility to develop cultural competency through the application of three core concepts necessary to be considered by clinicians working cross-culturally with client. The first, which has been

previously discussed, concerns the etic-emic dichotomy. The second core concept relates to the cultural ways used by individuals to express illness. More centrally, it is paramount for clinicians to comprehend the various terms used to describe illness as they are usually comprehended and approved by a specific culture. Illness being closely related to disease, we now direct our attention toward a second dichotomy: the disease-illness dichotomy.

While illness refers to the personal and culturally bound nature of a client's experience of his or her health condition, the term disease is anchored in the sphere of medicine. As such, it is of importance for clinicians to note the possibility of a discrepancy between these two concepts, because of differing influences from the local culture and the culture of the medical profession. Finally, the third core concept relates to the frequent differences between clients and medical health professionals regarding the cultural attribution of illness. More fundamentally, clients' comprehension of the illness and the interactive experiences of the various stakeholders including clients, their families and health care professionals (including healers who are not necessarily certified but who are culturally approved) may portray different explanatory models of illness. According to Osterman and De Jong (2007), to avoid ethnocentrism, an emic approach is required and necessitates in-depth knowledge of the culture, the cultural language of sickness and well being, explanatory models, and cultural healing practices and values to ascertain cultural competence.

## 6. Concluding comments

One goal of this section has been to investigate the influence of culture on the PTSD conceptualization and the applicability of this concept cross-culturally. The importance of developing awareness, knowledge, and training in order to be effective

with clients from various cultural backgrounds has been highlighted as well as cross-cultural core concepts, which are the foundation of clinical competency. Finally, the emic model for competent practice has been emphasized, a model instilled with clinicians' humility and curiosity. Readers are encouraged to perfect their knowledge about the best standard of practice in the field of cross-cultural counselling as a means of improving their clinical work with trauma survivors from various cultural backgrounds.

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### Section 9 : Historical Trauma

This section explores the following topics: 1. What is Historical Trauma? 2. Historical losses and current traumatic stressors in Aboriginal peoples' lives; 3. Historical Trauma Response; 4. Intergenerational transfer of Historical Trauma; 5. Some models of coping with historical and current traumatic experiences; 6. Non-Aboriginal counsellors working with Aboriginal clients; 7. Healing from Historical Trauma; 8. Concluding comments.

#### 1. What is Historical Trauma?

The theory of Historical Trauma has emerged in the field of traumatology during the last two decades as a result of clinical practice and observations, as well as quantitative and qualitative research studies (Brave Heart, 2003, p. 7). Described as the passage of massive and cumulative trauma over the lifetime and across generations (Brave Heart, 2003), Historical Trauma can also be defined as “a collective complex trauma inflicted on a group of people who share a specific group identity or affiliation-ethnicity, nationality, and religious affiliation” (Evans-Campbell, 2008, p. 320). As such, Historical Trauma is also conceptualized by scholars as intergenerational trauma as well as collective trauma.

Supported by the general trauma literature and, more specifically the exploration of trauma among the Jewish Holocaust survivors, Historical Trauma applies to other groups of people including the Japanese American internment camp descendants and the African-American descendants of slaves. However, as noted by Whitbeck, Adams, Hoyt, and Chen (2004a), a prominent distinctive feature between the Nazi Holocaust traumatic experiences and that of Native American communities resides in the persistence of losses

for Native Americans. Rather than being specific to a single traumatic period, these losses are transmitted across generations and act as reminders on a daily basis.

Although collective traumatic experiences have been endured by other groups deserving our attention which will be discussed subsequently under the rubric of Intergenerational Trauma, this section is especially reserved to the overview of chronic and cumulative traumas experienced by Aboriginal peoples. Throughout the literature, the concept of Historical Trauma and its underlying theory is mostly associated with this population.

## 2. Historical losses and current traumatic stressors in Aboriginal peoples' lives

Despite various differences in the types of events leading to Historical Trauma, Evans-Campbell (2008) notes three distinct and fundamental shared characteristics of these traumatic events. First, during their occurrence, many individuals in the community have either experienced these events or were impacted by them. Second, these massive traumatic events resulted in high levels of communal distress and mourning in modern communities. Finally, the traumatic acts are most frequently committed by outsiders with resolute and frequent destructive intention. According Evans-Campbell (2008), the third characteristic is crucial to the conceptualization of Historical Trauma as "many of these events are not only human initiated and intentional but also fall under the category of genocide (e.g., physical, cultural, or ethnocide), making them particularly devastating" (p. 321).

Similarly, Duran and Duran (1995) write about the exposure of Native American people to one of the most organized ventures of genocide ever seen in the world. More specifically, when the colonization process began in North America, over 10 million

Native American people were living on the continent. This number declined to 250,000 people by the year 1900. As stated by these authors:

For over five hundred years Europeans have attempted to subjugate, exterminate, assimilate, and oppress Native American people. The effects of this subjugation and extermination have been devastating both physically and psychologically. Whole tribal groups have been completely exterminated; most of the land that was inhabited by Native Americans has been stolen. (p. 28)

The concept of genocide is extensively used throughout the literature to describe the efforts of colonizers to fade out the presence of Native Americans (e.g., Quinn, 2007; Walters & Simoni 2002; Whitbeck, Chen, Hoyt, & Adams, 2004b) and its horrific consequences in Native American populations.

Another key concept embedded in Historical Trauma is the concept of loss, also referred to as Historical Loss. As stated by Whitbeck and his colleagues (2004a), “American Indian people are faced with daily reminders of loss: reservation living, encroachment of Europeans on even their reservation lands, loss of language, loss and confusion regarding traditional religious practices, loss of traditional family systems, and loss of traditional healing practices” (p. 121).

In modern lives, other reminders of losses are continuously displayed throughout the oppression, discrimination, racism, low socio-economic conditions, and heightened mortality rates endured by these communities (Brave Heart, 2003). Conversely, as pointed out by Brave Heart (2003) these elements render Aboriginal people more at risk for trauma exposure as well as traumatic loss. According to Walters and Simoni (2002),

Native Americans are more likely than individuals of any other racial groups to report interracial violence. Noteworthy for future clinicians, research findings indicate a relationship between discrimination and various ailments including psychological distress, depressive and anxiety symptoms, poor physical health and a general sense of distress (Walters & Simoni, 2002). In their investigation of possible predictors of resilience in Native American adolescents, Laframboise, Hoyr, Oliver, and Whitbeck (2006) highlight a relationship between report of racist attitudes, such as discrimination, and a significant decrease in the likelihood of a resilient outcome.

In their study on Historical Trauma among a group of Native Americans, Whitbeck, Adams, Hoyt, & Chen (2004a) investigated the types of losses these individuals thought were mostly related to their own experience of Historical Trauma and the kind of emotions these losses evoked in the elders. Results from this study indicate the striking presence of historical losses on Native Americans' minds, giving additional support to the conceptualization of Historical Trauma. More precisely, the types of losses most often thought about daily and weekly were, in order of importance, the losses engendered from the impacts of alcoholism on Native Americans; the loss of respect for elders by children and grandchildren; the loss of language; the loss of respect for traditional culture by children; the loss of culture; and the loss of traditional spiritual practice. Emotions most frequently associated with thoughts about historical loss were in the forms of anger, sadness and depression, intrusive thoughts, feeling uncomfortable around White people, and feeling fearful or distrustful about White peoples' intentions. Even though this study cannot be generalized across Native American cultures, it helps us

to understand how Native Americans may be impacted by historical losses and the prominent daily presence of these losses on their minds.

The traumatic effects of specific policies instituted by the colonizers such as the removal of children from their families, communities and, ultimately, their culture, is another example of Historical Trauma (Raphael, Swan, & Martinek, 1998). The horrific abuses endured by many Native Americans in residential schools are exhaustively discussed throughout the literature and have been publicly acknowledged by the media. In residential schools, Native Americans children were forbidden to speak their own languages or practice their traditional modes of culture and spirituality (Quinn, 2007). In Canada, between 1894 and 1984, approximately 100,000 children (20-30 percent) of Aboriginal parents were enrolled in residential schools. Many Canadian staff working in residential schools have pleaded guilty to numerous kinds of physical, sexual, psychological, and spiritual abuse towards First Nations, Métis, and Inuit children living under their care (Quinn, 2007). Building upon research findings, Shepard, O'Neill and Guenette (2006) report a cluster of shared symptoms endured by numerous First Nation adults who have been forcefully enrolled in residential schools during their childhoods: hyper-vigilance, mistrustfulness, guardedness, low self-worth, alienation, depression, and confusion about their family origins.

Data relative to current Native Americans traumatic life stressors are astonishing. For instance, building upon research studies, Walters and Simoni (2002) report a heightened rate of victimization through violent crimes (124 per 1000) in Native American communities, more than 2.5 times the national average. In Native American populations, depression is one of the most prevalent psychiatric disorders, and the

conjoint occurrence of mental health problems and substance abuse problems is estimated to be as elevated as 80% among Native Americans (Walters & Simoni, 2002).

Furthermore, making reference to the Lakota and Dakota/Nakota reservations, Brave Heart (2003) emphasizes the particularly high mortality rates from alcoholism, close to 29 times higher than the rate for the United States.

Of interest, higher rates of lifetime traumatic events have resulted in elevated rates of PTSD in these populations. Brave Heart (2003) states a prevalence of PTSD in Native Americans and Alaska Natives estimated at 22%, in comparison to 8% for the general population.

### 3. Historical Trauma response

Despite the remarkable resilience displayed by Native Americans and Aboriginal people in Canada, this passage written by Henderson (2002), illustrates some of the disastrous consequences of the five hundred years of colonialism on this population:

After the British treaties, the colonizers created a systemic colonialism and racism that estranged Indigenous people from their beliefs, languages, families, and identities: that deprived Indigenous peoples of their dignity, their confidence, their souls, and even their shadows. (p. 29)

The historical trauma response involves the PTSD constellation of symptoms identified in the DSM-IV-TR (APA, 2000) in addition to a wide range of psychological, emotional, and social responses. According to Brave Heart (2003), the shared attribute of all the historical trauma responses reside in their association with unresolved grief across generations, occurring along with multiple traumas. Historical unresolved grief refers to a pervasive sense of pain arising from traumatic occurrences happening to ancestors as well

as losses that have not been completely mourned (Brave Heart & DeBruyn, 1998). The passage below, portraying a 15 year old Pueblo Indian girl referred for a suicide attempt from an aspirin overdose, exemplifies this phenomenon:

G: I just can't talk to my parents. I don't want to burden them with my problems and feelings. They have so much pain of their own. I just can't bring myself to do that, but I felt like I had no one to talk to. That's why I took those pills- I just felt so tired. I wish I could take away their pain. They have suffered so much themselves in boarding schools. I'd like to go away to college but I can't leave them. I feel so guilty, like I have to take care of them. (Brave Heart & DeBruyn, 1998, p. 66)

As pinpointed by the authors of this quote, a protective attitude toward her parents is displayed by this young girl, as well as feelings of guilt about her personal pain.

In order to best comprehend the various responses from Historical Trauma, Evans-Campbell (2008) points out the necessity to view its impacts through three different, but undeniably interrelated, perspectives: the individual, the family, and the community. At the individual level, responses are in the domains of individual physical and mental health and may include PTSD symptoms along with feelings of guilt, grief, anxiety, and depressive symptoms. Historical trauma responses at the familial level, even though much less researched, seem to comprise impaired family communication and stress related to parenting. Finally, at the community level, responses may encompass a wide range of afflictions including the disintegration of traditional values and culture, high ratios of alcoholism and physical illness, the lost of traditional rites of passage, and the internalization of racism.

Other reactions from community trauma have been reported by Brave Heart (2003) and may encompass a wide range of effects such as low self-esteem, anger, suicidal thoughts and gestures, difficulty labeling and expressing emotions, substance abuse and other types of self-destructive behaviors. Brave Heart also pinpoints the exacerbation of historical trauma responses by such means as racism, socio-economic conditions and oppression. Robin, Chester, and Goldman (1996) report the possibility for cumulative trauma and symptoms of PTSD to be basic precursors to future psychiatric disorders among Native American communities, with alcoholism and depression being the most frequently reported ailments. Referring to four epidemiological studies, these authors note a higher prevalence of mental health disorders in Native American populations, compared to non-Indigenous communities. They specified, however, that cross-cultural components diminish the validity of research conducted on Native Americans. While some disorders such as depression and schizophrenia may be over-reported “due to unfamiliarity with culture-specific mourning and grieving patterns and practice identified among several populations”, others may be under-diagnosed because of “mistrust and misunderstanding” (Robin et al., 1996, p. 240). As specified by Duran and Duran (2002):

Many Native American people are diagnosed based on erroneous criteria; the diagnostic process never takes a historical perspective in placing a diagnosis on the client. We fantasize that one day the DSM (Diagnostic Statistical Manual for Mental Disorders) will have diagnostic criteria such as “acute or chronic reaction to genocide and colonialism”. (p. 99)

Because of the nature and variety of responses generated by Historical Trauma, the diagnosis of PTSD does not adequately capture both its core characteristics and its various responses. Evans-Campbell (2008) pinpoints some reasons underlying the PTSD limitations to fully reflect the extent of Historical Trauma. She highlights the focus on the familial and social consequences of historical trauma responses, the potentially blending nature of reactions to intergenerational stressors, and the interpretation of current trauma experiences in the context of historical trauma.

#### 4. Intergenerational transfer of Historical Trauma

Brave Heart (2003) explains the intergenerational transmission of trauma by means of “internal intuitive representations of generational trauma, which become the organizing concepts in their [descendants’] lives and perpetuate trauma transfer to successive generations” (p. 10). Alternatively, Gagne (1998) qualifies the various social, economic and political consequences of colonialism on First Nations as intergenerational because their effects are transferred across generations. For instance, Gagne explains that alcoholism, as well as sexual and physical abuses, came to submerge entire communities because of children exposed to the aforementioned abuses in the context of residential schools.

According to Evans-Campbell (2008), the intergenerational transfer of historical trauma can happen in at least two different ways: at the interpersonal or the community level. At the interpersonal level, it is speculated that intergenerational transfer can be done both directly, for instance, when children hear parental experiences through story telling and suffer psychological consequences as a result, or indirectly, as displayed by heightened stress levels in children, due to defective parenting practices or diminished

parental mental health. At the community level, the consequences of trauma may encompass losses as well as interconnected effects and as long as these losses are not replaced, the effects will continue to impact people at different levels of their beings. As noted by Evan-Campbell: "In others words, the community could retain the loss from the time of the initiating event into present life" (p. 328). By this process, the trauma can be transferred across generations, bringing in its flow a wide array of detrimental effects.

#### 5. Some models of coping with historical and current traumatic experiences

In order to both better understand and resolve the paramount social problems experienced by Native American nowadays, various scholars (Brave Heart and DeBruyn, 1998; Walters, Simoni, & Evans-Campbell, 2002) posit the necessity to include the concept of Historical Trauma and historical unresolved grief into any examination of the current social afflictions.

What can be observed in the general population is also displayed in Native Americans and Aboriginal people in Canada. Not everyone exposed to heightened levels of traumatic stress develop substance abuse dependency or other health-related detrimental consequences. A useful model conceptualized by Walters, Simoni, and Evans-Campbell (2002), the "Indigenist Stress-Coping Model" (p. 105), offers a framework to comprehend Native Americans and Alaska Natives ways of coping with traumatic life events in the context of colonization such as Historical Trauma, violent crimes, and child abuse and neglect. This model also evaluates the effects of these stressors on Native Americans' physical and mental health, as well as on their alcohol and drug use. In reference to this model, Walters and Simoni (2002) assert that cultural

factors, including identity attitudes, enculturation, spiritual coping, and traditional health practice, moderate the effects of life stressors on Native Americans health.

The importance for Native Americans to develop a positive self-identity towards themselves and others is highlighted by Walters et al. (2002). In addition, traditional health practices (e.g., traditional medicines and healing, dances) and spiritual practices (e.g., Native Americans religious practices, access to sacred sites and funerary rites) are of paramount importance as they provide comfort when dealing with adversity. In fact, building upon empirical research findings in the general literature, Walters et al. (2002) report an association between spiritual methods and better psychological, social, and physical adjustment to challenging life circumstances, as well as physical and mental health. For additional information regarding Aboriginal and Native American traditional healing practices, readers are invited to refer to Avery (1991), Cohen (1998), and Heilbron and Guttman (2000).

Walters et al. (2002) also propose other factors acting as moderators of the effects of traumatic experiences on Native Americans such as the process of enculturation which occurs when individuals who are part of a minority group uncover and identify with their cultural background, traditional values, and norms. Finally, other moderating factors found in this model include family support, more specifically, parental bonding, as well as extended families ties and community practices. Although the "Indigenous" Stress-Coping model has not been validated in relation to variables including gender, tribes, and geographic regions, it still gives us an appreciation of some means by which Native Americans can create a better present and future life for themselves.

Another program proposed by Brave Heart (2003), the Historical Trauma and Unresolved Grief Intervention (HTUG) developed by the Takini Network, is acknowledged by the Centre for Mental Health Services as an exemplary model. Similarly, this program emphasizes the necessity to focus on improving the historical trauma response, as well as encouraging Native American people to reestablish a close attachment to traditional values in order to both prevent and treat Historical Trauma and substance abuse. As such, this program is highly promising not only for informing Lakota children and families about risk and substance use prevention but also for potentially decelerating the transfer of trauma across generations (Brave Heart, 2003).

#### 6. Non-Aboriginal counsellors working with Aboriginal peoples

Most Western clinicians working in the context of cumulative and Historical Trauma with Aboriginal or Native American people have much to learn. The richness of Native American and Aboriginal culture is most often than not ignored by Westerners and this, of course, deeply influences their encounters with these populations. I argue that clinicians must be instilled with humility as it is reflected in the following passage:

I have a need and a responsibility to create necessary change; however, I must seek further knowledge and have those who have been oppressed inform me how these issues are to be defined and what needs to be done to create solutions. (Hingley, 2002, p. 108)

This passage brings us back to the emic epistemologies for culturally competent practice discussed in the previous section. Coming from a stance of curiosity, humility, and openness, Western clinicians can best offer quality and relevant services to diverse populations.

Shepard, O'Neill and Guenette (2006) highlight some characteristics inherent to effective counsellors. In their clinical work with First Nations women, these authors speak about the importance of counsellors possessing cultural empathy. This ability is considered necessary to accurately understand the intrinsic self-experience of a person from another culture. In the context of First Nations people, this deep understanding encompasses a basic comprehension of not only the historical and socio-political circumstances of each individual, but also the impacts these factors may have had on each client's personal life story. Furthermore, Shepard et al. (2006) remind us of the importance for clinicians to ascertain the different ways by which stressors such as racism, discrimination, and oppression have affected each individual's life while recognizing personal strengths and resilience. Finally, these authors pinpoint that effective counsellors working with First Nations' women need to develop the ability to respond to a large array of needs including suicide, violence, communication with the criminal justice system, loss and grieving, and impacts of sexual abuse.

Other researchers propose valuable suggestions. For instance, Thomason (1991) pinpoint the impossibility of making general recommendations about Native Americans because of their extremely diversified population. Bands or Tribes differ from each other as well as members of the same group. Furthermore, Heilbron and Guttman (2000) emphasize the frequent failure of counselling services offered to First Nations clients because cultural and traditional beliefs are overlooked in therapy. In fact, most providers are trained to offer services to Westerners and are therefore unaware of individual's life experiences shared by people from other cultural backgrounds (Duran & Duran, 2002). Some scholars remind non-Aboriginal clinicians that "they must first be willing to accept

the legitimacy and importance of traditional healing beliefs and practices” (Heilbron & Guttman, 2000, p. 3) if they wish to be effective with First Nations clients. Because of the historical context of these populations, non-Aboriginal counsellors should be particularly sensitive to trust issues as well as respect in the therapeutic relationship.

The use of group therapy for working through Historical Trauma with Native Americans is also advocated by various scholars throughout the literature (e.g., Brave Heart, 2003; Brave Heart and DeBruyn, 1998). As stated by Brave Heart (2003), “[G]roup trauma and psychoeducational interventions which seek to restore an attachment to traditional values manifest promising results for the Lakota” (p. 11). Besides stimulating the expression of emotions, the group process both enhances the development of awareness about Historical Trauma and encourages the experience of associated grief, through the utilization of audiovisual materials illustrating traumas for instance (Brave Heart & DeBruyn, 1998).

## 7. Healing from Historical Trauma

As a final note, healing from Historical Trauma requires actions directed toward the empowerment of the community and the local cultural traditions for “regaining control, healing wounds, and building a bridge from a difficult past to a more positive future” (Wessells, 1999, p. 269). In the process of dealing with unresolved grief and mourning, Walters and colleagues (2002) write:

Validation of traumatic events is a critical step toward healing. Acknowledgment and remorse on the part of perpetrators can be immensely valuable in the healing process. The United States has yet to acknowledge its role in the historical and continuing traumatization of

indigenous peoples. This lack of validation contributes to a shared sense of unresolved grief and mourning. (p. 110)

As pinpointed by Doka (1989) disenfranchised grief can be defined as a grief experienced by individuals who go through a loss that is not or cannot be confessed openly, mourned publicly, or supported socially. Making reference to the historical representation of Native Americans as being stoic and savage, Brave Heart and DeBruyn (1998) posit that this past conceptualization has led to the prominent societal belief in the incapacity of Native Americans to have feelings, to mourn their losses and, ultimately, to feel the need or to have the right to grieve. When the mourning process is not facilitated by the means of rituals, this can severely impact the grief resolution. Consequently, as noted by Brave Heart and DeBruyn (1998), disenfranchised grief experienced by Native Americans has resulted in an exacerbation of various typical emotional reactions such as guilt, anger, sadness, and helplessness. Furthermore, when the legitimacy of grief among a group is disenfranchised by a society, this has various repercussions such as the development of shame and other associated feelings including powerlessness, helplessness, and feeling of inferiority.

#### 8. Concluding comments

This section has revolved around Historical Trauma in Native Americans and Aboriginal people in Canada. The deliberate efforts at fading out the existence of Native Americans and Aboriginal peoples and the constellation of losses endured by these populations have led many scholars to use the concept of genocide as a framework to explain the atrocities directed towards these populations. In the trauma literature, the concept of resilience or positive adaptation in face of adversity, is a relatively new

concept in regard to Native Americans and Aboriginal people in Canada. Even though Aboriginal people in Canada and Native Americans have displayed much resilience throughout history, the focus of research on resilience redirects our attention “from pathologies to opportunities for supportive action” (Fleming, & Ledogar, 2008, p. 16). Future counsellors may want to investigate in what ways they can guide Aboriginal clients to recognize and foster their resilience. They may also wish to reflect on this quote from Whitbeck (2006): “Native American cultures contain all the necessary knowledge to socialize mentally healthy, alcohol and drug-free children. This knowledge need not be replaced with information and socialization techniques derived from European culture” (p. 185). This quote is an invitation for clinicians to work with an attitude of humility, openness and respect.

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### WEEK 10: Intergenerational Trauma

This section explores the following topics: 1. What is Intergenerational Trauma? 2. Worldwide occurrences of massive trauma; 3. Some modes of Intergenerational Trauma transmission and their effects on descendants; 4. Discrepancies between clinical and empirical research; 5. The “conspiracy of silence” in clinicians and society; 6. Countertransference in mental health professionals; 7. The role of testimonies and reparative justice in massive trauma; 8. Concluding comments.

Traumatization can have subtle ways of invading people’s lives. At a systemic level, parental influences on children are extensively discussed throughout the general literature. In the context of experiencing trauma, however, a question worth asking is whether or not there is any possibility that parental trauma can influence or be passed on to subsequent generations.

#### 1. What is Intergenerational Trauma?

Dass-Brailsford (2007) defines intergenerational or multigenerational trauma as “the cumulative emotional and psychological wounding that is transmitted from one generation to the next (p. 5). The concept of intergenerational trauma has been studied in different contexts such as the Nazi Holocaust, the Vietnam War, genocides, domestic violence, repressive regimes, and with diverse populations such as African Americans, First Nations, Japanese Americans, and survivors of the Nazi Holocaust (Allen 1996; Danieli, 1998; Duran, Duran, Brave Heart & Horse-Davis, 1998; Nagata, 1998), giving birth to an extensive literature on the transmission of trauma across generations.

Additionally, because “a stressor does not require physical contact for it to be severe or

traumatizing,” (Bryant-Davis, 2007, p. 137) various researchers hypothesized that phenomenon such as oppression and discrimination may have the potential to negatively impact future generations (Allen, 1996; Burstow, 2003; Danieli, 1985; Dass-Brailsford, 2007; Laub, 2002).

In contrast to PTSD and complex trauma, which both result from direct trauma exposure(s), many descendants of trauma survivors have not been directly exposed to their parents traumatic experiences and, in many cases, were born after their parents experienced a traumatic event (Albeck, 1994). As noted by Burstow (2003): “Significantly, people subjected to transgenerational trauma may not have directly experienced, witnessed, or even been confronted by traumatic events. Indeed, they may have experienced nothing but the particular ways their parents respond to the world” (p. 1297). Nevertheless, offspring may be deeply affected by their indirect encounter with traumatization, influencing many to request therapeutic help in order to come to terms with issues related to histories of traumatic experiences occurring in the context of their parents’ lives (Albeck, 1994).

The recognition of the possible transmission of pathology across generations is not included in the current DSM-IV-TR (APA, 2000) definition of PTSD and this has been identified as a limitation. As pinpointed by Danieli (1998a), this omission may lead to inaccurate diagnosis of the behaviors of the children of some survivors, misunderstanding their behaviors’ etiology and ultimately not responding to their treatment needs. Understandably, some trauma researchers find it ironic to accept Vicarious Traumatization as potentially affecting clinicians working with trauma survivors, while at the same time disputing the fact that young children may be seriously

affected when they identify with a parent displaying trauma symptomatology (Auerhahn & Laub, 1998).

As noted by Dass-Brailsford (2007), the intergenerational impacts of trauma can be observed in various domains of functioning such as cultural loss of language and traditions, emotional (depression, anger, stress, hyperarousal, low self-esteem), and social, as exhibited by a significantly higher occurrence of social ailments among minority group members, including substance dependency, domestic violence, and a heightened rates of suicide, homicide, and incarceration. Furthermore, as will be noted subsequently in this section, symptoms of PTSD can be exhibited in offspring of parents who have experienced traumatic events.

## 2. Worldwide occurrences of massive trauma

Massive acts of traumatization have happened worldwide in the past and continue to occur nowadays. Even though North Americans are well aware of massive traumas such as the Second World War concentration camps, the Vietnam War, the Aboriginal and Native American genocide and the Japanese American Internment, other massive traumatic events are less familiar. The “International Handbook of Multigenerational Legacies of Trauma” (Danieli, 1998) presents numerous examples of worldwide massive traumas as well as their devastating effects across generations. For instance, Edelman, Kordon, and Lagos (1998) describe the 1976-1983 dictatorship period in Argentina as “the worst form of political repression in Argentina’s entire history” (p. 447) leading to psychological effects in subsequent generations. Furthermore, Klain (1998) reports the intergenerational consequences of the conflict in the former

Yugoslavia, and Becker and Diaz (1998) discuss the extreme traumatization of children born from persecuted parents in Chile.

In the United States, Dass-Brailsford (2007) identifies three major historical massive traumas responsible for the transmission of intergenerational consequences in many descendants (1) The Native American Genocide, (2) The African American enslavement, and (3) The Japanese American Internment.

Conceptualized as a form of Historical trauma, the Aboriginal and Native American Genocide has been the centre of much deserved attention by researchers (e.g., Brave Heart, 2003; Duran & Duran, 2002; Evans-Campbell, 2008) and was overviewed in the previous section of this handbook. Therefore, this section will focus on other groups of people who survived massive forms of traumatization.

Even though Allen (1996) did not directly assert the presence of intergenerational trauma in African American lives, he speaks about the “legacy of slavery”, a 250-year period when the slave trade was carried out in America, and he qualifies “racism as traumatic stress” (p. 221). This author highlights the tremendous suffering brought by the slavery/segregation history on many generations of African Americans and the subtlety of racism in everyday lives, potentially accounting for the passage of much stress across generations. Similarly, Tully (1999) reports the trauma of slavery as “the crucible of African Americans culture” (p. 26) and she states that “past abuses persist in African American lives” (p. 28) by the means of low socio-economic status, racial segregation and a restricted access to political, economic, and social domains. While other authors have rooted the origins of current African American problems to slavery (e.g., Cross, 1998), the recent

emergence of a “race-based trauma” literature (e.g., Bryant-Davis, 2007; Bryant-Davis & Ocampo, 2005; Carter, 2007; Nagata and Cheng, 2003; Williams and Williams-Morris, 2000) is building the foundation for a better understanding of the effects of race-based trauma in the current lives of African Americans as well as the possible transmission of race-based emotional and psychological wounds to subsequent generations.

For Japanese-Americans, the removal and imprisonment of 120,000 men, women, and children by the Canadian and United States governments during the World War II represents a horrific past trauma, which continues to affect present generations. Nagata and Northampton (1991) state:

In reality, there was no evidence to support the need for this massive and racist military action. No formal charges were ever brought against them nor did they have an opportunity for a trial of any kind. Often given less than a week's notice of their removal, the Japanese-Americans took only what they could carry and had to sell businesses, property and personal possessions for a fraction of their worth... The Japanese-Americans lived an average of two to three years in the camps enclosed by barbed wire and armed guards. (p. 3)

During their internment, Japanese Americans endured various traumatic experiences such as the social injustice of their internment and their forced relocation to remote areas, which generated, among others, intense safety concerns, termination of employment, significant economic losses and the collapse of their traditional family arrangement (Nagata, 1998). Nagata (1998) explained that this

mass internment was first and foremost an act of racism, as Japanese Americans were already victims of discrimination. Furthermore, as the internment was humanly and intentionally planned, this author highlighted the possibility that victims have endured more severe and extended PTSD symptoms than those resulting from natural or accidental sources. As stated in the DSM-IV-TR (APA, 2000), PTSD “may be especially severe or long lasting when the stressor is of human design (e.g., torture, rape)” (p. 464). The goal of ‘The Sansei research project’ conducted by Nagata (1998) was to study the effects of the internment on offspring (Sansei) born to former internees after the war. In spite of scarce overt communication between parents and Sansei about the internment, Nagata found that Sansei (either born from one or both interned parents) felt affected by their parents’ traumatic experiences, reflected more particularly by a significantly low level of confidence regarding their right as citizens of the United States. Furthermore, this research project highlighted the impact of the internment on the Sanseis’ sense of self-esteem and ethnic identity. More specifically, parental internment appeared to have affected and lead to Sanseis’ loss of their Japanese language and culture as well as their Japanese sense of identity, resulting in some Sansei experiencing “feelings of shame and inferiority about their ‘Japaneseness’” (Nagata, 1998, p. 133).

### 3. Some modes of Intergenerational Trauma transmission and their effects on descendants

The Nazi Holocaust gave birth to the first clinicians’ observation of the intergenerational transmission of trauma when, in 1966, many children of Nazi

Holocaust survivors were searching therapeutic treatment in Canadian clinics (Danieli, 1998a). In her exhaustive work with this population, Danieli (1998a) explains that children of survivors have immersed- both consciously and unconsciously- their parents' traumatic experiences into their own personal lives. She states:

Children of such families, although remembering their parents' and lost families' war histories "only in bits and pieces," attested to the constant psychological presence of the Holocaust at home, verbally and nonverbally, or in some cases, reported having absorbed the omnipresent experience of the Holocaust through "osmosis". (p. 5)

Danieli (1998a) reports that children of survivors, like their parents, exhibit behaviors derived from the Holocaust, especially on the anniversaries of their parents' trauma. Furthermore, they too internalized images of those who died as a component of their own identity.

In her article "Healing their wounds: Psychotherapy with Holocaust survivors and their families", Kestenberg (1989) presents the concept of transposition, which she qualifies as "the most important aspect of the psychology of children of survivors" (p. 67). As she explains, "children of survivors have a tendency to go back in time and explore their parents' past. In their fantasies, they live during the Holocaust and transpose the present into the past." (Kestenberg, 1989, p. 78) During the process of transposition, considered a normal phenomenon, Kestenberg notes that children of survivors exhibit similar symptoms to those having actually experienced the Holocaust themselves. Even though the process of transposition is based on identification with either one or both

parental figures, Kestenberg specifies that it transcends identification as it serves to pass on the influence of paramount historical occurrences across generations.

According to Nader (1998), the transmission of trauma can be effectuated through various means such as (1) overt communication; (2) overt behaviors; (3) covert (metacommunications), subliminally; and/or (4) genetically or biochemically.

Nader (1998) emphasizes the nature of traumatic memories, explicit or implicit, as being the factor determining whether the transmission is overt or covert. While explicit memory is open, conscious, and characterized by factual information, implicit memory operates without conscious awareness, highlighting the covert quality of this type of memory. According to this author overt transmission of traumatic material can be done through verbal prescriptions (e.g., preparing children to anticipate trauma) modeling (e.g., modeling abusive behaviors or psychological features such as helplessness and hopelessness) or caregivers' posttraumatic abusive behaviors. On the other hand, covert transmission includes nonverbal communications of material such as beliefs, themes, as well as intense and unsettled personal matters.

Referring to research with both animals and human beings, Nader (1998) reports evidence that "characteristics affecting life circumstances are genetically or biochemically transmitted from one generation to another" (p. 573). For instance, Suomi and Levine (1998) studied Rhesus monkeys who produced higher rates of the adrenocorticotrophic hormone (ACTH) and cortisol when placed in stressful situations, giving birth to offspring who, in turn, exhibited elevated levels of ACTH and cortisol. Furthermore, in their examination of the relationship between PTSD characteristics of Holocaust survivors and their adult children, Yehuda, Schmeidler, Giller, Siever, and

Binder-Brynes (1998) found a significant relationship between parents and children concerning the impact of trauma on personal's life and level of intrusiveness, but not avoidance, symptoms in reaction to reminiscence of the Holocaust. Furthermore, in this study, Yehuda et al. (1998) found that children who encountered traumatic experiences were more prone to develop the symptoms of PTSD if their parents had PTSD. In another study, Yehuda, Engel, Brand, Seckl, Marcus, and Berkowitz (2005) investigated the relationship between maternal PTSD symptoms and salivary levels of cortisol in infants of mothers who were directly exposed to the World Trade Center collapse on September 11, 2001 during pregnancy. Yehuda et al. (2005) found lower cortisol levels in both mothers and babies of mother who developed PTSD in reaction to September 11 compared to mothers and their babies who did not develop PTSD. As suggested by these authors, effects of maternal PTSD related to cortisol can be observed in the offspring very early in life. These examples suggest that vulnerability regarding the development of PTSD may be transmitted in families.

Finally Ancharoff, Munroe, and Fisher (1998) highlight four mechanisms of trauma transmission, which they qualified as "simplified working models" (p. 263): (1) silence, (2) overdisclosure, (3) identification, and (4) reenactment. As they note, these mechanisms can greatly overlap and propagate functional or dysfunctional messages.

According to Ancharoff et al.(1998), "silence can often communicate traumatic messages as powerfully as words" ( p. 263). They report that silences may develop by means of two different modes of functioning in families. Firstly, in their attempts to avoid increasing their parents' distress, children of survivors may refrain from speaking about issues having the potential to prompt uncomfortable feelings or the exhibition of parental

symptoms. Secondly, in their attempts to avoid triggering the manifestation of intense behaviors in parents, children of survivors may refrain from talking about delicate issues, events, emotions, thoughts or situations which they believe may provoke these behaviors.

On the other hand, traumatic material has an inherent painful nature and children may not be ready to hear such content. As noted by Ancharoff et al. (1998), despite their desire to protect their children from the pain of their traumatic experience, direct disclosure of traumatic material by survivors does happen and may traumatize children. Thus, factors including children's age appropriateness, degree of parental support, quantity of traumatic material disclosed, approach taken by survivors when delivering trauma information and survivor's integration of trauma are all important to consider when making the choice to disclose traumatic material to children.

The process of identification can be exemplified by the case of Alan, a Vietnam veteran's child, who "was aware that his father had 'violent' dreams in which he 'wakes up swinging'" (Rosenbeck & Nathan, 1985, p. 538). As a result, Alan:

...found going to sleep a disturbing time in which he worried about being killed or kidnapped. His main fear was that he, his father, or both would be shot "like in the war." In many of his fantasies, it was as if he was living in one of his father's flashbacks rather than in his own reality.

(Rosenbeck & Nathan, 1985, p. 538)

As pinpointed by the authors of this quote, this case of secondary traumatization exemplifies a child's exposure to the "reliving" experiences of a traumatized father and his subsequent identification with him. By internalizing his father's scary reality, in

fantasy, various feelings experienced by Alan mimicked his father's PTSD symptoms such as insomnia, guilt, helplessness, and anxiety.

Lastly, Ancharoff, et al. (1998) note that reenactment of traumatic experiences involves the participation of others, often family members, who "may be engaged or induced to participate in relationships based on this worldview [of the survivor] and to act out various roles that vary in accordance with the specific dynamics of the original trauma" ( p. 265). As a consequence of their participation in reenactments, the various affects aroused in family members parallel those of the trauma survivor. Therefore, individuals close to trauma survivors may come to think, feel and behave as if they were themselves perpetrators or had been traumatized.

#### 4. Discrepancies between clinical and empirical research

The exhaustive literature focusing on the possible intergenerational transmission of Holocaust parental traumatic experiences on children highlights disparities between clinical and empirical findings (Felsen, 1998). As noted by Felsen (1998), while the encounters between researchers and subjects in clinical research (e.g., in-depth and face-to-face interviews) are more directed toward the individual experience, involving an experiential dimension and the emergence of components associated with this experience, empirical research (e.g., questionnaires) is more focused on the subjects (including researchers) who have a specific task to accomplish in a limited time, and who are engaged in a less personal interaction. Consequently, the choice of research procedures will render different views of the experience of individuals in respect to the same event. As a word of caution, it is important to understand that "not every child of a trauma survivor will become a dysfunctional adult" (Ancharoff et al., 1998, p. 261). As specified

throughout the trauma literature, empirical research exploring the possible intergenerational transmission of trauma is still in its infancy and, consequently, more research is necessary in order to fully understand the extent of the consequences of parental trauma in children.

##### 5. The “conspiracy of silence” in clinicians and society.

Building upon her personal clinical experience with Nazi Holocaust survivors and their children as well as massive clinical documentation, Danieli (1984) mentions that “survivors and children of survivors have frequently complained of neglect and avoidance of their Holocaust experiences by mental health professionals” (p. 24). According Danieli (1998a; 2009), this lack of understanding toward Holocaust survivors and their children since the Second World War, is not limited to mental health professionals but extends to society in general. Danieli pinpoints the mixed societal reaction of indifference, repression, avoidance, and denial about the Holocaust, leading survivors and their offspring to conclude that only those who had gone through the Holocaust atrocities could truly comprehend them. Consequently, Holocaust survivors became silent about their Holocaust experiences, sharing them only with each other and withdrawing to the confines of their own families.

The “conspiracy of silence” about Nazi Holocaust survivors, as coined by Danieli (1998a, p. 4), brought in its realm various detrimental effects. In fact, this phenomenon has not only negatively impacted survivors’ adaptations in the aftermath of the Holocaust but has also deepened their already established sense of loneliness and distrust toward society. Furthermore, the conspiracy of silence has “impeded the possibility of their intrapsychic integration and healing, and made their task of mourning their massive

losses impossible.” (Danieli, 1998a, p. 4). Clinician’s countertransference reactions to survivors stories of traumatic experiences has a prominent role in the conspiracy of silence. Consequently, developing awareness about our countertransference reactions, as clinicians, has an essential role in our therapeutic encounters with traumatized individuals (Danieli, 1998).

#### 6. Countertransference in mental health professionals

The possibility for an individual to be traumatized by direct as well as indirect exposure to a traumatic experience is supported by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000) definition of the PTSD. In the trauma literature, the phenomenon of traumatic countertransference has been widely acknowledged. Defined as the clinicians’ reactions to patients’ traumatic stories about their victimization, not their behaviors, some researchers refer to this phenomenon as Vicarious Traumatization (Danieli, 1994). Being an intrinsic component of any therapeutic encounters as well as a natural process to be expected, the understanding of countertransference reactions and how they can impede the therapeutic process are paramount for clinicians. In the context of the Holocaust, Danieli (1994) writes:

...countertransference reactions are the building blocks of the societal, as well as professional, conspiracy of silence. They inhibit professionals from studying, correctly diagnosing, and treating the effects of trauma. They also perpetuate the traditional lack of training necessary for professionals to cope with massive, real, adult trauma and its long-term effects. (p. 546)

In her study about the emotional reactions and attitude of clinicians working with Holocaust survivors and their children, Danieli (1984) extricated forty nine countertransference themes experienced by clinicians. While clinicians most commonly reported feelings of bystander's guilt, the second most frequent feeling was rage. Other countertransference themes included dread and horror, grief and mourning, shame and associated emotions, defense (e.g., numbing, denial, avoidance, distancing), viewing the survivor as a hero, inability to tolerate vehement emotions and feelings associated with parent-child relationships.

As a means to provide a framework to clinicians, in their work with trauma victims, Danieli (1984) highlights the importance for clinicians to possess knowledge about the Holocaust, the pre-Holocaust background, as well as the long-term diverse consequences of massive trauma on survivors and their offspring. Having a basic understanding of these subjects, clinicians would be better prepared to "know what to look for, and what types of questions to ask" (Danieli, 1984, p. 40). However, she also emphasizes how important it is to acknowledge the wide diversity of reactions to the Holocaust and post-Holocaust life experiences in survivors families. Even though Danieli's suggestions are made in the context of the Holocaust tragedy, they still hold their usefulness and value in the context of other types of massive trauma.

#### 7. The role of testimonies and reparative justice in massive trauma

In the context of large scale traumas, when entire populations have been unfairly treated and are feeling deeply hurt, some programs are in place which attempt to help survivors in their struggle with the overwhelming effects of trauma caused by past human rights violations.

Truth commissions or truth and reconciliation commission are commissions aimed at discovering and addressing past wrongdoing by a government (or in some cases, non-state individuals), with the intent of resolving conflict left behind (Truth and Reconciliation Commission, n.d.). As pinpointed by Hamber (2000), truth commissions can be a first step for individuals and countries in the process of addressing the devastative effects of massive trauma. For instance, established partly as a means of national healing, the South African Truth and Reconciliation Commission has been concretized after the abolition of apartheid in this country (Swartz & Drennan, 2000). Despite providing a framework for both public discussion and public memory of past human rights violations truth commissions “can assert an over-simplistic view of what it takes to move on from the past” (Hamber and Wilson, 2002, p. 37). As a matter of fact, ‘revealing’ is not necessarily to be equated with ‘healing’.

Reparations for wrong-doings are one of the paramount ways by which commissions hope to reach reconciliation between nation and individuals (Hamber & Wilson, 2002). Either material (e.g. payments) or symbolic (e.g. reburials, apology, monuments, museums, plaques), acts of reparations “can, although not necessarily, play an important role in processes of opening space for bereavement, addressing trauma and ritualizing symbolic closure” (Hamber & Wilson, 2002, p. 38). For instance, according to Hamber and Wilson (2002), by concretizing a traumatic occurrence, reparations help to reassigned responsibility and, as such, rightfully redirect blame towards those responsible for the crimes, therefore reducing the moral ambivalence and guilt frequently felt by survivors. However, the reparations process is also seen as a double-edged sword, as reparations “can never bring back the dead or be guaranteed to converge with, and

ameliorate, all the levels of psychological pain suffered by a survivor” (Hamber, 2000, p. 219).

Consequently, Hamber (2000) pinpoints the necessity to link reparations and truth recovery in order to avoid the possibility for reparations to be considered by survivors as a governmental tactic designed to prematurely shut the door on the past and hide past atrocities. As highlighted by this author, to assure the success of reparation programs, ongoing space must be furnished to survivors as a means to express the whole range of feelings they experience in their struggle to resolve the detrimental psychological and emotional effects of their loss.

At an individual level, the process of giving testimony, telling one’s life story, is one way by which traumatized individuals can begin to integrate their catastrophic experiences and grieve their suffering and losses. For instance, Luebben (2003) describes a testimony project used conjointly with therapeutic help and informed advocacy for traumatized Bosnian refugees in Germany, who were in danger of deportation. According to Luebben, even though many survivors were unable to face their traumatic experiences, for those who participated, the testimony process:

...has therapeutic significance, because the emotional and cognitive work of remembering and the chronological reconstruction of events supports an initial mental integration by the survivor of their traumatic experiences and makes it possible for them to begin to develop a coherent life story from a post-war perspective. (p. 394)

Luebben (2003) reveals that the testimony method has the advantage of meeting survivors need to acknowledge and record the trauma, while deciding what and how

much they wish to share as well as preserving their authority over the final document. In fact, "giving testimony has a lot to do with wanting to tell the truth, and showing the perpetrators, who prefer to remain in the dark, evidence of their crimes" (Luebben, 2003, p. 397). Similarly, Laub (2002) describes her experience of using videotaped testimonies in the therapeutic treatment of Holocaust survivors and she emphasizes the necessity for trauma survivors to have their testimonies reach and be heard by perpetrators, in order for the victimization process to end. As stated by Laub (2002):

If the perpetrator does not hear the victim's pain, the process of victimization does not stop and is frozen in perpetuity. The only possibility for movement to resume, for exploring alternatives, and thus, perhaps, for approaching closure, is if the victim can perceive that the perpetrator is open to the victim's perspective. (p. 68)

As such, Laub asserts the moral and therapeutic necessity of the perpetrator's testimony in order to repair the wounds caused by atrocities.

## 8. Concluding comments

Intergenerational trauma deserves clinicians attention. Researchers (Albeck, 1994; Goodman & West-Olatunji, 2008) suggest assessing for intergenerational trauma. However, in the absence of both a specific category representing the intergenerational impacts of traumatization in the DSM-IV-TR and the existence of standardized psychometric assessment measures relative to this concept (Albeck, 1994), clinicians are left with only their personal knowledge about past massive trauma and their devastating consequences, as a means of guidance in their encounters with certain populations. As reminded by Danieli (1998a), developing awareness about the possible transmission of

pathology associated with intergenerational victimization as well as deepening our understanding of the various mechanisms of transmission should empower ourselves to find valuable ways to prevent the transmission of the detrimental effects of massive trauma to following generations.

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Section 11: Secondary Traumatic Stress, Vicarious Traumatization, clinician self-care  
and Vicarious Resilience.

This section explores the following topics: 1. Learning about traumatic experiences; 2. Outcomes of Secondary Traumatic Stress; 3. Vulnerability to Secondary Traumatic Stress; 4. Secondary Traumatic Stress prevention; 5. Vicarious Traumatization; 6. Vulnerability to Vicarious Traumatization; 7. Self-care strategies to counteract Secondary Traumatic Stress (STS) and Vicarious traumatization (VT); 8. Vicarious Resilience (VR); 9. Concluding comments.

### 1. Learning about traumatic experiences

There is no doubt that working with trauma clients is gratifying in many ways. While some qualify this work as meaningful and rewarding (Kassam-Adam, 1999), others link trauma counselling to “personal growth, a deeper connection with both individuals and the human experience, and a greater awareness of all aspects of life” (Pearlman, 1999, p. 51). However, throughout the trauma literature, many authors mention the potential negative impacts of trauma on mental health professionals, families, and systems (e.g. Chrestman, 1999; McCann & Pearlman, 1990), as well as the detrimental outcomes trauma can have on people, not only personally but also professionally and socially (Kassam-Adams, 1999; Pearlman & Saakvitne, 1995). To represent this reality, Figley (1995) speaks about the “cost of caring” (p. 1), Herman (1997) states that “trauma is contagious” (p. 140), and Kassam-Adams (1999) cautions that “the challenges of frequent exposure to human trauma are great” (p. 38).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000) definition of PTSD involves the possibility for someone to be traumatized either by direct or indirect exposure to traumatic experiences. More specifically, Criterion A1 stipulates that witnessing or learning about a traumatic event have the potential to be traumatizing. As noted by Jenkins and Baird (2002), "STS [Secondary Traumatic Stress] describes the sudden adverse reactions people can have to trauma survivors whom they are helping or wanting to help" (p. 424). Essentially, while traumatized individuals may develop PTSD following a traumatic encounter, clinicians may develop STS in the aftermath of learning about a traumatic encounter (Figley, 1995). Various terms are used by researchers to describe the effects of secondary trauma exposure, including Vicarious Traumatization (VT) (McCann and Pearlman, 1990; Pearlman & Saakvitne, 1995), Secondary Traumatic Stress (STS; Figley, 1995) and compassion fatigue (Figley, 1995). While some of these concepts, such as STS and compassion fatigue, are used interchangeably by numerous researchers, others, such as VT, carry a different meaning. In the following, we will explore the meaning of these constructs, hoping to help future clinicians both develop awareness about and prevent the potential negative impacts they can have on their lives.

## 2. Outcomes of Secondary Traumatic Stress

Secondary exposure to traumatic events may result in a variety of symptoms in the helper and these symptoms mimic the PTSD symptoms (Baird, & Kracen, 2006). For instance, helpers have reported experiencing symptoms which are very similar to the intrusive and avoidant symptoms experienced by their clients (Pearlman 1999), as well as physiological arousal (Figley, 1999; McCann & Pearlman, 1990), distressing emotions

(Herman, 1997), addictive and compulsive behaviors (Dutton & Rubenstein, 1995; Herman, 1997; McCann & Pearlman, 1990), somatic complaints (Herman, 1997) and sharing the survivors' nightmares (Danieli, 1984). Symptoms of compassion fatigue or Secondary Traumatic Stress (STS) in clinicians are supported by numerous studies. For instance, clinicians who were part of Killian's (2008) study about work stress and coping strategies relative to their work with trauma survivors reported job stress by means of bodily symptoms (such as muscle tension, headaches, and lack of energy), mood changes (feeling edgy, impatient, anxious, and panicky), sleep disturbances, experiencing increased difficulties concentrating, and being easily distracted. As noted by Killian, this study provides evidence not only for the existence of STS in clinicians, but also for the similarities between STS and PTSD symptoms. Furthermore, Kassam-Adams' (1999) survey of 100 graduate level psychotherapists treating sexually traumatized clients indicated the presence of intrusive and avoidant symptoms in some participants, as represented by their narratives: "I had waves of strong feelings about it"; "Pictures popped into my heads"; and "I tried not to think about it" (p. 41).

Another significant outcome of STS in clinicians is exhibited by changes relative to their personal sense of safety. In Chrestman's (1999) study, an increase in clinicians' caseload of trauma clients was associated with more trauma-related symptoms in the form of performing more protective behaviors such as checking doors and listening for noises. Even though Chrestman noted that these behavioral changes were not in the clinical range and could be representative of "an increased awareness of true danger rather than phobic avoidance" (p. 33), they still deserve our attention as they may be indicative of the subtle ways by which STS can affect clinicians' daily lives. Finally, in

the sample surveyed by Chrestman, the fact that the most distressed clinicians were the least experienced is of concern and supports the necessity for new clinicians to understand the impact that STS can have in their personal and professional lives. In contrast, the increase in professional experience, income, additional training, and percentage of time used in research pursuits, each taken individually, was associated with a decrease of trauma-related symptoms.

One tool made available for mental health professionals in order to test themselves on compassion fatigue is the Figley Compassion Fatigue Self-Test (CFST) for psychotherapists (1995, see p. 13), composed of two subscales assessing PTSD-like symptoms (CFST-CF, for compassion fatigue) and burnout (CFST-BO, for burnout). Even though this test is widely used, Jenkins and Baird (2002) report about the scarcity of published empirical evidence it possesses.

### 3. Vulnerability to Secondary Traumatic Stress (STS)

Despite being considered a normal occupational risk, not all clinicians working with traumatized individuals develop STS in the aftermath of their encounters with trauma survivors (Figley, 1995). Thus, what are some factors explaining the development of STS in some while not in others? Figley (1995) notes that two fundamental factors are necessary for the development of STS: empathy and exposure. As noted by this author, if someone does not respond emphatically to a distressed individual and is not exposed to a traumatic story, STS can not be experienced. These two factors have particular importance for clinicians since empathy and exposure form the foundation of their therapeutic work with trauma survivors. According to Dutton and Rubinstein (1995), however, clinicians' exposure to trauma is much more complex than the exposure to the

trauma itself. More specifically, Dutton and Rubinstein point out that it also implies “the prolonged, and often compounded, aftermath of the trauma” (p. 91), meaning the survivor’s response to the traumatic experience (such as intense emotional pain, rage, despair, fear, and hopelessness), as well as the survivor’s exposure to social and institutional responses to trauma survivors. More fundamentally, the social context can revictimize trauma survivors, leaving clinicians with little or no control at all over this situation. Figley (1995) points out three other factors associated with increased vulnerability to STS in clinicians: (1) when clinicians have experienced a traumatic event of some kind in their lives; (2) when they have unresolved trauma, which can be activated when learning about a client’s similar trauma; and (3) when they are confronted with trauma in children. In Killian’s (2008) study, interviewed therapist identified the following risk variables to compassion fatigue, from the most frequently occurring to the least: (1) elevated caseload demands and/or workaholism; (2) personal trauma history; (3) amount of regular access to supervision; (4) lack of a supportive work environment; (5) worldview (e.g., too much optimism or cynicism, etc); and (6) aptitude to be aware of and fulfill one’s needs.

#### 4. Secondary Traumatic Stress prevention

One question worth asking for clinicians is whether there are some factors which have the potential to prevent the development of STS. Cerney (1995) proposes four preventive measures for trauma therapists. First, she suggests developing therapeutic realism, meaning that clinicians have to know and accept their own limitations relative to the types and number of cases they can efficiently handle. Second, Cerney proposes seeking regular supervision. As she states: “...within the supervision process, blind spots

can be detected, overidentification corrected, alternative treatment procedures discussed and evaluated, and the therapist's overextension or overinvolvement analyzed and understood" (p. 139). Third, creating a balance between personal and professional lives is seen as imperative for trauma clinicians, and fourth, maintaining physical and mental health is of paramount importance. Chrestman's (1999) study highlights regular involvement in training activities as being an important buffer against STS. Apart from minimizing other sources of stress in personal lives, which has been emphasized in Chrestman's study, including non-trauma cases in the clinician's caseload and non-clinical activities in their professional lives were also valuable ways to intercede the negative consequences of STS. In reference to the prevention of STS, Figley (2002) states:

The first is to speak openly about our own struggles with compassion stress and compassion fatigue. The conspiracy of silence among the profession about this compassion fatigue is no different than the silence about family violence, racism, and sexual harassment in the past. (p. 1440)

As such, openness and humility for the challenges we encounter in our clinical work with traumatized individuals is of importance in the prevention of STS.

Finally, in her ecological model, Yassen (1995) suggests individual as well as environmental components for the prevention of STS disorder. Individual components include personal interventions in the physical, psychological, and social domains while professional strategies encompass the establishment of a balance between work and other activities, setting personal boundaries with clients, and getting support and help when necessary. In contrast, environmental components include societal interventions such as

educational interventions as a means to change people's attitude regarding STS or providing them with information on this subject, in addition to environmental interventions relative to one's work setting. This last kind of interventions encompass the physical setting of one's work environment (e.g., noise level, furnishings, security) and its "cultural" setting (e.g., value system, expectations, culture).

### 5. Vicarious Traumatization

Similar to STS, Vicarious Traumatization (VT) is considered a normal reaction to working with traumatized clients and for which clients are not to blame (Rosenbloom, Pratt, & Pearlman, 1999). As stated by Pearlman (1999), "VT is neither a reflection of inadequacy on the part of the therapist nor of toxicity or badness on the part of the client" (p. 32). Even though STS and VT are both conceptualized as occupational hazards (Pearlman, 1999), a distinctive attribute of VT is its heightened frequency in clinicians helping survivors of sexual assault and incest (Jenkins & Baird, 2002).

VT is defined as the permanent "transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material" (Pearlman & Saakvitne, 1995, p. 31). According to Rosenbloom et al., (1999), VT presents the following common characteristics. First, its impacts are cumulative, resulting from regular exposure to traumatic material which, slowly but surely, reinforces clinicians' changing ways of thinking about themselves and the world. Second, its impacts are permanent and may therefore result in lifelong changes in clinicians' ways of thinking and feelings about themselves, the world, and others. As such, VT results in covert changes in thinking and feeling, in comparison to STS, which is exhibited as symptoms similar to PTSD (Jenkins & Baird, 2002). Third, its impacts may be

emotionally intrusive, as indicated by images and feelings that may continue to haunt clinicians even when there is no more contact with some particular trauma material or a specific client. Fourth, its impacts are modifiable, as actions can be initiated in order to not only reduce, but also improve the adverse effects of working with trauma patients.

#### 6. Vulnerability to Vicarious Traumatization

According to Pearlman and Saakvitne (1995), two categories of factors play a part in clinicians' Vicarious Traumatization (VT). The first category relates to the distinct characteristics of the therapy and its context, such as the types of clients (e.g., survivors of incest and abuse, clients with dissociative disorders), as well as the working environment (e.g., racism, victim blaming). The second category is associated with the distinct clinician's characteristics and vulnerabilities, such as the clinician's past history of childhood sexual abuse or neglect, insufficient supervision, clinician's high expectations, rescue ideals, and an overemphasis on wanting to fulfill all clients' needs. These two sets of factors contribute to an increased vulnerability to VT. Similarly, Rosenbloom et al. (1999) report that clinicians' personal trauma histories is an important contributor to VT. More specifically, she states that when clinicians' own trauma histories are not recognized, processed, or resolved, they "may be sensitized to their own disrupted need areas, and at a greater risk for missing the client's more pressing themes" (Rosenbloom et al., 1999, p. 75). Furthermore, these authors point out the degree of receptiveness of clinicians' workplace organization (encouraging, undermining, compassionate ) to the work they do, as an important contributor to VT.

## 7. Self-care strategies to counteract Secondary Traumatic Stress (STS) and Vicarious Traumatization (VT)

Self-care is of paramount importance for all clinicians and particularly for those working with trauma survivors. As pointed out by Rosenbloom et al. (1999), when clinicians' personal reactions to their clients' trauma narrative are unexamined or unprocessed, this may result in numerous reactions. As stated by Rosenbloom, "helpers may feel unable to hear additional trauma material, thereby discouraging clients from fully exploring feelings because the helper does not feel able to tolerate more affect" ( p. 66). Furthermore, unprocessed reactions to trauma material may jeopardize clinicians' ability to help clients exploring other areas of themselves, their lives, or the trauma they experienced (Rosenbloom et al., 1999).

Therefore, self-care strategies are of foremost importance as they can help clinicians to prevent and/or deal with STS and VT. Self-care strategies are classified into two different domains: personal and professional. Killian (2008) reported some specific clinicians' self-care strategies protecting against STS, such as debriefing particularly difficult cases, having regular supervision, sharing quality time with family and friends, having leisure time and/or hobbies, exercising, and finding comfort in spirituality, spirituality being defined as sharing a relationship with a "larger force" that guides clinicians not only in their personal lives, but also in their practices. Killian's 2008 study confirmed that social support was the most important factor protecting professionals against secondary traumatization, which included debriefing with supervisors, colleagues, and consultants. As such, Killian suggests that "therapists may wish to reflect on how

much time for socializing, leisure, and/or hobbies they are allowing themselves to recharge after working with traumatized clientele” (p. 40).

Other self-care strategies to deal with STS identified by Williams and Sommer (1999) include the necessity for clinicians to (1) build a strong foundation in trauma theory by means of training in trauma counselling, (2) resolve their own issues as well as their past trauma history, (3) acquire competence in therapy practices, and (4) be aware of the potential impact of working with traumatized individuals and develop strategies to reduce secondary effects.

Pearlman and Saakvitne (1995) suggest three categories of interventions tailored to improve the effects of VT: personal, professional, and organizational. Personal strategies include the clinician’s identification of her/his disrupted schemas, which usually centre around areas of safety, intimacy, trust, esteem, and control, in order to diminish the intrusiveness of clients’ traumatic stories; establishing a balance between work, play, and relaxing time; making use of personal psychotherapy; and creating a list of personal restorative self-care activities and engaging oneself in the listed activities regularly. Professional strategies include ongoing supervision or professional consultation with an experienced supervisor specialized in trauma-therapy; building connections with other professionals by such means as attending workshops, gathering with colleagues to discuss coping techniques, and participating in support groups; developing a balance between clinical work and other professional activities; and reminding oneself of the value, meaning, and importance of doing this work not only for oneself but also for trauma survivors. Finally, organizational strategies include the

provision of a work place that is comfortable, and grounding, as well as a work atmosphere instilled with respect for clients and employees.

The consequences of STS and VT are not only destructive for clinicians but also for the clients they treat. Speaking about clinicians working with traumatized individuals, Williams and Sommer (1999) point out that “they are instruments of healing or hurting” (p. 232). These authors further state:

It is therefore important that they are aware of the areas of vulnerability they face as instruments and attempt to use themselves in a manner which maximizes the healing and minimizes the hurting, both for their clients and secondarily for themselves. (p. 232)

Similarly, O’Halloran and O’Halloran (2001) assert that clinicians have a responsibility not only to themselves, but also to their clients, to be knowledgeable about STS and to undertake self-care strategies as a means to avoid the detrimental effects of secondary traumatization.

## 8. Vicarious Resilience

One of the latest addition to the field of traumatology is the phenomenon of Vicarious Resilience (VR) proposed by Hernandez, Gangsei, and Engstrom (2007), who investigated whether therapists working with trauma survivors of torture “learn something about overcoming adversity from their clients” (p. 230). Based on clinicians’ narratives, the Hernandez et al. study supports a natural phenomenon of positive change in clinicians by means of their clients’ stories of coping with adversity. This phenomenon has been called Vicarious Resilience (VR). More specifically, clinicians’ emotions, attitudes, and behavior were affected by their clients’ resiliency, resulting in significant

changes in clinicians' perceptions of self, relationships and the environment. As stated by Engstrom, Hernandez, and Gangsei (2008), "through a process of introspection, clinicians apply lessons of client resilience to their own lives, which allows them to reframe and better cope with personal difficulties and troubles" (p. 19).

In their research, Engstrom et al., (2008) have found three main themes reflecting VR in clinicians. First, clinicians are positively affected by their client's resilience. Second, VR results in changes in clinicians' perspectives on their personal lives. Third, VR results in clinicians giving more value to their work. In contrast to Vicarious Traumatization (VT), VR is not a cumulative process nor is it a general term which encompasses all factors which motivate the clinicians (Hernandez et al., 2007). Thus, as proposed by Hernandez et al., VR offers a counterbalance to VT, as both processes can co-exist in clinicians. As pointed out by Hernandez et al., "both processes can be managed: VT can be identified and decreased, and VR can be identified and increased by developing awareness, purposefully cultivating and expanding from it" (p. 239).

Despite the fact that VR has been mostly investigated in the clinical context of torture survivors, it still provides evidence about the positive emotional components of trauma work for clinicians working in the field of traumatology.

## 9. Concluding comments

In reference to the American Psychiatric Association (1994) code of conduct, Munroe (1999) speaks about a "duty to warn" (p. 213) trauma professionals about the possibility of being harmed as a result of working with traumatized individuals. As such, the first goal of this section has been essentially to provide an overview regarding the possible negative impacts of working with trauma survivors in clinicians. By becoming

knowledgeable about STS and VT, and developing awareness about the emotional, cognitive, and physical manifestations of these two phenomena, clinicians are better prepared to plan and carry out self-care strategies which can be helpful to counteract their detrimental effects. Finally, this section aimed at presenting the concept of VR which, ultimately, conveys us to the conclusion that working with trauma survivors can be gratifying in many ways.

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## Section 12: Coping strategies and Posttraumatic Growth

This section explores the following topics: 1. Coping strategies in the aftermath of trauma; 2. What is Posttraumatic Growth? 3. The process of Posttraumatic Growth; 4. Domains of Posttraumatic Growth; 5. Factors influencing Posttraumatic Growth; 6. Facilitating Posttraumatic Growth in clients; 7. Posttraumatic Growth in clinicians; 8. Concluding comments.

How do people cope with adversity? Is it possible to experience some “benefits” from going through traumatic experiences? In this last section, we will explore answers to these questions.

### 1. Coping strategies in the aftermath of trauma

Throughout the trauma literature, researchers have noted the tremendous abilities of humans to cope with the unbearable. For instance, making reference to the legacy of slavery, Cross (1998) reports that “trauma conjures images of victims, pain, and damage; however, slavery was a long-term, multidimensional experience involving black victimization as well as effective black-coping”. Furthermore, building upon massive research findings, Felsen (1998) highlights the presence of remarkable ego strengths among Holocaust survivors’ children, displayed by their heighten motivation toward achievement as well as their increased empathic capacities. These examples raise our spirit towards the recognition that trauma brings in its realms not only vulnerability but also remarkable coping strategies and resilience.

In the literature, adaptive and maladaptive coping strategies following traumatic life events have been conceptualized in two ways: (1) problem-focused or emotion-

focused strategies, and (2) approach-focused or avoidance-focused strategies (Littleton, Horsley, John, and Nelson, 2007).

Problem-focused coping strategies center on addressing the problem engendering distress. Some examples would be developing an action plan, searching knowledge about the stressor and thinking about the next steps to take to find solutions about the stressor. In contrast, emotion-focused strategies revolve around managing the emotional distress linked with the stressor. Venting emotions, disconnecting from the emotions associated with the stressor, and searching emotional support are some examples of emotion-focused strategies. As pinpointed by Littleton and her colleagues (2007), some scholars posit the superiority of problem-focused over emotion-focused strategies because problem-focused strategies target directly the cause of distress and, consequently, they are thought to be more adaptive. In contrast, other scholars argue that problem-focused strategies are more adaptive in controllable situations whereas emotion-focused strategies are more adaptive in uncontrollable situations. Van der Kolk, van der Hart, and Marmar (2007) posit that “different styles of coping can be useful under different conditions” (p. 304). For instance, despite being helpful when there is a need to escape danger, avoidance can be dangerous when a child is being sexually or physically abused or an individual is being tortured (van der Kolk et al., 2007).

As pointed out by Littleton et al. (2007), approach-focused strategies focus on the stressor itself or one's responses to it. For example, searching emotional support and seeking information about the stressor would qualify as approach-focused strategies. On the other hand, avoidance strategies centers on the avoidance of the stressor or one's responses to it. Disconnecting from one's emotions and thoughts about the stressor,

denying the existence of the stressor and isolating ourselves from others are some examples of this type of coping strategies. In their study evaluating the relationship between the use of approach and avoidance strategies in the aftermath of trauma and the subsequent manifestation of psychological distress, Littleton et al. (2007) found that reliance on avoidance coping strategies is maladaptive, as displayed by a significant relationship between overall avoidance and more psychological distress such as depression, PTSD symptoms, and general distress.

In her article *The aftermath of victimization: Rebuilding shattered assumptions*, Janoff-Bulman (1985) presents other forms of coping strategies used by traumatized individuals in their efforts to reconstruct their shattered world. This author divides coping strategies into (1) intrapsychic/cognitive processes, focusing on the reduction of tension by the means of cognitive activity, and (2) direct action. For instance, in their attempts to diminish the threat to their assumptive world, some individuals try to cope by redefining the event in ways allowing their prior basic theories of reality to be maintained. As pinpointed by Janoff-Bulman, by minimizing the perceived impact of victimization in their own mind, traumatized individuals are less likely to seriously challenge their fundamental assumptions about oneself and one's world. Noteworthy, Taylor, Wood, and Lichtman (1983) have proposed a theory of individual's responses, termed selective evaluation, used by traumatized individuals in order to reduce their perceived sense of victimization. These responses, which are all strategies used to redefine the event, are the following: (1) using downward comparison or comparing one self with less fortunate others; (2) construing benefit from the traumatic event; (3) selectively highlighting and focusing on evaluative dimensions making one appear advantaged; (4) construing

hypothetical worse worlds; and (5) manufacturing normative standards of adjustment.

While the first four of these strategies minimize victimization, the fifth fully acknowledge the occurrence of victimization but maintains that one was able to manage the situation extremely well. As stated by Taylor et al. (1993), “this strategy is embodied by the statement, ‘I’m doing very well under the circumstances’”(p. 33). Another cognitive process used to cope with victimization consists in finding meaning in one’s experience of victimization by attempting to find some purpose in what happened or by making causal attributions providing an explanation for the occurrence of the traumatic event in one’s life (Janoff-Bulman, 1985).

Finally, coping strategies in the category of direct action encompass the modification of one’s behaviors (e.g., enrolling in self-defense training to increase self-confidence and reduce feelings of fear and helplessness after a criminal assault) and seeking social support for emotional and other types of help. As noted by Janoff-Bulman (1985), the ultimate goal of all these coping strategies is to rebuild shattered assumptions in the aftermath of a traumatic encounter.

## 2. What is Posttraumatic Growth?

In the previous sections of this course, we have mostly discussed the devastating outcomes of trauma on people’s lives, taken both from an individual and community point of view. Even though fundamentally characterized by much distress and pain, we now turn our attention to the idea that a traumatic encounter can also generate a growth process in some people (Tedeschi & Calhoun, 2004). In our attempts to fully comprehend the various features of trauma, understanding this concept from a different perspective is highly valuable. As stated by Linley and Joseph (2004):

Focusing only on the negative sequelae of trauma and adversity can lead to a biased understanding of posttraumatic reactions. Any understanding of reactions to trauma and adversity must take account of the potential for positive as well as negative changes if it is to be considered comprehensive. (p. 11)

Various forms of literature throughout the world instruct us about the possibilities for change and meaning arising from adversity. For instance, numerous religions depict instances of transformation and renewal deriving from suffering and affliction. What is more, many of us would agree that going through life difficult circumstances change us in many ways which may include positive attributes. As pinpointed by McFarlane and Yehuda (1995), "trauma can have positive effects on those who survive the ordeal; it need not necessarily result in an enduring sense of demoralization or of having been damaged" (p. 164). Similarly, Albeck (1998) highlights our tendency to pathologize the psychological reactions to traumatic events. Speaking about the intergenerational transmission of trauma, this author reminds us that "the possibilities for growth as a result of trauma in both generations, in addition to any injuries sustained, must not be overlooked" (Albeck, 1998, p. 109).

Even though adversity results in a loss of faith and an existential vacuum in some individuals, many others report positive changes. Making reference to numerous descriptive accounts of self-reported growth, Nolen-Hoeksema and Davis (2004) assert that in the aftermath of almost any kind trauma, at least 50% of individuals most directly impacted are apt to account for at least one benefit or positive life transformation that they relate directly to their experience. Similarly, building upon empirical studies

reviews, Janoff-Bulman (2006) asserts that between 75% and 90% of trauma survivors report positive changes or benefits after trauma exposure. Although these numbers reflect the exceptional potential for human nature to adapt, cope, and survive extreme life events, this author reminds us that they do not nullify the emotional and psychological pain trauma represents in people's lives.

Posttraumatic Growth (PTG) is defined as the positive psychological changes experienced by some individuals in the aftermath of their struggle with highly challenging life experiences (Tedeschi & Calhoun, 2004). More specifically,

PTG describes the experience of individuals whose development, at least in some areas, has surpassed what was present before the struggle with crises occurred. The individuals has not only survived, but has experienced changes that are viewed as important, and that go beyond what was the previous status quo. (Tedeschi & Calhoun, 2004, p. 4)

As such, PTG is much more related to the adaptation process of individuals in the aftermath of trauma than the characteristics of traumatic stressors (Tedeschi & Calhoun, 2006).

PTG has been reported in people exposed to a wide range of life crisis including heart attacks, combat, sexual abuse, cancer, plane crashes, refugee experiences and bereavement, (Linley & Joseph, 2004; Tedeschi & Calhoun, 2004). Furthermore, both males and females have reported experiencing PTG and this phenomenon has been found throughout different cultural context (e.g., Israelis, Germans, Latins, American, British) as well as across various developmental stages (Sheikh, 2008). Named differently by researchers in the trauma literature, the process of growth is also referred to as "positive

psychological changes”, “stress-related growth”, “flourishing”, “positive by-products”, “discovery of meaning”, and “thriving”, among others (Tedeschi & Calhoun, 2004).

At the outset of this section on PTG, however, it is paramount to understand this phenomenon as taking place along with people’s tremendous efforts to adapt to extraordinary circumstances. Consequently, the presence of growth does not imply a cessation of the felt emotions, the psychological reactions and the tremendous pain associated with the trauma, nor does it occur along with considering the traumatic experience as desirable (Tedeschi and Calhoun, 2004). These authors point out the mixed evidence regarding the relationship between higher levels of growth and lower levels of distress. More specifically, while some studies have uncovered an association between these two variables, others have not found a reliable relationship between PG and distress.

The relationship between PTSD and growth has been investigated by various researchers. Some studies indicate that the experience of growth increases linearly with PTSD (Tedeschi & Calhoun, 1996, 2004). However, in their study using the largest sample in the literature (4,054 Israeli adolescents), Levine, Laufer, Hamama-Raz, Stein, & Solomon (2008) found that highest levels of growth were achieved by individuals with average PTSD.

In Calhoun and Tedeschi’s (2006) view, it is paramount to establish a definite separation between the concept of resilience - which has been mostly defined as the capacity to positively adapt despite adverse experiences (Fleming & Ledogar, 2008; LaFromboise, Hoyr, Oliver, & Whitbeck, 2006; Lepore & Revenson, 2006) – and that of PTG. As PTG fundamentally implies some success in coping with extraordinary

circumstances, as a prerequisite to begin the cognitive process of what happened into a perspective having components of PTG, Calhoun and Tedeschi (2006) emphasize the importance of keeping these two concepts distinctly separated. In their study of two wide samples of survivors of war and terror, Levine, Laufer, Stein, Hamama-Raz, and Solomon (2009) found an inverse relationship between resilience, measured by a lack of PTSD, and PTG. As pinpointed by Levine et al. (2008), it would seem logical, at first glance, to find a positive relationship between resilience and Posttraumatic Growth, as they are both positive outcomes of adversity. However, if growth relates to the search for meaning in a traumatic encounter, thus, it is less likely to find resilient people engaging in the meaning-making process associated with growth, as they are unlikely to fight with the outcomes of trauma.

### 3. The process of Posttraumatic Growth

How does the process of PTG unfold? This question can be answered from different theoretical frameworks. Taking a cognitive lens, Janoff-Bulmann (1992) views a traumatic encounter as fundamentally challenging a person's basic assumptions about the world (predictability, benevolence, controllability) and happening along with intense psychological distress. According to Janoff-Bulman and Berger (2000), a traumatic experience generates the creation of a new meaning-making by the means of two divergent but interwoven components of meaning: meaning as comprehensibility and meaning as significance. While the former gets shattered by the trauma as it is more concerned with whether or not an event makes sense in the tapestry of our life, the latter is more concerned with the value and worth of coping with the traumatic situation. This last form of meaning-making is therefore more of an existential and spiritual nature

(Sheikh, 2008) and more likely to stimulate the development of PTG (Tedeschi & Calhoun, 2006)

Similarly, the general model of PTG proposed by Tedeschi and Calhoun (2004) implies the presence of a significant disturbance, such as a traumatic encounter, in a person's assumptive world. This overwhelming event generates a cognitive processing and a restructuring taking into account the altered reality of one's life in the aftermath of trauma, resulting in the creation of a new set of schemas. These new schemas, which include the trauma, are less susceptible to being shattered again. According Tedeschi and Calhoun (2004), one key element for the occurrence of PG is the necessity for the events to be "challenging enough to the assumptive world to set in motion the cognitive processing necessary for growth" (p. 7).

Stemming from a constructive narrative perspective, Meichenbaum (2006) posits that people are storytellers. More specifically, people construct narratives and do not simply respond to events but rather to their personal interpretation of these events. As such, Meichenbaum (2006) states that "various individual and group 'healing' activities work in large part because of their ability to have individuals engage in the 'power of nonnegative thinking'" (p. 356). In his article titled *Resilience and Posttraumatic Growth: A constructive narrative perspective*, Meichenbaum (2006) presents a table, which may be of interest to future clinicians, incorporating a summary of research findings relative to the characteristics of narrative linked with continual and superior level of distress in the aftermath of a traumatic experience. Furthermore, this author presents examples of ways of thinking and behaving leading trauma survivors in the direction of growth.

#### 4. Domains of Posttraumatic Growth

In what areas do PTG is mostly experienced in trauma survivors lives? Building upon personal accounts of individuals exposed to traumatic experiences, as well as on quantitative research on PTG, Calhoun and Tedeschi (2006) have identified five domains of growth commonly experienced by individuals reporting positive changes arising from the processing of a traumatic encounter. While the first area of growth relates to changes in self-perception, the self being viewed as stronger than before the traumatic encounter, the second relates to new possibilities such as new activities, interests and life directions. The third area of growth is linked to changes in relationships with others, experienced not only as a heightened sense of connection to others but also as being more compassionate for those in pain. The fourth area of growth refers to changes in personal philosophy of life reflected as an enhanced appreciation for life in general, more gratitude for what is part of one's life, and a new perspective on what is to be prioritized in one's personal life. Finally, the fifth area of growth is directed towards changes in the spiritual realm reported as greater satisfaction, purpose and meaning in life as well as more understanding about concepts of existential nature. As pinpointed by Zoellner and Maercker (2006): "Those dimensions of PTG point to a deepened sense of connection with oneself, the world, other people, or a higher power" (p. 338).

Importantly, these five areas of growth have been reported in various studies (e.g., Morris, Shakespeare-Finch, Rieck, & Newbery, 2005; Weiss, 2004). Furthermore, these levels of growth can be measured by the Posttraumatic Growth Inventory (PTGI; Tedeschi and Calhoun, 1996) and they continue to be revealed in descriptive and qualitative studies (Sheikh, 2008). In fact, the term *growth* implies that individuals have

surpassed their prior level of functioning as an outcome of coping with the traumatic experience; as such, it is not only a matter of recovering from the challenging circumstances (Zoellner & Maercker, 2006). Any of these five domains of PG represents some benefits people derive from having struggled with adversity, even though these positive changes are accompanied by pain and losses. Of interest, evidence supporting the validity of the PTGI for the measurement of positive changes in the aftermath of trauma has been gathered by various authors (e.g., Linley & Joseph, 2004; Shakespeare-Finch & Enders, 2008; Taku, Cann, Calhoun, & Tedeschi, 2008).

### 5. Factors influencing Posttraumatic Growth

One area worth investigating in the domain of PTG is whether there are some factors having the potential to increase the possibilities of experiencing PTG. Building upon several empirical studies investigating positive changes in the aftermath of adversity, some authors report variables which are consistently affiliated with PTG. For instance, numerous studies found an association between greater perception of threat, harm or levels of stress connected with the traumatic occurrence and higher PTG (Linley & Joseph, 2004; Tedeschi & Calhoun, 2004).

Another component positively linked to psychological growth is the level of cognitive processing, also referred to as “rumination” of the traumatic event, in which individuals engage when they create new schemas incorporating the trauma (Calhoun & Tedeschi, 2006; Linley & Joseph, 2004). Taken in the sense of “to turn over in the mind” (Calhoun and Tedeschi, 2006, p. 9), or trying to make sense of what happened, rumination is akin to a reflective process associated with beneficial findings or PTG. Throughout the trauma literature, various studies indicate a significant relationship

between the amount of growth and individuals cognitive processing of the event (Calhoun, Cann, Tedeschi, & McMillan, 2000; Linley & Joseph, 2004).

Finally, some personality characteristics such as extraversion, openness to experience, agreeableness, and conscientiousness (Linley & Joseph, 2004) as well as optimism, high self-esteem and high self-efficacy (Sheikh, 2008) are also reported to be positively connected to growth. Coping variables such as problem-focused coping, positive reinterpretation, acceptance coping, and positive religious coping have also been positively linked to growth (Linley & Joseph, 2004). Research findings by Cadell, Regehr, and Hemsworth (2003) on HIV/AIDS caregivers suggest that social support positively contributes to PG.

#### 6. Facilitating Posttraumatic Growth in clients

While working with individuals who have been traumatized, some counselling strategies can help the process of growth. Clinicians can encourage growth by “listening carefully to how the trauma survivor’s descriptions of events include ways they showed strength and capability before, during, and after the traumatic experiences” (Tedeschi & Calhoun, 2006, p. 295). According to Neimeyer (2006) much research in psychology confirms the importance of disclosure in the path of integrating and transcending challenging life circumstances. Similarly, Tedeschi and Calhoun (2006) closely relate self-disclosure to rumination and highlight the crucial role of clinicians as recipients of clients’ disclosures. As clinicians reactions to clients’ disclosures can either encourage or hinder cognitive processing, clinicians can consequently affect the extent by which clients experience PTG outcomes.

Throughout the trauma literature, researchers highlight the possibility of exploring the client's involvement with meaning-making in counselling. For instance, Sheikh (2008) proposes that

...a comparison of pre-trauma and post-trauma self may be explored on a range of variables, including coping strategies and self-efficacy, providing clients an opportunity to create realizations- for example, acknowledgement of a particular personal strength through successful coping with one aspect of the trauma. (p. 90)

Fostering growth in the aftermath of trauma can be also be accomplished through the process of constructing a posttraumatic narrative (Meichenbaum, 2006; Neimeyer, 2006; Neimeyer & Levitt, 2000) and these authors emphasize the crucial role of supporting trauma survivors in the reconstruction of their life narratives in order for them to integrate the trauma into their current lives and identities. However, according to Meichenbaum (2006), "it is *not* only the opportunity to tell one's story, but how one changes the nature of the storytelling over time, that influences the adjustment process" (p. 362). As such, whether an individual or a group will experience chronic and continual distress and PTSD or, conversely, resilience and PG, depends upon the nature of the self or group-narrative. Meichenbaum (2006) proposes some activities that have the potential to encourage PTG. As stated by this author:

These activities may range from using spiritual rituals to employing social supports, from using distraction procedures of keeping busy to retelling their stories in the form of artistic expression or commemorative activities. It is proposed that these varied activities "work" or contribute to healing

because they reduce the likelihood of individuals and groups engaging in “negative” counterproductive storytelling and accompanying stress-reducing behaviors. (p. 356)

In their book *Facilitating Posttraumatic Growth: A clinician's guide*, Calhoun and Tedeschi (1999) suggest some guidelines for counsellors, which have the potential to stimulate clients PTG. First, it is important to focus on listening without trying to provide a solution – this guideline invites clinicians to be fully present when listening to clients creating their narratives and developing their growing understanding of the trauma as well as its various impacts into their lives, without mitigating the affects exhibited by clients in response to their personal experience. Second, focus on growth only when the client begins to reflect on the possibility of positive changes. Clinicians must be ready and open to focus on PG that is not only explicit in verbal exchanges, but also implicit in clients narrative, or “what is expressed beneath the words” (p. 63), while, at the same time, accepting that clients are better at recognizing their own PG. The third suggestion is to label and enhance growth only when it is expressed by clients, not before. Clinicians should emphasize the positive perceptions of growth arising from the individual's struggle with trauma, not from the trauma itself. Of course, for clients who are still overwhelmed by the traumatic event, the centre of attention needs to be directed towards helping them with matters of survival and coping strategies before attempting to stimulate PTG.

## 7. Posttraumatic growth in clinicians

Even though working in trauma counselling involves potential negative effects for the clinician, material explored in the previous section, it is comforting to know that PG can also be experienced by means of their clinical work with trauma survivors.

According Calhoun and Tedeschi (1999), clinicians may experience growth vicariously, through their secondary exposure of their therapeutic encounter with traumatized individuals. For instance, one way by which clinicians can be changed is simply through their client's personal accounts of heroic battle with extreme circumstances and survival: the tremendous courage displayed by clients can become a source of inspiration for clinicians. Furthermore, while empathically listening to clients' narratives about their traumatic experiences, clinicians may find themselves reflecting about their own personal life priorities and therefore make decisions about what really matters to them. Finally, through their clinical encounters with individuals dealing with highly challenging circumstances, clinicians can have the opportunity to "experience positive changes in their worldviews and general philosophies of life" (Calhoun & Tedeschi, 1999, p. 130). As such, clinicians can be transformed by the means of their client's encounter with adversity and they can derive personal positive attributes from their work with traumatized individuals.

#### 8. Concluding comments

This section has been reserved for the investigation of individuals' coping strategies following a traumatic encounter, as well as the concept of PG. The positive psychological changes which can be experienced both by trauma survivors, following their struggle to survive highly distressing circumstances, and mental health professionals, as positive outcomes of their therapeutic work with patients, encompass

five different spheres of transformation. In the last section of our journey on trauma counselling, it is comforting to realize that clinicians can not only encourage a growth process in trauma survivors but may also develop awareness into their own constructive transformation in the context of their clinical work with survivors of trauma.

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## Conclusion

At the end of this course on trauma counselling, I hope that students: (1) have a better understanding regarding the devastating impacts of trauma in people's lives, (2) feel more prepared both to deal with trauma issues in their daily clinical work and to provide high quality services to trauma survivors, (3) have developed an awareness concerning the potential danger of working in trauma counselling, (4) have reflected on self-care strategies they can adopt to ensure their well-being as mental health professionals, and (5) have realized the inherent rewards clinicians can derive from working with trauma survivors.

The field of traumatology has grown extensively in the last few decades, and will continue to do so. Consequently, there are some subjects deserving clinicians' attention that have not been addressed in this work. One such case is that of drug therapies for posttraumatic outcomes. For further information on these therapies, readers are invited to consult Briere and Scott (2006) and Davidson and van der Kolk (2007). Another subject relates to the legal issues surrounding PTSD. Readers can refer to Pitman, Sparr, Saunders, and McFarlane (2007) for additional direction on the subject. A final subject concerns the effects of prior traumatization on the elderly, for which readers can consult Aarts and Op den Velde (2007).

As reminded occasionally throughout this handbook, readers are encouraged to persistently continue to perfect their knowledge about trauma as well as their skills related to successfully treating trauma survivors.

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