

NOTICE: PERMISSION IS GRANTED FOR REPRODUCTION & DISSEMINATION OF THIS DOCUMENT

M. Traumatic Stress: An Overview

Reprinted from *A Practical Guide for Crisis Response in Our Schools*
 © 2003 by The American Academy of Experts in Traumatic Stress—Reproduced with Permission
 368 Veterans Memorial Highway, Commack New York 11725
 Tel. (631) 543-2217 • Fax (631) 543-6977 • www.aaets.org • www.schoolcrisisresponse.com

Traumatic stress encompasses exposure to events or the witnessing of events that are extreme and/or life threatening. Traumatic exposure may be brief in duration (e.g., an automobile accident) or involve prolonged, repeated exposure (e.g., sexual abuse). The former type has been referred to as “Type I” trauma and the latter form, as “Type II” trauma (Terr, 1991). In North America, four out of ten people are exposed to at least one traumatic event in their lifetime (Meichenbaum, 1994). Approximately, 25% to 30% of individuals who witness a traumatic event may develop chronic posttraumatic stress disorder (PTSD) and other forms of mental disorders (e.g., depression) (Yehuda, Resnick, Kahana, & Giller, 1993). Approximately 50% of individuals who develop PTSD continue to suffer from its effects decades later without treatment (Meichenbaum, 1994). Knowledge about traumatic stress- how it develops, how it manifests, and how it affects the lives of those who suffer with it- is the first step in its assessment and, ultimately, its treatment.

History of Traumatic Stress

Traumatic exposure and its aftermath are not new phenomena. Humans have experienced tragedies and disaster throughout history. Evidence for post-traumatic reactions date back as far as the Sixth century B. C.; early documentation typically involved the reactions of soldiers in combat (Holmes, 1985). Beginning in the 17th century, anecdotal evidence of trauma exposure and subsequent responses were more frequently reported. In 1666, Samuel Pepys wrote about individual's responses to the Great Fire of London (Daly, 1983). It had been reported that the author Charles Dickens suffered from numerous traumatic symptoms after witnessing a tragic rail accident outside of London (Trimble, 1981).

Traumatic stress responses have been labeled in numerous ways over the years. Diagnostic terms applied to symptoms have included *Soldier's Heart*, *Battle Fatigue*, *War Neurosis*, *Da Costa's Syndrome*, *Tunnel Disease*, *Railway Spine Disorder*, *Shell Shock*, *Gross Stress Reaction*, *Adjustment Reaction of Adult Life*, *Transient Situational Disturbance*, *Traumatic Neurosis*, *Post-Vietnam Syndrome*, *Rape Trauma Syndrome*, *Child Abuse Syndrome*, and *Battered Wife Syndrome* (Everly, 1995). The *Diagnostic and Statistical Manual of Mental Disorders-Third Edition* (DSM-III) first recognized Posttraumatic Stress Disorder (PTSD) as a distinct diagnostic entity in 1980 (APA, 1980). It was categorized as an anxiety disorder because of the presence of persistent anxiety, hypervigilance, exaggerated startle response, and phobic-like avoidance behaviors (Meichenbaum, 1994). This recognition of stress-related reactions was a major step in the development of an empirical literature base investigating traumatic stress. In 1994, The *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition* (DSM-IV) was published and the current diagnostic criteria reflect the findings of numerous empirical studies and field trials (APA, 1994).

Types of Traumatic Events

Traumatic events are typically unexpected and uncontrollable. They may overwhelm an individual's sense of safety and security and leave a person feeling vulnerable and insecure in their environment. Events that are abrupt, often lasting a few minutes and as long as a few hours can be referred to as short-term or Type I traumatic events (Terr, 1991). Included within this category are natural and accidental disasters as well as deliberately caused human-made disasters. *Natural disasters* include events such as hurricanes, floods, tornadoes, earthquakes, volcanic eruptions, and avalanches. *Accidental disasters* may include motor vehicle accidents (MVA), boat, train, airplane accidents, fires, and explosions. *Deliberately caused human-made disasters* (i.e., intentional human design or IHD) involve bombings, rape, hostage situations, assault and battery, robbery, and industrial accidents.

Sustained and repeated traumatic events (or Type II traumatic events) typically involve chronic, repeated, and ongoing exposure. Examples include *natural and technological disasters* such as chronic illness, nuclear accidents, and toxic spills. Events resulting from *intentional human design* include combat, child sexual abuse, battered syndrome (i.e., spousal abuse), domestic violence, being taken as political prisoner or

prisoner of war (POW), and Holocaust victimization. It is important to consider that research indicates that, despite the heterogeneity of traumatic events, individuals who directly or vicariously experience such events show similar profiles of psychopathology including chronic PTSD and commonly observed comorbid disorders such as depression, generalized anxiety disorder, and substance abuse (Solomon, Gerrity, & Muff, 1992).

Current Diagnostic Criteria and Other Considerations

The DSM-IV stipulates that in order for an individual to be diagnosed with posttraumatic stress disorder, he or she must have experienced or witnessed a life-threatening event and reacted with intense fear, helplessness, or horror. The traumatic event is persistently reexperienced (e.g., distressing recollections), there is persistent avoidance of stimuli associated with the trauma, and the victim experiences some form of hyperarousal (e.g., exaggerated startle response). These symptoms persist for more than one month and cause clinically significant impairment in daily functioning. When the disturbance lasts a minimum of two days and as long as four weeks from the traumatic event, Acute Stress Disorder may be a more accurate diagnosis.

It has been suggested that responses to traumatic experience(s) can be divided into at least four categories (for a complete review, see Meichenbaum, 1994). *Emotional* responses include shock, terror, guilt, horror, irritability, anxiety, hostility, and depression. *Cognitive* responses are reflected in significant concentration impairment, confusion, self-blame, intrusive thoughts about the traumatic experience(s) (also referred to as flashbacks), lowered self-efficacy, fears of losing control, and fear of reoccurrence of the trauma. *Biologically-based* responses involve sleep disturbance (i.e., insomnia), nightmares, an exaggerated startle response, and psychosomatic symptoms. *Behavioral* responses include avoidance, social withdrawal, interpersonal stress (decreased intimacy and lowered trust in others), and substance abuse. The process through which the individual has coped prior to the trauma is arrested; consequently, a sense of helplessness is often maintained (Foy, 1992).

Post-traumatic symptoms often co-occur with other psychiatric conditions; this is referred to as comorbidity. For instance, substance abuse (especially, alcoholism), anxiety (e.g., panic disorder), depression, eating disorders, dissociative disorders, and personality disorders may all co-occur with PTSD. With regard to specific populations, Matsakis (1992) reported that between 40% to 60% of women in treatment for bulimia, anorexia, and obesity had described traumatic experiences at some point in their life. Kilpatrick et al. (1989) reported that, among crime victims with PTSD, 41% had sexual dysfunction, 82% had depression, 27% had obsessive-compulsive symptoms, and 18% had phobias. Sippelle (1992) reported that personality disorders were especially widespread among Vietnam Veterans. Thus, it is important to assess for comorbid disorders when seeing a patient who presents with trauma-induced symptoms.

Assessment of Traumatic Stress

The clinician working with survivors of traumatic stress and posttraumatic stress disorder must consider the multifaceted nature of these disorders. Meichenbaum (1994) recommends a multimodal approach which involves the collection of information from a number of sources, using several different methods over multiple contacts. For a complete review of assessment measures across victim and survivor populations, see Wilson and Keane (1997).

A comprehensive clinical interview is a primary assessment tool in the evaluation of traumatic stress. Careful questioning during an interview allows the survivor to tell his or her account of the event. Individuals need the opportunity to talk about their experience in a safe, non-judgmental setting. Survivors (and oftentimes, their significant others) need to feel understood and supported as they try to make sense of the traumatic event. Questioning also facilitates a working alliance with the person; the "connection" that the person feels with the treating clinician is often associated with continuation of treatment and psychotherapy treatment outcome (Safran & Segal, 1990; Wolfe, 1992). Questioning allows for the gathering of details about the trauma, assessment of current and past levels of functioning, and the development of a treatment plan. Interviews with family members and significant others may provide further insight into the nature of the trauma and presenting symptomatology.

Commonly-used structured interviews include the Clinician Administered PTSD scale (CAPS; Blake et al., 1990) and the Anxiety Disorders Interview Schedule-IV (ADIS-IV; DiNardo, Brown, & Barlow, 1994). A number of paper-and-pencil assessment measures of PTSD have evolved over the past few years as

well. Some of the more popular measures include the PTSD subscale of the Minnesota Multiphasic Personality Inventory (MMPI and MMPI-2; Keane, Malloy, & Fairbank, 1984; Schlenger & Kulka, 1987), the Penn Inventory for PTSD (Hammarberg, 1992) and the Trauma Symptom Inventory (Briere, 1995). Some screening instruments for anxiety and depression that are also useful include the Beck Anxiety Inventory (BAI; Beck, 1993) and Beck Depression Inventory- Second Edition (BDI-II; Beck, Steer, & Brown, 1996). One performance-based measure that has been used successfully with combat, rape, and accident disaster patients is the Stroop Color Word Test (McNally, English, & Lipke, 1993). As indicated earlier, assessment for comorbid disorders must be part of the evaluative process.

Treatment of Traumatic Stress

Many techniques have been used to treat survivors after exposure to traumatic events. Presently, no one form of intervention has been shown to be superior for the treatment of traumatic stress and PTSD. Ochberg (1995) divides treatment methods into four categories. *Education* is the first method. This includes educating the survivor (and their families) about trauma and its effects on daily functioning. Cognitive, behavioral, and physical aspects of the stress response are explored with the individual. The clinician and patient may share books and articles relevant to the treatment of the traumatic symptoms (see Matsakis, 1996). This process helps give meaning to the symptoms that he or she experiences and may ultimately facilitate a sense of control or mastery over them.

The second category involves *holistic health*. This includes physical activity, nutrition, spirituality, and humor as they contribute to the healing of the individual. The clinician functions as both a teacher and a coach to his patient, offering support and encouragement as the individual attempts various ways to appropriately heal him or herself.

The third group of treatment techniques includes methods to enhance *social support* and *social integration*. Included within this category are family therapy and group psychotherapy. The former typically helps to improve communication and cohesion between family members. Group treatment allows individuals to reduce feelings of isolation, share difficult feelings and perceptions regarding the trauma, and learn more adaptive coping strategies.

Finally, there are clinical interventions best described as *therapy*. The goal of most forms of therapy is to help the individual work through their grief, extinguish fear responses, and improve the quality of the individual's life. For example, cognitive-behavior therapy typically relies on exposure strategies to reduce intrusive memories, flashbacks, and nightmares related to the traumatic experience. Exposure to fear-producing stimuli and cognitions in a safe and supportive environment, over time, often reduces the impact of these stimuli on the individual's reactivity (Foa & Kozak, 1986). Cognitive restructuring strategies are also utilized to address the meaning and, oftentimes, distortions in thought processes that accompany traumatic exposure (e.g., "Life is awful," "All people are cruel"). Problem-solving training (D'Zurilla, 1986) may help the individual combat indecisiveness and perceptions of helplessness. Other techniques include relaxation training, and guided imagery-based interventions.

Pharmacological treatment of traumatic stress and PTSD indicates that different medications may affect the multi-faceted symptoms of PTSD. For example, Clonidine has been shown to reduce hyperarousal symptoms. Propranolol, Clonazepam, and Alprazolam appear to regulate anxiety and panic symptoms. Fluoxetine may reduce avoidance and explosiveness whereas re-experiencing of traumatic symptoms and depression may be treated with tricyclic antidepressants and selective serotonin reuptake inhibitors. It is important to note that pharmacotherapy as a sole source of intervention is rarely sufficient to provide complete remission of PTSD (Vargas & Davidson, 1993).

As indicated earlier, traumatic stress and particularly, PTSD, are complex and multi-faceted and consequently, a multimodal assessment is recommended. It is suggested that effective treatment will involve a number of the aforementioned techniques. Future research needs to address the outcomes of combining various treatment approaches and maintaining treatment gains over time.

Conclusion

It has been stated that post-traumatic stress may represent "one of the most severe and incapacitating forms of human stress known" (Everly, 1995, p. 7). Fortunately, traumatic stress and its consequences continue to gain recognition and investigation in the helping professions although, clearly, more research needs to be done. For example, motor-vehicle accidents (MVAs) are quite common and often precipitate traumatic stress and PTSD, yet there is a dearth of literature examining their impact as well as the treatment

of survivors of motor-vehicle accidents. There is also a need for greater investigation of secondary traumatic stress reactions. This involves the emotional, cognitive, and behavioral consequences for caregivers who work with traumatized people on a regular basis. That is, through their efforts to help a traumatized population, the helpers themselves, become overwhelmed and are traumatized indirectly or secondarily. Moreover, the research examining the effects of traumatic stress in children is in its infancy. This area is especially crucial to study in light of the growing rates of domestic violence in our society.

Recognition of trauma-related stress is the first step in an individual's road to a healthier life. Medical and mental health providers as well as other workers (e.g., emergency care workers) are in an ideal position to offer information, support, and/or the appropriate referrals to victims of traumatic stress. In fact, Lerner and Shelton (2001) have developed **Acute Traumatic Stress Management (ATSM)** as a means to assist individuals *during* a crisis (see www.atism.org). Unlike other methods for intervention which are typically employed in the aftermath of a traumatic event such as “demobilizing,” “defusing” and “debriefing,” ATSM can be used when a person is most suggestible and vulnerable to traumatic stress—while the incident is occurring. ATSM, with its emphasis on offering support within the context of a *facilitative or helping attitudinal climate*, has the potential to stimulate healthy, adaptive functioning. It offers a cognitive “road map” to keep people functioning during traumatic events and ultimately, to mitigate long-term emotional suffering. If more ongoing psychological treatment is indicated, then intervention with a clinician knowledgeable and experienced in working with anxiety and trauma-related difficulties can be a crucial factor in helping victims learn to cope and live life more fully.

Article References

- American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders (3rd ed.)*. Washington, DC: Author.
- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders (4th ed.)*. Washington, DC: Author.
- Beck, A.T., Steer, R.A., & Brown, G.K. (1996). *Beck Depression Inventory (2nd ed.)*. San Antonio, TX: The Psychological Corporation.
- Beck, A. T. (1993). *Beck Anxiety Inventory*. San Antonio, TX: The Psychological Corporation.
- Blake, D., Weathers, F., Nagy, L., Kaloupek, D., Klauminzer, G., Charney, D., & Keane, T. (1990). *Clinician Administered PTSD Scale (CAPS)*. Boston: National Center for Post-Traumatic Stress Disorder, Behavioral Science Division, Boston VA.
- Briere, J. (1995). *Trauma Symptom Inventory professional manual*. Odessa, FL: Psychological Assessment Resources.
- Cummings, N., & Vanden Bos, G.R. (1981). The twenty year Kaiser-Permanente experience with psychotherapy and medical utilization. *Health Policy Quarterly*, 1, 159-175.
- Daly, R.J. (1983). Samuel Pepys and posttraumatic stress disorder. *British Journal of Psychiatry*, 143, 64-68.
- DiNardo, P.A., Brown, T.A., & Barlow, D.H. (1994). *Anxiety Disorders Interview Schedule for DSM-IV: Clinician's Manual*. New York: Graywind.
- D'Zurilla, T.J. (1986). *Problem solving therapy: A social competence approach to clinical intervention*. New York: Springer.
- Everly, G.S. (1995). Psychotraumatology. In G.S. Everly & J.M. Lating (Eds.), *Psychotraumatology: Key papers and core concepts in post-traumatic stress* (pp. 9-26). New York: Plenum.
- Foa, E.B., & Kozak, M.J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, 99, 20-35.
- Foy, D.W. (1992). Introduction and description of the disorder. In D. W. Foy (Ed.), *Treating PTSD: Cognitive-Behavioral strategies* (pp 1-12). New York: Guilford.
- Hammarberg, M. (1992). Penn Inventory for posttraumatic stress disorder: Psychometric properties. *Psychological Assessment*, 4, 67-76.
- Holmes, R. (1985). *Acts of war*. New York: Free Press.
- Keane, T.M., Malloy, P.F., & Fairbank, J.A. (1984). Empirical development of an MMPI subscale for the assessment of combat-related post-traumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 52, 888-891.
- Kilpatrick, D. G., Saunders, B.E., Amick-McMullen, A., Best, C.L., Veronen, L.J., & Resnick, H.S. (1989). Victim and crime factors associated with the development of crime-related posttraumatic stress disorder. *Behavior Therapy*, 20, 199-214.
- Lerner, M., & Shelton, R. (2001). *Acute Traumatic Stress Management: Addressing emergent psychological needs during traumatic events*. New York: The American Academy of Experts in Traumatic Stress.
- Matsakis, A. (1992). *I can't get over it: A handbook for trauma survivors*. Oakland, CA: New Harbinger Publications.
- Matsakis, A. (1996). *I can't get over it: A handbook for trauma survivors*. (2nd ed.) Oakland, CA: New Harbinger Publications.
- McNally, R.J., English, G.E., Lipke, H.J. (1993). Assessment of intrusive cognition in PTSD: Use of the modified Stroop paradigm. *Journal of Traumatic Stress*, 6, 33-42.
- Meichenbaum, D. (1994). *A clinical handbook/practical therapist manual for assessing and treating adults with post-traumatic stress disorder*. Ontario, Canada: Institute Press.
- Ochberg, F.M. (1995). Post-traumatic therapy. In G.S. Everly & J.M. Lating (Eds.), *Psychotraumatology: Key papers and core concepts in post-traumatic stress* (pp. 245-264). New York: Plenum.
- Safran, J.D., & Segal, Z.V. (1990). *Interpersonal process in cognitive therapy*. New York: Basic Books.
- Schlenger, W.E., & Kulka, R.A. (1987). Performance of the Keane-Fairbank MMPI scale and other self-report measures in identifying post-traumatic stress disorder. Paper presented at the 95th annual meeting of the American Psychological Association, New York.
- Sippelle, R.C. (1992). A vet center experience: Multievent trauma, delayed treatment type. In D.W. Foy (Ed.), *Treating PTSD: Cognitive-Behavioral strategies* (pp 13-38). New York: Guilford.
- Solomon, S., Gerrity, E.T., & Muff, A.M. (1992). Efficacy of treatments for posttraumatic stress disorder: An empirical review. *Journal of the American Medical Association*, 268, 633-638.
- Terr, L. (1991). Childhood trauma: An outline and overview. *American Journal of Psychiatry*, 148, 10-20.
- Trimble, M.R. (1981). *Post-traumatic neurosis*. Chichester: Wiley.
- Vargas, M.A., & Davidson, J. (1993). Post-traumatic stress disorder. *Psychopharmacology*, 16, 737-748.
- Wilson, J. P., & Keane, T.M. (Eds.). (1997). *Assessing Psychological Trauma and PTSD*. New York: Guilford.
- Wolfe, B.E. (1992). Integrative psychotherapy of the anxiety disorders. In J.C. Norcross & M.R. Goldfried (Eds.), *Handbook of Psychotherapy Integration*. (pp 373-401). New York: Basic Books.
- Yehuda, R., Resnick, H., Kahana, J., & Giller, E. (1993). Long-lasting hormonal alterations to extreme stress in humans: Normative or maladaptive? *Psychosomatic Medicine*, 55, 287-297.