Psychological trauma

Psychological trauma is a type of damage to the mind that occurs as a result of a severely distressing event. Trauma is often the result of an overwhelming amount of stress that exceeds one's ability to cope, or integrate the emotions involved with that experience.[1] A traumatic event involves one's experience, or repeating events of being overwhelmed that can be precipitated in weeks, years, or even decades as the person struggles to cope with the immediate circumstances, eventually leading to serious, long-term negative consequences.

However, the definition of trauma differs among individuals by their subjective experiences. People will react to similar events differently. In other words, not all people who experience a potentially traumatic event will actually become psychologically traumatized.[2] This discrepancy in risk rate can be attributed to protective factors some individuals may have that enable them to cope with trauma. Some examples are mild exposure to stress early in life,[3] resilience characteristics, and active seeking of help.[4]

Definition

DSM-IV-TR defines trauma as direct personal experience of an event that involves actual or threatened death or serious injury; threat to one's physical integrity, witnessing an event that involves the above experience, learning about unexpected or violent death, serious harm, or threat of death, or injury experienced by a family member or close associate. Memories associated with trauma are implicit, pre-verbal and cannot be recalled, but can be triggered by stimuli from the in vivo environment. The person's response to aversive details of traumatic event involve intense fear, helplessness or horror. In children it is manifested as disorganized or agitative behaviors.[5]

Trauma can be caused by a wide variety of events, but there are a few common aspects. There is frequently a violation of the person's familiar ideas about the world and of their human rights, putting the person in a state of extreme confusion and insecurity. This is also seen when institutions that are depended upon for survival, violate, humiliate, betray, or cause major losses or separations.[6]

Psychologically traumatic experiences often involve physical trauma that threatens one's survival and sense of security.[7] Typical causes and dangers of psychological trauma include harassment, embarrassment, abandonment, abusive relationships, rejection, co-dependence, physical assault, sexual abuse, partner battery, employment discrimination, police brutality, judicial corruption and misconduct, bullying, paternalism, domestic violence, indoctrination, being the victim of an alcoholic parent, the threat or the witnessing of violence (particularly in childhood), life-threatening medical conditions, and medication-induced trauma.[8] Catastrophic natural disasters such as earthquakes and volcanic eruptions, large scale transportation accidents, house or domestic fire, motor vehicle accident, mass interpersonal violence like war, terrorist attacks or other mass tortures like sex trafficking, being taken as a hostage or kidnapped can also cause psychological trauma. Long-term exposure to situations such as extreme poverty or milder forms of abuse, such as verbal abuse, exist independently of physical trauma but still generate psychological trauma.

Some theories suggest childhood trauma can increase one's risk for mental disorders including posttraumatic stress disorder (PTSD), depression, and substance abuse. Childhood adversity is associated with neuroticism during adulthood.[9] Parts of the brain in a growing child are developing in a sequential and hierarchical order, from least complex to most complex. The brain's neurons are designed to change in response to the constant external signals and stimulation, receiving and storing new information. This allows the brain to continually respond to its surroundings and promote survival. Our five main sensory signals contribute to the developing

brain structure and its function.[10] Infants and children begin to create internal representations of their external environment, and in particular, key attachment relationships, shortly after birth. Violent and victimized attachment figures impact infants' and young children's internal representations.[11] The more frequent a specific pattern of brain neurons is activated, the more permanent the internal representation associated with the pattern becomes.[12] This causes sensitization in the brain towards the specific neural network. Because of this sensitization, the neural pattern can be activated by decreasingly less external stimuli. Childhood abuse tends to have the most complications with long-term effects out of all forms of trauma because it occurs during the most sensitive and critical stages of psychological development.[4] It could also lead to violent behavior, possibly as extreme as serial murder. For example, Hickey's Trauma-Control Model suggests that "childhood trauma for serial murderers may serve as a triggering mechanism resulting in an individual's inability to cope with the stress of certain events."[13]

Often psychodynamic aspects of trauma are overlooked even by health professionals: "If clinicians fail to look through a trauma lens and to conceptualize client problems as related possibly to current or past trauma, they may fail to see that trauma victims, young and old, organize much of their lives around repetitive patterns of reliving and warding off traumatic memories, reminders, and affects."[14]

Symptoms

People who go through these types of extremely traumatic experiences often have certain symptoms and problems afterward. The severity of these symptoms depends on the person, the type of trauma involved, and the emotional support they receive from others. Reactions to and symptoms of trauma can be wide and varied, and differ in severity from person to person. A traumatized individual may experience one or several of them.[15]

After a traumatic experience, a person may **re-experience** the trauma mentally and physically, hence avoiding trauma reminders, also called triggers, as this can be uncomfortable and even painful. They may turn to psychoactive substances including alcohol to try to escape the feelings. Re-experiencing symptoms are a sign that the body and mind are actively struggling to cope with the traumatic experience.

Triggers and cues act as reminders of the trauma, and can cause anxiety and other associated emotions. Often the person can be completely unaware of what these triggers are. In many cases this may lead a person suffering from traumatic disorders to engage in disruptive or self-destructive coping mechanisms, often without being fully aware of the nature or causes of their own actions. Panic attacks are an example of a psychosomatic response to such emotional triggers.

Consequently, intense feelings of anger may frequently surface, sometimes in inappropriate or unexpected situations, as danger may always seem to be present, as much as it is actually present and experienced from past events. Upsetting memories such as images, thoughts, or flashbacks may haunt the person, and nightmares may be frequent.[16] Insomnia may occur as lurking fears and insecurity keep the person vigilant and on the lookout for danger, both day and night. Trauma doesn't only cause changes in one's daily functions but could also lead to morphological changes. Such epigenetic changes can be passed on to the next generations, thus making genetics as one of the components of the causes of psychological trauma. However, some people are born or later develop protective factors such as genetics and sex that help lower their risk of psychological trauma.[17]

The person may not remember what actually happened, while emotions experienced during the trauma may be re-experienced without the person understanding why (see Repressed memory). This can lead to the traumatic

events being constantly experienced as if they were happening in the present, preventing the subject from gaining perspective on the experience. This can produce a pattern of prolonged periods of acute arousal punctuated by periods of physical and mental exhaustion. This can lead to mental health disorders like acute stress and anxiety disorder, traumatic grief, undifferentiated somatoform disorder, conversion disorders, brief psychotic disorder, borderline personality disorder, adjustment disorder...etc.[18]

In time, emotional exhaustion may set in, leading to distraction, and clear thinking may be difficult or impossible. Emotional detachment, as well as dissociation or "numbing out", can frequently occur. Dissociating from the painful emotion includes numbing all emotion, and the person may seem emotionally flat, preoccupied, distant, or cold. Dissociation include depersonalisation disorder, dissociative amnesia, dissociative fugue, dissociative identity disorder...etc.

Some traumatized people may feel permanently damaged when trauma symptoms do not go away and they do not believe their situation will improve. This can lead to feelings of despair, transient paranoid ideation, loss of self-esteem, profound emptiness, suicidality, and frequently depression. If important aspects of the person's self and world understanding have been violated, the person may call their own identity into question.[15] Often despite their best efforts, traumatized parents may have difficulty assisting their child with emotion regulation, attribution of meaning, and containment of post-traumatic fear in the wake of the child's traumatization, leading to adverse consequences for the child.[11][19] In such instances, it is in the interest of the parent(s) and child for the parent(s) to seek consultation as well as to have their child receive appropriate mental health services.

Assessment

As "trauma" adopted a more widely defined scope, traumatology as a field developed a more interdisciplinary approach. This is in part due to the field's diverse professional representation including: psychologists, medical professionals, and lawyers. As a result, findings in this field are adapted for various applications, from individual psychiatric treatments to sociological large-scale trauma management. However, novel fields require novel methodologies. While the field has adopted a number of diverse methodological approaches, many pose their own limitations in practical application.

The experience and outcomes of psychological trauma can be assessed in a number of ways.[20] Within the context of a clinical interview, the risk for imminent danger to the self or others is important to address but is not the focus of assessment. In most cases, it will not be necessary to involve contacting emergency services (e.g., medical, psychiatric, law enforcement) to ensure the individuals safety; members of the individual's social support network are much more critical.

Understanding and accepting the psychological state an individual is in is paramount. There are many mis-conceptions of what it means for a traumatized individual to be in crisis or 'psychosis'. These are times when an individual is in inordinate amounts of pain and cannot comfort themselves, if treated humanely and respectfully they will not get to a state in which they are a danger. In these situations it is best to provide a supportive, caring environment and communicate to the individual that no matter the circumstance they will be taken seriously and not just as a sick, delusional individual. It is vital for the assessor to understand that what is going on in the traumatized persons head is valid and real. If deemed appropriate, the assessing clinician may proceed by inquiring about both the traumatic event and the outcomes experienced (e.g., posttraumatic symptoms, dissociation, substance abuse, somatic symptoms, psychotic reactions). Such inquiry occurs within the context of established rapport and is completed in an empathic, sensitive, and supportive manner. The clinician may also inquire about possible relational disturbance, such as alertness to interpersonal danger, abandonment issues, and the need for self-protection via interpersonal control. Through discussion of interpersonal relationships, the clinician is better able to assess the individual's ability to enter and sustain a

clinical relationship.

During assessment, individuals may exhibit activation responses in which reminders of the traumatic event trigger sudden feelings (e.g., distress, anxiety, anger), memories, or thoughts relating to the event. Because individuals may not yet be capable of managing this distress, it is necessary to determine how the event can be discussed in such a way that will not "retraumatize" the individual. It is also important to take note of such responses, as these responses may aid the clinician in determining the intensity and severity of possible posttraumatic stress as well as the ease with which responses are triggered. Further, it is important to note the presence of possible avoidance responses. Avoidance responses may involve the absence of expected activation or emotional reactivity as well as the use of avoidance mechanisms (e.g., substance use, effortful avoidance of cues associated with the event, dissociation).

In addition to monitoring activation and avoidance responses, clinicians carefully observe the individual's strengths or difficulties with affect regulation (i.e., affect tolerance and affect modulation). Such difficulties may be evidenced by mood swings, brief yet intense depressive episodes, or self-mutilation. The information gathered through observation of affect regulation will guide the clinician's decisions regarding the individual's readiness to partake in various therapeutic activities.

Though assessment of psychological trauma may be conducted in an unstructured manner, assessment may also involve the use of a structured interview. Such interviews might include the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995), Acute Stress Disorder Interview (ASDI; Bryant, Harvey, Dang, & Sackville, 1998), Structured Interview for Disorders of Extreme Stress (SIDES; Pelcovitz et al., 1997), Structured Clinical Interview for DSM-IV Dissociative Disorders- Revised (SCID-D; Steinberg, 1994), and Brief Interview for Posttraumatic Disorders (BIPD; Briere, 1998).

Lastly, assessment of psychological trauma might include the use of self-administered psychological tests. Individuals' scores on such tests are compared to normative data in order to determine how the individual's level of functioning compares to others in a sample representative of the general population. Psychological testing might include the use of generic tests (e.g., MMPI-2, MCMI-III, SCL-90-R) to assess non-trauma-specific symptoms as well as difficulties related to personality. In addition, psychological testing might include the use of trauma-specific tests to assess posttraumatic outcomes. Such tests might include the Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995), Davidson Trauma Scale (DTS: Davidson et al., 1997), Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001), Trauma Symptom Inventory (TSI: Briere, 1995), Trauma Symptom Checklist for Children (TSCC; Briere, 1996), Traumatic Life Events Questionnaire (TLEQ: Kubany et al., 2000), and Trauma-related Guilt Inventory (TRGI: Kubany et al., 1996).

Treatment

A number of psychotherapy approaches have been designed with the treatment of trauma in mind—EMDR, progressive counting (PC), somatic experiencing, biofeedback, Internal Family Systems Therapy, and sensorimotor psychotherapy.

There is a large body of empirical support for the use of cognitive behavioral therapy[21][22] for the treatment of trauma-related symptoms,[23] including posttraumatic stress disorder. Institute of Medicine guidelines identify cognitive behavioral therapies as the most effective treatments for PTSD.[24] Two of these cognitive behavioral therapies, prolonged exposure[25] and cognitive processing therapy,[26] are being disseminated nationally by the Department of Veterans Affairs for the treatment of PTSD.[27][28] Recent studies show that a combination of treatments involving dialectical behavior therapy (DBT), often used for borderline personality disorder, and

exposure therapy is highly effective in treating psychological trauma.[17] If, however, psychological trauma has caused dissociative disorders or complex PTSD, the trauma model approach (also known as phase-oriented treatment of structural dissociation) has been proven to work better than simple cognitive approach. Studies funded by pharmaceuticals have also shown that medications such as the new anti-depressants are effective when used in combination with other psychological approaches.[29]

Trauma therapy allows processing trauma-related memories and allows growth towards more adaptive psychological functioning. It helps to develop positive coping instead of negative coping and allows the individual to integrate upsetting-distressing material(thoughts, feelings and memories) resolve internally. It also aids in growth of personal skills like resilience, ego regulation, empathy...etc.[30]

Process' involved in trauma therapy are:

- Psychoeducation: Information dissemination and educating in vulnerabilities and adoptable coping mechanisms.
- Emotional regulation: Identifying, countering discriminating, grounding thoughts and emotions from internal construction to an external representation.
- Cognitive processing: Transforming negative perceptions and beliefs to positive ones about self, others and environment through cognitive reconsideration or re-framing.
- Trauma processing: Systematic desensitization, response activation and counter-conditioning, titrated extinction of emotional response, deconstructing disparity (emotional vs. reality state), resolution of traumatic material (state in which triggers don't produce the harmful distress and able to express relief.)
- Emotional processing: Reconstructing perceptions, beliefs and erroneous expectations like trauma-related fears are auto-activated and habituated in new life contexts, providing crisis cards with coded emotions and appropriate cognition's. (This stage is only initiated in pre-termination phase from clinical assessment & judgement of the mental health professional.)
- Experiential processing: Visualization of achieved relief state and relaxation methods.

Causative discourses

Situational trauma

Trauma can be caused by man-made and natural disasters, including war, abuse, violence, mechanized accidents (car, train, or plane crashes, etc.) or medical emergencies.

Responses to psychological trauma: There are several behavioral responses common towards stressors including the proactive, reactive, and passive responses. Proactive responses include attempts to address and correct a stressor before it has a noticeable effect on lifestyle. Reactive responses occur after the stress and possible trauma has occurred, and are aimed more at correcting or minimizing the damage of a stressful event. A passive response is often characterized by an emotional numbness or ignorance of a stressor.

Those who are able to be proactive can often overcome stressors and are more likely to be able to cope well with unexpected situations. On the other hand, those who are more reactive will often experience more noticeable effects from an unexpected stressor. In the case of those who are passive, victims of a stressful event are more likely to suffer from long-term traumatic effects and often enact no intentional coping actions. These observations may suggest that the level of trauma associated with a victim is related to such independent coping abilities.

There is also a distinction between trauma induced by recent situations and long-term trauma which may have been buried in the unconscious from past situations such as childhood abuse. Trauma is often overcome through healing; in some cases this can be achieved by recreating or revisiting the origin of the trauma under more psychologically safe circumstances, such as with a therapist.

In psychoanalysis

Main article: Psychoanalysis

French neurologist Jean-Martin Charcot argued in the 1890s that psychological trauma was the origin of all instances of the mental illness known as hysteria. Charcot's "traumatic hysteria" often manifested as a paralysis that followed a physical trauma, typically years later after what Charcot described as a period of "incubation". Sigmund Freud, Charcot's student and the father of psychoanalysis, examined the concept of psychological trauma throughout his career. Jean Laplanche has given a general description of Freud's understanding of trauma, which varied significantly over the course of Freud's career: "An event in the subject's life, defined by its intensity, by the subject's incapacity to respond adequately to it and by the upheaval and long-lasting effects that it brings about in the psychical organization".[31]

The French psychoanalyst Jacques Lacan claimed that what he called "The Real" had a traumatic quality external to symbolization. As an object of anxiety, Lacan maintained that The Real is "the essential object which isn't an object any longer, but this something faced with which all words cease and all categories fail, the object of anxiety *par excellence*".[32]

Stress disorders

Main articles: Posttraumatic stress disorder and Complex post-traumatic stress disorder

All psychological traumas originate from stress, a physiological response to an unpleasant stimulus.[33] Long term stress increases the risk of poor mental health and mental disorders, which can be attributed to secretion of glucocorticoids for a long period of time. Such prolonged exposure causes many physiological dysfunctions such as the suppression of the immune system and increase in blood pressure.[34] Not only does it affect the body physiologically, but a morphological change in the hippocampus also takes place. Studies showed that extreme stress early in life can disrupt normal development of hippocampus and impact its functions in adulthood. Studies surely show a correlation between the size of hippocampus and one's susceptibility to stress disorders.[35] In times of war, psychological trauma has been known as shell shock or combat stress reaction. Psychological trauma may cause an acute stress reaction which may lead on to posttraumatic stress disorder (PTSD). PTSD emerged as the label for this condition after the Vietnam War in which many veterans returned to their respective countries demoralized, and sometimes, addicted to psychoactive substances. The symptoms of PTSD must persist for at least a month for diagnosis. The main symptoms of PTSD consist of four main categories: Trauma (i.e. intense fear), reliving (i.e. flashbacks), avoidance behavior (i.e. emotional numbing), and hypervigilance (i.e. irritability).[36] Research shows that about 60% of the US population reported as having experienced at least one traumatic symptom in their lives but only a small proportion actually develops PTSD. There is a correlation between the risk of PTSD and whether or not the act was inflicted deliberately by the offender.[17] Psychological trauma is treated with therapy and, if indicated, psychotropic medications.

The term *continuous post traumatic stress disorder* (CTSD)[37] was introduced into the trauma literature by Gill Straker (1987). It was originally used by South African clinicians to describe the effects of exposure to frequent, high levels of violence usually associated with civil conflict and political repression. The term is also applicable

to the effects of exposure to contexts in which gang violence and crime are endemic as well as to the effects of ongoing exposure to life threats in high-risk occupations such as police, fire and emergency services.

As one of the processes of treatment, confrontation with their sources of trauma plays a crucial role. While debriefing people immediately after an event has not been shown to reduce incidence of post-traumatic stress, coming alongside people experiencing trauma in a supportive way has become standard practice.[38]

See also

- Comfort object
- Emotion and memory
- Grief
- Hypervigilance
- Maladaptive daydreaming
- Psychogenic pain
- Psychological pain
- Trauma model
- Unthought known

Specific:

- Historical trauma
- Rape trauma syndrome
- Vicarious traumatization
- Remote Location Stress Reaction

Psychosomatic impact:

- Complex post-traumatic stress disorder
- Psychoneuroimmunology
- Psychosomatic medicine
- Stress (medicine)

Physical:

- Physical trauma
- Traumatology

Psychotraumatologists:

- Gottfried Fischer

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External links

- Psychological abuse at DMOZ

Abuse

Types	Anti-social behaviour · Bullying · Child abuse (neglect, sexual) · Cruelty to animals · Domestic abuse · Elder abuse · Gaslighting · Harassment · Humiliation · Incivility · Institutional abuse · Intimidation · Neglect · Persecution · Professional abuse · Proxy abuse · Psychological abuse · Physical abuse · Religious abuse · Sexual abuse · Stalking · Structural abuse · Verbal abuse
Related topics	Child grooming · Complex post-traumatic stress disorder · Dehumanization · Denial · Destabilisation · Exaggeration · Isolation · Lying · Manipulation · Minimisation · Personality disorders · Power and control in abusive relationships · Psychological projection · Psychological trauma · Psychopathy · Rationalization · Traumatic bonding · Victim blaming · Victim playing · Victimisation

Bullying	
Types	Abusive supervision · Cyberbullying · Disability bullying · Gay bashing · Hazing · Military bullying · Mobbing · Parental bullying of children · Passive aggression · Peer victimization · Prison bullying · Rankism · Relational aggression · School bullying · Sexual bullying · Workplace bullying (Academia · Higher education · Information technology · Legal aspects · Legal profession · Medicine · Nursing · Teaching)
Elements	Betrayal · Blacklisting · Bullying and emotional intelligence · Bullying culture · Character assassination · Control · Coercion · Climate of fear · Defamation · Destabilisation · Discrediting · Embarrassment · False accusation · Gaslighting · Gossip · Harassment · Humiliation · Incivility · Innuendo · Insult · Intimidation · Isolation · Kiss up kick down · Mind games · Moving the goalposts · Nagging · Name calling · Personal attacks · Psychological abuse · Physical abuse · Rudeness · Sarcasm · School pranks · Setting up to fail · Silent treatment · Smear campaign · Social undermining · Taunting · Teasing · Whispering campaign · Workplace incivility · Verbal abuse · Yelling
Organizations	Act Against Bullying · Ditch the Label · Bullying UK · It Gets Better Project · Kidscape · GRIN Campaign · Jer's Vision
Activists	Andrea Adams · Louise Burfitt-Dons · Tim Field · SuEllen Fried · Heinz Leymann · Gary Namie · Kenneth Westhues · Liam Hackett
Actions	Anti-Bullying Day · Anti-Bullying Week · International STAND UP to Bullying Day · Anti-bullying legislation · International Day of Pink
Notable suicides (List)	Kelly Yeomans (1997) · Dawn-Marie Wesley (2000) · Nicola Ann Raphael (2001) · Ryan Halligan (2003) · Megan Meier (2006) · Tyler Clementi (2010) · Phoebe Prince (2010) · Jamey Rodemeyer (2011) · Jamie Hubley (2011) · Kenneth Weishuhn (2012) · Amanda Todd (2012) · Audrie Pott (2012) · Jadin Bell (2013) · Rehtaeh Parsons (2013)
Murder–suicides (incidents)	Eric Harris and Dylan Klebold (Columbine, 1999) · Jeff Weise (Red Lake, 2005) · Elliot Rodger (Isla Vista, 2014)
Related topics	Control freak · Complex post-traumatic stress disorder · Dehumanization · Depression · Emotional blackmail · Machiavellianism in the workplace · Narcissism in the workplace · Personal boundaries · Personality disorders · Psychological manipulation · Psychological projection · Psychological trauma · Psychopathy in the workplace · Scapegoating · Self-esteem · Suicide among LGBT youth · Sycophancy · Victim blaming · Victim playing · Victimisation · Whistleblowing

Authority control	BNF: cb119459471 (data) · NDL: 00806627

Psychological trauma information of streetwise psychiatry to Socio-psychologist. Ref: Mathews, Mark, Harry. SocSci(open), 2011, Open University, Milton Keynes, U.K, 2007 [1]

1. ↑ http://psychologicaltrauma.info