SECTION I: TRAUMA, CRISIS, AND CONTEXT

CHAPTER 1

An Introduction to Counseling Survivors of Trauma: Beginning to Understand the Historical and Psychosocial Implications of Trauma, Stress, Crisis, and Disaster

LISA LÓPEZ LEVERS

CHAPTER OVERVIEW

This chapter introduces foundational knowledge necessary for understanding the effects of psychosocial trauma, stress, crisis, and disaster. It offers brief discussions about the historical implications of how psychosocial trauma has come to be defined as well as how the related diagnostic categories have developed. Finally, the importance of recognizing the human capacity for resilience and growth, in the face of trauma, is emphasized.

LEARNING OBJECTIVES

After reading this chapter, the reader should be able to:

1. Identify basic concepts regarding trauma and the effects of trauma;
2. Discern the history of professional understandings about trauma;
3. Develop awareness of how the developing constructs of trauma and posttraumatic stress disorder (PTSD) have evolved into diagnostic criteria in the various iterations of the *Diagnostic and Statistical Manuals*; and,
4. Recognize that, in spite of stressful and traumatic experiences, individuals have the capacity to build resilience, to make meaning and derive purpose from what has happened to them, and to grow and develop as a result.

INTRODUCTION

Traumatic events are a part of life. The types of lived experiences of trauma that result from human violence, medical crises, natural disasters, and other disruptive circumstances have had repeated histories that span millennia. Scientific, religious, literary, and artistic traditions have captured and represented this history, and contemporary media continue to replay the effects of trauma on a daily basis. Perhaps the first narrative of interpersonal violence resides in the

account of the offspring of Adam and Eve. Cain killed his brother Abel, thus committing the first homicide, as recorded in the Old Testament as well as in the Holy Quran. Adam and Eve not only had to deal with the existential consequences of “the fall,” but two of their children set the stage for the primordial discourse on the traumatic effects of homicide. Modern archaeological discoveries have revealed early evidence of killing and warfare (e.g., Handwerk, 2016; University of Wyoming, 2021). Representations of trauma continue to be depicted in contemporary art (e.g., Kulasekara, 2016; Pollock, 2009); film (e.g., Elm et al., 2014; Koehne & Kabalek, 2014; Levers, 2001; Lowenstein, 2005; Spallacci, 2019); and literary discourses (e.g., Heidarizadeh, 2015; Mambrol, 2018; Stringer, 2009). With 24/7 cable news, horrific traumatic images are aired in our living rooms and on our personal devices, sometimes in real time or only moments after an event has occurred.

The reality is that there always have been, and, unfortunately, there most likely always will be, perpetrators who prey on the vulnerable, as well as natural disasters and accidents that decimate populations and dramatically alter the lives of individuals and families. In other words, the experience of trauma is a long-lived human dilemma, and in spite of everything that we have learned over the millennia, we continue to deal with the overwhelming consequences of trauma and associated elements of stress, crisis, and disaster. Most mental health-related training programs have seemed relatively reluctant to include issues of trauma as a part of preservice training, at least until very recently (Courtois & Gold, 2009; Kumar et al., 2019; Levers, 2020). The Council for the Accreditation of Counseling and Related Educational Programs (CACREP, 2016) requires that counselors receive preservice training on the effects of crisis, disasters, and trauma on clients, but without further specificity (Tarvydas et al., 2017, 2018). The American Psychological Association (APA, 2015) has published guidelines on trauma competencies for education and training but does not mention trauma in its accreditation manual for health service psychology. Likewise, the accreditation manual for the Council on Social Work Education (CSWE, 2015) also does not mention trauma. Major mental health-related preservice training programs have been slow to design and offer trauma-informed curricula to students, while at the same time, based upon the actual needs of the field, it is essential for all mental health professionals to have received preservice training in areas related to working with trauma. It is important for all mental health professionals to grasp just how ubiquitous trauma is among the clients who see us, and how the stressors of trauma, crisis, disaster, and modern life affect both the psyche and the body. In fact, recent brain science continues to illuminate the powerful physiological effects of trauma on our bodies (e.g., Gerge, 2020; Porges, 2011; Portwood et al., 2021), which has moved the trauma–response paradigm, significantly, from talk-only therapy to modalities that incorporate relevant somatic work with clients.

People experience and live through traumatic events in many different ways. This textbook aims to explore these variations in a manner that can help social science and human service students and clinicians to understand trauma from neurobiological, psychosocial, systemic, and contextual perspectives. It also aims to illuminate the best-practice theories and interventions for managing trauma as well as managing stress, crisis, and disaster. The first section of this book, particularly the first three chapters, establishes an important foundation for understanding stress, crisis, and trauma, what I am referring to as a *trauma scaffold*—such a scaffolding process builds upon basic knowledge about trauma, in order to prepare for understanding increasingly more complex issues that are presented throughout the book. This foundation also provides the groundwork for understanding human responses to disaster and larger scale violence, issues that are discussed in later sections of the book. This first chapter offers an introduction to counseling survivors of trauma as well as a beginning reference point for a professional understanding of the historical and psychosocial implications of trauma; theories that ground the practice of trauma counseling are presented in the next chapter, along with important foundational information drawn from recent neuroscience regarding how trauma affects the brain. Stress management and crisis intervention are discussed in Chapter 3.

The purpose of this chapter is to provide a basic professional understanding of psychosocial trauma and associated issues. This is accomplished in discussions in the following sections:

Basic Understanding of Trauma, Historical Implications of Trauma, Modernity and the Conceptualization of Trauma, Posttraumatic Stress Disorder and the *Diagnostic and Statistical Manuals*, and Resilience. Following the discussions in these sections, counseling implications are identified, and the content of the chapter is summarized. The chapter concludes by offering helpful resources for instructors, students, and clinicians.

BASIC UNDERSTANDING OF TRAUMA

The Dalai Lama has stated that “pain is inevitable, suffering is optional.” I find this to be a helpful beginning point in understanding trauma. Life can be challenging and difficult; even in ideal circumstances, some painful experiences are a part of human existence, so in this sense, emotional pain is inevitable. However, getting stuck in pain and continuing to suffer is not a necessary consequence of psychosocial pain. In fact, one of the reasons that it is important for mental health professionals to understand the implications of stress, crisis, trauma, and disaster is so that we are able to assist people who are experiencing psychological distress, thus helping them to make meaningful transformations. The purpose of this brief section, then, is to offer operational definitions of key terms, in order to become conversant with more advanced concepts that are detailed and further discussed in chapters throughout this textbook.

A first important part of this conversation is to highlight the role of stress, both as a motivational force and in dealing with uncomfortable situations. A second aspect of this discussion is to make a distinction among the terms “crisis,” “trauma,” and “disaster.” Briefly, not all crisis situations are traumatizing; however, all traumatic events involve some element of crisis. All disaster events involve some element of crisis and may very well be traumatizing, but not necessarily. It is important to establish, early in this textbook, that not every individual exposed to trauma necessarily feels traumatized. In fact, many individuals either are resilient or are able to develop greater resilience, thus mitigating negative effects that may occur under difficult circumstances; many individuals are able to experience interpersonal growth as they make meaning of whatever traumatic event has occurred. These are issues that are discussed, from various angles, later in this chapter and in other chapters throughout the book.

Stress and Crisis

Stress is a natural part of our biological functioning and is a normal part of life; everyone experiences stress (Levers, 2020). In fact, some stress, originally called “eustress” (Selye, 1956), is productive. An example of “eustress” may involve a student who wants to earn a good grade preparing a presentation for class. This small amount of positive stress is enough to motivate the student to conduct the requisite research, in order to construct a PowerPoint and prepare for the presentation. Without a burst of eustress, the person might succumb to the temptation to procrastinate, which would not facilitate the kind of work that the student wants to do for the class. However, the complexities of modern life produce many stressors that, cumulatively, can be harmful. Too much stress can lead to surges of hormones, like adrenaline and cortisol, which in excess then upset the natural balance of the body (Mayo Clinic, 2019). Individuals may experience acute stress, which is short-term stress, or chronic stress, which is long-term stress.

Not all stress leads to trauma, although a particular stressor or set of stressors can become traumatizing. The concept of adverse life experiences helps us to understand that there is a continuum from normal stress to trauma, with varying degrees of adversity occurring at various points between stress and trauma. Prolonged stress eventually can lead to anxiety. Clients may seek help after recognizing that a stressor or adversity has affected them negatively; counselors then can assist with managing the stress in ways that may prevent stressors and adversity from producing anxiety or even becoming traumatizing. The issue of stress is discussed more fully in Chapters 2 and 3 of this textbook, as well as its connections to larger physiological processes in the body and particularly in the brain.

A crisis can precipitate both danger and opportunity. Crisis is defined in a number of ways, and people experience many differing types of crises. Chapter 3 of this textbook provides a full discussion of crisis and crisis intervention. However, as a foundation for beginning to understand crisis in relationship to the broader issue of trauma, a brief definition is offered here. A crisis is an event that a person perceives as threatening or potentially harmful; this leads to distress that may interrupt or impair the individual's usual coping mechanisms (Kanel, 2019).

Trauma

Stated simply, "trauma is an emotional response to a terrible event" (American Psychological [APA], 2019, "Trauma," para. 1). However, as detailed in Chapter 2 of this textbook, when we unpack the term "emotional," in reference to the impact of trauma, the matter becomes more complex, because what we call an emotional response to trauma actually entails physiological processes that involve the brain and other major organs in the body. There are many types of traumatic events, and different people experience trauma in different ways. Common trauma events include some of the following examples (this is not intended to be an exhaustive list):

- Sexual assault;
- Physical abuse;
- Domestic or intimate partner violence;
- Community, workplace, and school violence;
- Medical and health-related trauma;
- Mass public health concerns, such as the COVID-19 pandemic;
- Motor vehicle accidents;
- Acts of terrorism;
- War experiences;
- Natural and human-made disasters;
- Anthropogenic climate change and resulting weather disasters;
- Homicides and suicides; and,
- Other traumatic losses.

People typically suffer when they experience these types of events. However, we can mitigate the effects of traumatic experiences through trauma counseling and other types of therapeutic interventions. While individuals may not forget the trauma that they have experienced, trauma survivors can learn to manage the effects and resume productive lives. In this sense, trauma may disrupt—or even severely disrupt—the lives of those affected, but recovery is always possible; it is thereby imperative that traumatized individuals receive some type of clinical intervention sooner rather than later. The longer that treatment is delayed, the possibility increases that a traumatized person may develop posttraumatic stress disorder (PTSD). Mental health professionals help clients to deal with trauma in its early stages as well as to deal with PTSD. Several important dynamics, often associated with psychosocial trauma, are discussed here; the issues are foundational to understanding trauma, and the discussions are intended to be brief, as these facets are examined more fully in later chapters of this textbook.

Attachment

The concept of attachment, originally proposed by Bowlby (1958), is highly relevant to the discussion of early childhood trauma. The term has referenced the emotionally close and important social relationships that people have with each other. Bowlby's (1958) work provided the framework for identifying four basic characteristics of attachment that have assisted professionals in understanding bonding—or the lack thereof—in relationships between children and their caregivers: having a safe haven, having a secure base, engaging in proximity

maintenance, and showing separation distress. It is widely thought that if attachment is seriously interrupted, as is often the case with early childhood trauma, significant developmental problems may result, and attachment disruptions can affect people across the life-span. Recent neurobiological research regarding the effects of trauma on the brain has assisted us in understanding more about the integrative effects of a particular individual's attachment and neurobiology (e.g., Newman et al., 2015).

Loss, Grief, and Suffering

"Loss is at the heart of life and growth," according to Walter and McCoyd (2009, p. 1). A similar sentiment concerns the experience of trauma: loss, grief, and suffering are at the center of experiencing trauma. Not all experiences of loss, grief, and suffering necessarily involve trauma. However, loss, grief, and suffering are implicit aspects of trauma across the varying circumstances that may manifest as traumatic experience (Levers, 2020). This point underscores the importance of these constructs and illuminates their centrality to the experience of trauma.

Kübler-Ross (1969) wrote *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families*, the source of the now widely accepted and reified stages of grief: (a) Denial and Isolation, (b) Anger, (c) Bargaining, (d) Depression, and (e) Acceptance. At the time of the original publication, professional helpers were eager to view these concepts as linear stages through which clients would progress. However, this was never Kübler-Ross's intention. The book was the result of her interviews with clients facing death; the aim was to understand their experiences and to illuminate the phenomena. Eventually, clinicians learned that clients facing loss and grief issues do not necessarily experience any or all of these, and further, individuals may not experience these stages sequentially. Bowlby later (1980/1998) postulated these stages of loss:

- Numbness (defined as being shocked and stunned, not as denial);
- Separation Anxiety (viewed as yearning/searching);
- Despair and Disorganization (as the loss sinks in, the person attempts to recognize the loss and to develop a "new normal" without the object of the loss); and,
- Acquisition of New Roles/Reorganization (the bereaved begins to relinquish efforts aimed at preparing for the deceased's return, like getting rid of the loved one's clothing; this movement toward new aspects of life and relationships with others is seen as moving through reorganization).

More recently, Worden (2008) has offered his task-based grief theory and intervention framework. This theory emerged in response to some of the stage- and phase-based models of the late 1960s through the early 1990s, thereby providing clinicians with a more behavioral and process-oriented perspective to make clinical intervention decisions. Worden's model includes the following steps: (a) accept the reality of the loss; (b) experience the pain of the grief; and (c) adjust to a world without the deceased.

Shame

Although survivors of trauma may experience a myriad of emotions following a traumatic event, a sense of shame can be particularly insidious. Shame is a self-conscious feeling of painfulness and humiliation. It is important to distinguish between shame and guilt (Tull, 2020); shame is a negative judgment or evaluation of one's entire being as less worthy, whereas guilt is the consequence of a negative behavior. One can alleviate guilt by making amends and repairing relationships, but absolving a sense of shame is much more difficult. Studies have shown that trauma survivors' shame can lead to greater self-isolation and other types of avoidance behaviors (Saraiya & Lopez-Castro, 2016) and is linked to a sense of betrayal, based on the emotional proximity of the perpetrator (e.g., proximal family member versus distal stranger) (Platt &

Freyd, 2015). Shame can be debilitating for some trauma survivors and can serve as an impediment to recovery, at least until fully processed.

Disaster

A disaster is any catastrophic event that causes or has the potential to cause serious and widespread material damage and loss of life. In the context of mental health services, disaster situations usually are divided into two types: natural disasters and human-made disasters. Natural disasters include events like tornados, hurricanes, floods, earthquakes, and fires and require special response training for intervention; these issues are discussed in detail in Chapter 22 of this textbook. A variety of human-made disasters are examined across several chapters in this book and include the following: accidents (Chapter 11), mass violence (Chapter 20), war (Chapters 23 and 25), and anthropogenic climate change (Chapter 24).

HISTORICAL IMPLICATIONS OF TRAUMA

People long have recognized the profound impact that trauma can have upon the psychological well-being of those who encounter it (Herman, 1992b; Sexton, 1999; van der Kolk, 2014). However, it only has been since 1980 that the formal diagnosis of the trauma-related disorder PTSD has been included in the *Diagnostic and Statistical Manual of Mental Disorders*, the diagnostic nosology published by the American Psychiatric Association (APA). PTSD specifically was introduced in the *DSM-III* (APA, 1980). Following that pivotal event, acute stress disorder (ASD) was added to a later revision of the manual, the *DSM-IV* (APA, 1994) in 1994. These inclusions constituted the first criteria-based clinical distinctions between shorter-term responses to trauma, that is, those lasting for less than a month (ASD), and longer-term responses of over 1 month (PTSD).

The presentation of a full history of the evolving perceptions and understandings of psychosocial trauma is not possible here, yet some understanding of the historical context is important, especially for students who are new to the mental health field. Contemporary understandings of trauma are perhaps more relevant than recapitulations of long-ago historical events, so the focus here is primarily on relatively more recent clinical landscapes; however, at least a brief discussion of high-impact past events can be instructional, especially as this might illuminate the often-violent past treatment of those with psychiatric disorders. This discussion also forecasts important information detailed in other chapters in this volume, particularly those chapters that deal with gender and age-related issues (Chapters 7, 8, 9, and 12), scapegoating and “othering” (Chapter 16), racial and ethnic intolerance (Chapters 17 and 19), gender orientation (Chapter 18), and massive ethnic and political violence and genocide (Chapter 23). Discussion of historical events, social injustice, and the role of the scapegoat naturally leads to the discussion of a relatively new concept in traumatology, that of historical trauma, which Chapters 2 and 19 examine more fully. Therefore, the remaining parts of this section deal with these important issues: The Role of Social Scapegoat as Victim and The Abuse of Power.

The Role of Social Scapegoat as Victim

We often may find ourselves wondering, especially in the face of daily catastrophic news coverage, how one human being (or group of humans) can treat another human being (or group of humans—or any other sentient being, for that matter) in such a violent manner. Our perceptions about trauma are culturally and historically determined, and yet inflicting violence is highly personal. The effects of interpersonal violence, social violence, warfare, and natural disaster have marked ancient societies, just as they have modern ones. Although we could learn much from an examination of the Greek and Roman empires, along with non-Western civilizations, such a full historical examination is beyond the scope of this textbook. It suffices to

note that the norms of civilization tend to oppose violent practices, while tending to endorse acts that assist others, especially in times of crisis or disaster. It seems that historical events, over at least the last several centuries (spanning the Dark/Middle Ages and the Age of Reason/Enlightenment), have influenced how our contemporary psychiatric paradigm has come to conceptualize the impact of traumatic events on the human psyche.

Psychosocial stressors and their aftermath often have led to the institutionalization and marginalization of those who have mental health problems, and, by extension, those who have experienced trauma. Indeed, the history of institutionalizing people for medical and psychiatric reasons in Western society offers rich illustrations of scapegoating. This information is an important backdrop for trying to make sense of how victims of violence so often have been—and continue to be, even now—cast as scapegoats. Understanding this offers insight regarding how it is that the mental health professions came to take so long to address trauma issues in *helpful* rather than *victim-blaming* ways. Many survivors of sexual assault, as an example, end up being victimized further, not only by mental health and legal systems, but also by other citizens for even reporting the crime. Box 1.1 presents a brief historical account of some particular types of social scapegoating.

BOX 1.1

A Lesson From History: The “Other” as Scapegoat

In his book, *Madness and Civilization: A History of Insanity in the Age of Reason*, Foucault (1973) traced the origins of the mental asylum in Western civilization to the leprosy epidemic in the Middle Ages. He illuminated how the number of leprosaria, the asylums in which lepers were institutionalized, grew in proportion to the number of cases of leprosy that were diagnosed. Foucault posited that as the need for the leprosaria declined, the centers originally built for the seclusion of lepers began to be filled with paupers, “incurables,” the “mentally ill,” and others perceived as socially deviant. Foucault (1973) suggested that although leprosy disappeared, the residential structures remained, and “the formulas of exclusion would be repeated, strangely similar 2 or 3 centuries later. Poor vagabonds, criminals, and ‘deranged minds’ would take the part played by the leper” (p. 7). The “part” referenced by Foucault was the social role played by groups of people who have been marginalized; these disenfranchised persons have represented the social “other,” thereby enabling societal institutions to justify, in far too many cases, brutal treatment.

Foucault outlined the history of the leprosaria, or lazar houses, as they came to be known, through their transformation to asylums for the “insane” throughout Western Europe; he cited this as the birth of the classical experience of “madness.” In the introduction to Foucault’s book, Jose Barchilon, MD, pointed out that “as leprosy vanished, in part because of segregation, a void was created and the moral values attached to the leper had to find another scapegoat” (Foucault, 1973, p. vi). Cast in a parallel fashion by Berger and Luckmann (1967) is an assertion of the institutional world as being of human construction, one that does not have “ontological status apart from the human activity that produced it” (pp. 60–61). Foucault also noted that, although it was common knowledge that, in the 17th century, large hospitals/houses of confinement were created, it was not commonly known that “more than one out of every hundred inhabitants of Paris found themselves confined there within several months” (p. 38). This legacy continued and gave birth to the “mental asylum”; even well into the 20th century, “insane” people were placed into abhorrent conditions and exposed to horrendous treatments. In an attempt to redress this situation, the clients’ rights movement of the 1970s and 1980s led to deinstitutionalizing psychiatric clients and returning them to their “home” communities; unfortunately, communities did not have sufficient resources, and an entire set of additional community-based problems surfaced.

(continued)

Foucault (1973) offered an astute inquiry of the architectural confinement of the scapegoat. Thomas Szasz (1970/1997) illustrated how the myth of “mental illness,” in his view, has been manufactured by a society in need of a scapegoat, thus providing social sanction and cultural legitimacy to the persecution of certain people. In his book, *The Manufacture of Madness*, Szasz examined the powerful metaphoric constructions of “mental illness,” suggesting parallels between the Inquisition and some of the consequences of modern psychiatry. Szasz clearly delineated the persecution of witches, the persecution of Jewish people, and ultimately the persecution of people with psychiatric disorders as artifacts of the Inquisition. In doing so, he illuminated the ways in which multiple strands of human behavior, belief, or status can become encoded as violations of the ideology of those in power, thereby assisting the powerful to maintain control. Throughout history, we have seen many instances in which the maintenance of power has involved violence against those without power. According to Szasz, the transformation of the role of social scapegoat to witches, heretics, Jewish people, and “the insane” paralleled the moralistic transformation of dogmas from religion to science: “The metamorphosis of the medieval into the modern mind entailed a vast ideological conversion from the perspective of theology to that of science” (p. 137). He concluded that the evolving construct of mental illness is an artifact of this paradigm shift. This is not intended to cast doubt upon legitimate principles of science, but rather to comment on the misrepresentation of dogma as science. In a public health crisis, science reigns; when socially constructed metaphors are used to castigate the “other” into further marginalization, then such dogma needs to be questioned and analyzed.

As the role of one social scapegoat declined, new scapegoats emerged (Thurston, 2007). The Inquisition, initiated by the politically powerful Roman Catholic Church in the 12th century, was aimed at the persecution of heretics. People were tortured and killed in gruesome ways during the centuries that spanned the Inquisition. Some groups of people were affected more than others, and this included the persecution of anyone thought to be a witch and anyone thought to be of Jewish ancestry. For the first time in history, in 1215, by decree of Pope Innocent III, Jewish people were ordered to wear yellow badges in order to identify themselves (Szasz, 1970/1997). The roots of anti-Semitism were embedded in European culture long before the expulsion of Jews from Spain in 1492 and long before the 20th century Holocaust; unthinkable, we are witnessing a horrific reemergence of anti-Semitism in the 21st century.

Misfortunes of all sorts were blamed on witches and Jewish people, who were massacred for such events as epidemics and poor crops. During the Inquisition, witches—or at least those accused of witchcraft—also took on the role of societal scapegoat. Thousands, and by some estimates hundreds of thousands, of (mostly) women, were executed throughout Europe from the 14th to the 17th centuries (Ehrenreich & English, 1973; Thurston, 2007). Intended to systematize the persecution of witches, Pope Innocent VIII’s papal bull was implemented in 1486, along with the publication of the infamous manual for witch-hunters, the *Malleus Maleficarum* (*The Hammer of Witches*); the manual detailed how to identify the so-called witches and prescribed ensuing treatments of heinous and unspeakable natures. Not surprisingly, the publication of the nosology was followed by an “epidemic” of witchcraft (Szasz, 1970/1997). Szasz explained that

the incidence of witches increased, as the authorities charged with their suppression covertly demanded that it should; and a corresponding increase of interest in methods aimed at combating witchcraft developed. For centuries, the Church struggled to maintain its dominant role in society. For centuries, the witch played her appointed role as society’s scapegoat. (p. 7)

Szasz (1970/1997) affirmed that in the 17th century, as the power of the Church and its religious worldview began to decline, an “inquisitor-witch complex disappeared” and was replaced by an “alienist-madman complex” (p. 13). In this new secular and scientific order,

(continued)

parallel conformity was still demanded; Szasz cited this shift in the social order as a move from a worldview, conceptualized in terms of “divine grace,” to one cast more in terms of health.

In reference to institutional psychiatry (“forced” psychiatry, in contrast with what he regarded as a less imposing contractual psychiatry), Szasz (1970/1997) asserted that violence always has been, and remains to be, the key problem. This violence dialectic involves, on the one hand, the feared or perceived violence of the “madman,” and, on the other hand, what Szasz refers to as the “actual counter-violence of society and the psychiatrist against him” (p. xvii). If we were to cast these dynamics in a more contemporary landscape, we perhaps would be discussing the feared violence of the “other” and the counterviolence of society against the marginalized “other.”

The Abuse of Power

One may or may not agree with Szasz’s (1970/1997) position regarding institutional psychiatry and its historical implications. However, this type of “official” projective dynamic arguably has been at play in myriad ways across societies and social structures; it unfortunately has been linked with peoples around the world, representing various types of societal needs for scapegoats and also representing the ways in which individuals are willing to act, uncritically, in accordance with institutional demands that equate with evil. For instance, the “good Nazi soldier” has constituted an example of this, as have the results of social psychology experiments in the 1960s and 1970s (e.g., the Milgram experiment and the Stanford Prison experiment), which have served to underscore the dynamics. Such power-related links between Inquisition-era violence and social scapegoats perhaps have become clearer in some of the more recent atrocities spanning the last several centuries. These include the near-extermination of indigenous peoples in the Americas and other parts of the world, the brutal abduction and enslavement of Africans, the Jewish Holocaust, genocides in Rwanda and Sudan, the high-profile genocide of the Rohingya in Myanmar, and the horrifying treatment of asylum seekers at the southern border of the United States, especially during 2016 to 2020 and especially concerning the separation of children from their families. These examples represent manifestations of a psychology of exclusion or marginalization, of othering, in ways that are marked by an abuse of power and serve as an antecedent lack of morality, and in ways that have had egregious consequences.

The perpetration of violence has presumed the ability to instill fear, and ultimately to control or to take power over others; indeed, it has presumed the role of a more or less passive victim. In many ways, early conceptualizations of trauma were linked to sin, to a fall from grace, or to moral weakness on the part of the victim who somehow “deserved” punishment or persecution. Later conceptualizations of trauma, beginning with the rise of the psychiatric asylum, were subordinate to a diagnosis of mental illness; in fact, some sequelae of PTSD often were misinterpreted, and clients, usually women, were misdiagnosed as having hysteria or schizophrenia and placed in psychiatric hospitals, where they were traumatized further.

These historical examples have indicated as much about the perpetrators of violence—and the abusive power of the institutions that they have represented—as about the cultural assumptions regarding how experiences of trauma have been viewed. The effects of such brutal behaviors do not necessarily go away; they can continue to resonate, for many generations, among the offspring and in the family systems of people who have been brutalized and victimized. This raises the issue of historical trauma and its effects on marginalized groups of people. The field has developed a greater understanding of the effects of historical or racial trauma and consequential epigenetic changes; a fuller discussion of this is presented in Chapters 2 and 19 of this textbook. The field also has identified the impact of adverse childhood experiences (ACEs), which are expounded in Chapter 2. We do not fully understand as yet the social and cultural effects on the people who perpetrate such actions or who allow such conduct to occur in their midst, and this would seem to be an important area for further research.

MODERNITY AND THE CONCEPTUALIZATION OF TRAUMA

The modern study of how trauma affects the human condition is rooted in the genesis of modern psychiatry. In the mid-1800s, Jean-Martin Charcot studied young Parisian women who were hospitalized at the Salpêtrière. In his consideration of “neurosis,” Charcot examined the repercussions of lives filled with sexual assault, poverty, and violence. Charcot recognized that these women were acting out of their subjective realities and that their conditions were psychological in nature (Herman, 1992b). Charcot’s students, Sigmund Freud, Joseph Breuer, and Pierre Janet, expanded upon his exploration of hysteria and neurosis and further hypothesized that these conditions were caused by exposure to psychological trauma (Bogousslavsky & Dieguez, 2014). Freud, Janet, and Breuer’s conceptualization of what constituted psychological trauma was initially quite narrow and was constrained to the idea that hysteria and neuroses were caused by psychosexual events. However, by 1917, extensive exploration of the subject of traumatic conditions had created an expanded definition of psychological trauma.

Freud’s classical psychoanalytic approach emphasized the process of repression, replacing earlier notions of dissociation (Diamond, 2020). His contributions served as a launching pad for various contemporary approaches, which interestingly evolved to re-emphasize the process of dissociation (dissociation is discussed further in Chapter 2 of this book). In his *Introductory Lectures on Psychoanalysis*, Freud proposed a broadened concept of psychological trauma that included “war, railway collisions, and other alarming accidents involving fatal risks” (Freud & Strachey, 1966/1977, p. 274). This more inclusive definition later served as a foundation for delineating and classifying trauma-related disorders within the APA’s DSMs. The remaining parts of this section outline the emergent understanding of trauma in World Wars I and II as well as the growing awareness of the impact of trauma in recent decades (the effects of trauma on war veterans are detailed in Chapter 25 of this textbook).

World War I and World War II

Initial investigations into the psychological consequences of traumatic exposure were not limited to hysterical women. The advent of World War I, with its proliferation of what were viewed as emotionally disturbed soldiers, brought the psychological devastation that often resulted from combat to the attention of the field of psychology. Charles Myers, a pioneering psychologist in the study of combat-related disturbance, recognized that the soldiers’ symptoms appeared to be similar to behaviors that Freud observed in women who suffered from hysteria. Myers originally hypothesized that the behaviors had a physical cause and attributed the behaviors to the intensity of the concussions resulting from explosive weapons (Herman, 1992b). Because of his hypothesis, Myers labeled the syndrome “shell shock.” Probably to the dismay of the military, further study showed that many soldiers exhibited the characteristic symptoms of the syndrome, even without exposure to the physical trauma of concussive force (Herman, 1992b). Eventually, the soldiers’ neurosis was acknowledged to be the result of the psychological trauma and stress of combat, with its constant state of violence, threats to life, and horrific images (Herman, 1992b; van der Kolk, 1996, 2000, 2014).

By the end of World War I, psychiatric professionals had adopted the position that combat fatigue, or “war hysteria” as it became known, was a disease created by a lack of “will to be well” on the part of the affected soldier (van der Kolk, 1996). This view, especially prevalent among professionals serving in the military or in positions with connection to the armed services, followed a course of development similar to the earlier studies of hysteria in women. Soldiers were expected to be brave, heroic, and stoic in their adaptation to the rigors of their war experiences. Those who succumbed to psychological distress were categorized as being of poor moral character or of weak temperament (Herman, 1992b; van der Kolk, 1996). This view mirrored initial interpretations of women who exhibited neurotic symptoms as being internally weak and flawed.

Some psychiatrists of the time, most notably W. H. R. Rivers, viewed combat neurosis, or war hysteria, as a pathological, traumatic syndrome that was a result of the severity of the stressors of combat and not a weakness of character (Herman, 1992b; van der Kolk, 1996, 2014). Rivers, who based his treatment interventions upon psychoanalytic principles, strongly believed that combat-related hysteria could affect any soldier, regardless of moral character or capacity for bravery (van der Kolk, 1996). After the war ended, veterans' hospitals continued to serve the psychiatric needs of soldiers who experienced persistent disabilities resulting from their combat experiences. However, these veterans garnered little attention from the medical community, which seemingly adopted the view that the horrors of war and the lasting consequences either could be forgotten or erased, if only they were ignored (Herman, 1992b).

During the time of peace between World War I and World War II, there was little scientific interest in the field of traumatic study. However, the issue of traumatic exposure remained of interest to a few professionals within the arena of psychology. After a career in psychoanalysis and anthropology, American psychiatrist Abram Kardiner began to study combat-related disorders and psychological trauma (van der Kolk, 2001, 2014). Kardiner explored past assessments, theoretical frameworks, and studies on combat-related hysteria, synthesizing his findings in his 1941 work, *The Traumatic Neuroses of War*. Kardiner decried the use of the label "hysterical" in reference to suffering soldiers, as he felt that it promulgated the impression that the experienced disturbance was a result of character weakness or internal flaws (Herman, 1992b).

Growing Awareness of the Impact of Trauma

Social awareness of PTSD evolved concomitantly within the psychiatric community and the public (Friedman et al., 2007; Jones & Wessely, 2006). As an example of emerging public awareness, the symptoms of PTSD were portrayed in Hollywood *film noir* in the 1940s, more than 30 years before the diagnosis first was included in the *DSM-III* (Miller, as cited in Levers, 2001). Earlier war-related investigations of trauma eventually piqued the interest of the civilian sector, and conditions born from noncombat-related trauma began to be examined. As televised atrocities routinely aired in living rooms across the globe, the social movements of the 1960s and 1970s spawned an expansion of examining traumatic experiences and their impact. The experiences certainly were traumatic for those involved, but the news-consuming public also experienced the trauma, vicariously, vis-à-vis newspaper accounts and television news footage. Several of these movements relevant to this conversation are discussed in the following text.

Civil Rights Movement

The Tulsa Massacre occurred on May 31 and June 1, 1921, and its 100-year anniversary recently was commemorated, instructing a large swath of the population about a sordid incident in American history that had been covered up. This massacre was an extreme example of the many savage attacks on African American communities post emancipation (*Smithsonian Magazine* offers a vivid account of this atrocity at: www.smithsonianmag.com/history/tulsa-race-massacre-century-later-180977145/). The civil rights movement in the United States, during the 1950s and 1960s, unveiled the violence long associated with racism. Even though slavery had been abolished in the previous century, Jim Crow laws legalized segregation, continuing from after the Civil War through the end of the 1960s (Chapter 17 of this textbook offers more information about this). The fight for civil rights, led mostly by African Americans, but having some allies of other races, had a vicious backlash then, similar to what we are witnessing now (Glickman, 2020). Emmet Till, a 14-year-old African American male, was brutally murdered in Mississippi. Lynching of African Americans still was occurring in the United States through the late 1960s (NAACP, 2021). These types of events were traumatizing, and they were used by certain White Americans to terrorize and attempt to control Black Americans (Lartey & Morris, 2018). These types of events galvanized the civil rights movement.

Federal civil rights legislation was proposed in the early 1960s, first by President John F. Kennedy and then by President Lyndon B. Johnson. The response to the proposed legislation was vile and led to many instances of violence against African Americans, including murder. Groups of mostly African American civil rights activists formed, and they were called Freedom Riders (History.com Editors, 2021); the groups included both Black and White activists, and those who wished to deny the civil rights of African Americans targeted both. The late John R. Lewis, former U.S. Representative, was a youth activist and a Freedom Rider during the civil rights movement of the 1960s, continuing until his death in 2020. Although televised news coverage was not yet available to capture earlier atrocities, such as the Tulsa Race Massacre in 1921, people watched their television news programs in horror in 1965, as Mr. Lewis and other young activists were beaten, savagely, on the Edmund Pettus Bridge. It was on this bridge that state troopers attacked peaceful protesters, who were exercising their rights to free speech and to protest peacefully against racism; this day became etched in the memory of the public as “Bloody Sunday.” It is not surprising, then, that racism, along with its tantamount historical trauma, have contributed to and constituted the serious public health problem that we continue to face today (Cardarelli et al., 2021; Wamsley, 2021).

Vietnam

As the men and women who served in combat in Vietnam returned to the United States, interest arose, again, concerning the effects of combat upon the human psyche. The tensions related to the social discourse surrounding the war brought the issue to the forefront of the national media. Television news programs broadcast images of longhaired, wild-eyed soldiers into the homes of unsuspecting Americans, who were forced to consider the negative psychological results of war upon the nation’s sons and daughters. The images of the conquering hero, which had been the theme of the returning World War II soldier, were replaced with a more disturbing reality. American men and women were returning home with trauma-related mental health conditions that seriously affected their ability to function in all of the domains of their lives. This new breed of veteran often felt guilt-ridden, angry, and emotionally volatile, which had serious implications for their spouses and children (Z. Solomon et al., 1987). The general population was drawn into an emerging awareness of combat-related trauma conditions.

Violence Against Women and the Rape Crisis Movement

Professional and popular conceptualizations of trauma continued to expand through the end of the 20th century. With the advent of the second wave of the women’s liberation movement, issues related to the “tyranny of private life” for women began to be examined (Herman, 1992b). Early exercises of consciousness-raising groups, in the 1960s and 1970s, soon led to open, and heretofore unprecedented, discussions of the psychological impact of rape, sexual assault, incest, and the sexual subjugation of women for political purposes (Herman, 1992b; Lating & Everly, 1995; Sinha et al., 2017). The field of psychiatry then acknowledged that sexual assault led to psychological distress that substantially mimicked combat neurosis in its symptom presentation. Psychiatric nurses Lynda Holmstrom and Ann Burgess observed a pattern of numbing, increased startle response, nightmares, dissociative symptoms, nausea, and insomnia in rape victims who came to Boston Hospital for treatment (Burgess & Holmstrom, 1974). They labeled this pattern of symptom presentation as “Rape Trauma Syndrome,” thus pushing the field to consider an even broader definition of traumatic victimization that later was incorporated into the formal diagnostic criteria for PTSD.

Violence Against Children and the Child Protective Movement

As traumatic exposure in noncombat-related situations became more widely recognized as a source of emotional distress and disturbance, issues related to children emerged as a particular

area of focus. It long had been acknowledged that children are equally susceptible to the stressors of traumatic events as are their adult counterparts, but it was thought that the reactions of children were of a less severe nature and shorter lived than for adults (Yule, 1998). Prior to 1987, little research existed to define or delineate the differences in stress responses between adults and children. Since the 1990s, differential diagnosis of PTSD in children has included refinements of symptom presentation that may manifest in children. Some significant differences have included developmentally sensitive displays of disorganized or agitated behavior in children, as well as generalized nightmares and traumatic play (APA, 2000, 2013). The *DSM-5* (APA, 2013) has included a new subtype of PTSD that is specific to children under the age of 6 years (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016).

Statistics have suggested that children experience rape, robbery, assault, and physical violence at a greater rate than do adults (Finkelhor et al., 2013). According to a 1990 study by the U.S. Department of Justice, adolescents were 2.5 times more likely to be the victim of a violent crime than adults, although this trend has decreased since the mid-1990s to a little over one-sixth of what it had been (e.g., Child Trends, 2018; Wordes & Nunez, 2002). However, it has been alarming that these experiences often occur within the child's own family system.

One relatively recent development in the study of PTSD in children has been increased research regarding exposure to family and domestic violence as a catalyst for the development of children's stress-related disorders. Further confounding studies of family violence and PTSD, is the disturbing fact that children who experience trauma at home also are more likely to experience violence in their community, with their peers, and in their personal relationships (Margolin & Vickerman, 2007). Often these exposures are of a chronic nature, presenting challenges to accepted definitions of trauma and trauma experience. These challenges, referenced as complex trauma, are addressed later in this chapter and examined more fully in Chapter 9 of this textbook. It is widely accepted that PTSD appears to be one of the most common psychiatric disorders in children and young adults (SAMHSA, 2014).

POSTTRAUMATIC STRESS DISORDER AND THE *DIAGNOSTIC AND STATISTICAL MANUALS*

The construct of psychological trauma has changed over time. Especially pertinent to this discussion is how the construct has changed in relationship to mental health diagnostics, which has not been without controversy (Carvajal, 2018). This section briefly explores the evolution of trauma-related conceptualizations in the *Diagnostic and Statistical Manuals*, the relatively recent discussion of complex trauma, and the interface of trauma with multiple diagnostic categories.

The Articulation of Trauma in the *Diagnostic and Statistical Manuals*

In 1952, the American Psychiatric Association released the first *Diagnostic and Statistical Manual of Mental Disorders* as a means to mitigate some of the limitations found in using nomenclature from the *International Statistical Classification of Diseases, Injuries, and Causes of Death* (ICD-6). The ICD has been the World Health Organization's (WHO) diagnostic nosology, used globally since its inception. In the ICD-6, stress-related reactions were labeled as "acute situational maladjustment" (WHO, 1949). The *DSM-I* labeled stress-related conditions under the heading of "Transient Situational Personality Disturbance" (APA, 1952). The diagnosis of gross stress reaction was included under this heading and defined psychic disturbance related to combat or civilian catastrophe. Under the same heading, other stress-related conditions were given the labels of adult situational reaction as well as adjustment reaction of infancy, of childhood, of adolescence, or of late life (APA, 1952).

A revised edition of the *DSM* was released in 1968; the *DSM-II* (APA, 1968) reclassified traumatic experience into a category called "Adjustment Reaction of Adult Life." There was no longer a description of the diagnosis, and criteria were explained through the provision of three examples of qualifying experiences. These experiences were unwanted pregnancy,

military combat, and being sentenced to death (APA, 1968). There was an asterisk next to the category, which directed the reader to the appendices, where additional examples of similarly qualifying stressful events could be found. These events included railway, car, boat, and plane accidents (Wilson, 1995). One might wonder about the lack of explication of the various types of trauma and the resultant psychological manifestations, but clearly, the intent of the authors was to provide an inclusive category within which to place reactions related to all traumatic experiences that resulted in anxiety, fear, and feelings of overwhelming loss of control (van der Kolk et al., 2007; Wilson, 1995).

In 1980, the third edition of the manual, the *DSM-III* (APA, 1980), offered another reclassification of trauma-related syndromes, locating it within the anxiety disorder section of the manual. The manual contained a new diagnosis, PTSD, which encompassed combat neurosis, rape trauma syndrome, and battered women syndrome. Based substantially upon Kardiner's (1941) work, the diagnosis was a compendium of symptoms culled from clinical records, research, and literary explorations of those working with various trauma-related syndromes (van der Kolk, 1996, 2000). The symptoms of PTSD were clustered into three distinct categories, from which an individual needed to exhibit four symptoms in order to meet the criteria for diagnosis. These clusters encompassed symptoms of re-experiencing the trauma, a display of the effects of numbing and detachment, and changes in personality. In order to meet the diagnostic criteria, the manual further specified that a stressor of relatively universal concern or suffering must be present (APA, 1980). The requirement to identify a recognizable stressor replaced the previously provided list of examples of qualifying traumatic events that were present in earlier editions of the manual. Although there appeared to be a tacit understanding that certain types of events would be particularly distressing, there was neither a discussion of etiology nor an examination of how individual perceptions of events as being traumatic can vary from person to person (Everly & Lating, 1995). The notion of the variability of human perception of events as traumatic became a salient feature for the diagnosis of PTSD in future iterations of the *DSM* and is discussed at a later point in this chapter.

In 1987, the *DSM-III-R* (APA, 1987) was published, with further revisions to the diagnosis of PTSD. In an attempt to provide clarification of what constituted a traumatic event or recognizable stressor, the phraseology "outside of the range of normal human experience . . . that would be markedly distressing to almost anyone" was added to the criteria (APA, 1987, p. 250). Further, a list of examples of qualifying events was provided again. These examples included serious harm or threats of serious harm to self, children, spouse, or other loved ones; seeing another person killed or seriously injured as a result of violence or accident; and experiencing the sudden destruction of one's home (APA, 1987). Of note, traumatic events that were within the realm of normal human experience, such as being the victim of a violent crime or experiencing or witnessing a serious automobile accident, and that we now view as highly traumatic and as potential triggers for PTSD, were *not* included in the description (Spitzer et al., 2007). Additionally, the list of symptoms was expanded to 17, and the number of symptoms necessary for diagnosis was increased to six. The final significant change in the *DSM-III-R* diagnostic criteria for PTSD was the extension of special qualifiers that related to the manifestation of the disorder in children. Prior to this point, the field promulgated an assumption that children experienced, processed, and exhibited symptoms of traumatic exposure in much the same way as adults, if at all. The *DSM-III-R* clarified that children may display disorganized or agitated behavior instead of the fear, helplessness, or horror listed as adult symptoms under criterion A of the diagnostic category (APA, 1987). According to criterion B, children may demonstrate repetitive play with themes related to the trauma instead of having intrusive recollections, and further, children's dreams may be frightening but occur without recognizable content of the trauma, as would be present in adult experiences (APA, 1987). Although the revisions were intended to provide clarity and to refocus on PTSD as a disorder, debate continued well into the preparation of the *DSM-IV*.

The 1994 revision of the manual, *DSM-IV* (APA, 1994), again brought substantial changes to the PTSD diagnosis. The previously noted statements regarding the need for the stressor

to cause distress for most people and to be beyond the normal range of human experience were removed from the criteria in an effort to define trauma more explicitly and to address the problem of common, yet clearly traumatic, events being excluded from the criteria. Some clinical experts suggested that the stressor be defined in terms that are more subjective. Among the experts, most notably, were S. D. Solomon and Canino (1990), who advocated for defining the qualifying circumstances or traumas in a more general manner, such as an “extremely shocking event,” that would speak to the subjective perception of the individual and provide for broad inclusion of experiences. Others advocated for a more objective classification that further would delineate the symptom and response presentation necessary for differential diagnosis (Lasiuk & Hegadoren, 2006; van der Kolk et al., 2007). Eventually, a combination of subjective and objective measures was included within criterion A.

Criterion A1 addressed the subjective nature of traumatic exposure by defining a qualifying event in which the individual “experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others” (APA, 1994, p. 427). The addition of criterion A1 mitigated the previous omission of considering the subjective or perceptual reality of the individual who experienced the event. The external nature of the event sustained the notion that the etiology of the disorder is external to the individual. Criterion A2 addressed the need for an objective component of the definition by describing the individual’s response as one that demonstrated “intense fear, helplessness, or horror” (APA, 1994, p. 428). These changes propagated the controversy surrounding the diagnosis, perhaps going too far with the notion of perception by using the words “confronted with” in criterion A1 (APA, 1994, p. 427). As a broad concept, open for significant interpretation, the addition of this wording substantially expanded the number of individuals who met the criteria for the disorder and allowed for conceptual bracket creep, or a stretching of the boundaries of the diagnosis, beyond the categorical limitations of earlier definitions (McNally, 2003). The last substantive change to the diagnostic criteria of PTSD in the *DSM-IV* was the addition of specifications regarding the duration of symptoms. The following delimitations primarily affected time frames: (a) acute, which was defined as duration of symptoms of less than 3 months; (b) chronic, with duration of symptom presentation of 3 months or more; and (c) delayed onset, with a symptom presentation that did not appear until 6 months or more after exposure to the stressor (APA, 1994).

In an attempt to separate what could be viewed as an early, simple reaction to traumatic exposure from the more chronic, debilitating sequelae of PTSD, a new trauma-related disorder was included in the *DSM-IV*. Placed within the anxiety disorder category, ASD had many of the same diagnostic criteria as PTSD but had an onset of occurrence of symptom presentation within 1 month of the traumatic exposure and was described as lasting for at least 2 days and for a maximum of 4 weeks (APA, 1994). Additionally, ASD criteria included the presence of three or more dissociative symptoms from a list of five that was provided (APA, 1994). Some have argued that the high rates of individuals who progress from ASD to PTSD and the shared symptom profile of the two disorders strongly pointed to ASD as an early form of PTSD, not a separate condition (Classen et al., 1996; Marshall et al., 1999).

In 2000, the APA released the *DSM-IV-TR*. There were no substantive changes to the trauma-related diagnostic criteria in this edition. Rather, as the last edition was published some 16 years prior, and the next full revision was not expected until 2012 at the earliest, changes in the descriptive text were made to reflect the current state of research and empirical literature. Debate regarding trauma-related disorders continued, with many changes proposed for the *DSM-5* (with the fifth edition, the American Psychiatric Association switched from using a Roman numeral to using an Arabic numeral in the sequencing of the volumes). A number of dramatic events, in the first decade of the new millennium, compelled a renewed social science examination of human response to extraordinary circumstances. Some of these events of mass violence (further detailed in Chapter 20 of this book) and natural disaster (further detailed in Chapter 22 of this book) included the terrorist attacks of September 11, 2001; the Oklahoma City bombing; the shootings at Columbine High School and Virginia Tech; the shootings and bombing

in Norway; the 2010 earthquakes in Haiti and Chile; and the 2011 earthquake/tsunami/nuclear disaster in Japan.

The APA released the much-anticipated *DSM-5* in 2013. In this most recent revision, PTSD was removed from its previous category as an anxiety disorder in *DSM-IV-TR* (APA, 2000), and has been placed in the chapter on Trauma- and Stressor-Related Disorders in the *DSM-5*. However, the very location of the chapter has been significant, in that it immediately follows chapters on Anxiety Disorders and Obsessive-Compulsive and Related Disorders and appears right before the chapter on Dissociative Disorders. The introduction to the Trauma- and Stressor-Related Disorders chapter importantly notes that the sequencing of the chapter indicates a close relationship among these sets of diagnoses (APA, 2013). An understanding of the relationships among these diagnostic categories is essential for ruling out unsuitable diagnoses and for making accurate diagnoses (Tehrani & Levers, 2016). Other changes to the diagnostic criteria, from the *DSM-IV* to *DSM-5*, have included the following modifications: eliminating the subjective component in defining trauma, explaining and narrowing the definitions of trauma and exposure to it, increasing and rearranging the symptoms criteria, and alterations in additional criteria and specifiers (Pai et al., 2017).

Further revisions that are specific to the diagnostic criteria for PTSD in *DSM-5* (APA, 2013) have involved the addition of new items such as experiencing exaggerated negative expectations, having a distorted sense of self-blame, and experiencing persistent negative emotions. In addition, some of the revisions have offered clarification of what constitutes “experiencing a traumatic event” as well as a redefinition of the symptom presentation of dissociative reactions and the concept of avoidance. A number of scholars and clinicians have suggested that perhaps the best and most efficacious approach is to reconceptualize the diagnosis as a spectrum disorder rather than a single entity, with resilience at one end and severe symptomology at the other (e.g., Goodman, 2012; Lasiuk & Hegadoren, 2006; Wolf et al., 2018). The trauma- and stressor-related disorders included in the current *DSM-5* (APA, 2013) comprise the following:

- Reactive Attachment Disorder (RAD)
- Disinhibited Social Engagement Disorder (DSED)
- Posttraumatic Stress Disorder (PTSD)
- Acute Stress Disorder (ASD)
- Adjustment Disorders
- Other Specified Trauma- and Stressor-Related Disorder
- Unspecified Trauma- and Stressor-Related Disorder

The changes in the *DSM-5* (APA, 2013) have not gone without criticisms, which began significantly prior to publication (e.g., Rosen et al., 2008). It goes beyond the scope of this chapter to detail all of the controversies that surround the latest articulation of PTSD, but it is important to highlight some of the more widely discussed areas of concern. First, a number of experts consider criterion A to be too limiting—it requires actual exposure to a traumatic event as a specific benchmark, to the possible exclusion of those who have experienced other trauma-related clusters of symptoms. Second, many experts advocated for the inclusion of a complex posttraumatic stress disorder (CPTSD) diagnosis in *DSM-IV* (e.g., Courtois, 2008; Herman, 1992a) and, subsequently, in *DSM-5*. Other scholars (e.g., Resick et al., 2012; Rosen et al., 2008) have argued, conversely, that while the discussion magnifies the complexity of multiple traumatic events, the actual evidence has not supported the classification of a new diagnostic category. Finally, some experts have expressed concerns about referencing “disorder” as a descriptor for the trauma that people experience in the event of danger and potential or real harm. Ochberg (2012) has suggested the term “posttraumatic stress injury” (PTSI) as a less stigmatizing and more suitable designation. However, similar to the momentum for inducting CPTSD into the new manual, the drive simply did not gain adequate support for inclusion in the *DSM-5* (Tehrani & Levers, 2016). In the face of all of these changes over the decades since PTSD

first was included in the *DSM-III*, it is likely that the criteria will remain under scrutiny and that experts will continue to examine the nature of trauma and its effects. Whether CPTSD finds a designation in a future version of the *DSM* is anyone's guess, but the construct remains a useful one for clinicians (e.g., Ford, 2020; John et al., 2019; Kumar et al., 2019; Yearwood et al., 2019) and warrants a brief discussion here.

Posttraumatic Stress Disorder and the Effects of Complex Trauma

The diagnostic criteria for PTSD have undergone revisions, as research regarding the phenomena of traumatic experience has continued to elucidate its effect on the human condition. By the early 1990s, clinicians and researchers, who were exploring PTSD in people who had experienced domestic violence, child abuse, and other long-term exposures, began to identify that the symptom pattern produced by these types of exposures was not defined adequately by the prevailing diagnostic criteria (Briere, 1987; Courtois, 2008; Herman, 1992b). At issue seemed to be what were classified as "comorbid" conditions that, arguably, appeared to be a result of traumatic exposures of a more complex nature (Courtois, 2008). For example, children who have been exposed to family violence, child abuse, or other ongoing maltreatment have experienced trauma over extended periods. These experiences have occurred during different phases of the children's emotional development, and at the hands of their family members or other significant caregivers, which makes their experiences substantially different from those of combat veterans or individuals who experience acute types of trauma like accidents or natural disasters. Although the effects of such exposure were found to be similar in nature to the prevailing understanding of PTSD, there were significant differences (Herman, 1992b; John et al., 2019; Kliethermes et al., 2014; McCormack & Thomson, 2017; Yearwood et al., 2019). These differences seemed especially pronounced in relationship to the developmental trajectories of children experiencing maltreatment early in childhood, at the hands of the very caregivers whom the children *ought* to be able to trust. In evidence were psychological disturbances not incorporated within the *DSM-III* diagnostic criteria for PTSD, such as medical and somatic complaints, depression, anxiety, dissociative disorders, substance abuse issues, and interpersonal relationship problems (Courtois, 2008).

Because of research regarding the experience of complex exposure to trauma, experts in the field proposed that the PTSD committee, which had been empaneled to explore stress disorders for the *DSM-IV*, also conduct field trials regarding complex exposure to trauma. The committee set out to investigate the possibility of including a diagnosis of complex PTSD, as well as a constellation of trauma-related symptoms not under the umbrella of trauma-related conditions at the time, which could be classified as "Disorders of Extreme Stress Not Otherwise Specified (DESNOS)" (Roth et al., 1997). The DESNOS designation was intended to focus primarily on the effects of early interpersonal trauma. The DESNOS category would consist of the following seven additional criteria, which may result from chronic victimization: (a) changes in emotional regulation, including difficulty with modulation of anger and self-destructive behavior; (b) alterations in consciousness, including amnesias and dissociative episodes; (c) alterations in self-perception such as shame, guilt, and stigmatization; (d) changes in relationship to others, including a lack of trust or loss of intimacy; (e) somatic complaints; (f) changes in one's sense of meaning such as loss of faith or despair; and, (g) changes in perceptions about the perpetrator (Herman, 1992b; Pelcovitz et al., 1997; van der Kolk, 2001).

The *DSM-IV* field trial, conducted between 1991 and 1992, found 92% comorbidity between DESNOS and PTSD and, as such, a separate diagnosis was not included in the revision of the manual; however, the symptom pattern was incorporated as an associated feature of PTSD (APA, 1994). Since those first field trials, interest in the impact of early and repetitive exposure to relational trauma has continued to increase, and based on continuing research, support for a separate diagnosis has continued to grow (e.g., Ford, 2017; John et al., 2019; Kliethermes et al., 2014; McCormack & Thomson, 2017). Ford (1999, 2017, 2020) found that DESNOS could, in fact,

occur in the absence of PTSD, despite the substantial overlap. He further found that PTSD and DESNOS were substantially different in terms of symptoms and functional impairment features (Ford, 1999, 2017, 2020). Research continues to examine whether these conditions are, indeed, separate conditions that frequently may be comorbid but are patently unique.

A primary issue has arisen with the growing awareness that treatment interventions between individuals with PTSD and with DESNOS may need to be significantly different in order to intervene, safely and effectively, with those having complex trauma histories (Ford, 1999, 2017, 2020; John et al., 2019; Kliethermes et al., 2014; McCormack & Thomson, 2017; van der Kolk, 2001). Although the case that was made for complex trauma seemingly was not sufficient for inclusion in the *DSM-5*, the WHO has included complex posttraumatic stress disorder (C-PTSD) in its final draft of the 11th edition of the *International Statistical Classification of Diseases and Related Health Problems (ICD-11)* (Rosenfield et al., 2018). As previously suggested, while complex trauma is not officially recognized in the *DSM-5*, it is nonetheless a useful construct for clinicians in understanding the rippled effect that multiple and complex traumas may have on an individual client. The utility of understanding complex trauma is elaborated more fully in Chapter 9 of this textbook.

The Interface of Trauma With Multiple Diagnostic Categories

As previously discussed, the notion that traumatic exposure and stress can create psychiatric illness in “normal” individuals has had a long and well-researched history. By definition, the diagnosis of PTSD remains unique in that its etiology stems from an outside stressor. Demonstrated in an earlier study, although exposure rates of traumatic events among the general population ranged from 36% to 81%, only 7% to 10% of exposed individuals developed PTSD (Breslau et al., 1998). In a later study, Kilpatrick et al. (2013, p. 537) found that “Traumatic event exposure using *DSM-5* criteria was high (89.7%), and exposure to multiple traumatic event types was the norm.” What has continued to confound those in the field is the prevalence of comorbid conditions, which suggest that, perhaps, there is a combination of factors at work (Yehuda & McFarlane, 1995). Although any real consensus among experts has remained elusive, an existing body of PTSD research seems to describe a spectrum of disorders that often are present in those who have survived traumatic exposure.

An abundance of evidence has suggested that traumatic exposure can lead to a wide array of psychological disturbances that meet the diagnostic criteria within the *DSM*. The disorders vary in severity from adjustment disorders to more lasting and grave manifestations. Traumatic exposure has shown a strong correlation with anxiety disorders (Spinoven et al., 2014), substance abuse disorders (Killeen et al., 2015), dissociative disorders (McDowell et al., 1999; Swart et al., 2020), major depression (Flory & Yehuda, 2015; Spinoven et al., 2014), and eating disorders (Brewerton, 2007; Rijkers et al., 2019). Additionally, borderline personality disorder (BPD) displays commonality with the symptom cluster of complex PTSD and shares, at its core, a high frequency of interpersonal trauma (Cloitre et al., 2014; Harned et al., 2018; Yen et al., 2002). When a broad definition of trauma is applied to the life experiences of people seeking treatment for psychological disorders, most are found to have experienced at least one traumatic exposure across the life-span.

Given the statistical probability that individuals will experience traumatic exposure during their lifetimes, it is the expectation rather than the exception that mental health clients will present with trauma histories. Indeed, a significant percentage of clients who are diagnosed with serious mental disorders such as psychotic disorders, schizophrenia, and bipolar disorder detail extensive trauma backgrounds (Goodman et al., 1997; SAMHSA, 2014). Further, individuals with extensive trauma histories often present with complex symptom patterns that involve multiple disorders, making differential diagnosis difficult. Najavits et al. (2009) describe this as a “central paradox,” stating that “comorbidity with PTSD is the norm, yet treatment outcome studies routinely exclude clients with significant comorbid conditions and fail to assess for them” (p. 508).

RESILIENCE

An introductory discussion of trauma would not be complete without emphasizing the courage and resilience shown by survivors of trauma. It is important that mental health professionals bear in mind that not everyone who experiences trauma develops PTSD. For a variety of reasons, many individuals possess or are able to develop greater resilience and then can cope better with the immediate or aftereffects of traumatic experiences. The U.S. Department of Veterans Affairs (USDVA, 2018) has reported that about 60% of men and 50% of women experience a traumatic event in their lifetimes. Epidemiological research (Benjet et al., 2016) has indicated that about 70% of people, worldwide, have been exposed to at least one traumatic incident in their lives. About 7% to 8% of the population qualifies for a diagnosis of PTSD at some point in life (USDVA). So, as ubiquitous and terrifying as trauma may be, it appears that human beings have a real capacity for resilience in the face of traumatic events; the human spirit seems to have an innate ability to transcend adversity. In fact, research has suggested that between 30% to 70% of individuals who experience trauma also report positive change and growth emerging from the traumatic experience (Joseph & Butler, 2010).

Calhoun and Tedeschi (1998) have initiated the concept of posttraumatic growth (PTG), although the construct has remained somewhat controversial. PTG may account for the positive psychological change that results from an individual's engagement with a traumatic event. Tedeschi and Calhoun (2004) have defined PTG as representing

the experience of individuals whose development, at least in some areas has surpassed what was present before the struggle with crises occurred. The individual has not only survived, but has experienced changes that are viewed as important, and that go beyond the status quo. Posttraumatic growth is not simply a return to baseline—it is an experience of improvement that for some persons is deeply profound. (p. 4)

Posttraumatic growth has been associated with a number of interrelated constructs, including resilience, hardiness, and a sense of coherence (Almedom, 2005). However, even though PTG has been reported in an array of samples, it remains controversial due to measurement challenges (Park & Lechner, 2006). Typically, PTG is assessed by self-report, through interviews, or in questionnaires, and sceptics question the validity of the construct (e.g., Frazier & Kaler, 2006; Park & Sinnott, 2018; Steger et al., 2006). A web-based study of 1,739 adults concluded that growth, following trauma, might entail the strengthening of character (Peterson et al., 2008). PTG should not be perceived as a consequence of trauma; rather, it is one possible outcome of the process of working through the aftermath of trauma (Levers, 2020). The discussion of growth after trauma does not discount, in any way, the negative effects of trauma. Rather, attention to growth-promoting therapeutic strategies can facilitate a meaning-making process that potentially enhances a survivor's sense of purpose and promotes personal growth and change (Altmaier, 2017). It is essential to understand how the various risk factors and protective factors existing in a person's life at the time of a trauma event and immediately after may contribute to the degree to which the trauma has a lesser or greater impact. Clinicians need to consider the resilience and hardiness of their clients and to maintain a growth-oriented and meaning-making perspective when working with clients who have been traumatized.

According to a publication by Harvard University's Center on the Developing Child (n.d., pp. 1–2), the following elements are important considerations regarding resilience:

- Resilience requires supportive relationships and opportunities for skillbuilding.
- Resilience results from a dynamic interaction between internal predispositions and external experiences.
- Learning to cope with manageable threats to our physical and social well-being is critical for the development of resilience.

- Some children respond in more extreme ways to both negative and positive experiences.
- Individuals never completely lose their ability to improve their coping skills, and they often learn how to adapt to new challenges.

COUNSELING IMPLICATIONS

As suggested by the rates of exposure to traumatic events among the general population, trauma is a factor that clinicians need to consider when they embark upon a course of treatment with any client. Although most mental health agencies and clinicians routinely obtain information regarding medical and psychosocial histories, it is not nearly as routine to ask about a history of trauma. This, in fact, should be a standard line of inquiry that is a part of any routine intake process, and the information should be requested in as normalized a fashion as possible—in other words, it should be posed as a simple and nonthreatening question that is a part of the larger intake protocol.

Diagnoses are not dogma; by reviewing the history of how the effects of traumatic events have been viewed through the ages, we can see that the psychosocial notion of trauma is one that has been constructed by humans, over time, and that is connected to the cultural ethos in which people pay attention to those affected by traumatic events. At the same time, we now understand that a traumatic event triggers a cascade of neurochemical responses that account for many trauma-related reactions (this is discussed further in Chapters 2, 3, and 4). Clinicians need to *listen* to the narratives of clients describing the effects of traumatic events and to pay attention both to interpersonal and to family dynamics. Statistically speaking, the potential is high that most therapists are likely to counsel clients who have trauma histories. It also is likely that any practicing clinician may see the effects of racial or transgenerational trauma.

One of the most robust implications across the various clinical fields is the need for more preservice training around issues pertaining to the effects of traumatic events. We need to assist students in understanding the evaluation and treatment of persons who have been exposed to trauma as well as to the effects of stress, crises, and disasters. I am hopeful that, by presenting related foundational knowledge as a trauma scaffold, students and clinicians alike can build upon this scaffold, incorporating other foundational practice and treatment information as we continue to understand increasingly more advanced and complex issues regarding trauma. Along these lines, more research is needed regarding assessment, treatment, and pedagogical issues associated with the effects of trauma.

CONCLUSION

In this chapter, we have explored the historical context of the way in which we have come to view the effects of traumatic events and how we have arrived at several trauma-related diagnostic categories. Although trauma has been a part of the human experience, probably since the beginning of time, an awareness of the impact of trauma on the lives of affected people has developed slowly and only within recent history. We have seen how, in certain historical eras, specific groups of people have been marginalized and actually targeted for violence. In these instances, the abuse of institutional power seems to be linked with the willingness of some members of society to perpetrate violence against the targeted groups. We also have seen how an interest in the experience of psychological trauma emerged with the advent of psychoanalysis and continued through the lens of war and particular social movements. A brief discussion regarding resilience has emphasized the importance of growth-oriented and meaning-making recovery processes, especially in an effort to mitigate diagnostic tendencies toward viewing trauma as necessarily psychopathological. Finally, I have identified some of the implications for understanding the historical and psychosocial contexts of trauma. I believe that an awareness of the historical context of certain traumatic events

and an understanding of societal responses can help those mental health professionals working with trauma, stress, crisis, and disaster to be more effective in their practice.

Author's Note

This chapter is a complete revision of a chapter that appeared in the first edition of this textbook: Hyatt-Burkhart, D., & Levers, L. L. (2012). Historical contexts of trauma. In L. L. Levers (Ed.), *Trauma counseling: Theories and interventions* (pp. 23–46). Springer Publishing Company.

ADDITIONAL RESOURCES

A robust set of instructor resources designed to supplement this text is located at <http://connect.springerpub.com/content/book/978-0-8261-5085-1>. Qualifying instructors may request access by emailing textbook@springerpub.com.

PRACTICE-BASED RESOURCES AND REFERENCES

RESOURCES

Websites

Blakemore, E. (2020, 17 June). How PTSD went from ‘shell-shock’ to a recognised medical diagnosis. *National Geographic*.

www.nationalgeographic.co.uk/history-and-civilisation/2020/06/how-ptsd-went-from-shell-shock-to-a-recognised-medical-diagnosis

The Institute on Trauma and Trauma-Informed Care. *What is trauma-informed care?* University at Buffalo, Buffalo Center for Social Research.

<http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html>

Without Sanctuary

<https://withoutsanctuary.org>

Videos

Understanding Trauma (2020; 2:21)

www.youtube.com/watch?v=v60Pi87sqhI

What Is Trauma? (2018; 1:33)

<https://youtu.be/uraDbhffvsk>

The Attachment Theory: How Childhood Affects Life (7:36)

www.youtube.com/watch?v=WjOowWxOXCg

Center on the Developing Child, Harvard University; Short Videos on Resilience:

- *In Brief: What Is Resilience?* (2015; 2:22)

<https://youtu.be/cqO7YoMscU>

- *In Brief: The Science of Resilience* (2015; 2:29)

<https://youtu.be/1r8hj72bfGo>

Gift From Within. (Producer). (2011). *Making peace with chronic PTSD—Marla's story*. [DVD].

REFERENCES

- Almedom, A. M. (2005). Resilience, hardiness, sense of coherence, and posttraumatic growth: All paths leading to “light at the end of the tunnel”? *Journal of Loss and Trauma*, 10, 253–265. <https://doi.org/10.1080/15325020590928216>
- Altmaier, E. M. (Ed.). (2017). *Reconstructing meaning after trauma: Theory, research, and practice*. Elsevier.
- American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders*. Author.
- American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Author.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Author.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., revised). Author.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- American Psychological Association. (2015). *Guidelines on trauma competencies for education and training*. <http://www.apa.org/ed/resources/trauma-competencies-training.pdf>
- American Psychological Association. (2019). *Trauma*. <https://www.apa.org/topics/trauma>
- Benjet, C., Bromet, E., Karam, E. G., Kessler, R. C., McLaughlin, K. A., Ruscio, A. M., Shahly, V., Stein, D. J., Petukhova, M., Hill, E., Alonso, J., Atwoli, L., Bunting, B., Bruffaerts, R., Caldas-de-Almeida, J. M., de Girolamo, G., Florescu, S., Gureje, O., Huang, Y., ... Koenen, K. C. (2016). The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium. *Psychological Medicine*, 46(2), 327–343. <https://doi.org/10.1017/S0033291715001981>
- Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge*. Anchor Books.
- Bogousslavsky, J., & Dieguez, S. (2014). Sigmund Freud and hysteria: The etiology of psychoanalysis? *Frontiers of Neurology and Neuroscience*, 35, 109–125. <https://doi.org/10.1159/000360244>
- Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of PsychoAnalysis*, XXXIX, 1–23.
- Bowlby, J. (1998). *Attachment and loss: Sadness and depression*. *Attachment and loss: Volume 3*. Pimlico. (Original work published in 1980).
- Breslau, N., Kessler, F., Chilcoat, H., Schultz, L., Davis, G., & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: The 1996 Detroit area survey of trauma. *Archives of General Psychiatry*, 55(7), 626–632. <https://doi.org/10.1001/archpsyc.55.7.626>
- Brewerton, T. D. (2007). Eating disorders, trauma, and comorbidity: Focus on PTSD eating disorders and PTSD. *Eating Disorders*, 15(4), 285–304. <https://doi.org/10.1080/10640260701454311>
- Briere, J. (1987). Predicting likelihood of battering: Attitudes and childhood experiences. *Journal of Research in Personality*, 21, 61–69. [https://doi.org/10.1016/0092-6566\(87\)90026-2](https://doi.org/10.1016/0092-6566(87)90026-2)
- Burgess, A. W., & Holmstrom, L. L. (1974). Rape trauma syndrome. *The American Journal of Psychiatry*, 131(9), 981–986. <http://search.ebscohost.com.authenticate.library.duq.edu/login.aspx?direct=true&db=psyh&AN=1975-03266-001&site=ehost-live>
- Calhoun, L. G., & Tedeschi, R. G. (1998). Posttraumatic growth: Future directions. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), *Posttraumatic growth: Positive changes in the aftermath of crisis* (pp. 215–238). Lawrence Erlbaum Associates, Publishers.
- Cardarelli, K. M., Perez-Figueroa, R. E., & Mathews, B. (2021). Health disparities and social justice. In K. Benner, D. Loeffler, & N. Pope (Eds.), *Social, economic, and environmental justice* (pp. 105–118). Springer Publishing.
- Carvajal, C. (2018). Posttraumatic stress disorder as a diagnostic entity - clinical perspectives. *Dialogues in Clinical Neuroscience*, 20(3), 161–168. <https://doi.org/10.31887/DCNS.2018.20.3/ccarvajal>
- Center on the Developing Child. (n.d.). *In brief: The science of resilience*. Harvard University. <https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2015/05/InBrief-The-Science-of-Resilience.pdf>

- Child Trends. (2018). *Violent crime victimization*. www.childtrends.org/indicators/violent-crime-victimization
- Classen, C., Koopman, C., Angell, K., & Spiegel, D. (1996). Coping styles associated with psychological adjustment to advanced breast cancer. *Health Psychology, 15*(6), 434–437. <https://doi.org/10.1037/0278-6133.15.6.434>
- Cloitre, M., Garvert, D. W., Weiss, B., Carlson, E. B., & Bryant, R. A. (2014). Distinguishing PTSD, complex PTSD, and borderline personality disorder: A latent class analysis. *European Journal of Psychotraumatology, 5*, 25097. <https://doi.org/10.3402/ejpt.v5.25097>
- Council for the Accreditation of Counseling and Related Educational Programs (CACREP). (2016). *2016 CACREP standards*. <http://www.cacrep.org/wp-content/uploads/2017/08/2016-Standards-with-citations.pdf>
- Council on Social Work Education. (2015). *Educational policy and accreditation standards educational policy and accreditation standards for baccalaureate and master's social work programs*. www.cswe.org/getattachment/Accreditation/Standards-and-Policies/2015-EPAS/2015EPASandGlossary.pdf.aspx
- Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(1), 86–100. <https://doi.org/10.1037/1942-9681.1.1.86>
- Courtois, C. A., & Gold, S. N. (2009). The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(1), 3–23. http://drchriscourtois.com/images/Need_for_Inclusion_of_Trauma_w_Gold_03_09.pdf
- Diamond, M. J. (2020). Return of the repressed: Revisiting dissociation and the psychoanalysis of the traumatized mind. *Journal of the American Psychoanalytic Association, 68*(5), 839–874. <https://doi.org/10.1177/0003065120964929>
- Ehrenreich, B., & English, D. (1973). *Witches, midwives, and nurses: A history of women healers*. Feminist Press at CUNY.
- Elm, M., Kabalek, K., & Köhne, J. B. (Eds.). (2014). *The horrors of trauma in cinema: Violence void visualization*. Cambridge Scholars Publishing.
- Everly, G. S. Jr., & Lating, J. M. (1995). *Psychotraumatology: Key papers and core concepts in post-traumatic stress*. Plenum.
- Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2013). Violence, crime, and abuse exposure in a national sample of children and youth: An update. *JAMA Pediatrics, 167*(7), 614–621. <https://jamanetwork.com/journals/jamapediatrics/fullarticle/1686983>
- Flory, J. D., & Yehuda, R. (2015). Comorbidity between post-traumatic stress disorder and major depressive disorder: Alternative explanations and treatment considerations. *Dialogues in Clinical Neuroscience, 17*(2), 141–150. <https://doi.org/10.31887/dens.2015.17.2/jflory>
- Ford, J. D. (1999). Disorders of extreme stress following war-zone military trauma: Associated features of posttraumatic stress disorder or comorbid but distinct syndromes? *Journal of Consulting and Clinical Psychology, 67*(1), 3–12. <https://doi.org/10.1037/0022-006X.67.1.3>
- Ford, J. D. (2017). Complex trauma and complex posttraumatic stress disorder. In S. N. Gold (Ed.), *APA handbooks in psychology®. APA handbook of trauma psychology: Foundations in knowledge* (pp. 281–305). American Psychological Association.
- Ford, J. D. (2020). New findings questioning the construct validity of complex posttraumatic stress disorder (cPTSD): Let's take a closer look. *European Journal of Psychotraumatology, 11*(1), 1708145. <https://doi.org/10.1080/20008198.2019.1708145>
- Foucault, M. (1973). *Madness and civilization: A history of insanity in the age of reason*. Vintage.
- Frazier, P. A., & Kaler, M. E. (2006). Assessing the validity of self-reported stress-related growth. *Journal of Consulting and Clinical Psychology, 74*(5), 859–869. <https://doi.org/10.1037/0022-006X.74.5.859>
- Freud, S., & Strachey, J. (1977). *Introductory lectures on psychoanalysis [Vorlesungen zur Einführung in die Psychoanalyse]*. Norton. (Original work published in 1966).
- Friedman, M. J., Keane, T. M., & Resick, P. A. (Eds.). (2007). *PTSD: Twenty-five years of progress and challenges. Handbook of PTSD: Science and practice*. Guilford Press.
- Gerge, A. (2020). What neuroscience and neurofeedback can teach psychotherapists in the field of complex trauma: Interoception, neuroception and the embodiment of unspeakable events in treatment of complex PTSD, dissociative disorders and childhood traumatization. *European Journal of Trauma & Dissociation, 4*, 100164. <https://doi.org/10.1016/j.ejtd.2020.100164>
- Glickman, L. (2020, May 21). How white backlash controls American progress: Backlash dynamics are one of the defining patterns of the country's history. *The Atlantic*. <https://www.theatlantic.com/ideas/archive/2020/05/white-backlash-nothing-new/611914>
- Goodman, L. A., Rosenberg, S. D., Mueser, K. T., & Drake, R. E. (1997). Physical and sexual assault history in women with serious mental illness: Prevalence, correlates, treatment, and future research directions. *Schizophrenia Bulletin, 23*(4), 685–696. <https://doi.org/10.1093/schbul/23.4.685>
- Goodman, M. (2012). Complex PTSD is on the trauma spectrum: Comment on Resick et al. (2012). *Journal of Traumatic Stress, 25*(3), 254–255. <https://doi.org/10.1002/jts.21695>

- Handwerk, B. (2016, January 20). An ancient, brutal massacre may be the earliest evidence of war. *Smithsonian Magazine*. <https://www.smithsonianmag.com/science-nature/ancient-brutal-massacre-may-be-earliest-evidence-war-180957884/>
- Harned, M. S., Wilks, C. R., Schmidt, S. C., & Coyle, T. N. (2018). Improving functional outcomes in women with borderline personality disorder and PTSD by changing PTSD severity and post-traumatic cognitions. *Behaviour Research and Therapy*, 103, 53–61. <https://doi.org/10.1016/j.brat.2018.02.002>
- Heidarizadeh, N. (2015). The significant role of trauma in literature and psychoanalysis. *Procedia: Social and Behavioral Sciences*, 192, 788–795. <https://core.ac.uk/download/pdf/82780838.pdf>
- Herman, J. L. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5, 377–391. <https://doi.org/10.1002/jts.2490050305>
- Herman, J. L. (1992b). *Trauma and recovery*. Basic Books.
- History.com Editors. (2021, March 29). *Freedom riders. History*. <https://www.history.com/topics/black-history/freedom-rides>
- John, S. G., Brandt, T. W., Secrist, M. E., Mesman, G. R., Sigel, B. A., & Kramer, T. L. (2019). Empirically-guided assessment of complex trauma for children in foster care: A focus on appropriate diagnosis of attachment concerns. *Psychological Services*, 16(1), 120–133. <https://doi.org/10.1037/ser0000263>
- Jones, E., & Wessely, S. (2006). Psychological trauma: A historical perspective. *Psychiatry*, 5, 217–220. <https://doi.org/10.1053/j.mppsy.2006.04.011>
- Joseph, S., & Butler, L. D. (2010, Summer). Positive changes following adversity. *PTSD Research Quarterly*, 21(3), 1–9. <https://cdn2.psychologytoday.com/assets/attachments/75676/positive-changes-following-adversity.pdf>
- Kanel, K. (2019). *A guide to crisis intervention* (6th ed.). Cengage.
- Kardiner, A. (1941). *The traumatic neuroses of war*. Washington, DC: National Research Council.
- Killeen, T. K., Back, S. E., Kathleen, T., & Brady, K. T. (2015). Implementation of integrated therapies for comorbid post-traumatic stress disorder and substance use disorders in community substance abuse treatment programs. *Drug and Alcohol Review*, 34, 234–241. <https://doi.org/10.1111/dar.12229>
- Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. *Journal of Traumatic Stress*, 26(5), 537–547. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4096796/pdf/nihms596966.pdf>
- Kliethermes, M., Schacht, M., & Drewry, K. (2014). Complex trauma. *Child and Adolescent Psychiatric Clinics of North America*, 23(2), 339–361. <https://doi.org/10.1016/j.chc.2013.12.009>
- Koehne, J. B., & Kabalek, K. (2014). *The horrors of trauma in cinema. violence, void, visualization*. Cambridge Scholars Publishing.
- Kübler-Ross, E. (1969). *On death and dying: What the dying have to teach doctors, nurses, clergy and their own families*. Macmillan Publishing.
- Kulasekara, D. (2016). Representation of trauma in contemporary arts. *Athens Journal of Humanities & Arts*, 4(1), 35–60. <https://www.athensjournals.gr/humanities/2017-4-1-3-Kulasekara.pdf>
- Kumar, S. A., Brand, B. L., & Courtois, C. A. (2019). The need for trauma training: Clinicians' reactions to training on complex trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. <https://doi.org/10.1037/tra0000515>
- Lartey, J., & Morris, S. (2018, May 1). *How White Americans used lynchings to terrorize and control Black people*. The Guardian. <https://www.theguardian.com/us-news/2018/apr/26/lynchings-memorial-us-south-montgomery-alabama>
- Lasiuk, G. C., & Hegadoren, K. M. (2006). Posttraumatic stress disorder part I: Historical development of the concept. *Perspectives in Psychiatric Care*, 42(1), 13–20. <https://doi.org/10.1111/j.1744-6163.2006.00045.x>
- Lating, J. M., & Everly, G. S. Jr. (Eds.). (1995). *Psychophysiological assessment of PTSD. Psychotraumatology: Key papers and core concepts in post-traumatic stress* (pp. 129–145). Plenum Press.
- Levers, L. L. (2001). Representations of psychiatric disability in fifty years of Hollywood film: An ethnographic content analysis. *Theory and Science*, 2(2). <http://theoryandscience.icaap.org/content/vol002.002/lopezlevers.html>
- Levers, L. L. (2020). Crisis, disaster, and trauma. In L. L. Levers & D. Hyatt-Burkhart (Eds.), *Clinical mental health counseling: Practicing in integrated systems of care* (pp. 91–116). Springer Publishing.
- Lowenstein, A. (2005). *Shocking representation: Historical trauma, national cinema, and the modern horror film*. Columbia University Press.
- Mambrol, N. (2018, December 19). *Trauma studies. Literary criticism*. Literariness.org. <https://literariness.org/2018/12/19/trauma-studies/>
- Margolin, G., & Vickerman, K. A. (2007). Posttraumatic stress in children and adolescents exposed to family violence: I. overview and issues. *Professional Psychology: Research and Practice*, 38(6), 613–619. <https://doi.org/10.1037/0735-7028.38.6.613>

- Marshall, R., Spitzer, R., & Liebowitz, M. (1999). Review and critique of the new *DSM-IV* diagnosis of acute stress disorder. *American Journal Psychiatry*, 156, 1677–1685. <https://doi.org/10.1176/ajp.156.11.1677>
- Mayo Clinic. (2019, March 19). *Stress management*. <https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/stress/art-20046037>
- McCormack, L., & Thomson, S. (2017). Complex trauma in childhood, a psychiatric diagnosis in adulthood: Making meaning of a double-edged phenomenon. *Psychological Trauma: Theory, Research, Practice, and Policy*, 9(2), 156–165. <https://doi.org/10.1037/tra0000193>
- McDowell, D. M., Levin, F. R., & Nunes, E. V. (1999). Dissociative identity disorder and substance abuse: The forgotten relationship. *Journal of Psychoactive Drugs*, 31(1), 71–83. <https://doi.org/10.1080/02791072.1999.10471728>
- McNally, R. (2003). Psychological mechanisms in acute response to trauma. *Biological Psychiatry*, 53(9), 779–788. [https://doi.org/10.1016/s0006-3223\(02\)01663-3](https://doi.org/10.1016/s0006-3223(02)01663-3)
- Najavits, L. M., Rynkala, D., Back, S. E., Bolton, E., Mueser, K. T., & Brady, K. T. (2009). Treatment of PTSD and comorbid disorders. In E. B. Foa, T. M. Keane, M. J. Friedman, & J. A. Cohen (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (2nd ed., pp. 508–535). Guilford Press.
- National Association for the Advancement of Colored People. (2021). *History of lynching in America*. <https://naacp.org/find-resources/history-explained/history-lynching-america>
- Newman, L., Sivaratnam, C., & Komiti, A. (2015). Attachment and early brain development–neuroprotective interventions in infant–caregiver therapy. *Translational Developmental Psychiatry*, 3(1), 1–13. <https://doi.org/10.3402/tdp.v3.28647>
- Ochberg, F. (2012, September 19). An injury, not a disorder. *Dart Center for Journalism and Trauma*. http://dartcenter.org/content/injury-not-disorder-0#.U6UFx_ldXms
- Pai, A., Suris, A. M., & North, C. M. (2017). Posttraumatic stress disorder in the *DSM-5*: Controversy, change, and conceptual considerations. *Behavioral Science*, 7(1), 7. <https://doi.org/10.3390/bs7010007>
- Park, C. L., & Lechner, S. C. (2006). Measurement issues in assessing growth following stressful life experiences. In L. G. Calhoun & R. G. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research & practice* (pp. 47–67). Lawrence Erlbaum Associates Publishers.
- Park, C. L., & Sinnott, S. M. (2018). Testing the validity of self-reported posttraumatic growth in young adult cancer survivors. *Behavioral Sciences*, 8(12), 116. <https://doi.org/10.3390/bs8120116>
- Pelcovitz, D., van der Kolk, B., Roth, S., Mandel, F., Kaplan, S., & Resick, P. (1997). Development of a criteria set and a structured interview for disorders of extreme stress (SIDES). *Journal of Traumatic Stress*, 10(1), 3–16. <https://doi.org/10.1023/a:1024800212070>
- Peterson, C., Park, N., Pole, N., D’Andrea, W., & Seligman, M. E. (2008). Strengths of character and posttraumatic growth. *Journal of Traumatic Stress*, 21(2), 214–217. <https://doi.org/10.1002/jts.20332>
- Platt, M. G., & Freyd, J. J. (2015). Betray my trust, shame on me: Shame, dissociation, fear, and betrayal trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, 7(4), 398–404. <https://doi.org/10.1037/tra0000022>
- Pollock, G. (2009). Art/trauma/representation. *Parallax*, 15(1), 40–54. <https://doi.org/10.1080/13534640802604372>
- Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, self-regulation*. W. W. Norton & Company.
- Portwood, S. G., Lawler, M. J., & Roberts, M. C. (2021). Science, practice, and policy related to adverse childhood experiences: Framing the conversation. *American Psychologist*, 76(2), 181–187. <https://doi.org/10.1037/amp0000809>
- Resick, P. A., Bovin, M. J., Calloway, A. J., Dick, A. M., King, M. W., Mitchell, K. S., Suvak, M. K., Wells, S. Y., Stirman, S. W., & Wolf, E. J. (2012). A critical evaluation of the complex PTSD literature: Implications for *DSM-5*. *Journal of Traumatic Stress*, 25, 241–251. <https://doi.org/10.1002/jts.21699>
- Rijkers, C., Schoorl, M., van Hoeken, D., & Hoek, H. W. (2019). Eating disorders and posttraumatic stress disorder. *Current Opinion in Psychiatry*, 32(6), 510–517. <https://doi.org/10.1097/YCO.0000000000000545>. PMID: 31313708
- Rosen, G. M., Spitzer, R. L., & McHugh, P. R. (2008). Problems with the post-traumatic stress disorder diagnosis and its future in *DSM-V*. *The British Journal of Psychiatry*, 192, 3–4. <https://doi.org/10.1192/bjp.bp.107.043083>
- Rosenfield, P. J., Stratyner, A., Tufekcioglu, S., Karabell, S., Mckelvey, J., & Litt, L. (2018). Complex PTSD in *ICD-11*: A case report on a new diagnosis. *Journal of Psychiatric Practice*, 24(5), 364–370. <https://doi.org/10.1097/PRA.0000000000000327>
- Roth, S., Newman, E., Pelcovitz, D., van der Kolk, B., & Mandel, F. S. (1997). Complex PTSD in victims exposed to sexual and physical abuse: Results from the *DSM-IV* Field Trial for Posttraumatic Stress Disorder. *Journal of Traumatic Stress*, 10(4), 539–555. <https://doi.org/10.1023/a:1024837617768>

- Saraiya, T., & Lopez-Castro, T. (2016). Ashamed and afraid: A scoping review of the role of shame in post-traumatic stress disorder (PTSD). *Journal of Clinical Medicine*, 5(11) 94. <https://doi.org/10.3390/jcm5110094>
- Selye, H. (1956). *The stress of life*. McGraw-Hill Books.
- Sexton, L. (1999). Vicarious traumatization of counselors and effects on their workplaces. *British Journal of Guidance and Counseling*, 27(3), 393–403. <https://doi.org/10.1080/03069889908256279>
- Sinha, P., Gupta, U., Singh, J., & Srivastava, A. (2017). Structural violence on women: An impediment to women empowerment. *Indian Journal of Community Medicine*, 42(3), 134–137. https://doi.org/10.4103/ijcm.ijcm_276_15
- Solomon, S. D., & Canino, G. J. (1990). Appropriateness of DSM-III-R criteria for post-traumatic stress disorder. *Comprehensive Psychiatry*, 31, 227–237. [https://doi.org/10.1016/0010-440x\(90\)90006-e](https://doi.org/10.1016/0010-440x(90)90006-e)
- Solomon, Z., Mikulincer, M., Fried, B. I., & Wosner, Y. (1987). Family characteristics and posttraumatic stress disorder: A follow-up of Israeli combat stress reaction casualties. *Family Process*, 26(3), 383–394. <https://doi.org/10.1111/j.1545-5300.1987.00383.x>
- Spallacci, A. (2019). Representing rape trauma in film: Moving beyond the event. *Arts*, 8(8), 1–11. <https://doi.org/10.3390/arts8010008>
- Spinoven, P., Penninx, B. W., van Hemert, A. M., Rooij, M., & Elzinga, B. M. (2014). Comorbidity of PTSD in anxiety and depressive disorders: Prevalence and shared risk factors. *Child Abuse & Neglect*, 38(8), 1320–1330. <https://doi.org/10.1016/j.chiabu.2014.01.017>
- Spitzer, R. L., First, M., & Wakefield, J. (2007). Saving PTSD from itself in DSM-V. *Journal of Anxiety Disorders*, 21(2), 233–241. <https://doi.org/10.1016/j.janxdis.2006.09.006>
- Steger, M., Frazier, M. F., Oishi, S., & Kaler, P. (2006). The meaning in life questionnaire: Assessing the presence of and search for meaning in life. *Journal of Counseling Psychology*, 53(1), 80–93. <https://doi.org/10.1037/0022-0167.53.1.80>
- Stringer, D. (2009). *“Not even past”: Race, historical trauma, and subjectivity in Faulkner, Larsen, and Van Vechten*. Fordham University Press.
- Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed care in behavioral health services. Treatment Improvement Protocol (TIP) Series 57*. HHS Publication No. (SMA) 13-4801. Substance Abuse and Mental Health Services Administration. <https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>
- Substance Abuse and Mental Health Services Administration. (2016, June 3). *DSM-5 changes: Implications for child serious emotional disturbance: DSM-5 child mental disorder classification*. Author. <https://www.ncbi.nlm.nih.gov/books/NBK519712/>
- Swart, S., Wildschut, M., Draijer, N., Langeland, W., & Smit, J. H. (2020). Dissociative subtype of posttraumatic stress disorder or PTSD with comorbid dissociative disorders: Comparative evaluation of clinical profiles. *Psychological Trauma: Theory, Research, Practice, and Policy*, 12(1), 38–45. <http://doi.org/10.1037/tra0000474>
- Szasz, T. S. (1997). *The manufacture of madness: A comparative study of the Inquisition and the mental health movement*. Syracuse. Syracuse University Press. (Original work published in 1970).
- Tarvydas, V., Levers, L. L., & Teahen, P. R. (2017). Ethical guidelines for mass trauma and complex humanitarian emergencies. *Journal of Counseling and Development*, 95, 260–268. <https://doi.org/10.1002/jcad.12140>
- Tarvydas, V., Levers, L. L., & Teahen, P. (2018). Ethics narratives from lived experiences of disaster and trauma counselors. In J. Webber & J. B. Mascari (Eds.), *Disaster mental health counseling: A guide to preparing and responding* (4th ed., pp. 97–109). American Counseling Association Foundation.
- Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry*, 15(1), 1–18. https://doi.org/10.1207/s15327965pli1501_01
- Tehrani, N., & Levers, L. L. (2016). Working through the pain. In D. A. Lane, M. Watts, & S. Corrie (Eds.), *Supervision in the psychological professions: Building your own personalized model* (pp. 104–124). Open University Press/McGraw-Hill Education.
- Thurston, R. W. (2007). *The witch hunts: A history of the witch persecutions in Europe and North America*. Pearson Longman.
- Tull, M. (2020, September 28). *The relationship between PTSD and shame*. Verywell Mind. <https://www.verywellmind.com/ptsd-and-shame-2797529>
- University of Wyoming. (2021, March 10). *Oldest documented site of indiscriminate mass killing*. ScienceDaily. www.sciencedaily.com/releases/2021/03/210310150456.htm
- U.S. Department of Veterans Affairs. (2018). *How common is PTSD in adults? PTSD: National Center for PTSD*. https://www.ptsd.va.gov/understand/common/common_adults.asp
- van der Kolk, B. A. (1996). The complexity of adaptation to trauma: Self-regulation, stimulus discrimination, and characterological development. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming stress on mind, body, and society* (pp. 182–213). Guilford Press.

- van der Kolk, B. (2000). Posttraumatic stress disorder and the nature of trauma. *Dialogues in Clinical Neuroscience*, 2(1), 7–22. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181584/>
- van der Kolk, B. A. (2001). The assessment and treatment of complex PTSD. In R. Yehuda (Ed.), *Traumatic stress*. American Psychiatric Press. https://www.researchgate.net/profile/Onno-Hart/publication/265099248_The_Assessment_and_Treatment_of_Complex_PTSD/links/545a3d1f0cf2cf5164843be5/The-Assessment-and-Treatment-of-Complex-PTSD.pdf
- van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Books.
- van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (Eds.). (2007). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. Guilford Press.
- Walter, C. A., & McCoyd, J. L. M. (2009). *Grief and loss across the lifespan: A biopsychological perspective*. Springer Publishing.
- Wamsley, L. (2021, April 8). *CDC director declares racism a serious public health threat*. National Public Radio. https://www.npr.org/2021/04/08/985524494/cdc-director-declares-racism-a-serious-public-health-threat?utm_source=npr_newsletter&utm_medium=email&utm_content=20210409&utm_term=5303909&utm_campaign=news&utm_id=47559301&orgid=727&utm_att1=
- Wilson, J. P. (1995). Traumatic events and PTSD prevention. In B. Raphael & E. D. Barrows (Eds.), *The handbook of preventative psychiatry* (pp. 281–296). Elsevier North-Holland.
- Wolf, E. J., Miller, M. W., Sullivan, D. R., Amstadter, A. B., Mitchell, K. S., Goldberg, J., & Magruder, K. M. (2018). A classical twin study of PTSD symptoms and resilience: Evidence for a single spectrum of vulnerability to traumatic stress. *Depression and Anxiety*, 35(2), 132–139. <https://doi.org/10.1002/da.22712>
- Worden, J. W. (2008). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (4th ed.). Springer Publishing.
- Wordes, M., & Nunez, M. (2002, May). *Our vulnerable teenagers: Their victimization, its consequences, and directions for prevention and intervention*. National Council on Crime and Delinquency, and National Center for Victims of Crime. https://victimsofcrime.org/doc/teen_victim_report.pdf
- World Health Organization. (1949). *International statistical classification of diseases and related health problems* (6th ed.). Author.
- Yearwood, K., Vliegema, N., Chau, C., Corveleyn, J., & Luyten, P. (2019). When do peers matter? The moderating role of peer support in the relationship between environmental adversity, complex trauma, and adolescent psychopathology in socially disadvantaged adolescents. *Journal of Adolescence*, 72, 14–22. <https://doi.org/10.1016/j.adolescence.2019.02.001>
- Yehuda, R., & McFarlane, A. C. (1995). Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. *The American Journal of Psychiatry*, 152(12), 1705–1713. <https://doi.org/10.1176/ajp.152.12.1705>
- Yen, S., Shea, M. T., Battle, C. L., Johnson, D. M., Zlotnick, C., Dolan-Sewell, R., Skodol, A. E., Grilo, C. M., Gunderson, J. G., Sanislow, C. A., Zanarini, M. C., Bender, D. S., Rettew, J. B., & McGlashan, T. H. (2002). Traumatic exposure and posttraumatic stress disorder in borderline, schizotypal, avoidant, and obsessive-compulsive personality disorders: Findings from the collaborative longitudinal personality disorders study. *The Journal of Nervous and Mental Disease*, 190(8), 510–518. <https://doi.org/10.1097/00005053-200208000-00003>
- Yule, W. (1998). Posttraumatic stress disorder in children and its treatment. In T. W. Miller (Ed.), *Children of trauma: Stressful life experiences and their effects on children and adolescents* (pp. 219–243). International Universities Press.
- Goodman, M. (2012). Complex PTSD is on the trauma spectrum: Comment on Resick et al. (2012). *Journal of Traumatic Stress*, 25(3), 254–255. <https://doi.org/10.1002/jts.21695>
- Portwood, S. G., Lawler, M. J., & Roberts, M. C. (2021). Science, practice, and policy related to adverse childhood experiences: Framing the conversation. *American Psychologist*, 76(2), 181–187. <https://doi.org/10.1037/amp0000809>