1

What Is Psychological Trauma?

Jenna was 14 years old when a fellow student, a young man named James, started paying attention to her. He periodically showed up at her house, wanting to talk. Jenna's father had never liked James, but Jenna was grateful that someone was interested in her. All of her friends had boyfriends, and she wanted one, too. She was thrilled when James finally asked her to go to the movies. He took her to a drive-in; during the movie, he raped her. After he was finished, as she sobbed in the passenger seat of his car, he asked whether she wanted something to eat. He then took her home as if nothing had happened. Several weeks after the assault, Jenna told a group of her astonished friends what had happened. Her friends were also 14 years old, and they didn't know what to say. It was the 1970s, and rape was not something people talked about.

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Jenna had symptoms of posttraumatic stress disorder (PTSD) throughout high school and college; she was unable to go to sleep until almost dawn. Her symptoms dramatically affected her ability to perform at school. She suffered many physical symptoms as well, including chronic pain so severe that she made several trips to the emergency department. Doctors never identified the cause of Jenna's chronic health problems, but she did manage to reduce her symptoms using a variety of alternative health modalities. Jenna has managed to live her life, but her sexual assault has never been addressed.

April worked at a top finance firm in New York City. She earned a lot of money and was well regarded in her field. She traveled constantly but enjoyed the pace of her life, and she loved being able to do work that she did well.

When she became pregnant with her first child, she was elated. She assumed that she would handle the demands of birth and new motherhood with her normal aplomb. What she had not expected was the frightening ordeal she experienced at the hospital. She was stripped and exposed, overwhelmed by pain, completely shocked at the lack of care taken by the staff. She did not think she would survive the experience. She did survive—but nothing will ever be the same for her. She is truly questioning many of the assumptions she has held throughout her successful life. Where was the justice in what she experienced? Why hadn't she checked out the hospital and doctor more carefully? What could she have done differently? Why did her body fail her so miserably?

April just can't get the memories of her birthing experience out of her head. She is having trouble sleeping and feels disconnected from her baby. She wonders whether she will ever recover from the trauma she experienced at the hands of her medical providers.

Sam was a teenager when he was drafted into the army and sent to Vietnam. He was eventually captured by the Viet Cong and was a prisoner of war for 3 years. During his captivity, he was

frequently tortured; somewhere along the way, he contracted hepatitis C. When he returned to the United States, he found that he needed to keep his service to his country secret—the Vietnam War was very unpopular at home. Years later, he continues to have nightmares about his experiences, and he suffers intrusive thoughts during the day.

Sam's health was also seriously compromised, largely by his hepatitis C. He experiences chronic pain and has frequently been subjected to painful medical testing, including regular liver biopsies. His chronic pain symptoms have continually triggered his PTSD. It took 2 years before he was finally approved within the Veterans Affairs system to receive pain medications, which his health care providers were reluctant to prescribe because of his PTSD. Only after his psychiatrist insisted that he be prescribed was Sam finally treated for chronic pain.

Sam's PTSD and health problems have detrimentally affected his family as well, leading to two divorces. After his second divorce, Sam moved to another state to be closer to his oldest son.

Sarah, a mother of three children, was in her early 20s when her town in her native Liberia was raided by rebel forces. Her father and brother were gunned down when they tried to stop soldiers from raping her. Afterward, the soldiers raped her. Sarah escaped to a refugee camp with one of her daughters, but even at the camp she never felt safe. She was eventually relocated to the United States with the daughter who stayed with her in the camp, but she was forced to leave two of her children behind in Liberia.

Sarah was sent to a state in northern New England, where the population was predominantly White. She speaks English, so she was able to get by. But the culture was so different. And she struggled as she tried to figure out how to live in a place where it seemed cold and dark most of the year. She misses her native country and the family she was forced to leave behind. But it is not safe for her to return.

CHAPTER 1

WHAT ARE TRAUMATIC EVENTS?

Life as you know it can change in an instant. One day you are living your life. You're worried about getting all your tasks finished on your to-do list, being late for a meeting, or getting your car to start. The next thing you know, the bottom falls out of your world. It could be a street crime. A natural disaster might sweep through your city. Your child might be hit by a car. Or you might be diagnosed with a life-threatening illness. The hard reality is that traumatic events are remarkably common. In volume 2 of his seminal work *Trauma and Its Walk*, trauma pioneer Charles Figley said that an event will be troubling to the extent that it is "sudden, dangerous, and overwhelming." Almost three decades later, that description of traumatic events is as apt as ever.

There is confusion among the general population about what "traumatic" means. In popular parlance, people use the term not only to describe truly traumatic events, but also to describe events that are merely unpleasant (such as missing a plane). There is another, more technical definition of trauma. Psychological trauma can occur when a person experiences an extreme stressor that negatively affects his or her emotional or physical well-being. Trauma can cause emotionally painful and distressing feelings that overwhelm a person's capacity to cope and leave him or her with feelings of helplessness. Traumatic events can lead to PTSD and myriad other reactions, such as depression, substance abuse, sleep problems, and—potentially—chronic health problems, such as heart disease, diabetes, and cancer.

Individuals may directly experience a trauma, witness the trauma happen to someone else, or learn about a traumatic event happening to close family members or friends. According to the older definition of trauma in the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition, text revision (*DSM-IV-TR*, American Psychiatric Association [APA], 2000), an event is considered traumatic when it results in the actual or threatened injury or death of the person exposed to the trauma or in threat

to the physical integrity of the person and when the person's emotional response to the traumatic event includes intense fear, helplessness, or horror.

With the advent of the new *DSM-5* (APA, 2013), the definition of what constitutes a traumatic event has changed. An event is considered traumatic if the event resulted in death or threatened death, actual or threatened physical injury, or actual or threatened sexual violation. The individual no longer needs to have had an intense emotional reaction to the experience—studies have shown that the emotions experienced at the time of or after trauma exposure (e.g., intense fear, helplessness, horror) are not necessarily predictive of later distress or mental health problems; thus they are no longer part of the definition of a traumatic event. The person could have directly experienced the event, witnessed the event, or learned of the event happening to a close friend or relative.

It was previously believed that exposure to trauma was outside the realm of normal human experience, but research has shown that traumatic events are quite common and can have long-lasting, even lifelong, consequences. Trauma exposure cuts across all walks of life, regardless of age, race, ethnicity, socioeconomic status, religion, and cultural background. Epidemiological studies estimate that approximately 30% to 80% of individuals living in the United States have been exposed to one or more traumatic events (Breslau, 2009; Kessler, Chiu, Demler, & Walters, 2005).

Psychological trauma can occur after exposure to a single event or multiple events compounded over time. The likely impact of a traumatic event is often determined by a variety of factors including individual, relational, and social and contextual variables, all of which work in concert to bring about resolution of the trauma. Some individuals have significant protective factors that promote resilience in the face of trauma exposure. Others experience immediate distress after the trauma, which resolves without intervention. Still others experience significant distress and difficulty recovering that result in lifelong functional impairment.

TYPES OF TRAUMATIC EVENTS

Although clinicians first started describing "shell shock" as early as World War I, PTSD is a relatively recent diagnosis, first becoming a formal diagnostic category in the third edition of the *DSM* (*DSM-III*; APA, 1980). Much of the work leading up to its inclusion in the *DSM-III* came from work with combat veterans, Holocaust survivors and their offspring, sexual assault survivors, and those who experienced political violence. More recently, medical events, such as a psychologically traumatic birth, cancer diagnosis, ICU stays, heart attack, or having a preterm baby, were also recognized as causing trauma. What follows is a brief overview of the most common types of traumatic events that an individual might be exposed to during his or her lifetime.

Child Maltreatment

Child maltreatment, a multifaceted problem that occurs all over the world, includes the abuse and neglect of a child under the age of 18. According to the Child Abuse Prevention and Treatment Act (CAPTA, 2010), child maltreatment is

> any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm.

Physical abuse has been defined as nonaccidental physical acts that injure a child and may include behaviors such as punching, hitting, beating, or burning a child. Sexual abuse has been defined as attempted or completed sexual acts with a child (e.g., fondling or sexual intercourse) or sexual exploitation of a child through using the child for prostitution or child pornography. Emotional abuse (or psychological abuse) is a pattern of behavior that impairs a child's emotional development or sense of

self-worth and may include behaviors such as harshly criticizing or denigrating the child (Cicchetti & Toth, 2005). Since there are often no overt signs of emotional abuse, it can be one of the most difficult forms of abuse to verify (Heim, Shugart, Craighead, & Nemeroff, 2010).

Exposure to domestic violence, parental substance abuse, and abandonment of a child are also seen as forms of child maltreatment. Physical, sexual, and emotional abuse all involve direct acts of violence against a child. In contrast, neglect (another form of child maltreatment) involves failure to take care of a child's basic needs (CAPTA, 2010; Mennen, Kim, Sang, & Trickett, 2010; Pereda, Guilera, Forns, & Gómez-Benito, 2009). Parents and caregivers are considered neglectful when they fail to provide for their children's shelter, food, clothing, emotional support, education, health care, and supervision.

Reported incidence rates of child maltreatment are generally assumed to poorly reflect the magnitude of the problem, because child victims may not readily admit their experiences due to feelings of shame, guilt, and continued dependence on the perpetrators (Pereda et al., 2009). The U.S. Department of Health and Human Services' (USDHHS) Children's Bureau's Child Maltreatment Report (2011) indicates that approximately 2 million cases of child maltreatment were reported and investigated during 2011, with 681,000 of those cases substantiated. Of substantiated cases, approximately 79% involved neglect, 15% involved physical abuse, and 10% involved sexual abuse. Children under age 1 had the highest rates of victimization, and racial and ethnic minority children were disproportionately represented among the victims. Tragically, in 2011, 1,545 children died as a result of child abuse and neglect (USDHHS Children's Bureau, 2011).

Studies indicate that maltreated children are typically exposed to multiple types of abuse that are chronic and unrelenting and that often lead to significant adverse physical and psychological outcomes throughout childhood and adulthood (Muela, de Arana, Barandiaran, Larrea, & Vitoria, 2012). Childhood maltreatment is

particularly devastating because it occurs during a neurobiologically vulnerable time period when the brain is still developing and is more susceptible to harmful effects. Studies show that exposure to child maltreatment may disrupt or alter normal brain development, which then places these individuals at increased risk for later psychological and physical problems (Heim et al., 2010).

Some of the risk factors associated with child abuse and neglect include individual factors, such as younger age, female gender, and child physical disability; relationship factors, such as negative parent–child interactions, particularly if the parent is under high stress and has mental health/substance abuse problems of his or her own; environmental and community factors, including poverty, social isolation, and poor neighborhood contexts; and social and cultural factors, including negative beliefs about the rights of children and specific disciplinary practices (Crosson-Tower, 2009).

Intimate Partner Violence/Domestic Violence

The Centers for Disease Control and Prevention (CDC, 2013) define intimate partner violence (IPV) as "actual or threatened physical, sexual, psychological or stalking violence by current or former intimate partners (whether of the same sex or opposite sex)." These various forms of IPV tend to co-occur. Epidemiological studies reveal that up to 12 million individuals are exposed to IPV in any given year (CDC, 2013). Women experience IPV at an alarmingly higher rate than men and suffer significantly greater negative consequences.

The National Violence Against Women Survey (NVAWS) revealed that approximately 20% of the women in the survey (1 in 5 women) reported a lifetime history of physical assault by their current or former partner, compared to only 7% of the men in the survey (Tjaden & Thoennes, 2000). Moreover, women reported a greater likelihood of being raped and stalked by intimate partners in their lifetime than men (4.5% versus 0.2% and 4.1% versus 0.5%, respectively; Tjaden & Thoennes, 2000). The

National Crime Victimization Survey (NCVS; Rennison & Welchans, 2000), revealed similar findings: Women reported victimization by their intimate partner at 5 times the rate of men and were more likely to be injured as a result of their victimization (50% versus 32%). A more recent survey conducted by the CDC, the National Intimate Partner and Sexual Violence Survey (NISVS; Black et al., 2011), underscored the ubiquity of violence in intimate relationships, with 1 in 4 women and 1 in 7 men reporting exposure to severe physical violence.

Although studies show that men and women are equally likely to perpetrate IPV (Ehrensaft, Moffitt, & Caspi, 2004; Finkel & Eckhardt, 2011), the frequency, duration, and consequences of IPV are significantly greater for women than men, with women experiencing more life threats, reporting greater fear of bodily harm and greater physical and psychological consequences—including injuries requiring medical treatment and the need for mental health services—as a result of their exposure to IPV (Breiding, Black, & Ryan, 2008; Rennison & Welchans, 2000). In 2007, IPV-related homicide was the cause of 2,340 deaths, of which women accounted for 64% of the fatalities.

These findings clearly indicate that women experience more negative consequences from IPV than men. It is also likely that these figures grossly underestimate the extent of the problem, as women are less likely to report exposure to IPV for fear that they will not be believed, to avoid the stigma of being a victim of IPV, and out of concern about the well-being of their partner (see Hien & Ruglass 2009, for review). Moreover, since the legal responses to IPV (arrests, prosecutions, orders of protection) are only moderately effective—with protective or restraining orders being routinely violated by 50% of the perpetrators—this leaves women at heightened risk for further victimization (Jordan, 2004).

The risk factors contributing to IPV are multifaceted and likewise include individual, relationship, community, and social factors. Individual-level risk factors may include childhood exposure to violence (witnessing IPV or being physically

abused as a child), low self-esteem, younger age, social isolation, lower educational attainment, and unemployment. Relationship factors may include relationship conflict, low marital satisfaction, dysfunctional interaction patterns, financial problems, and impending separation or divorce. Community-level risk factors may include poverty and living in violent neighborhoods. Social factors may include traditional gender norms related to power and control and beliefs about the acceptability and appropriateness of violence (see Hien & Ruglass, 2009, for a comprehensive review).

When examining racial and ethnic differences in exposure to IPV, a more insidious picture emerges. The prevalence rates of IPV are greater among racial and ethnic minority women than in White women (Field & Caetano, 2005; Rennison & Welchans, 2000; Tjaden & Thoennes, 2000). For instance, Black females had a 35% higher reported rate of IPV than White women between 1993 and 1998 (Rennison & Welchans, 2000) and were more than 2.36 times more likely to report experiencing severe violence (Hampton & Gelles, 1994). Hispanic women reported a greater frequency of rapes and Native American women reported experiencing more physical violence (e.g., Tjaden & Thoennes, 2000) than White females. Finally, rates of IPV-related homicides were higher for Native Americans and Blacks than Whites in 2007 (2.1 and 1.6 per 100,000 population, respectively).

The disproportionately greater rate of exposure to IPV among racial and ethnic minority women is likely related to their overrepresentation among individuals who are of lower socioeconomic status (e.g., being poor, low educational attainment, limited or no access to health insurance and health or mental health services), a consequence of structural inequalities that persist in our society (e.g., Hampton, Oliver, & Magarian, 2003; West, 2004). Being from a lower socioeconomic status places one at a greater risk of experiencing interpersonal violence (Sorenson, Upchurch, & Shen, 1996).

The NCVS found that the typical characteristics of IPV victims between 1993 and 1998 were "being black, young, divorced or separated, earning lower incomes and living in urban areas" (Rennison & Welchans, 2000, p. 3). Consistent with these theories, racial and ethnic differences in IPV exposure either disappear (e.g., Walton-Moss et al., 2005) or decrease substantially when socioeconomic status and substance use are controlled for (Field & Caetano, 2004), suggesting that perceived differences related to race may be more likely due to the effects of additional contextual factors such as poverty, discrimination, or substance abuse history (Bent-Goodley, 2007; Field & Caetano, 2004).

Rape or Sexual Violence

While the definition of rape has evolved over the years and can vary from state to state, it is generally defined as any completed sexual penetration that is nonconsensual and perpetrated with the use of threats, coercion, or physical force, or when the individual involved is not able to provide consent through physical or mental incapacity (Briere & Scott, 2012). For example, if someone is unconscious or impaired physically or psychologically due to alcohol or drugs or has a cognitive limitation, that person is deemed incapable of consenting. The NISVS study estimates that approximately 1 in 5 women (18%) and 1 in 71 men (1%) have experienced adult rape (Black et al., 2011). Moreover, in the 12 months prior to the NISVS survey, 1.3 million women reported experiencing rape or sexual assault.

The CDC (2013) utilizes the term *sexual violence*, a broader term that encompasses completed rape, attempted (but not completed) rape, unwanted sexual contact, and sexual harassment. Exposure to rape or sexual violence is associated with a variety of short-term and long-term psychological and physical consequences, including unintended pregnancies, sexually transmitted infections, depression, and PTSD (Jordan, Campbell, & Follingstad, 2010).

Military Sexual Trauma

Military sexual trauma (MST) has received increased research and clinical attention over the past 2 decades with a rapid upsurge occurring since the recent military conflicts (i.e., Operation Enduring Freedom [OEF] and Operation Iraqi Freedom [OIF]). The U.S. Department of Veterans Affairs (USDVA, 2014) defines MST as unwanted "experiences of sexual assault or repeated, threatening acts of sexual harassment that a Veteran experiences during his/her military service." Prevalence estimates of MST vary depending on the methodology, sample, and definitions utilized. For example, in face-to-face interviews, estimates of MST range from 4% to 71% (Suris & Lind, 2008). Surveys conducted via telephone or mail reveal estimates of MST ranging from 17% to 30% (Suris & Lind, 2008).

As with other types of traumas, women are more likely to be exposed to MST than men. One in 5 women has been exposed to MST, compared to only 1 in 100 men (USDVA, 2014). However, because there are more men in the military than women, the actual numbers of men and women who experienced MST are about equal (Suris & Lind, 2008; USDVA, 2014). As with other types of traumas, these figures may underestimate the true nature of the problem since many veterans may not disclose their MST out of shame, fear of blame, or fear of retaliation—or simply because they were not asked. The USDVA, however, has implemented a national screening policy whereby every service member is asked directly about exposure to MST and offered referrals to free treatment services if indicated.

A recent comprehensive review of screening data for 125,729 returning OEF and OIF veterans who received primary or mental health care found that 15% of women and 0.7% of men reported a history of MST while on active duty (Kimerling et al., 2010). A study by Rowe, Gradus, Pineles, Batten, and Davison (2009) of female veterans who sought outpatient mental health trauma treatment found that approximately 70% of the women reported

experiencing MST. MST is associated with a range of psychological and physical health consequences. The risk factors associated with MST are varied and include younger age, being of enlisted rank, and childhood history of sexual abuse or assault (Suris & Lind, 2008).

Sex Trafficking

The federal Victims of Trafficking and Violence Protection Act of 2000 (VTVPA, 2000) defines sex trafficking as

> the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act where such an act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age.

Sexual trafficking is a significant and growing worldwide problem. Estimates of sex trafficking are variable and change over time. However, recent estimates indicate that approximately 800,000 people are trafficked across international borders for commercial sexual activities annually, 80% of whom are women and girls and 50% of whom are under the age of 18 (Deshpande & Nour, 2013; U.S. State Department, 2013).

Most commonly, individuals are deceived, coerced, or forced into sex trafficking through various means, including the promise of a better life in another country, being sold into the trade by their poor parents, or being kidnapped (Deshpande & Nour, 2013; Hodge, 2008). Once obtained, these individuals are then forced into prostitution or other forms of commercial sexual exploitation such as child pornography or work in strip clubs, massage parlors, or escort services.

Sexual exploitation is often associated with significant deprivation and with physical and psychological abuse. For those entrenched in the trafficking industry, it is very difficult

to escape. Sex trafficking is associated with significant psychological and physical health consequences, including sexually transmitted infections, HIV/AIDS, depression, and PTSD (Deshpande & Nour, 2013; Hodge, 2008). Risk factors associated with sex trafficking are multifaceted and include individual, structural, and economic factors such as poverty, gender bias, living in vulnerable areas, and demand for commercial sex and economic profits (Deshpande & Nour, 2013; Hodge, 2008).

Combat-Related Trauma

Combat trauma refers to direct or indirect exposures to extremely stressful events in a war zone and includes situations such as experiencing serious injuries, witnessing the serious injury or death of a friend, exposure to hostile enemy or friendly fire, and exposure to rocket attacks, bombs, and the grotesque (e.g., seeing and smelling decomposing dead bodies). In combat situations, the threat of danger and death is often constant, placing service members on a constant state of alert. Service members may also have to wound or kill enemy combatants or civilians while on duty and are often witness to brutality toward detainees. Being away from home for extended periods of time adds a further layer of stress.

Recent military actions (OEF and OIF) are unique in that a higher proportion of service members are being deployed for longer and multiple periods of time with limited breaks in between (Tanielian, 2009). Moreover, with the advent of new safety technology, more OEF/OIF service members are surviving their injuries and avoiding death than in the Vietnam and Korean wars. Although a significant proportion of veterans do not develop PTSD, the extent and severity of their psychological distress depends on pre-, peri-, and postdeployment factors such as history of childhood trauma, intensity and duration of combat exposure, and military, family, social, and political support on return home (Richardson, Frueh, & Acierno, 2010).

Civilian War Trauma and Torture

Civilian exposure to armed conflicts, war traumas, and torture is quite common and occurs on a large scale across the world. During the last 60 years, there have been a documented 200 civil conflicts or wars during which serious human rights violations have occurred (Johnson & Thompson, 2008; Kienzler, 2008). Civilians exposed to war are often exposed to multiple cumulative traumas, including torture, defined as any psychological or physical act that intentionally inflicts severe pain or suffering in service of obtaining information, confession, or punishment for a perceived transgression (United Nations General Assembly, 1984).

Steel et al. (2009) conducted a systematic review and meta-analysis of studies related to torture and found that 21% of participants in 84 surveys reported personal experiences of torture. In addition to the direct experiences of war, such as exposure to physical assault, brutal killings, massacres, torture, destruction of personal property, and loss or disappearance of loved ones, populations exposed to war traumas also have to face additional stressors such as displacement to refugee camps, loss of social networks, and exposure to extreme poverty and poor living conditions, all of which compound the already profound psychological and physical effects of war trauma (Miller & Rasmussen, 2010).

In 2012, the United Nations High Commissioner for Refugees estimated that there were 15.4 million forcibly displaced refugees worldwide, 28.8 million internally displaced people, and 893,700 asylum seekers, highlighting the large numbers of people affected by war trauma and possibly in need of mental health services (United Nations Refugee Agency, 2013). Studies indicate that greater exposure to cumulative war traumas, female gender, age (children and the elderly), and refugee status were significant risk factors for the development of subsequent PTSD or other psychiatric distress (Murthy & Lakshminarayana, 2006). In contrast, social support, level of preparedness for torture, and certain belief systems were protective factors in the aftermath of war (Johnson & Thompson, 2008).

Disasters

Disasters are large-scale traumatic events, often called "mass traumas," that are experienced collectively by many groups of people who may suffer from direct or indirect experiences, such as physical harm, loss of a loved one, destruction of personal and community property, depletion of social resources, and identification with those worst affected. The spectrum of consequences associated with disasters is vast and includes personal, communal, and economic aspects. Moreover, the psychological consequences in the aftermath of disasters are variable and depend on a combination of individual characteristics, extent and severity of disaster exposure, and level of postdisaster social resources (Arnberg, Johannesson, & Michel, 2013; Neria, Nandi, & Galea, 2008; Norris, 2006). Since disasters are unpredictable in their occurrence, it is often difficult for researchers to quickly enter the field to assess the immediate consequences and longitudinal course of recovery (Neria et al., 2008; Norris, 2006).

Disasters are often categorized in several ways: (1) *man-made disasters*, such as the September 11, 2001, terrorist attacks on New York City and Washington, DC, or the 1995 Oklahoma City bombing, (2) *technological disasters*, such as the 1989 Exxon Valdez oil spill in Alaska or the 2001 Chernobyl nuclear power plant accident in Ukraine, and (3) *natural disasters*, such as the 2004 tsunami in Asia and the 2005 Hurricane Katrina in the United States. Disasters are further classified in terms of scale, from those that affect hundreds of people to those that might affect an entire nation, and in terms of outcome (i.e., the psychological and physical effect on those directly and indirectly affected; Neria et al., 2008).

Neria et al. (2008) conducted a systematic review of posttraumatic stress subsequent to disasters and found that among those who experienced man-made disasters, PTSD was most prevalent among survivors (those directly exposed to the event) and first responders or rescue workers. Technological disasters also had a high rate of PTSD prevalence among survivors and

rescue workers (15%–75%). Exposure to natural disasters led to lower rates of PTSD prevalence compared to man-made and technological disasters (Neria et al., 2008). Neria and colleagues point out, however, that studies of natural disasters tend to combine those directly and indirectly affected, which may dilute the average level of severity of exposure to the disaster and resultant PTSD.

Longitudinal studies—research in which people are studied at regular intervals over the course of many years—on man-made and technological disasters indicate a general decline in PTSD prevalence over time (Neria et al., 2008). However, as noted by Arnberg et al. (2013), longitudinal studies often do not cover enough years to provide reliable estimates of the course of PTSD. Another difficulty associated with obtaining proper estimates of the psychological distress experienced in the aftermath of disaster is determining who exactly are the disaster victims. As expected, studies show that those most directly affected had the highest rates of psychiatric distress and the general population the least. But what about those who may have been traumatized by the media coverage of a disaster? Because of the scope of disasters, especially natural disasters, it can be difficult to assess all those affected. Also, cross-cultural differences in disaster readiness, wealth distribution, and what theorists call "collateral stressors," or secondary stressors, all contribute to the negative consequences that disasters may leave behind (Arnberg et al., 2013).

Serious Accidents

Motor vehicle accidents (MVAs) are one of the most common causes of traumatic stress. In 2011, close to 1.5 million individuals were injured in MVAs (National Highway Traffic Safety Administration, 2013). Males are more likely to report exposure to MVAs than women (35% versus 15%, respectively; Buckley, 2013). Often these accidents lead to significant chronic pain, disability, or even death. Significant predictors of psychological

distress post-MVA include the amount of physical injury experienced, rate of recovery from the accident, and level of social support (Buckley, 2013).

Life-Threatening Medical Illness

Being diagnosed with a life-threatening medical illness such as breast cancer or lung cancer or learning that a family member has a life-threatening illness can also be another source of traumatic stress. A recent study found that 23% of 1,139 women who were newly diagnosed with breast cancer reported symptoms of PTSD (Vin-Raviv et al., 2013). Black and Asian women were more likely to develop PTSD symptoms in response to their cancer diagnosis than White females. The experience of receiving the diagnosis, obtaining treatment for one's illness, worrying about side effects of the treatments, and fearing recurrence of the illness may all contribute to the development of significant psychological distress.

OUR GOALS FOR THIS BOOK

The preceding review shows the wide range of events that can cause psychological trauma. But there is much more to know about this field. Research on trauma over the past 3 decades has been rich and varied. Our goal in this book is to provide an overview of these findings. For example, there is a strong evidence base that describes the effects of trauma on both physical and mental well-being. Researchers have also identified the types of treatment that are the most likely to be effective. We now understand much of the mechanism by which trauma can affect mental and physical health, as well as how clinicians can help their clients avoid these problems. Researchers have found that family members of people with PTSD also suffer, and organizations

such as the National Center for PTSD offer specific suggestions to help families cope. And we now know that trauma survivors can also experience posttraumatic growth. These are perhaps the most hopeful findings in this field.

We hope that you find this topic as interesting as we do. There is always room for more workers in this field, or for more people who are trauma-aware. It's an exciting time to be in this field.

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