

The History of Trauma

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Introduction:

Trauma, danger, crisis, and fear appear to be prevalent in today's unsettled environment. An individual does not have to go further than the television in the living room to see images of death, destruction, and mayhem. The media has presented trauma as the "top story" and "headline news" to the point where they must vie for the most shocking story for the higher ratings. In the 1990's, the public had been witness to numerous occurrences of psychological trauma and people in crisis. Events included, but were not limited to, the advent of road rage, school violence and mass execution of students, corporate violence, airline tragedies, government unrest, and the impeachment of a president. These images take not only a toll on an individual's view of society; they take a toll on the individual's sense of well-being. Prolonged exposure to violence and trauma has severe effects on an individual's psychological state. The need for a model of intervention is paramount to help the individual cope with life's tragedies. We must first define the nature of trauma and crisis, and then view the current models of treatment.

Crisis, according to Gilliland and James (1993), refers to a perception of an event or situation as an intolerable difficulty that exceeds the resources and coping skills of a person. The event or situation can manifest itself in many forms, but it is the emotional reaction to the event or situation that causes the state of crisis. This crisis can be too overwhelming for the individual and

may cause the individual to respond in a pathological manner. The state of crisis may cause a person to respond with ideations of suicide and homicide. The crisis itself has the potential to cause serious damage to an individual's cognitive, affective, and behavioral states.

Individuals in crisis have suffered from a psychological trauma. Psychological trauma is an affliction of the powerless (Herman, 1992, p.33). Trauma renders a person helpless and powerless due to the overwhelming force of the event. The traumatic event causing the crisis alters the individual's belief of a just and fair world. The event or situation destroys the individual's sense of control, connection, and meaning (Herman, 1992, p.33). The individual's mind responds to this trauma similar to the body responding to distress. The mind will attempt to reach a state of homeostasis. The psychological trauma represents a condition of acute distress causing a disturbance in the balanced state, thus creating psychological disequilibrium (Everly & Mitchell, 1999, p.2). This psychological disequilibrium is a result of the individual's usual coping skills failing to respond to the psychological trauma. As a result of this response, the individual will suffer from acute distress paired with functional impairment.

The degree of distress and functional impairment can fluctuate from mild to severe. Without some form of relief from the crisis, the individual may become increasingly more disturbed and their behavior may become more disruptive to normal functioning. Acute intervention is then needed to help the individual achieve adaptive functioning to the trauma and crisis. The goals of this crisis intervention, according to Everly and Mitchell (1997), should include: 1) stabilization of the symptoms of acute distress, 2) restoration of a "steady state" of psychological functioning, and 3) assist in the return to an adaptive level of functioning. The intervention should only deal with the current incident of trauma causing crisis and not past maladaptive functioning.

It is clear psychological trauma will alter an individual's mental status. Crisis intervention is used to provide "first aid" for this altered mental status that will help reduce the individual's distress and promote adaptive behavior. There are many theories surrounding psychological trauma that attempt to provide the much-needed "first aid" for the individual in crisis.

Literature Review:

The study of psychological trauma has its roots in the later part of the nineteenth century with the work of the French neurologist Jean Martin-Charcot. Charcot was the first person to attempt to study and define a disease known as "hysteria". Before Charcot's research, hysteria had been considered a disease with incoherent and incomprehensible symptoms (Herman, 1992, p. 10). Charcot was able to document, in great detail, the development and characteristics of the disease. Charcot was able to demonstrate the disease was psychological in nature. He demonstrated his theory by artificially producing the disease's symptoms in patients by using hypnosis. Charcot was unable to produce the nature of the disease and did not offer a reasonable intervention for treatment. It was the goal of his students, including Sigmund Freud, William James, and Pierre Janet, to research the nature and possible cure for hysteria.

Both Janet and Freud deduced the symptoms of hysteria were the result of psychological trauma. They believed the symptoms were the result of an altered state of consciousness produced by the unbearable emotional reactions to the traumatic events. Janet called the reaction "dissociation" and Freud called it "double consciousness" (Herman, 1992, p. 12). Janet and Freud discovered symptoms could be alleviated if the patient was able to verbalize the traumatic event stored in unconscious memory. Janet would call this treatment "psychological analysis" and Freud would eventually call it "psychoanalysis". The work by Janet, Freud and, Freud's counterpart Joseph

Brueur gave birth to modern psychotherapy. This method of treatment would allow a person to discuss the hysteria in a manner that would be conducive to the alleviation of the symptoms.

Psychoanalytic theory dominated the research into trauma for the later part of the nineteenth century and the early twentieth century. Psychoanalysis became “a study of the internal vicissitudes of fantasy and desire, dissociated from the reality of experience” (Herman, 1992, p 14.). Freud based most of his research on the exploration of women’s sexual lives. Freud found a correlation between sexually abuse women and hysterical behavior. Freud later recanted his study of hysterics in women reporting the women were not sexually abused. He reported the patients “made up” the fantasies of sexual abuse. This recantation was the turning point away from the study of hysteria and trauma as associated with the unconscious.

After the death of Charcot and the recantation of Freud’s work, the study of psychological trauma resurfaced during World War I. Charles Myers, a British psychologist, was one of the first to examine soldiers who suffered from what he termed “shell shock” (Herman, 1992, p. 20). This nervous disorder was thought to be the result of the concussive effects of exploding shells. It was later discovered that soldiers, who did not see combat, would suffer the same nervous condition, as did the soldiers in combat. The prolonged exposure to war and the aftermath produced hysterical symptoms in men similar to the symptoms reported in women by Charcot and Freud. The diagnosis of combat neurosis was not viewed as being “honorable”.

Traditionalists questioned the moral integrity of the soldier and questioned whether to treat a soldier with this disorder. Traditionalists viewed the soldier afflicted with combat neurosis as a coward and an inferior human being (Herman, 1992, p. 22). Lewis Yealland, a British Psychiatrist, held on to the beliefs of the Traditionalists. Yealland used a method, which included

threats, punishment, and shame. If a soldier presented with mutism due to the effects of the psychological trauma, Yealland would apply electric shocks to the soldier's throat until the soldier spoke. Yealland would apply the shocks after tying the soldier to a chair while yelling patriotic jargon for hours.

The Traditionalist view continued its form of treatment until W.H.R Rivers, a physician, offered a more humane treatment based on psychoanalytic principles. His work with a young officer, Siegfried Sassoon, demonstrated the humane approach to treatment could help the soldier return combat without the hysterical symptoms. Rivers' approach proved to be a success, but a few years after World War I, the interest in combat neurosis faded.

Abram Kardiner, an American psychiatrist schooled in Vienna, began his research of combat neurosis in the 1920's. Kardiner first attempted to develop a theory from the Psychoanalytic point of view on combat neurosis. He eventually abandoned the theory and replaced it with a framework based on the research of Janet. In 1941, Kardiner published his second book, *The Traumatic Neuroses of War*, which eventually gave way to his development of the modern framework of traumatic syndromes.

During World War II, Kardiner joined another American Psychiatrist, Herbert Spiegel, to revise his text and begin treatment based on the work of Rivers. Kardiner and Spiegel found soldiers to be suffering from the loss of attachment to their fighting unit. The treatment would then have to be relatively close to the battlefield and include recreation of the traumatic event through hypnosis. This form of treatment proved effective, but Kardiner and Spiegel warned military psychiatrists the effects of treatment would not be permanent due to the lasting effects of trauma.

on the mind. This treatment style stayed in practice until the end of World War I when, once again, the study of trauma would fade.

The Vietnam War would be the next reappearance in the interest of combat neurosis by two American psychiatrists, Robert Lifton and Chaim Shatan. Lifton and Shatan developed “rap groups” for combat veterans suffering from the psychological trauma of war and antiwar sentiment. These “rap groups” offered the soldier a place to discuss their experiences and raise awareness about the effects of war (Herman, 1992, p. 27). By the 1970’s, the “rap groups” spread across the nation forcing the Veterans Administration to begin research into the effects of combat exposure to soldiers. It was also during this time, the feminist movement began to raise awareness about the everyday violence in the sexual and domestic lives of women. Women suffered the same effects of combat neurosis in their civilian lives. The effects of rape, sexual abuse, and sexual violence were more prevalent in women than the trauma of war on men. Freud touched on this sexual issue before his recantation several decades prior to the feminist movement.

In 1980, the American Psychiatric Association developed the category of posttraumatic stress disorders. This category was based on the work of Kardiner. It included the traumatic symptoms suffered by all effected by trauma. This category of disorders gave rise to the challenge of treating such disorders. The theories of crisis and crisis intervention began to take form amidst the newly found appreciation for traumatic stress.

There is no single theory or school of thought that encompasses every model on crisis or crisis intervention (Gilliand & James, 1993, p. 16). During the early 1980’s, three crisis theories emerged: 1) basic crisis theory, 2) expanded crisis theory, and 3) applied crisis theory. The basic

theory focuses on helping people in crisis to recognize and change cognitive, behavioral, and emotional distortions that are brought on temporarily by the traumatic event. The resolution of these temporary maladaptive states may lead to positive self-growth and diminished negative feelings. The expanded theory draws on the psychoanalytic, systems, adaptational, and interpersonal theories. This theory holds that anyone can fall victim to transient psychological symptoms if the right combination of developmental, psychological, sociological, environmental, and situational determinants exist. The applied theory is a more flexible approach which views each individual reacts differently in any given crisis. This theory supports three types of crisis: 1) normal developmental crisis, 2) situational crisis, and existential crisis.

The three crisis theories opened the door for crisis intervention. All crisis intervention models are based on theory (Gilliand & James, 1997, p. 21). Three basic crisis intervention models were developed. The models are the equilibrium model, the cognitive model, and the psychosocial transition model. The equilibrium model helps an individual achieve a state of precrisis equilibrium. The equilibrium is used as a result of a person falling into a state of disequilibrium following a crisis. The model would help the individual regain a sense of control over the malfunctioning coping skills. The cognitive model's basic premise is that people can gain control of the crisis by changing their thinking (Gilliand & James, 1997, p. 22). This premise is best described by viewing the state of crisis as faulty thinking about the events unfolding around the crisis. The psychosocial transition model is similar to the cognitive model. This model holds that the individual must gain control of their internal and external difficulties surrounding the crisis. The individual would need to incorporate coping skills and social supports with adequate resources to find a noncrisis state.

The aforementioned theories and models were the product of the research done in the late 1970's and throughout the 1980's. After nearly 100 years of research, the value of crisis intervention after a psychological trauma appeared to be on the rise. This new research began to uncover many other facets of psychological trauma. Child sexual abuse was now viewed in the same category as posttraumatic stress disorder. In 1998, Christine Courtuois, a clinical psychologist, authored *Healing the Incest Wound*, which was one of the first texts to describe treatment for adult survivors of sexual abuse (Chu, 1998, p. 11). Sexually abused children and adult survivors displayed the same maladaptive functioning as female rape survivors and male combat veterans.

Discussion:

The trend continued by research being done on the effects of trauma with civilian paraprofessionals such as police officers, emergency medical technicians, paramedics, and firefighters. A new model of crisis intervention began to take shape with the research of a former paramedic and a clinical psychologist. Jeffery Mitchell and George Everly developed a model of crisis intervention designed specifically to aid in "the prevention of acute, disabling psychological discord and the rapid restoration of adaptive functioning in the wake of a critical (crisis) incident" (Everly & Mitchell, 1999, p. 12). This model, first used with the paraprofessionals, helped the individual cope with the crisis and allowed the individual to return to normal duty. This is the same premise of treatment used by Kardiner and Spiegel during World War II. Everly and Mitchell (1999) defined Critical Incident Stress Management as an integrated and comprehensive multicomponent programmatic approach to the prevention and mitigation of crisis states and subsequent critical incident stress. Mitchell later developed a technique called Critical Incident Stress Debriefing (CISD). CISD is a direct, action oriented

crisis intervention technique designed to prevent traumatic stress following a traumatic event (Everly & Mitchell, 1988, p. 8).

As Critical Incident Stress Management (CISM) was defined and refined, the International Critical Incident Stress Foundation (ICISF) was formed in 1989. This was the first and largest standardized crisis response organization in the world. The ICISF was devoted to preventative mental health care for people in crisis. In 1992, The American Red Cross became the first agency to formalize training for disaster relief using a multicomponent mental health network. The American Red Cross was designated as the first response team in lieu of an airline disaster. The ICISF's primary focus was on the reaction to psychological trauma by the paraprofessional whereas the American Red Cross' focus was on civilians.

During major disasters in the 1990's, the services of the American Red Cross and the ICISF were used extensively. The two organizations were vital in the healing process after the bombing of the federal building on Oklahoma City in 1995 and the TWA 800 mass air disaster in 1996. In 1994, The American Psychiatric Association published the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). This edition now recognized Acute Stress Disorder that emphasized the impairments found in Post Traumatic Stress Disorder. By 1995, research into Acute Stress Disorder and Post Traumatic Stress Disorder was at an all time high. OSHA, the Gore Commission, the US Air Force, and the US Coast Guard began to implement crisis intervention models and techniques nationwide. The need for appropriate models of crisis intervention for trauma survivors appeared to be at its peak.

In 1997, Francine Shapiro, a clinical psychologist, developed a form of therapy for overcoming anxiety, stress and trauma. This therapy departed from the current models and trends as it was

billed as a “cure for trauma”. Shapiro’s therapy was called Eye Movement Desensitization and Reprocessing (EMDR). This form of therapy worked with rapid eye movements to diminish anxiety consistently over time (Shapiro, 1997, p. 10). Shapiro incorporated techniques from many schools of psychotherapy including psychodynamic, cognitive, systems, and body oriented. Shapiro would move her finger in front of a traumatized individual encouraging the individual to follow the finger with the eyes-only. During this process, Shapiro would have the individual recount the traumatic event and would begin to process the nature, emotions, and behavior around the traumatic event. Shapiro reported tremendous success with this technique, but was unable to offer any clinical data supporting her findings. Clinicians trained by Shapiro and her staff only sanctioned Shapiro’s technique.

Conclusion:

Currently, many other forms of trauma therapy, such as Thought Field Therapy, are being developed and used throughout the country. Research into psychological trauma and the effects of the trauma have increased steadily. The tremendous advancements in crisis intervention have only surfaced in the past three decades, but is that only due to the amount of trauma found in the world. Initially, trauma was only researched because of war and tragedy. If there is not a push for steady research or the amount of violence in our society decreases to an acceptable level by the government, will trauma research fade away as it did in the past? The simple truth is trauma, in all forms, is a part to the human experience. All humans will suffer through some form of trauma in their lives. Crisis intervention techniques offer hope for victims for a solid and mentally healthy future.

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