55

Key Information about Trauma and Traumatic Reactions* **

[Adapted from *Loving Someone With PTSD*, by A. Matsakis, Oakland, CA: New Harbinger Publications, 2013. Updated, 2019.]

*The sources for this article include the *DSM-5, Diagnostic and Statistical Manual of Mental Disorders* (2013) Washington, DC: American Psychiatric Association and the articles and books listed in reference sections of *Trust After Trauma (2009)* and *Loving Someone with PTSD* (2013) by A. Matsakis, Oakland, CA: New Harbinger Publications.

** For the most current official definition of trauma or any other term used in this article, consult the most recent edition of the *DSM*.

1. What is Trauma?

The word trauma comes from a Greek word, trauma, used by ancient Greek physicians to distinguish physical injuries needing immediate or intensive treatment from those requiring little or no outside help. For example, if you fall on a flat cement surface and scrape your knee, as long as no glass or sharp objects were involved, eventually your bleeding will stop. Then, without the help of a doctor, a scab will grow over your injury, followed by new skin.

Hence your scraped knee would not be considered a traumatic injury. But if your fall resulted in a broken leg, substantial treatment would be needed. Hence, medically, your injury would be considered traumatic.

Applying this physical model of traumatic injury to psychological trauma is not as simple. Indeed, the definition of trauma has been, and continues to be, the subject of heated debate among mental health professionals and researchers.

From ancient times, physicians, poets, and others wrote about various mental disorders, including the effects of war, torture, earthquakes, and other catastrophes on the human psyche. But it wasn't until Sigmund Freud (in the late 1800s), that the mental health field as we know it began. Freud is called the "Father of Modern Psychiatry" because prior to Freud, psychiatrists and psychologists did not exist.

Freud himself didn't start out as a psychiatrist, but as a neurologist. But his work with patients in so-called insane asylums led him to explore the workings of the human psyche. And it was from Freud's work, along with the work of some of his fellow neurologists, that the field of psychiatry was born. Over time, this led to the fields of psychology, social work, and other mental health professions.

Freud wrote about birth trauma: the shock and fear infants experience upon leaving the security of the womb and entering a world where they were helpless to protect and sustain themselves. Freud also spoke about the psychological trauma of childhood physical and sexual abuse. Later on his career, however, he recanted his position and stated that his patients' memories of childhood abuse were fantasies.

Most of Freud's contemporaries followed suit. But some of them insisted that their clients' memories of abuse were real, not figments of their imaginations.

The outbreak of World War I brought forth a similar debate regarding the nightmares, tremors, and other symptoms of what was then referred to as "shell shock," "war neurosis," or "combat fatigue," and later referred to as war-related PTSD (post-traumatic stress disorder). Some psychiatrists and physicians viewed the soldiers' symptoms as arising from the horrors of war. Other professionals, however, viewed these symptoms as signs of cowardice, personal weakness, or moral failure. In fact, some English and French soldiers who displayed PTSD symptoms were put on trial for treason and subsequently executed.

During World War 2, the same debate regarding the traumatic reactions of combat troops continued to rage. Were the soldiers' symptoms legitimate reactions to war, or were they signs of a personal weakness or a preexisting mental disorder? Or were these soldiers simply faking these symptoms in order to evade further combat duty?

On the home front, the so-called "nervous disorders" and other symptoms suffered by survivors of train wrecks, shipping disasters, and other severe accidents were viewed by some as stemming directly from the accident. Other professionals, however, viewed these survivors as malingerers who were inventing or exaggerating their symptoms in hopes of receiving financial compensation.

Contributing to the heated nature of this debate was that, at the time, there were no standardized definitions for depression, paranoia, or any other mental health problem. This lack of clarity led to confusion not only in the medical and mental health community, but in the military, the courts, medical insurance companies, etc. Hence, in 1952 the American Psychiatric Association published the first *DSM* (*Diagnostic and Statistical Manual of Mental Disorders*), which listed and defined all mental health problems considered to be valid.

Since 1952, the *DSM* has been revised multiple times, leading to the *DSM-2*, the *DSM-3*, *DSM-4*, etc. Nevertheless, today (2019), as in the past, if a particular mental health problem or diagnosis isn't listed in the most current *DSM* , then it's considered invalid and won't be taken seriously by the courts, the military, insurance companies, or most health professionals.

One problem in trying to diagnose someone is that the same symptom can be part of more than one diagnosis. For example, a pervasive sense of hopeless can be a sign of clinical depression, as well as of PTSD and any number of other diagnoses. Thus, in addition to providing a list of officially recognized diagnoses, the *DSM* also describes the specific kind and number of symptoms required for each diagnosis. For example, in order to be diagnosed as suffering from some type of clinical depression, it isn't enough to report "feeling blue." You must also have a certain number and kind of other symptoms.

With each new publication of the *DSM*, existing diagnoses were refined; new diagnoses were added; and some diagnoses were eliminated. Until 1980, however, there was no diagnosis regarding trauma. Basically all mental illnesses were assumed to reflect a person's internal difficulties: i.e., mental health problems were believed to originate from within.

The sole exception was the diagnosis of adjustment disorder. If an individual developed symptoms after having experienced a highly distressing or traumatic event, they were given the diagnosis of adjustment disorder. But this diagnosis was only good for three months. If the symptoms lasted any longer, the person was diagnosed as having some other mental illness unrelated to the trauma.

In 1980, however, for the first time in history, the mental health profession officially recognized that long-term mental health problems can originate from traumatic events outside the individual. Hence, the diagnosis of post-traumatic stress disorder (PTSD) appeared in the 1980 version of the *DSM* (the *DSM-3).*

With each subsequent revision of the DSM, the definition of trauma has changed. According the 2013 *DSM-5* (the most current *DSM* as of the writing of this article), trauma is defined as

(a) directly experiencing or witnessing (in person) a life-threatening situation or a situation involving actual or threatened bodily harm or sexual violence;

(b) learning that a close relative or friend was involved in a life-threatening event or was harmed or died as the result of violence (e.g., suicide or homicide) or as the result of a serious or extreme unexpected accident; or

(c) being repeatedly exposed to the horrific and graphic details of a traumatic event (e.g., child abuse or war)—not through movies or other electronic media—but as part of one's profession (e.g., as a fireman, trauma therapist, or child abuse investigator).

Hence, according to the most current definition of trauma, the expected or natural death of an elderly loved one, the death of a pet, an unwanted miscarriage, a painful divorce, and other highly distressing events are not considered traumas unless they involve sexual or physical violence or a serious or extreme unexpected accident. Note, however, that any number of mental health professionals disagree with the official definition of trauma and argue that any number of other situations should qualify as traumas.

As noted previously, the word trauma was originally used by ancient Greek physicians to refer to bodily injuries so severe that they could not heal by themselves. In this sense, perhaps psychological trauma can be viewed as a life-threatening or highly dangerous situation that so shatters your faith in yourself, your sense of safety, and your understanding of the world that more than the mere passage of time will be required to absorb the event.

By absorbing the event, I mean (a) coming to understand enough of what happened and why so that you can put your role in the event in proper context and (b) being able to manage some of the inevitable physiological, emotional, and mental consequences of the event so that you can function well enough to love, work, and play.

2. Trauma and Threat

Trauma involves threats to life, physical health, and /or sexual integrity. In addition, trauma can give rise to other kinds of threats such as those listed below.

1. **Self-ideal threat:** During or after your trauma, you might find yourself acting, thinking, or feeling in ways that contradict your image of your ideal self and/or feeling dirty, contaminated, damaged, or otherwise spiritually, emotionally, or physically defiled.
2. **World view threat**: Trauma challenges the "just world" hypothesis which asserts that:
   "You get what you deserve, and you deserve what you get."
   "The world is basically safe, orderly, and fair."
   "If you are careful, competent, and good, you can avoid harm to yourself and your loved ones."
3. **Impulse threat**: Trauma can give rise to strong feelings of anger, revenge, self-hate, and self-doubt. Such feelings can disrupt your former view of yourself as being an emotionally-controlled, loving, peaceful, kind, and well-adjusted person.
4. **Loss of positive self-image**: The sense of powerlessness involved in being traumatized can damage your self-esteem, as can the stigma of being given a mental illness label or of being viewed as a victim in a culture of "winners" and "overcomers."

3. Range of Possible Traumatic Reactions

Not everyone who is traumatized automatically develops PTSD. Instead, trauma survivors can develop a wide range of other disorders. Hence it's important to distinguish the term PTSD (post-traumatic stress disorder) from the term post-traumatic reaction.

Although PTSD is a traumatic reaction, PTSD refers to having **a** certain number of various classes of symptoms. In contrast, the term post-traumatic reaction is more general and refers to a wide range of symptoms including, but not limited to, clinical depression and dissociation.

Depressive and/or dissociative symptoms, however, can also be a part of PTSD. Yet there is one aspect of PTSD that distinguishes it from other traumatic reactions. This is the phenomenon of involuntarily re-experiencing the trauma in the form of intrusive thoughts, flashbacks, nightmares, or acting or feeling as if the original trauma was happening in the present.

The following pages provide a brief overview of some of the most common reactions to trauma, including PTSD, clinical depression, dissociation, and other possible aftereffects.

Keep in mind, however, that the research on the biological and psychological impact of trauma is still in its infancy and that all statements made in this article regarding the aftereffects of trauma may well be out-of-date in a few years.

4. PTSD (Post-traumatic Stress Disorder)

Common symptoms of PTSD include flashbacks, intrusive thoughts, nightmares, night terrors, insomnia, emotional numbing, negativity, the startle response (jumpiness), hypervigilance (constantly on the lookout for danger), feelings of impending doom, fear of mental instability, mood swings, and avoidance of thinking or talking about the trauma or of people, places, and things reminiscent of the trauma.

Since PTSD first appeared in the 1980 *DSM* -3, the definition of PTSD has been expanded to include reckless behavior, chronic guilt and shame, and various forms of dissociation. Yet two important symptoms have persisted: hyperarousal and emotional numbing.

As has been repeatedly established, life-threat can trigger the release of biochemicals that can lead to fight, flight, and freeze responses. In this sense, both the fight or flight response (hyperarousal) and the freeze response (numbing) are involuntary physiological responses to danger.

These two physiological reactions to trauma, and remembering trauma, seem to encompass two seemingly diametrically opposed extremes: overreacting (hyperarousal) and underreacting (numbing). Although on the surface these two reactions seem like opposites, they are interrelated. Prolonged hyperarousal can lead to numbing, and some trauma survivors suffer from both hyperarousal and numbing symptoms within a short period of time.

(Note: Although hyperarousal and numbing may be labeled differently or subsumed under some other category of symptoms, they are included in the most current definition of PTSD, as well as in other officially recognized traumatic reactions. Furthermore, the *DSM* -5 provides separate categories for post-traumatic reactions in children.)

5. Hyperarousal

Hyperarousal, currently described as having significant physiological reactions to a reminder of the trauma, can result in symptoms such as, self-destructive or reckless behavior, irritability, anger, aggressive behavior, hypervigilance (being "on guard"), the startle response, and sleep and concentration problems.

Other possible consequences of hyperarousal (not specified in the *DSM*, but noted by many trauma researchers and therapists) include:

Increased heart rate, blood pressure, skin conductance, and other physiological stress responses in response to unexpected sounds, smells, sights, touches or emotionally charged situations.

Agitated movements, tremors, gastric distress, urinary incontinence

Immediate response to situations

Memory problems

Selective attention to possible threats in one's surroundings

Difficulties problem-solving due to high levels of anxiety, anger, and arousal

Feeling "crazy," "brain damaged" or otherwise ashamed of one's difficulties remembering, thinking, and problem-solving and/or one's high levels of anxiety and anger

Difficulties calming one's self, which can lead to substance abuse and eating disorders

Increased sense of vulnerability due to emotional reactivity and mental impairment

6. Hyperarousal and the Alarm State

Hyperarousal is closely related to what is frequently referred to as the alarm state, which is conceptualized as follows:

1. The brain develops in a use-dependent fashion in both childhood and adulthood.
2. All parts of the brain are capable of changing in relation to external teaching and stress.
3. Two kinds of experience can alter the brain: extreme deprivation and prolonged alarm.
4. If someone is in the alarm state for a prolonged period of time or if the alarm is intense enough, the brain can remain in a state of alarm; i.e. like practicing the piano, being alarmed can become automatic.

5. Trauma can also elevate a person's baseline heart rate and blood pressure. Consequently, a severely or repeatedly traumatized person is more likely to be hyperreactive to life changes and, as a result, less able to cope with subsequent stress.
6. At baseline (rest), a person who has been repeatedly or severely traumatized is usually not as calm and is more hypervigilant than others (unless s/he is in ***"a"*** **or** ***"the"*** numbing state).
7. When they perceive a threat or are confronted with some other severe or unexpected major stressor, most people can move rapidly from being calm into a state of alarm.

The severely traumatized person, however, generally starts out at a higher level of arousal. Therefore, even slight annoyances or mild threats or frustrations can move them very rapidly along the following continuum from mildly annoyed to livid or from slightly anxious to panic.
8. When anxiety level and heart rate, blood pressure, etc., escalate to a certain critical threshold (which may vary from one person and situation to the next), it's not uncommon for individuals to begin dissociating or go numb in some fashion.
9. During the alarm state, some individuals' mental abilities are sharpened. However, they may have tunnel vision (i.e., be focused on only one or a few aspects of the situation) and therefore, be unable to take in the situation as a whole. For others, cognitive functions are impaired.
10. The awareness that one can't remember, concentrate, think, or otherwise mentally function at an optimal or previous level can create more alarm.

Thus begins a vicious cycle of ever increasing flow of adrenaline, heart rate, blood pressure, etc., which further diminish cognitive abilities and/or the ability to respond appropriately, which, in turn, creates more panic, and so forth.

7. Numbing

Emotional numbing (commonly referred to as "going numb" or "tuning out") is worded in the *DSM-5* as the inability to experience positive emotions (such as love, tenderness, satisfaction, or happiness) and viewed as one of the negative changes in thinking and mood related to trauma. Common consequences of numbing include:

Blunting of emotional and physical responsiveness to pain, pleasure and other sensory input

Difficulties discriminating pain from pleasure

Vulnerability to re-victimization

Poor memory

Increased need for stimulation and stimulants to feel alive

Self-mutilation and substance abuse

Retreat from life

At extreme levels, numbing can lead to feelings of panic

8. Consequences Common to Both Hyperarousal and Numbing

Concentration problems

Memory problems

Emotions are no longer good guides or signals.

Difficulty evaluating situations as to potential danger

Difficulties learning from past mistakes

Fear that new people/situations may cause further arousal/numbing or internal disorganization

Retreat from others: Too much effort required to control arousal or numbing

9. Dissociation

Dissociation refers to involuntary changes in memory, identity, and consciousness that are not due to substance abuse, concussion, epilepsy, or brain injury. These changes can be partial or total and can vary over time or by situation.

Dissociative disorders such as, dissociative identity disorder (multiple personality disorder), dissociative amnesia, and depersonalization/derealization disorder are frequently found among survivors of childhood trauma. Common symptoms of a dissociative disorder include:

Feelings of detachment from one's body, emotion, or mind

Derealization or feelings of unreality

Depersonalization or not feeling like a person, but like a machine/robot

Partial or total amnesia/variable memory (sometimes remembering, sometimes not)

Sleepwalking

Trance states or "spacing out"

Out-of-body experiences

Sudden unexpected travel away from home with no memory of one's identity

10. Clinical Depression

There are several kinds of clinical depression. Each kind is associated with a specific type and number of symptoms. In general, however, when five or more of the following symptoms persist for least two weeks and are not the effects of a substance, a general medical condition, or bereavement, they may signify some form of clinical depression in adults:

1. Depressed mood, feelings of sadness and emptiness
2. Markedly diminished interest in all or almost all activities most of the day, nearly every day
3. Significant weight loss (or gain)
4. Insomnia or hypersomnia
5. Psychomotor agitation (or retardation) nearly every day
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness and/or exaggerated feelings of guilt nearly every day
8. A pervasive sense of hopelessness
9. Social withdrawal
10. Inability to experience pleasure
11. Bouts of uncontrollable crying/sobbing
12. Thoughts of death
13. Suicidal thoughts
14. Diminished ability to think or concentrate
15. Indecisiveness nearly every day

11. Other Potential Traumatic Reactions

Although not listed in the *DSM*, trauma researchers and therapists have noted the following as other possible traumatic reactions:

Somatization: In somatization, the body expresses the pain, anger and other trauma-related feelings in the form of physical pain or impairment. Somatization tends to occur more

commonly in situations where the open expression of feelings is dangerous, may be punished, or may be cause for social ostracism or rejection.

Somatization does not mean that the pain is imaginary or "in one's head." The pain is true bodily pain. But the pain or illness is expressing feelings and memories that cannot be easily or sufficiently put into words because, if expressed, they will put the individual in jeopardy of psychological disorganization; of familial or social disapproval or scorn, of social or economic difficulties; or of life threat.

Precipitant of Latent Psychiatric Disorders: Trauma can bring to the surface latent psychological problems including obsessive-compulsive disorder, bipolar disorders, and schizophrenia.

Physical Illness: Many physical illnesses are known to be stress-related, e.g., asthma and bronchitis); certain allergies, heart conditions, and skin problems; and urinary or bladder infections. The degree to which stress contributes to these problems is not clear.

Recent studies, however, have found that persons who have traumatic reactions suffer from more reported medical problems than persons who have never been traumatized. According to one theory, trauma and/or unrelenting stress can wear out or otherwise damage the immune system, leaving one more vulnerable to illness.