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Trauma Through the Life Cycle: A Review of Current Literature

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Abstract This paper provides an overview of common traumatic events and responses, with a specific focus on the life cycle. It identifies selected "large T" and "micro" traumas encountered during childhood, adulthood and late life, and the concept of resilience. It also identifies the differences in traumatic events and reactions experienced by men compared to women, those related to the experience of immigration, and cross generational transmission of trauma. Descriptions of empirically-supported treatment approaches of traumatized individuals at the different stages of the life cycle are offered.

Keywords PTSD · Large-T and micro-traumas · Neurobiology · Gender differences · Immigrants · Treatment approaches

The past is never dead. It's not even past.
William Faulkner

The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma.
Judith Lewis Herman

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Introduction

As recognized by William Faulkner and Judith Herman, as well as by many other writers and mental health professionals, trauma can take a tremendous psychological toll that may not disappear even with the passage of time. The term "trauma" comes from the Greek language meaning a "wound" or "hurt" (Oxford Dictionaries, 2013). Psychologically, "trauma" refers to an experience that is emotionally painful, distressful, or shocking, and one that often has long-term negative mental and physical (including neurological) consequence. An event is thought to produce a traumatic response when the stress resulting from that event overwhelms the individual's psychological ability to cope (McGinley and Varchevker 2013).

Although we often think of trauma as being synonymous with the identified *objective* cause of the trauma, such as a soldier losing his legs to a roadside bomb explosion, the effect of the trauma is always *subjective* and refers to the impact—the perceived "wound" or "hurt" as identified by the early Greeks—that it has on the individual (Miller 2004). Thus what might be a traumatizing, life-shattering event for one individual might have minimal effects on another. Such differential reaction is based on many factors, including the individual's age, gender identity, pre-morbid ego strength, previous traumatic experiences, the chronicity of the trauma, family history of trauma, current life stressors, social supports, and one's cultural, religious or spiritual attitude toward adversity (Amir and Lev-Wiesel, 2003; Brewin et al. 2000; Felitti et al. 1998; Foa et al. 2009; Stamm and Friedman 2000; Straussner and Phillips 2004a).

Unfortunately, the experience of trauma is not uncommon. Although there is a lack of recent national epidemiological findings about trauma among adults [Centers for Disease Control and Prevention (CDC) 2006], studies during the

1990s found that over 60 % of men and 51 % of women in the United States report having experienced at least one traumatic event during their lifetime (Giaconia et al. 1995; Kessler et al. 1995). Traumatic stress can cause disorganization of thinking, awareness, impaired judgment, altered reaction time, hyper vigilance, and unhelpful attempts at coping. While most people will experience time limited reactions, such as acute stress disorder, a smaller percentage may continue to manifest more severe and often longer lasting trauma-related impacts. These may include panic disorders, depression, sleep disorders, substance use disorders, as well as post-traumatic stress disorder (PTSD) (Kessler et al. 1995; Leskin and Sheikh 2002; Ringel and Brandell 2012).

While trauma can impact an individual at any time in the life cycle, from pre-natal development through old age, the impact and the treatment approaches vary depending on the individual's developmental needs and the psychosocial environment. The purpose of this article is to provide an overview of common traumatic events and responses with a specific focus on the life cycle—identifying selected traumas encountered during childhood and adolescences, adulthood and late life. The differential impact of trauma on men and women, on immigrants, transgenerational transmission of trauma, the concept of resilience, and the implications for the treatment of traumatized individuals at the different stages of the life cycle are identified.

Nature of Trauma: "Large T" and "Micro-Traumas"

There are many different kinds of traumas, ranging from what Francine Shapiro, the originator of Eye Movement Desensitization and Reprocessing (EMDR) treatment approach (Shapiro 1995) has termed *"large- T"* traumas to *"small- t"* or, what Straussner (2012) refers to as "micro-traumas." Large-T traumas can impact individuals, families, groups and communities and include natural disasters, such as hurricanes, floods, wildfires, or nuclear disasters, as well as human-caused disasters, such as deadly car accidents, individual and mass violence, and other one-time traumatic events. Large-T traumas can also include, what Judith Herman (1997) termed as "complex traumas," and which others refer to as Complex Traumas and Disorders of Extreme Stress (DESNOS- *disorders of extreme stress not otherwise specified*)—traumas that involve events of prolonged duration or multiple traumatic events (van der Kolk, Roth, Pelcovitz, Sunday and Spinazzola, 2005). Examples of complex, large-T traumas [also referred to as Type II trauma by Terr (1991)], include on-going interpersonal violence, child physical or sexual abuse spanning several years, never-ending wars, or constant acts of terrorism.

Small-t or micro-traumas are the more common traumas encountered by many of us. While large-T traumas are easily identified, many micro-traumas, such as being bullied in school or in the workplace (Idsoe et al. 2012; Mishna 2012), being stalked by someone (Purcell et al. 2005), living in severe poverty (Kiser 2007), childbirth (Kendall-Tackett 2013), or being the recipient of on-going individual discrimination because of one's race, religion, gender identity, or sexual orientation, often go unrecognized and unacknowledged. Yet these micro-traumas may still cause much psychic pain and life-long damage.

Exposure to and Impact of Trauma

In her classic book *Shattered assumptions: Towards a new psychology of trauma*, Janof-Bulman (1992) reflects on the psychological shattering of one's worldview experienced by traumatized individuals, especially if the trauma is caused through deliberate human acts (Straussner and Phillips 2004a). Whereas the world was previously viewed as being trustworthy and benevolent, this belief may become transformed into the sense that "people will hurt me, and I can't trust anyone." Additionally, trauma survivors might find that the world they used to perceive as being stable and predictable, now seems unpredictable and out of their control. Consequently, their previous sense of empowerment and of being in control of their environment and their lives gives way to one in which they feel disempowered, helpless, and unable to predict and plan for the future. They may even have a sense of being psychologically damaged and defective (Janof-Bulman 1992).

The idea that trauma could result in specific clusters of symptoms first became formalized by the inclusion of the diagnosis of PTSD in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* [DSM; American Psychiatric Association (APA) 1980]. This new diagnostic category was precipitated by awareness of the psychological problems experienced by returning Vietnam War veterans in the late 1970s and the growing literature by European writers who survived their own traumatic experiences during the Second World War—such as Gunter Grass, Primo Levy, and Eli Wiesel among others—and who vividly described the profound impact of mass violence on individuals, families and communities (Straussner and Phillips 2004a). Studies of survivors of the Nazi-caused Holocaust (Krystal and Niederland 1968) and of the Hiroshima atomic bombing by the United States (Lifton 1968), introduced the concept of "survivors' guilt" into our vocabulary.

The more recent recognition that traumatic reactions can result from response to events other than war, such as sexual assault, exposure to child abuse, domestic violence, and accidents has made PTSD a widely recognized disorder throughout the world (Herman 1997; van der Kolk et al. 2005). The importance of PTSD as a diagnostic category is

reflected in the newly revised DSM-5 (APA, 2013), where PTSD and related conditions are no longer listed under Anxiety Disorders or Adjustment Disorders as previously, but are located in a separate chapter titled "Trauma- and Stressors-Related Disorders."

While the experience of trauma is common, PTSD diagnosis is relatively rare. The estimated lifetime prevalence rate of PTSD in the US is thought to range between 6 and 12 %, averaging around 9 % of the population (APA 2013; Breslau et al. 1991; Kessler et al. 1995; Resnick et al. 1993). However, the initial prevalence rates among active duty military exposed to war conditions and among survivors of mass trauma, such as the September 11, 2001 World Trade Centers in New York, can range as high as 30 % and more (Galea et al. 2005; Susser et al. 2002). According to the latest edition of the DSM, the "[h]ighest rates (ranging from one-third to more than one-half of those exposed) are found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide" (APA2013, p. 276). Recent United States- based studies document higher rates of PTSD among African-Americans, Latinos and American Indians than among white or Asian populations (APA 2013). International annual prevalence rates are believed to be somewhat lower than those in the US (APA 2013; Landolt et al. 2013), although studies in areas with on-going conflict, such as in Israel and the Palestinian territories, point to rates that are similar to those in the US among individuals who have been or are still exposed to combat (Dimitry 2011; Gelkopf et al. 2008; Solomon et al. 1996).

As pointed out earlier, trauma has a differential impact depending on age, gender, and psychosocial factors, which are discussed below.

Trauma and Children

As is recognized in the new *Diagnostic and Statistical Manual* (DSM-5; APA 2013), while trauma has a profound impact on all individuals, its impact on young children is unique and particularly pernicious. Millions of children throughout the world are currently growing up amidst traumatic environments—they are being sexually and physically abused at home, bullied at school, and traumatized in their communities (Finkelhor et al. 2009). Many lack adequate food and shelter, and some live in unsafe communities and war zones witnessing violence occurring to friends and family, including rape, torture and murder. Numerous studies have shown evidence of long term repercussions of exposure to violence at an early age (Anda et al. 2006; Steele 2004). The implications of exposure to trauma are now believed to have an effect on the infant even before birth. A more detailed discussion of the impact of trauma on children follows, starting with prenatal impact.

Prenatal Impact

Preliminary research shows that children are impacted even before birth by trauma that is experienced by their mothers. Studies in New York City comparing pregnant women who were close to Twin Towers on September 11 and suffered "post traumatic stress syndrome" (PTSS) with pregnant women who were in different locations, found that newborns of mothers manifesting PTSS had significant smaller head circumference at birth (Engel et al. 2005). As we know, decrements in head circumference influence subsequent neurocognitive development. More recent studies, using modern technologies such as Functional MRI, reveal that fetal exposure to maternal stress is significantly associated with a variety of impacts on brain activity, endocrine function, and on autonomic nervous system function (Sandman and Davis 2012). While these studies have small sample sizes and need to be validated further, we are recognizing that it is not enough to assess, when appropriate, whether a child was born prematurely or not, or whether the mother was malnourished during pregnancy, but also whether she was being abused by her husband or partner, or lived in a violent community or a war zone during her pregnancy, and how this may be related to the some of the problems exhibited by her children (Lieberman and Van Horn 2008; Pine and Cohen 2002). It is also worth noting that the biophysiological impact of paternal trauma on the fetus and newborn child has yet to be considered as worth studying, even though there is growing evidence that spontaneous changes in genetic makeup in the sperms of fathers impacts on the mental health of their children (Kandel 2013). Whether paternal trauma impacts the sperm, and thus the child, needs to be researched in the future.

Impact on Young Children and Adolescents

The impact of trauma on the brain of traumatized children continues after birth and even during adolescence and young adulthood, as evidenced by recent studies suggesting that the brain continues its development until age 25 (Cicchetti and Curtis 2006; Giedd 2008). Trauma, particularly complex or ongoing trauma in early life, affects brain development, especially the development of right hemispheric brain functions, which include among other things, regulation of mood and social adjustment. Moreover, "[n]europsychological studies suggest an association between child abuse and deficits in IQ, memory, working memory, attention, response inhibition, and emotion discrimination. Structural neuroimaging studies provide

evidence for deficits in brain volume, gray and white matter of several regions, most prominently the … prefrontal cortex but also hippocampus, amygdala, and corpus callosum (CC). Diffusion tensor imaging (DTI) studies show evidence for deficits in structural interregional connectivity between these areas, suggesting neural network abnormalities" (Hart and Rubia 2012 p. 52). While the authors acknowledge the limitations of such studies, particularly the lack of control for co-morbid psychiatric disorders, which make it difficult to disentangle which of the above effects are due to maltreatment, other researchers have found that even indirect exposure to trauma, such as witnessing family or community gang violence, plays an important role in altering brain mechanisms involved in the processing of emotions and may predispose children to problems managing strong emotions and difficulty with emotional regulation. Such children appear to experience changes in stress hormonal regulatory systems and neural patterns that are associated with heightened emotional reactivity as well as weakened emotional resiliency, increasing their vulnerability to problematic behaviors, future traumas, as well as their own potential for violence (Grasso et al. 2013; Heide and Soloman 2006).

Data from the well regarded Adverse Childhood Experiences (ACE) study (Felitti et al. 1998) suggests that ACEs are "related to a greater likelihood of developing a variety of behavioral, health, and mental health problems, including smoking, multiple sexual partners, heart disease, cancer, lung disease, liver disease, sexually transmitted diseases, substance abuse, depression, and suicide attempts" (Lu et al. 2008 p. 1018).

Various authors have identified other negative consequences resulting from exposure to trauma during early life:

- Preschool children are likely to exhibit passive reactions and regressive symptoms, such as enuresis, decreased verbalizations and clinging behavior, indicative of anxious attachment (APA 2013; Lieberman and Van Horn 2008; Steele 2004).
- School age children may display both more aggression and more inhibition. They also develop somatic complaints, depression, sleep disturbance, cognitive distortions and learning difficulties manifested by impaired concentration and memory problems (Steele 2004; Terr 1991).
- Adolescents exposed to trauma tend to respond by acting-out and self–destructive behavior: substance abuse, promiscuity, delinquent behavior, and life-threatening reenactments of violent episodes (APA 2013; Bava and Tapert 2010; Brent and Silverstein 2013; Garbarino et al. 1992; Pat-Horenczyk et al. 2007).
- Children and adolescents who witness the death of close friends or family members may experience *survivor guilt* (Herman 1997; Steele 2004).
- Like many traumatized adults, children may exhibit classic symptoms of PTSD without any understanding of what is going on with them (Derluyn et al. 2004).
- Some children exposed to severe trauma may not show many of the classical trauma symptoms until later in life, reflecting the new DSM-5 specifier of "delayed expression" (APA 2013).
- Children may exhibit traumatic bonding reflecting maladaptive attachment as well as inappropriate modeling of the behaviors of their abusers (a behavior also seen in adults and known as "identification with the aggressor" or "the Stockholm syndrome") (Cohen et al. 2006; Derluyn et al. 2004; Weierstall et al. 2012).
- Studies show that almost 100 % of those witnessing the murder or the sexual assault of a parent, and 35 % of urban youth exposed to community violence develop PTSD, although some of these highly traumatized children are more resilient than others (Derluyn et al. 2004; Garbarino et al. 1992; Malmquist 1986).

These young people with a history of, or current trauma need to be identified and treated in order to prevent lifelong physiological, cognitive, emotional, behavioral, and social sequelae of their traumas (Anda et al. 2006).

Impact of Trauma on Adults

Ever since the tragedy of September 11, 2001 much has been researched and written about the impact of trauma on adults, especially in the United States. A exploration of the literature finds a variety of specialized journals devoted to this topic (to wit: *Journal of Trauma Practice*, *Journal of Loss and Trauma*, *Journal of Traumatic Stress*, *Traumatology*, *International Journal of Emergency Mental Health*, *Journal on Rehabilitation of Torture Victims and Prevention of Torture,* among others), as well as various textbooks aimed at different health professions, including social work (e.g., Courtois and Ford 2009; Foa et al. 2009; Ringel and Brandell 2012; Straussner and Phillips 2004b, etc.). What we would like to emphasize in this article are some of the lesser known factors effecting millions of adults by focusing on gender differences[1] and the impact of trauma on immigrants and refugees.

[1] While this article discusses the available research focusing on trauma among individuals with traditional gender identities, the authors recognize that transgender individuals experience disproportionate levels of trauma. Since a comprehensive discussion on this topic is beyond the scope of this paper, readers are referred to Mizock and Lewis (2008) for further information.

Gender and Trauma: What Do We Know?

Studies have found that men and women experience trauma in very different ways with somewhat different consequences. For instance, while men are much more likely to experience trauma, women are more likely to develop PTSD (APA 2013): for every traumatized man, three women have a lifetime prevalence rate of PTSD (Foa et al. 2009). Moreover, men are two times as likely as women to experience trauma due to physical assault, yet women are fifteen times more likely to develop PTSD as a result [World Health Organization (WHO), 2011a]. While there are a variety of hypothesized explanations for these findings, ranging from the fact that women are more likely to seek professional help than men to possible neurobiological and hormonal differences, to women's greater exposure to intrusive interpersonal violence (Hien et al. 2009), there is a lack of conclusive studies explaining these findings. Moreover, it appears that for men the most common factors associated with a diagnosis of PTSD are: rape, combat exposure, childhood neglect, and childhood physical abuse, while women are most likely be diagnosed with PTSD that is associated with sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse (Janof-Bulman 1992). These differences are particularly noteworthy among young adults. Recent data on military veterans show that over 15 % of US women veterans returning from the wars in Afghanistan and Iraq report being sexually traumatized in the military compared to .7 % of the men (Kimerling et al. 2010; Risen 2012).

Violence against women seems to be a growing worldwide pandemic. According to *Key Facts Regarding Intimate Partner and Sexual Violence Against Women in the World*, published by the World Health Organization (WHO 2011a):

- Violence against women is a major public health problem and violation of women's human rights. Approximately 20 % of women report being victims of sexual violence as children.
- The WHO multi-country study found that between 15 and 70 % of women reported experiencing physical and/or sexual violence by an intimate partner at some point in their lives, ranging from the extremely high rate of 70 % of women in Ethiopia and Peru to a low rate of 15 % among women in Japan.
- First sexual experience for many women is reported as forced, with 40 % of young women in South Africa having such an experience. Such violence results in physical, mental, sexual, and reproductive health problems, and may increase the vulnerability of women to HIV/AIDS.
- Population-based studies of relationship violence among young people (i.e., "dating violence" or "date rape") show that it affects a substantial proportion of youth throughout the world. Moreover, worldwide, 1 in 2 female murder victims are killed by their male partners, often during an ongoing, abusive relationship.
- Finally, situations of political conflict, post conflict and displacement may exacerbate existing violence and present new forms of violence against women.

Trauma and Immigration/Migration

In 2010, some 214 million people—3 % of the world's population—lived outside of their country of origin (Batalova and Lee 2012). While many people migrate for positive reasons, the so called *pull factors* –to seek better education or jobs, to reunite with family, and so on—more and more people today move for negative reasons, or *push factors*, i.e. they are being pushed from their home communities due to natural disasters, economic situations, or local conflicts and wars (Castex 2006). Worldwide, there are currently over 15 million refugees uprooted from their home countries, the highest number since the 1990s Rwandan genocide (McClelland 2014). For many of these individuals, trauma is compounded by grief over loss—loss of family members and friends, loss of homes, neighborhoods, language, and even familiar smells. Cultural anchors, such as local religious and educational institutions, familiar medicines, native healers and/or known medical and psychological treatment approaches are missing. For many, particular political refugees and those with undocumented status, migration itself becomes traumatic with numerous obstacles along the way and an uncertain future. For some, prejudice and discrimination, lack of recognition of previously achieved economic and personal status (the micro-traumas) compound the reactions. For those whose migration status is undocumented or illegal, seeking or obtaining help for their big T, much less their micro-traumas is often impossible; thus their trauma may remain unresolved and may carry over to the next generation.

The dynamics of intergenerational transmission of trauma was first identified in studies of adult children of Holocaust survivors (Danieli 1998; Yehuda et al. 2001). The growing attention in the US on what is being termed "historical trauma", relating mainly to Native American populations (Heart 1999), and "Post Traumatic Slave Syndrome" (DeGruy Leary 2006), which focuses on the consequences of slavery on African Americans, point to the increasing recognition and need to address the psychological, social, political, and cultural impact of widespread trauma *over time*. A study by Mollica et al. (1998) found

that in a group of Cambodian survivors the impact of trauma remains decades after the original experience and that mental health symptoms may increase when individuals experience additional traumas, findings that were confirmed by other researchers studying refugee populations from different parts of the world (Bogic et al. 2012; Steel et al. 2002). Thus, the frequency of traumatic events (multiple traumatic exposures) is an important predictor of long term mental health outcomes, especially for traumatized refugee populations.

Trauma and Older Adults

The finding that cumulative trauma is more likely to increase the risk of poor psychiatric outcomes is of particular relevance to aging populations. The global population of people aged 60 years and older is expected to reach about 1.2 billion in 2025, more than doubling in the last 30 years (WHO 2011b). As the world's population ages, the special issues of trauma among the elderly need to be recognized more widely. The concept of "cumulative life stressors" is well known in the psychosocial literature (Dohrenwend 1998), and "cumulative trauma" is seen as reflecting multiple traumas experienced by an individual in multiple situations (Landau and Litwin 2000; Mollica et al. 1998). Thus the older an individual, the more likely he or she is to have been exposed to a variety of traumatic situations, and the more frequent exposure to life-threatening events has been associated with a lower capability to handling stress and higher risks of PTSD (Brandler 2004; Ursano et al. 1995). Moreover, the elderly are at a greater risk for psychological distress post- disaster than middle aged adults due to a greater risk for bodily injury, loss of resources, and lack of social networks or supports (Marsella 2008; Ursano et al. 1995). These issues play an even greater role among disabled older adults who are dependent on others for both physical as well as emotional support.

While the elderly may suffer trauma from the same sources as younger people, like children they are particularly vulnerable to being maltreated or abuse at home and even more so in institutions aimed to protect them, such as nursing homes and hospitals. According to the WHO (2011b), an estimated 4–6 % of elderly people in high-income countries have experienced some form of maltreatment at home. Many of the abusive acts against the elderly in homes or institutions consist of micro-traumas, such as: being physically restrained, deprived of dignity by being left in soiled clothes, being over- or under-medicated, and emotionally neglected and abused. One study found that more than half the residents of intermediate care facilities were receiving psychoactive drugs and 30 % received long-acting drugs *not recommended* for elderly persons (Beers et al. 1988). Some acts against older adults do rise up to the level of large-T traumas of physical abuse that can be life threatening or can result in serious, long-lasting, psychological consequences, including depression, anxiety and PTSD.

While accurate, generalizable data are scarce (Ben Natan and Lowenstein 2010), one survey of nursing-home staff in the US, found that (Pillemer and Moore 1989):

- 36 % witnessed at least one incident of physical abuse of an elderly patient in the previous year;
- 10 % committed at least one act of physical abuse towards an elderly patient;
- 40 % admitted to psychologically abusing patients.

For those cared for at home, studies indicate that the social isolation of both caregivers and the older adults, and the ensuing lack of social support, is a significant risk factor for elder maltreatment by caregivers. Thus help needs to be provided not only to the elderly, but also to their caregivers.

Moreover, when dealing with community trauma, whether natural, such as earthquakes, or man-made, such as a terrorist attack, or individual micro-traumas, such as having a spouse who has been diagnosed with Alzheimer's, older adults are particularly vulnerable to what has been termed as "ambiguous loss" (Boss 2009) or "disenfranchised grief" (Doka 1989). For example, while the parents of an adult son killed in a terrorist attack may be acknowledged and supported by the community, the great-aunt of the murdered young man may be totally ignored, even though for many years he may have been her major source of emotional support. Finally, it is important to recognize that the nature of trauma among older adults varies among different ethnic and racial groups, even in the same community (Marsella 2008). For example, Higgins and Park (2012) in a comparison of African American and Caribbean Black older adults in New York found that African Americans experienced more spousal abuse, incarceration, and combat involvement, while Caribbean Black older adults experienced more natural disasters.

Trauma and Resilience: A Strength-Based Perspective

As George Bonanno (2004) reminds us, as professional helpers we tend to see people who have difficulties coping with trauma. We thus forget that many people are exposed to traumatic events at some point in their lives, and yet they continue to have positive emotional experiences and show only minor or transient disruptions in their ability to function. The concept of *resilience* reflects the individual's ability to effectively use resources in the environment, notably relationships with others, as well as their own internal resources and potentialities (Bonanno et al. 2007;

Bonanno et al. 2011). Hauser (1999; Hauser et al. 2006) point out that resilience is a process, not a state. Doing longitudinal studies of youth, most of whom were physically and sexually abused at home and then put into psychiatric hospitals, the authors found that those young men, who as adults were able to achieve a satisfying life despite horrendous childhoods, reflected three general characteristics:

1. A belief that one can influence one's environment (self efficacy),
2. The ability to handle one's thoughts and feelings (cognitive-behavioral skills), and
3. The capacity to form caring relationships.

What is important to note is that these traumatized yet resilient youth did not show a normative development. Their lives had not been easy; they made seemingly unwise choices and often got into social and legal troubles. What characterized them was, however, an ability to *learn from experience*. The authors point out is that "Resilience does not lie in either the competence or relationship; it lies in the development of competence or relationship where they did not exist before" (Hauser et al. 2006, p. 261). It is this ability to learn from one's traumatic experience and to achieve what we now refer to as *Post-Traumatic Growth* (PTG) (Tedeschi and Calhoun 2004; Zoeller and Maercker 2006) that is the ultimate goal of effective trauma treatment.

Treatment Approaches with Traumatized Individuals

The last few decades have brought extensive research and innovative treatment approaches to helping traumatized individuals. Since, as indicated previously, the experiencing and the consequences of trauma are highly subjective, there is no single treatment approach for helping all individuals who have experienced and suffered trauma, and particularly those suffering from chronic PTSD. Moreover, as trauma can occur at different ages, interventions must be age appropriate as well as gender and culturally relevant.

Interventions with Traumatized Children

As with traumatized adults, the main goal of treatment with traumatized children is to engage them in activities and experiences that allow them to safely express feelings, regulate their emotions and manage overwhelming sensations. The natural language of young children is play. Play therapy, and related expressive arts therapies (Harris 2007), provide a way for the child to reenact the traumatic event through symbolic play and movement, and is an empirically-based intervention for working with traumatized children from the age of 3–11 (Bratton et al. 2005; Malchiodi 2008; Ryan and Needan 2001; Webb 2011). Play therapy with a caring, empathic adult allows the traumatized child to develop a sense of trust and provides an opportunity to achieve a sense of control over their trauma (Steele 2004; Webb 2011). While play therapy is usually conducted with an individual child, other approaches focus on involving the parents, and include:

Child-Parent Psychotherapy (CPP) (Lieberman and Van Horn 2008). CPP is a psychodynamically based therapeutic approach has shown to be very effective in treating trauma in young children while working with parents to repair the impact of the trauma to the family system. CPP is a flexible, culturally sensitive intervention that can be utilized in unstructured weekly session over the course of a year. It focuses on helping the child to rebuild trust by creating a trauma narrative where the caregiver can act out the protective role through the use of play. CPP has been supported by a number of randomized trials showing efficacy in increasing attachment security and maternal empathy (Berlin et al. 2008).

Parent–Child Interaction Therapy (PCIT; Eyberg and Bussing, 2010). While not specific to traumatized children, it is an empirically-based behavioral short term intervention for children age 2–7 who are experiencing emotional and behavioral disorders. PCIT draws on both attachment and behavioral theories and is provided over the course of 12 1-h weekly sessions. PCIT involves the parent interacting with the child with the therapist observing through a one-way mirror and coaching through a hearing aid device. The coaching consists of helping the parents to utilize two sets of skills: a. Child Directed Interaction, which teaches parents to use traditional play therapy techniques, and b. Parent Directed Interaction, which teaches the parents skills to address disruptive behaviors while increasing compliance by the child. These skills include establishing rules, praising compliance, using time-out chair for non-compliance, and so on (Ware et al. 2008).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen and Mannarino 2008).

TF-CBT is a psychosocial intervention found to be effective in treating PTSD and other behavioral and emotional problems related to a variety of traumatic experiences in children and adolescents. It can be used with children and parents in individual and conjoined sessions, as well as in multi-family groups. TF-CBT usually lasts from 12 to 16 sessions. The treatment model focuses on applying the acronym PRACTICE, which summarizes the nine components of this model: Psychoeducation and parenting skills; Relaxation skills; Affect expression and regulation skills; Cognitive coping skills and processing; Trauma narrative; In-vivo exposure (when needed); Conjoint parent–child sessions; and Enhancing safety and future development (Cohen and Mannarino 2008; Cohen et al. 2006).

Intervention with Traumatized Adults

Many different treatment approaches have been shown to be effective for traumatized adults. They include: Psychoeducation, cognitive behavioral therapy, exposure therapy, desensitization and imaginal flooding, Eye Movement Desensitization and Reprocessing (EMDR), narrative therapy, group therapy and medications.

Psychoeducation

Psychoeducation is the "process of teaching clients with mental illness and their family members about the nature of the illness, including its etiology, progression, consequences, prognosis, treatment and alternatives" (Barker 2003, p. 347). While there has been limited empirical evidence proving the importance of psychoeducation (Lukens and McFarlane 2004), clinical experience has shown that understanding the physiological responses to trauma can help individuals develop new coping strategies in dealing with others and learning to calm oneself physically (Creamer and Forbes 2004). It has also been shown to improve the quality of life for family members traumatized by others or to better understand the sometimes irrational behaviors of their traumatized loved one (Solomon et al. 2005).

Cognitive Behavioral Therapy [CBT]

CBT has been shown to be very effective at helping individuals who have experienced trauma by dealing with their thoughts and beliefs, as well as with their behavior patterns. Among the various empirically-based CB treatments are:

1. Exposure/Desensitization, which consists of direct confrontation with trauma by having individuals visualize the event, talk about it, and expose themselves gradually to stimuli which reminds them of the trauma. This is repeated several times until the person becomes accustomed or desensitized to these thoughts and images. Through these repeated exercises, the traumatic memory becomes just a regular memory, allowing the individual to have a sense of control rather than feeling helpless over the past traumatic event. One particular approach is known as "Prolonged Exposure" (PE; Foa et al. 2007), and is rooted in the tradition of exposure therapy for anxiety disorders and emotional processing for PTSD. PE uses both imaginal exposure (confront feared trauma memories and thoughts via imagining the feared object, event, or situation), and in vivo (experience/confront feared objects, places, events, and situations in real world settings). Individuals also are provided with psychoeducation on trauma reactions and on the use of PE to reduce symptoms, as well as breathing training to manage their anxiety. PE may not be appropriate for individual who have a history of multiple traumas (particularly in childhood), those with anger problems, and those who dissociate (Foa et al. 2007, 2009).
2. Another empirically supported cognitive-behavioral treatment for PTSD is Dialectical Behavior Therapy (DBT) (Linehan 1993), which was developed for individuals diagnosed with borderline personality disorder (BPD). The emotional dysregulation that is the hallmark of BPD is also associated with symptoms of complex-PTSD (DESNOS). The treatment combines group skill training sessions, individual psychotherapy, and phone coaching. It is designed to help individuals label and regulate arousal, tolerate emotional distress, and trust their emotional reactions. Emotional regulation, interpersonal effectiveness, and self-management skills, including mindfulness and meditation skills are core skills in DBT. Validation and dialectical strategies are used to balance acceptance and change during treatment.
3. A different treatment model found to be effective in treating traumatized adults is Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro 1995). For many traumatized individuals, remembering an event can feel as real as if it were happening again before their eyes. EMDR uses the person's eye movements to help the natural processing and relaxation mechanisms available in the brain. During treatment, people are asked to think of a picture, emotion or thought relating to their trauma and at the same time to watch the therapist's moving finger or listen to a repeating sound of a drum or a bell, leading to cognitive dissonance and a diminished power of the intrusive traumatic memory. EMDR can be delivered in a short series of sessions and does not involve detailed narrative of the traumatic event.

Narrative Therapy

This approach is based on the belief that trauma disrupts the normal narrative processing of everyday experiences by interfering with psychophysiological coordination, cognitive processes, and social connections, and such incomplete narrative leads to symptoms of posttraumatic distress (Wigren 1994). Narrative therapy thus allows for the completion and reframing of the traumatic event. While there is some evidence showing the effectiveness of this approach (Amir et al. 1998; Schaal et al. 2009), there seems to be no single narrative treatment model. Further

research is needed in order to identify the best narrative approaches.

Group Therapy

While group therapy has been found to be effective at providing support for individuals in many circumstances, the use of certain group approaches, such as Critical Incidence Stress Debriefing (CISD) has been shown to have the potential for retraumatization. This is a particular danger for some individuals who are mandated to participate in such a group and listen to other people's stories of their traumatic events before they had a chance to process their own trauma (Rose et al. 2002). Thus caution must be taken when utilizing any group approaches to trauma treatment.

One highly effective treatment model, used mainly in group settings, is *Seeking Safety*, developed by Lisa Najavitis (2006), The Seeking Safety Model is a present-focused therapy to help people attain safety from both trauma/PTSD and substance abuse. Treatment is flexible and utilizes 25 different topics that focus on both cognitive and behavioral areas. Seeking Safety is based on five central ideas: Safety as the priority of treatment; integrated treatment of trauma and substance use; a focus on ideals; content addressing cognitive, behavioral, interpersonal skills and case management; and attention to the clinician. Originally developed as an empowerment model for women, it is now recognized as being an effective and widely used approach for many others, including traumatized US veterans (Boden et al. 2012). The program focuses on teaching traumatized individuals to view themselves in more positive ways and helping clients build their self-esteem and self-confidence.

Medications

While there are no medications specific for trauma or PTSD, some medications have been shown to be effective at treating certain symptoms of PTSD, such as depression, anxiety or sleeping disorders. Currently the US Federal Drug Administration (FDA) has approved only two anti-depression medications for use with patients diagnosed with PTSD: sertraline (Zoloft) and paroxetine (Paxil), although other medications are being used off-label (Jeffreys 2013). It is worth noting that some medications have been found to be dangerous for those using or recovering from a substance use disorder, or those who are potentially suicidal (for a full review of medication use for those with PTSD, see Jeffreys 2013).

In general, when working with traumatized adults, the most important task is the establishment and maintenance of a physical and emotional sense of safety. It is critical to determine if the individual is at risk for imminent interpersonal violence or other maltreatment in their psychosocial environment, if they are suicidal or homicidal, and if they are psychologically stable and capable of caring for themselves (Briere and Scott 2012).

Interventions with Older Adults

While there is a growing acknowledgement of the need for psychosocial interventions with this population, the literature tends to focus more on programs and policies devoted to identification and reporting of elder abuse than actual clinical interventions (Brandler 2004, Donovan and Regehr 2010). Literature on empirically supported interventions with traumatized older adults seems to be almost non-existent, although some believe that CBT may be effective (Foa et al. 2009). Obviously, more needs to be done to identify effective clinical approaches to this growing population.

Conclusion

Unfortunately, traumatized children and adults comprise a significant number of individuals in our communities and will continue to be with us in the foreseeable future. Many remain untreated. It is therefore critical for clinicians to be familiar with the various traumas encountered by individuals, families and communities, and to become knowledgeable about the most effective treatment approaches for a given population. Despite the growing research that is providing us with a base of scientific knowledge regarding promising interventions, there is much to be learned about effective interventions with traumatized children and adults—to make sure that we "do no harm." Particularly important is research focusing on the resilience that many traumatized individuals' exhibit and learning how best to encourage clients to access their strengths and abilities both in and out of the treatment process. Finally, because of the risk of experiencing secondary trauma, clinicians also need to be aware of the risk of working with high caseloads of traumatized individuals and to learn to take care of themselves so that they do not become part of the problem, but are an effective part of the solution.

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