

# The Need for Inclusion of Psychological Trauma in the Professional Curriculum: A Call to Action

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An appreciable disparity exists between the need for services by professionals with expertise in psychological trauma and the availability of these services. Despite the establishment of a solid base of scientific literature on trauma and the growing attunement of society and the media to the adverse psychological impact of traumatic events, this area has yet to be decisively incorporated into the core curriculum of graduate training in psychology and other professions. This paper provides an overview of the prevalence, scope, and impact of trauma in the general population and the current lack of adequate resources to address the psychological difficulties engendered by traumatic experiences. Existing models of trauma training are discussed, and strategies for expanding the availability of trauma training are recommended.

*Keywords:* trauma training, curriculum, trauma studies, trauma inclusion

For several decades now, the knowledge base about psychological trauma has been continually expanding in the professional literature (Friedman, Keane, & Resick, 2007). In the earliest days of the practice of psychotherapy in Europe in the late 19th century, trauma was recognized as playing an important role in the genesis and exacerbation of many psychological difficulties; however, for various reasons, appreciation of the relevance of the experience of trauma to many psychological problems waned through much of the 20th century (Friedman, Resick, & Keane, 2007; Herman, 1992b; van der Kolk, 2007; Monson, Friedman, & La Bash, 2007). It was only in the 1970s that the focused attention on psychological trauma resumed. This trend was catalyzed largely by the difficulties exhibited by Vietnam War veterans and emerging awareness, via the feminist movement, of the alarming prevalence of rape, domestic violence, and all forms of childhood

abuse, especially sexual abuse, in the life experience of women and children.

Renewed awareness of trauma in the 1970s culminated in the inclusion of the diagnosis of posttraumatic stress disorder (PTSD) and the dissociative disorders (DDs) in the *DSM-III* in 1980 (American Psychiatric Association [APA], 1980). Since that time empirical and clinical exploration of psychological trauma has sustained and flourished. The extensive literature that has accumulated since the 1970s has simultaneously been accompanied by burgeoning awareness on a societal level of the broad reach, financial costs, and lasting adverse impact of traumatic events. In the final two decades of the 20th century, increasing sensitivity arose about the widespread and emotionally damaging nature of domestic violence, childhood abuse, and sexual assault. More recently, acts of terrorism such as the attacks in the United States on September 11, 2001, and much more recently those in Mumbai, India, the return of thousands of veterans of the wars in Afghanistan and Iraq, and widespread natural disasters such as the tsunami in Southeast Asia in 2004 and Hurricane Katrina have been increasingly framed through the lens of trauma by both professionals and the news media.

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verse psychological and societal impact of traumatic events, this area has yet to be decisively incorporated into the core curriculum of graduate training in psychology or in those of other professions (Courtois, 2002). As a result, only the small proportion of students across the legal/criminal justice, medical and behavioral sciences, public health/public policy, and spiritual professions, who are fortunate enough to have mentors in their graduate programs who are knowledgeable about or specialize in psychological trauma, receive formal training in this area (Miller, Coonrod, Brady, Moffitt, & Bay, 2004). The vast majority of those professionals interested in developing expertise on psychological trauma must find a way to accomplish it on their own, often after their graduate studies are completed. These individuals often rely on their own selection of readings and attendance at specialized conferences and continuing education workshops to accrue their knowledge and skills in trauma, and on their own assessment of their abilities to work with this population. Obviously, this alternative is a relatively haphazard one in that it does not reflect the planning, structure, comprehensiveness, and supervised practice that are the hallmarks of an organized professional training program, especially where direct services are involved.

Consider the consequences of this state of affairs for just one population of traumatized individuals: the large numbers of veterans currently returning from combat in the Middle East. At present, the demand for services by professionals trained in this area far outstrips the supply. Once other forms of trauma exposure experienced by sizable sectors of the general population in need of assessment and treatment, by professionals with expertise in psychological trauma, such as childhood abuse, intimate partner violence, criminal assault, life-threatening injuries, and natural disasters, are factored in, the disparity between need for and availability of services increases exponentially.

This article has three main objectives. The first is to discuss the ubiquity of trauma in human experience and to survey different categories of posttraumatic reactions and disorders that have so far been identified and researched. The second is to clarify reasons that make it crucial that the topic of psychological trauma become an integral component of the standard curricula in graduate level education in psychol-

ogy and allied professions, and to identify some core issues and challenges in incorporating such material. The third objective is to offer some general suggestions for how to implement this curricular inclusion.

## The Prevalence of Exposure to Traumatic Events

### *Trauma in Adulthood*

There was a time when it was assumed that traumatic events were rare occurrences, as evidenced by the conceptualization of trauma as “outside the range of usual human experience” (p. 236) in the original diagnostic criteria for PTSD in the *DSM-III* (APA, 1980). Accumulating empirical evidence since that time clearly contradicts the supposition that traumatic events are rare or encountered by a minority of individuals. Although Criterion A in the *DSM-III-R* (APA, 1987) retained the proviso that a traumatic event was one that was outside the realm of common human experience, it was more precise than the earlier definition in that it specified that it consisted of “serious threat to . . . life or physical integrity” (p. 238). In a particularly carefully designed study of a general population sample conducted in Sweden (Frans, Rimmö, Åberg & Fredrikson, 2005), it was found that 80.0% of respondents—84.8% of the men and 77.1% of the women—reported having experienced at least one event conforming to the newer *DSM-IV* PTSD Criterion A definition of trauma (APA, 1994). Similar findings were obtained in the United States among a general population sample of young urban adults (Breslau et al., 1998) and a nonclinical college student sample (Vrana & Lauterbach, 1994). Moreover, it has become increasingly evident that trauma can occur across the course of adulthood and into the individual’s later years, and indeed, across the life span. Unfortunately, being of older age or elderly does not shield one from being traumatized and, some characteristics of old age (i.e., loss of physical strength and mobility, loss of faculties, loss of independence, and increasing dependence on others) may increase vulnerability to being victimized or may intensify symptoms of chronic PTSD or cause them to emerge (in delayed onset) or reemerge (Cook & Niederehe, 2007).

### *Trauma in Childhood*

It would be logical to expect that trauma exposure is considerably less prevalent in children and adolescents than in adults. For one thing, simply by virtue of their younger age, they children could be assumed to have had less to time encounter instances of trauma. Moreover, it is generally assumed that children are protected from the dangers and extreme circumstances to which adults are routinely exposed. Brief reflection on current events disseminated by the news media highlights the fallacy in this thinking. Consider, to name a few examples, exposure of large masses of civilians including children to genocide in Darfur and to combat in Afghanistan and Iraq, and the recruitment or abduction of children into serving as combatants in Colombia and Uganda. Add to these instances widespread exposure to interpersonal violence and to street violence among children in many urban settings in the United States (Schwab-Stone et al., 1995); abuse, neglect, and other forms of trauma in the child's own home by family members and acquaintances (Dong, Anda, Dube, Giles, & Felitti, 2003) including exposure to intimate partner violence (Dong et al., 2003; Holden, 1998); natural disasters such as the 2004 tsunami in Southeast Asia (Bhushan & Kumar, 2007) and the devastation of Hurricane Katrina in the United States in 2005 (Scheeringa & Zeanah, 2008); and it becomes evident that children are not as shielded from traumatic events as we may wish or believe. In light of these examples, it is not surprising that a sizable segment of children in the general population have been exposed to or directly experienced trauma. A telephone survey of youth aged 10 to 16, (Boney-McCoy & Finkelhor, 1995) gave evidence of how prevalent trauma is in this age group: fully 40.5% reported violent victimization, attempted kidnapping, or attempted sexual molestation. A much more recent study was designed to assess for the presence of all types of traumatic events as defined by Criterion A for PTSD in the *DSM-IV*. In this representative community sample of 1,420 children ages 9, 11, and 13 years that was followed longitudinally, an even higher percentage was reported than in the Boney-McCoy and Finkelhor (1995)

study: 67.8% were found to have been exposed to such experiences by age 16 (Cope-land, Keeler, Angold, & Costello, 2007).

### Varieties of Trauma Experience and Exposure

Traumatic events and experiences (also known as traumatic stressors) have been broadly categorized into two main types, 1) "Acts of God" and 2) acts of humans (the latter is also called "human-induced"). The first category involves natural disasters, accidents, illnesses and physical/medical conditions, and emergencies where causation is random and no one is directly responsible. The second does involve responsibility: events that are human-induced often, although not always, involve premeditation, planning, and deliberateness in their implementation. This category includes all forms of sexual and physical assault, psychological and verbal abuse, bullying, acts of terrorism and torture, combat and genocide, human trafficking, and so forth. Betrayal-trauma is an especially virulent form of human-induced trauma involving major perfidy of a kinship or a role relationship (Freyd, 1996). Relational/attachment trauma and all forms of domestic violence, child physical, emotional and sexual abuse (including incest), and neglect perpetrated by related and quasi-related individuals within and outside of the family, involve betrayal-trauma. Other forms of betrayal-trauma are found in organizations where abuse of some members by others (i.e., sexual harassment in organizations; sexual assault within the military) is covertly allowed while overtly forbidden, is inadequately responded to when reported, and/or the victim is blamed for its occurrence and for complaining about it. Similarly, it occurs when help is sought or expected and is not offered, or is accompanied by rejection, criticism, and maltreatment/substandard care (i.e., medical or psychological treatment). It also occurs in cultural and ethnic groups where strict penalties are applied by the family or a larger community if an individual operates outside of prescribed norms (i.e., honor killings or maiming of women by their husbands and other family members) or to enforce norms (i.e., genital mutilation/female circumcision). Although human-induced events are often quite deliberate, they also occur by accident or due to negligence

or human error (as in the case of a transportation accident or building failure caused by the use of substandard materials as a result of fraud or cost-cutting; an injury or death caused by alcohol, drug abuse, or negligence; or lack of expected response from those with the responsibility and resources to help, i.e., Hurricane Katrina).

Although both types of trauma can be quite damaging to victims, on average, trauma that is human-induced and involves betrayal as well as interpersonal violence results in greater severity of response (Herman, 1992b). The greater psychological damage is due precisely to the fact that the event was deliberate and willful and/or due to human error, negligence, or disregard. Those hurt by other human beings often experience a deep sense of betrayal from having been objectified in the process, thus adding "insult to injury." Primary trauma can be further compounded in what one author referred to as "the second injury" (Symonds, 1980). When helpers are insensitive to the victim's plight in ways that cause additional shame and blame (e.g., the rape victim who is told she asked for it or the child abuse survivor who is not believed) and when expected help is not forthcoming (e.g., a an abused child whose bruises are ignored and/or whose disclosure is not believed and who is subsequently not protected, Hurricane Katrina victims who expected help that never arrived) or when care is sloppy, inadequate, or even causes additional injury or distress (e.g., the derision experienced by an adult survivor or childhood trauma who coped through self-injury and who, when she sought care at a local emergency room, was verbally reprimanded by the doctor and attending nurse and who received sutures that were larger than the injury and that caused it to be more pronounced when it healed).

The primary victim may experience the traumatic events directly and/or may witness them. Whatever the form of exposure, traumatic experiences can cause major posttraumatic emotional/psychological and physical repercussions. Studies of trauma have also found that traumatic events and posttraumatic reactions often have a ripple effect, that is, they impact others besides the primary or identified victim. Secondary and tertiary victimization (also known as vicarious traumatization, discussed later in this paper) occurs when those who are

exposed to the trauma or the traumatized individual in some way, for example, in a professional and/or helping capacity (as a first responder/emergency medical technician /police, medical or mental health personnel, or photojournalist/reporter); in a family/personal way (parent, spouse, child, friend); or in a collegial/community way (coworker, neighbor, acquaintance) have reactions similar to those of the victim. Individuals can also be sensitized via highly detailed and/or graphic accounts and pictures of traumatization. Researchers are now investigating whether such media exposure can, in and of itself, cause posttraumatic reactions in some individuals, especially those who are most vulnerable and who are least able to understand/assimilate media reports (e.g., young children, adolescents, or the elderly).

Primary, secondary, or tertiary traumatization can cause a myriad of responses ranging from those that are relatively minor to ones that are devastating, life-altering, and even life-ending. The vast majority of people who are traumatized will have posttraumatic *responses*. The majority of these responses will abate and resolve after a period of time (usually several weeks to several months; see the discussion below about acute stress disorder), especially when the victim receives psychosocial support and understanding, and when practical as well as emotional help is available. It is not unusual however for victims and others to remain symptomatic at subclinical levels, enough to make them uncomfortable but not enough to meet full criteria for PTSD as currently defined in the *DSM-IV TR* (APA, 2000). Research has substantiated that reactions meeting the criteria for a diagnosis of PTSD constitute the *atypical response* in adults who are traumatized (occurring in approximately 18% to 25%; Yehuda & Flory, 2007). Exceptions to this percentage are found in adults who were subjected to complex forms of traumatization, severe and repetitive trauma (such as combat, refugee status, sexual harassment, human trafficking, or genocide), and when it occurs in layered form in adulthood to an individual who was previously traumatized as a child (Herman, 1992, a & b). Significantly, this statistic is virtually reversed for the majority of seriously abused and neglected children, a population at high risk to develop PTSD at the time or later. Researchers are currently developing criteria for children who are trauma-

tized and develop PTSD (childhood PTSD) and for those children repetitively traumatized over the course of childhood, mainly within the family and by family members (complex or developmental PTSD) (van der Kolk, 2005). The National Child Traumatic Stress Network (www.nctsn.com) was funded and organized specifically to expand knowledge about and interventions for traumatized children.

### Varieties of Posttraumatic Spectrum Disorders

Certainly the diagnosis most closely identified with exposure to trauma at this time is PTSD. It is important, however, to recognize that PTSD assumes diverse forms. The classic triadic groups of symptoms of PTSD—intrusive reminders of the traumatic experience, avoidance of stimuli associated with the trauma, and experiential numbing and hyperarousal—are common features of the variations of PTSD. Major differences between those forms of PTSD that most closely conform to the standard symptom picture of this syndrome involve onset and duration of the disorder.

#### *Acute Stress Disorder*

Acute stress disorder (ASD), first introduced in the *DSM-IV* (APA, 1994), is primarily distinguished from PTSD in that its onset is *within 4 weeks* of the traumatic event, and its duration is *no more than a maximum of 4 weeks*. Many individuals exposed to a traumatic event will initially respond with reactions that correspond to one or all of the three main symptom clusters of PTSD. However, in an appreciable proportion of this group, these difficulties will naturalistically subside within a month of the traumatic incident, even in the absence of treatment. The ASD designation, therefore, serves at least two practical functions. First, it alerts the practitioner that the presence of subclinical traumatic stress reactions and symptoms immediately following a traumatic event are not necessarily indicative of the chronicity commonly associated with PTSD. In doing so, the ASD category helps dissuade clinicians from making pronouncements about the duration of symptoms that can unwittingly exacerbate and sustain what otherwise might be transient

symptoms. Second, ASD provides an avenue for treatment for trauma survivors whose difficulties may be short-lived but sufficiently severe and disabling to require intervention.

The evidence on the utility of ASD for predicting PTSD is decidedly mixed. Elklit and Brink (2004) report that in their sample of physical assault victims, 78% who met criteria for ASD met criteria for PTSD 6 months after the assault, and 60% of subclinical ASD participants (those who met all but one of the ASD criteria) also qualified for a diagnosis of PTSD after 6 months. Other recent studies, however, cast doubt on the ability of ASD to predict later PTSD in children (Kasam-Adams & Winston, 2004) as well as adults (Creamer, O'Donnell, & Pattison, 2004). Nevertheless, it is crucial to keep in mind that the primary value of ASD is not to predict later PTSD, but rather to make explicit that the emergence of even the full set of PTS symptoms, within the first few weeks following the traumatic event, often does not necessarily signal the existence of ongoing PTSD. Nevertheless, there may be specific symptoms from all three clusters that, although at subclinical levels, benefit from treatment intervention. It remains to be seen whether the diagnosis of ASD will remain in the next edition of the *DSM*, with some prominent researchers calling its relevance into question (Bryant, 2008).

#### *PTSD, Chronic and Delayed*

According to the *DSM-IV* criteria (APA, 1994), posttraumatic stress symptoms that *emerge within 1 month* of the traumatic event and *persist for more than 4 weeks*, warrant a diagnosis of PTSD. When the PTSD is diagnosed using the *DSM-IV*, one of two specifiers is included to denote its duration. If the symptoms have been present for less than 3 months, it is identified as “acute”; for persistence of 3 or more months, it is designated “chronic.” Especially using this relatively modest definition, the empirical evidence strongly suggests that PTSD is very frequently chronic. In a study of 2,648 German adolescents and young adults with PTSD, roughly half manifested no appreciable symptom remission when reassessed roughly 3 to 4 years later. Studies of adult trauma survivors similarly suggest that PTSD is very frequently a long-term disorder, and one with sig-

nificant comorbidities (Roy-Berne et al., 2004; Zlotnick et al., 2004), especially if left untreated. It is not uncommon, especially in adult survivors of childhood abuse and combat veterans, for PTSD to persist for many years. For example, in a sample of Vietnam era veterans, only 7.5% manifested PTSD for a duration of 5 years or less, and for 40.2% the duration was 20 years or more (Schnurr, Lunney, Sengupta, & Waelde, 2005).

Research supports the validity of *delayed onset* PTSD. It is fairly common for the emergence of PTSD to occur months or even years after the traumatic event itself and to occur in ways that make its etiology obscure or disconnected from the symptoms (Op den Velde, Hovens, Aarts, & Frey, 1996; Schnurr et al., 2005). However, in a careful review of the literature on delayed onset PTSD, Andrews, Brewin, Philpott, and Stewart (2007) caution that the definition of delayed onset in the *DSM-IV* is ambiguous, failing to distinguish between situations in which there is a *complete absence of posttraumatic stress* symptoms preceding diagnosable PTSD and a *subdiagnostic level of symptoms*. They conclude that the former set of circumstances is “extremely rare” but that the onset of PTSD months or years after some posttraumatic stress symptoms have been present but not enough to meet criterion for full diagnosis is not unusual. Nevertheless, the emergence of symptoms severe enough to meet diagnostic criteria years or decades later is understandably very upsetting to the individual and his or her significant others and, without identification, access to, or understanding of the precipitating event(s) and its relationship to the symptoms, it can be even more distressing. In not an inconsequential number of cases, it may have led to the individual or others questioning victim/survivor’s sanity, especially when symptoms were very intense, appeared to involve psychotic process, and/or led to unpredictable and out of character reactions and behaviors. Often, then reactions only become comprehensible once their origin is identified.

### *Developmental or Complex PTSD/Complex Traumatic Stress Disorders*

It has become widely accepted among many researchers and practitioners that, as opposed to

those who have experienced a single or circumscribed traumatic event, individuals exposed to ongoing or repeated trauma, especially in childhood and in the context of primary family relationships often display a considerably greater range of difficulties than is found in PTSD (Courtois & Ford, 2009; Herman, 1992a; McLean & Gallop, 2003). This more extensive pattern of symptoms has been variously labeled *complex PTSD* (Herman, 1992a, 1992b) or *disorders of extreme stress not otherwise specified* (DESNOS), or, more recently, developmental trauma disorder (van der Kolk, 2005) and complex traumatic stress disorders (Courtois & Ford, 2009). This disorder is marked by the simultaneous manifestation of a wide range of difficulties involving cognitive (including dissociative), affective, somatic, behavioral, relationship, and self-attributional problems (Herman, 1992a, 1992b; van der Kolk, 2005). Although it is not a separate diagnosis in the *DSM-IV*, but is acknowledged as an associated feature of PTSD, a substantial body of research supports the validity of this syndrome (Allen, Coyne, & Huntoon, 1998; Ford & Kidd, 1998; Jongedijk, Carlier, Schreuder, & Gersons, 1996; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997; Teegen & Schriefer, 2002) and calls for its inclusion in the *DSM* as a free-standing diagnosis. Although individuals with the additional symptoms associated with complex PTSD often also meet criteria for standard or classic PTSD, research supports the conception of complex PTSD as a separate diagnostic entity with a much greater range of symptoms that need to be specifically addressed to render treatment effective (Ford & Kidd, 1998; Roth et al., 1997).

### Beyond Posttraumatic Stress: Other Disorders Associated With a History of Trauma

There is such a close association between the experience of traumatic events and the development of PTSD that it may not be evident that there is a range of other disorders that are commonly observed in those with a history of trauma. Very frequently these disorders co-occur with PTSD (Bradley, 1997) and complex PTSD (Courtois & Ford, 2009), showing comorbidity rates as high as 76.6% (Jakovljevic, Saric, Nad, Topic, & Vuksan-Cusak, 2006) and

93% (Abram et al., 2007). However, to a much greater extent than is routinely recognized, they also are seen in those with a history of trauma in the absence of PTSD.

### *Dissociation*

It is widely recognized among mental health professionals who are knowledgeable about dissociation that it is very commonly the result of trauma. Research on both adolescent and adult samples, in the United States and abroad, has repeatedly demonstrated an appreciable relationship between a history of trauma and dissociation (Agargun et al., 2003; Boon & Draijer, 1993; Coons, 1994; Chu & Dil, 1990; Chu, Frey, Ganzel, & Matthews, 1999; Francia-Martínez, Roca de Torres, Alvarado, Martínez-Taboas, & Sayer, 2003; Ross, Miller, Bjornson, Reagor, & Fraser, 1991; Dalenberg & Palesh, 2004; Dominguez, Cohen, & Brom, 2004; van den Bosch, Verheul, Langeland, & van den Brink, 2003). This body of research suggests that the trauma of repetitive and cumulative child abuse is particularly strongly associated with dissociative symptoms.

It is unfortunate most professionals know very little about dissociation and are overly skeptical about its diagnostic validity. Likely the primary explanation for this state of affairs is that most undergraduate and graduate training programs provide little or no training in dissociation, or convey erroneous conceptions of about it (Gleaves, 2007). As a consequence, the professional resources for assessing and treating dissociative difficulties appear to be far outstripped by the need for such services.

A major reason that dissociation is often misunderstood is that it tends to be equated by some researchers and clinicians almost exclusively with the most extreme manifestation, dissociative identity disorder (DID, previously known as multiple personality disorder) despite research findings on its estimated prevalence in the general population. For example, in a recent Study 1.5% of a community sample were identified as meeting diagnostic criteria for DID, while the proportion with any type of dissociative disorder was 9.1% (Johnson, Cohen, Kasen, & Brook, 2006). Clearly, dissociative disorders cannot be accurately characterized when general dissociative symptoms are conflated with DID, and characterized as “exceed-

ingly rare”; however, it is noteworthy that even the 1.5% population figure for DID alone could not be reasonably depicted in this way.

Of interest, over half of the 9.1% of the Johnson and colleagues’ sample who were diagnosed with dissociation fell into the diagnostic category dissociative disorder not otherwise specified (DDNOS). This finding seems to suggest that many dissociative individuals present with patterns of symptoms that are not adequately captured by standard dissociative diagnoses currently included in the *DSM* but rather that they fit into the catch-all not otherwise specified (NOS) category. If this is indeed the case, it is easy to imagine that this would contribute to an underdetection of dissociative disorders in general and, simultaneously and paradoxically, a false positive and inflated rate of DID. The issues of the number and inclusiveness of categories of dissociative disorders will be taken up the dissociative disorder working group for the next edition of the *DSM*, currently under revision and expected to be published as *DSM-V* in 2011 or 2012.

### *Depression*

While PTSD is the disorder that for obvious reasons is most frequently associated in the minds of many with a history of trauma, a number of studies indicate that depression may be actually be more prevalent (Carey, Stein, Zungu-Dirwayi, & Soraya, 2003; Kilpatrick et al., 2003; McQuaid, Pedrelli, McCahill, & Stein, 2001). A dose-response relationship was found between the occurrence of depressive disorders and eight adverse childhood experiences, including sexual abuse, physical abuse and emotional abuse, and exposure to intimate-partner violence, in a sample of over 17,000 adults (Chapman et al., 2004). In regard to findings on the same sample, Felitti (2002) pointed out that participants reporting four or more of these eight adverse childhood experiences were 460% more likely to manifest depression than participants endorsing none of the eight; thus, some depression is clearly posttraumatic in nature.

Other studies of trauma survivors found higher rates of PTSD than depression. However, the proportions with depression were still considerable (e.g., Wenzel, Griengl, Stompe, Mirzael, & Kieffer, 2000). Moreover, depression

and PTSD frequently co-occur (Bleigh, Koslowsky, Dolev, & Lerer, 1997; Breslau, Davis, Andreski, & Peterson, 1991; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Stein & Kennedy, 2001) and may further put the individual at risk for suicide. One potential criticism of the finding of high levels of comorbidity between PTSD and depression is that some of the criteria for the two diagnoses, such as insomnia and difficulty concentrating, are the same. Franklin and Zimmerman (2001) offered a counter to this critique when they concluded on the basis of a study of 1,300 psychiatric outpatients that this overlap did not account for the frequent co-occurrence of major depression and PTSD.

### *Bipolar Disorder*

In contrast with depression, the recognition of an association between bipolar disorder and a history of trauma exposure is much more recent. In a sample of 977 medical patients, the 9.8% who screened positive for bipolar disorder were found to be 2.6 times more likely to have a history of physical or sexual assault, and 2.9 times more likely to screen positive for PTSD (Neria et al., 2008). A review of six earlier studies concluded that the prevalence of PTSD in patients with bipolar disorder was approximately twice the lifetime prevalence of PTSD in the general population. In a detailed clinical paper, Levy (2007) observes that among clients diagnosed with bipolar disorder who also manifested PTSD or trauma-related dissociation that was effectively addressed with psychotherapy, the symptoms of bipolar disorder subsided and mood stabilizing medication was no longer needed.

### *Anxiety Disorders*

PTSD has been included within the category of anxiety disorders in the *DSM*, a classification that is currently in question for the *DSM-V* (Phillips & Friedman, 2008). A considerable amount of research suggests that anxiety is an associated feature of PTSD and that many of the anxiety disorders are frequently comorbid with PTSD (Resick, 2008). However, some recent research has concluded that PTSD is not an anxiety disorder per se and is better categorized within an as-yet-to-be-established category of

posttraumatic disorders. On the other hand, there is quite a bit of evidence that anxiety disorders other than PTSD are related to a history of trauma exposure. These include panic disorder (Leskin & Sheikh, 2002), obsessive-compulsive disorder (Breslau et al., 1991), generalized anxiety disorder, and agoraphobia (Maes, Mylle, Delmeire, & Altamura, 2000).

### *Substance Abuse*

Another diagnosis with an association to trauma and to PTSD is that of substance abuse. Although it has long been believed that alcoholism and other substance abuse problems *precede* the occurrence of trauma (and may, in fact, contribute to its occurrence and recurrence, in the case of revictimization). Stewart (1996) and Ouimette and Brown, 2003 have provided documentation to the contrary. In their respective reviews of the literature, these researchers found that substance abuse usually occurs *in the aftermath* of trauma in individuals suffering from PTSD and is a way for them to modulate painful emotional states and reexperiencing symptoms. It may also be a way for the traumatized individual to numb emotions enough to be able to sleep.

### *Psychosis*

A similar set of questions accompanies the issue of psychosis and PTSD. Does psychosis precede trauma or is it a response to traumatization and the experience of PTSD? Recent research has suggested that psychosis often occurs in response to trauma, may be a form of posttraumatic response for some, and may be the result of having PTSD (Cusack, Grubaugh, Knapp, & Freuh, 2006; Gearon, Kaltman, Brown, & Bellack, 2003; Neria, Bromet, Sievers, Lavelle, & Fochtman, 2002; Kozarić-Kovačić, & Borovečki, 2005; Shevlin, Dorahy, & Adamson, 2007). Psychotic experiences have been found to be particularly strong related to childhood trauma (Ross & Joshi, 1992; Whitfield, Dube, Felitti, & Anda, 2005). Some researchers have argued based on the empirical evidence that psychosis may an even more frequent response to extensive childhood trauma than PTSD (Hammersley, Read, Woodall, & Dillon, 2007). Psychotic experiences have also been found to be elevated in adults subsequent

to exposure to natural disaster (Cardeña & Spiegel, 1993). Mueser and colleagues (2004) concluded that PTSD is one of the most frequently co-occurring conditions found among people with serious mental illness.

### *Personality Disorders*

Personality disorders have also been associated with trauma. Although the majority if not all personality disorders may have a relationship to an individual's traumatization (particularly, antisocial, avoidant, hysteric, narcissistic, or paranoid), is it borderline personality disorder (BPD) that is believed to be most often associated with trauma (Paris, 1997), with some research documenting attachment difficulties, childhood abuse, or other childhood trauma, at a rate of 80% or above in individuals diagnosed with BPD. Herman (1992a) and other clinical researchers (Schore, 2001) documented the effects of childhood trauma on personality development. Herman and others (Courtois & Ford, 2009) have suggested the term complex PTSD (or, alternatively, complex traumatic stress disorders) as a more accurate and less stigmatic designation that incorporates Axis I (symptoms) and II (personality) diagnoses [as well as Axis III (physical and medical) and IV (functioning)] and therefore is a more parsimonious way to incorporate the different symptoms and comorbidities into one diagnosis. Van der Kolk (2005) has suggested the diagnostic conceptualization of developmental trauma disorder. Similarly, Classen, Pain, Field, and Woods (2006) have proposed posttraumatic personality disorder (PTPD) to account for these personality dimensions. This latter conceptualization is in line with the "enduring personality change after catastrophic experience" diagnosis in *The International Diagnostic Categorization-10 (ICD-10)* of the World Health Organization (1992), as is the complex trauma formulation.

### *Physical Illness*

If all of these psychological symptoms were not enough, trauma has also been implicated in the development of a host of illnesses and other health problems (see Kendall-Tackett, 2009, for a comprehensive description). Trauma and PTSD are the prototypic mind-body conditions; research findings document that PTSD in par-

ticular involves alterations in the individual's physiology and even biochemistry, from the neuronal level on up (Schore, 2001; Siegel, 2001). In general, a history of trauma has been found to be associated with disorders of all body systems and with resultant illnesses and medical conditions (Schnurr & Green, 2004). The trauma itself may have been the cause of physical damage or can result in physical effects that become chronic and can last a lifetime.

### Interpreting the Relationship of Trauma Exposure to Psychological and Psychological Impairment

It should not be assumed simply because there is a relationship between a history of trauma exposure and a wide range of psychological and physical disorders that traumatic events are the sole or even a contributory *cause* of these all difficulties. There are a number of possible explanations for these findings. In some instances, as in the case of PTSD, it is presumed that trauma exposure is in fact a primary (and indispensable) cause of the disorder. In many of these symptom patterns trauma may be a contributor to, but not the main precipitant of the syndrome. In some disorders—including, for example, the psychoses, at least some proportion of the association may be accounted for by causation in the opposite direction: the presence of the disorder may render the person more vulnerable to interpersonal violence and other forms of trauma (Grubaugh, Cusack, Yim, Knapp, & Frueh, 2007). Trauma exposure may also act in certain situations as a moderator variable. The important point is not the nature of the association between trauma and such a broad spectrum of difficulties, but rather simply that these findings suggest that trauma is a factor of crucial relevance in our evolving understanding of many psychological and medical problems (Gold, 2004).

This overview briefly surveys some of the main ways that posttraumatic reactions and disorders are currently conceptualized and understood. As in all professional disciplines, it is expected that as more data accumulate and understanding of underlying mechanism evolve, these formulations might change. There might be, for example, a type of posttraumatic response and disorders that is broader than what is now conceptualized, that is age-specific, related

to type of trauma, that captures particular cultural or ethnic idioms, and that calls for different healing strategies. The contemporary field of traumatic stress studies is relatively recent and major discoveries have been made during the course of its 30-plus years, discoveries that are expected to continue leading to ongoing revision and evolution of the knowledge base undergirding understanding and practice.

### *Seeking Help*

Research has substantiated that victims of trauma, many of whom have physical as well as psychological manifestations, usually turn first to medical providers for treatment. Medical and allied medical professionals can therefore expect that a substantial number of their patients will have experienced trauma of one sort or another. It is a tragic consequence of lack of training about trauma in the professions that many primary care doctors (as well as those in other specialties) and other associated medical providers have little or no knowledge of physical or psychological posttraumatic manifestations and, as a result, often misdiagnose the symptoms or misattribute them to other causes. Many victims have been told, in essence, that their symptoms and concerns are “all in their head.” Unfortunately, if they also sought mental health services, they might have received the same message. Since many victims feel “crazy” due to their psychological and psychophysiological reactions (i.e., startle response, hyperarousal, memory and concentration loss, loss of personal continuity, feelings of rage and aggressive behavior, etc.), such responses exacerbate rather than explain and normalize their distress. Rieker and Carmen (1986) labeled this the victim-to-patient process, a circumstance that could be reversed with adequate knowledge.

Additionally, professionals without knowledge of trauma or sensitization to it or its consequences may experience strong negative and horrified reactions that can impact their ability to respond positively to their patients, or alternatively, they may erroneously assume that they have more competence than they have and make critical mistakes as a result (Wilson & Lindy, 1994). Professionals who are trauma-informed and sensitized to trauma and its common after-effects are able to offer a different type of response, one that includes the ability to empa-

thize, to listen, and to modify procedures and protocols to make them more tolerable (see Courtois, 1988 for a discussion of medical treatment), important factors in assisting those who have been injured and demoralized (especially those who were hurt and suffered betrayal by human-induced trauma; Wilson & Thomas, 2004).

Although the focus of this article is not specifically on ethics, obviously, the lack of training and its resultant consequences have major ethical implications. The ethics code of all helping professions includes the proscription to “do no harm.” This can be seen as especially applicable to the population of the traumatized and, in fact, could be changed to “do no *more* harm” given what they have already experienced (Courtois, in press). Ill-informed, insensitive, and inadequate responses by professional caregivers add to the original injury (Symonds’ “second injury” concept, discussed earlier [1980]) and retraumatize rather than heals, leading to additional pain and anguish, rather than resolution and well-being. Thus, the understanding of how critical adequate professional training in trauma is to the well-being of millions of trauma-exposed individuals is at root of the need for the inclusion of trauma studies in the curricula of all major professions.

### Call to Action: A Proposal for What’s Needed

Given the widespread prevalence of trauma in society, the growing recognition of the range and severity of its impact at the individual, cultural, ethnic group, community, societal, and global levels, and the rapidly expanding knowledge base about its occurrence, aftereffects and treatment, there is an urgent need for the inclusion of information about trauma in the psychology curriculum, starting at the undergraduate level. Indeed, the noninclusion of information in psychology about trauma as a major aspect of human experience and as a substantive contributor to derailment of normative development and the development of psychopathology, defies logic. Part of the reason has to do with difficulties adding content and issues to professional training. However, another explanation comes from the history of the study of trauma which, when taken into consideration, offers another more plausible explanation for this exclusion. It

appears that the lack of attention to trauma in the psychology curriculum (as well as the curricula of other professions) has mirrored societal ambivalence and episodic attention and disregard (Herman, 1992b; Monson, Friedman, & La Bash, 2007).

Historically, trauma has been identified in the classics and other great literature as a common human occurrence, often with a variety of profound consequences (both negative and positive) to the victim and to others. Despite this, little attention was accorded trauma within the nascent psychological and psychiatric communities, until the end of the 20th Century when Freud, Janet, and their contemporaries (such as Tardieu in France and Ferenczi in Hungary) studied hysteria in women who reported histories of sexual abuse by family members. Some writers suggest that Freud learned painfully and personally about society's denial of incest and other forms of sexual abuse, when his seduction theory, focusing on the reality of incest as etiology of later psychological symptoms, was rejected by his professional peers. He subsequently substituted the Oedipal theory for his original formulation, in the process repudiating his previous acknowledgment of actual sexual abuse in favor of proposing that children develop wishes and fantasies regarding sexual contact with the parent of the opposite sex. Herman (1992b) and others believe that this repudiation set the stage for the negation of all forms of sexual and interpersonal trauma, especially of the type that occurred in the context of the family (incest or intimate-partner violence toward wives and children), that she termed "women's trauma."

Herman (1992b) identified combat as the main domain of what she called "men's trauma." Combat-related trauma fared little better than domestic trauma in terms of professional study. It was actively investigated during times of war, mostly with the intent of finding a way to rehabilitate soldiers in order to return them to the battlefield (van der Kolk, 2007). Subsequently, the attention accorded to trauma and posttraumatic responses in combatants was rescinded when the country returned to peacetime status and soldiers returned to civilian life. The war and its horrors were excised from academic and social awareness in favor of the return to peacetime order and calm. In this century, this pattern of attention to and suppres-

sion of information about trauma occurred in response to the two world wars and the Korean conflict. Some researchers noted that this pattern of attention to war trauma and the subsequent censoring of the information were quite similar to the biphasic pattern observed in the classic posttraumatic reaction. This pattern consisted of remembering and reexperiencing the trauma on one hand and suppressing and numbing it on the other (Kardiner, 1941). Herman (1992b) wrote of societal attention alternating with amnesia. With regard to similar occurrences within the subfield of the study of dissociation, it has been noted that information about trauma and dissociation was routinely accumulated and then dissociated.

The status of the study of trauma changed dramatically in the 1960s and 70s as a result of the posttraumatic reactions experienced by large numbers of Vietnam veterans ("men's trauma") with the simultaneous attention that was being paid to child physical and sexual abuse, intimate partner violence, and rape as a part of the Women's Movement ("women's trauma"). Concurrent studies in both domains resulted in the acknowledgment of precipitating events/experiences as constituting trauma and reactions as posttraumatic, that is, as caused by and in the aftermath of the original and very real trauma. Another simultaneous occurrence was the reemergence of the study of dissociation, a study that had been mostly abandoned at the beginning of the century due to the ascendancy of Freud's theory of repression over Pierre Janet's theory of dissociation. The attention to dissociation, in turn, began to implicate chronic child sexual and physical abuse as major precipitants of dissociative responses in childhood and beyond and, in doing so, called to mind the studies of the hysterics of old and their reports of childhood sexual abuse and incest. The investigations of both trauma and dissociation resulted in the inclusion of criteria for the diagnoses of PTSD and five dissociative disorders (DD's) in the 1980 *DSM-III* (APA, 1980), a landmark event that served to legitimize trauma and codify posttraumatic reactions as never before.

Since 1980, the study of all forms of trauma has increased exponentially, leading Herman (1992b) to speculate that findings about trauma and dissociation would not so easily disappear this time since the knowledge was supported by

increased social consciousness and numerous social movements (i.e., Vietnam vets, child abuse and domestic violence activists, social justice advocates, etc.). This may well be the case, but the controversy over false/recovered memories of the 1990s (also known as the “memory wars,” the critique, directed mostly toward reports of incest on the basis of recovered memories reported by women and denied by family members, and the use of hypnosis and other forms of suggestive therapies by therapists) serve as a reminder of how easily the balance can be tipped from believing and paying attention to victims’ stories and their reactions (including their memories or lack thereof) to disbelieving and debunking these stories and reactions. *It is abundantly evident how difficult it is for a society to face trauma of all sorts but especially interpersonal violence occurring in the family and events that are simultaneously overtly forbidden and covertly allowed.*

Despite the setback (or the corrective, depending on one’s perspective) of the memory controversy, numerous major traumatic events since that time have captured global attention and made it more difficult to disregard trauma and its impact. Among the most well-publicized: the Oklahoma City bombing; the terrorist attacks in the United States and abroad; the wars in Afghanistan and Iraq along with other conflicts and unrest in the Middle East, India and elsewhere; the genocides in Rwanda, the Sudan, and in other countries; the increased number of displaced persons and refugees, many of whom suffer mistreatment and abuse during their passage; the AIDS epidemic in Africa; the tsunami in Southeast Asia; Hurricanes Ivan and Katrina and the devastation of the Gulf Coast; and the threat of nuclear proliferation in countries with unstable governments. To summarize, trauma is in public awareness as never before. In fact, it has been recognized by the US Surgeon General as a public health risk of major proportions. He noted that dealing with the effects of trauma is a health care priority since they are as serious as any major medical illness (US Surgeon General, 1999). *Despite the ever-increasing awareness and this and other calls to action* (Courtois, 2002), formal education across professions in the United States has not kept pace: trauma has been ignored or relegated to specialized courses outside of the main curriculum, taught by faculty members with a special interest or expertise. The

results of this exclusion and marginalization are widespread, tragic, and unnecessary. It is time for this to change and psychology is the ideal profession to lead the way.

### *Toward Greater Availability of Trauma Training*

Our proposal is to include and integrate basic information about trauma across the entire psychology curriculum, beginning at the undergraduate level. Such information would be especially needed in general and introductory, developmental, abnormal/psychopathology, and research methods courses. We recommend an inclusive approach rather than what has been the norm, of add-on or temporary courses that are not embedded with the rest of the curriculum. At the graduate level, much more specialized information can be included in all clinical training courses, all practicum, internships and externships, in all supervision models, and in research training in areas such as health psychology, neuropsychology and developmental psychology, again in an integrated way. Additionally, subspecializations in trauma studies and trauma services can be offered within and across all psychology programs. In addition to the inclusion of general information, a wide variety of topics could be offered as specializations (i.e., foundations and trauma theory; trauma and its effects across the life span; bio-behavioral responses and psychoneuroimmunology; risk and resilience factors; assessment of trauma; attachment and relational trauma/child abuse and their developmental impact; emergency and disaster trauma; family violence, sexual assault and abuse; interpersonal violence; cross-cultural and international issues; sexual slavery and human trafficking; gender-related issues; genocide; combat trauma; forensic issues; trauma memory and cognition; and treatment approaches and strategies for various types of trauma and different age group).

*Existing models.* Fortunately, in recent years, efforts have been made to do exactly that. A survey was conducted in 2007 by the Education and Training Committee of Division 56 of the APA (2007) that provided initial documentation of the number of courses, specializations, and programs that are currently available within formal psychology curricula. The committee’s findings are that specialized tracks or programs

exist in a growing number of psychology training programs; however, some of these are the result of the efforts of one or more faculty members and are not necessarily embedded in the core curriculum in a way that would ensure their continuance were the faculty member(s) to move elsewhere. The committee also documented externships and internships and training sites within psychology where part or all of the training emphasis was on trauma. These formal and institutional training opportunities are in addition to the large number of continuing education training institutes and freestanding courses that have developed. There is a need for similar surveys of other human-service, medical, public health and policy, journalism and media, legal/criminal justice, and religious/spiritual curricula.

Several organizations have published suggested models for trauma training to provide templates for the organization of specific training programs and subspecializations. The Society for Traumatic Stress Studies, (now renamed The International Society for Traumatic Stress Studies (ISTSS), a multidisciplinary professional organization for those who specialize in psychological trauma), published "The Initial Report of the Presidential Task Force on Curriculum, Education, and Training" in 1989 (The Society for Traumatic Stress Studies, 1989). The Task Force, commissioned by the Society president, Dr. Yael Danieli, has as its goal, "to develop model curricula for each subspecialty treating individuals with PTSD and to develop training for individuals wishing to learn about PTSD in other settings (undergraduate, graduate, continuing education, etc.). The curricula must be capable of meeting the needs of individuals within a specialty by providing for the education of students and traumata arising from diverse settings (war, natural disaster, sexual assault, etc.) and by providing a framework for integrating multidimensional sources of information (biological, psychological, social)" (no page number). The resultant report, a quite comprehensive document, through a network of service provider subcommittees, laid out models for the training for the following groups: clergy; creative arts therapy; media; nursing; organizations, institutions, and public health; paraprofessionals and other professionals; psychiatry; psychology; social work; and undergraduate education. Although its recommendations have

not been widely adopted, this report could still provide a preliminary foundation for all of these professions to build upon.

More recently, the ISTSS established a task force that generated "Guidelines for International Training in Mental Health and Psychosocial Interventions for Trauma Exposed Populations" (Weine et al., 2002), guidelines that appear in the article's appendix. They are divided into four major areas: values; contextual challenges; core curricular elements; and monitoring and evaluation of training. The specific focus of this training model is to prepare practitioners to respond to international emergencies, often in the form of natural disasters or related to combat operations. It is designed to encourage interventions that are culture and country-sensitive and to avoid the wholesale exporting of helping personnel trained only in Western forms of trauma and trauma intervention. In recent years, it has been noted that the imposition of the beliefs and interventions of non-native helpers has, at times, done more harm than good, especially when the beliefs and strategies of well-meaning caregivers may be at odds with those of the individuals they are attempting to help. Clearly, training in cultural competency in treating trauma is essential just as it is to studies conducted by nonindigenous researchers (See Brown, 2008 for a discussion of the myriad cultural issues and competencies that are needed).

A comprehensive curriculum for the inclusion of trauma training for work with adult trauma survivors of childhood abuse in various service settings entitled "Risking Connection" was developed in 2000 (Saakvitne, Gamble, Pearlman, & Lev, 2000). This innovative curriculum included a training of trainers module in order to ensure its expansion. The original work, in fact, has been revised and expanded to provide more specialized training for various service providers (i.e., clergy) and for other traumatized "consumer" groups (i.e., victims of domestic violence, victims of terrorism). Bloom (1997) developed a similar model that she titled "Creating Sanctuary" that included detailed training on trauma to orient the provision of services from a trauma-referenced perspective. Both curricula served as a model for other efforts and have been used by the states of Connecticut, New York, and Maine for their state-wide trauma initiatives, as well as by many

public and private social service agencies and public policymakers and organizations.

The Behavioral Science Division of the National Center for PTSD (NCPTSD), administered by the Department of Veteran Affairs (DVA), has developed a multimodal approach to trauma training that was summarized by Litz and Salters-Pedneault (2008). The major components of NCPTSD program include didactic instruction, supervision, case conferences, symposia, and colloquia. The primary concentration of the NCPTSD program, because of its affiliation with the DVA, is treatment of combat-related PTSD. The National Child Traumatic Stress Network has, as part of its organizational mission, the development and assessment of treatment approaches and the dissemination of training on effective and evidence-based treatments. It has initiated web-based training programs for some of its endorsed treatments.

Yutrzenka and Naifeh (2008) offer suggestions for training professional psychologists in disaster relief work. They outline the training provided by University of South Dakota's Disaster Mental Health Institute (DMHI) via a doctoral specialty track in clinical/disaster psychology. While natural disasters are unquestionably a form of trauma, this area of trauma practice differs from many others, in that it focuses on responding during or in the immediate aftermath of a catastrophic event. Although it certainly is one facet of the field of traumatic stress, it requires a markedly different conceptual framework and skill set from those appropriate for post-trauma work that addresses the lingering impact of the traumatic event anywhere from weeks to as long as decades after it has occurred.

Organizational, continuing education, and conference offerings have been especially important in the dissemination of information about trauma and treatment of the traumatized. A number of continuing education organizations have focused exclusively on trauma-related trainings and others routinely include attention to trauma training in their more general list of topics. Professionals have had to utilize these resources in order to get needed information to know how to approach the treatment of their traumatized clientele; however, as mentioned earlier, these lack the organization and oversight of a formal curriculum and also lack review and supervision of the practitioner's

skills. A number of organizations are now developing innovative training programs. One such program, a Post-Doctoral Institute consisting of eight 6-hour training courses on the treatment of trauma interspersed with small, expert-led discussion groups, was recently organized by the first author for the Maryland Psychological Association. Registrants were enthusiastic about attending a structured program that addressed a number of the most important topic areas across all types of trauma. Online courses, "webinars," and video/CD trainings are but some of the more innovative approaches also being applied to training.

An important recognition that has developed in all of these training efforts in psychological trauma is that preparation to work in this area, particularly for professional practice, requires a multifaceted approach. Comprehensive training to work with traumatized populations requires didactic instruction in the myriad forms of traumatic events and potential emotional, behavioral, cognitive, and somatic responses to psychological trauma. It also must include extensive professional skills training and supervised practical experience in working with trauma-exposed groups for the involved service-provider.

The models described above serve to underscore the vast range of the field of psychological trauma and the resultant scope of service areas and specialty areas. While there are clearly common elements between the training recommendations of ISTSS, NCPTSD, and the University of South Dakota's DMHI and Saakvitne et al.'s (2000) Risking Connection model, there are also divergences that reflect the particular aspect of the traumatic stress field on which each of these organizations focus: international emergencies, combat-related trauma, and disaster relief respectively. Training in, for example, treating survivors of prolonged child abuse (Gold, 1997) or of intimate-partner violence (Weiss, Kripke, Coons & O'Brien, 2000; Wingfield & Blocker, 1998), while overlapping with the general information provided within the programs in these other areas, would include a considerable body of distinct content, areas of focus, interventions, and skills. As the spectrum of types of trauma and of adverse responses to traumatic events surveyed in this paper demonstrates, the field of psychological trauma is var-

ied and extensive; therefore, the potential content of training in this area is equally extensive.

*Some core training principles.* Beyond the dimension of content and specialized skills and foci, working with traumatized individuals carries with it unique emotional and coping challenges to the professional practitioner. A growing literature documents the many adverse reactions that professional responders and caretakers (and even researchers) can develop as a result of stressors encountered in direct exposure to trauma on-site and/or indirect exposure working with traumatized clientele after the fact. These potential reactions have variously been referred to as secondary traumatization (Stamm, 1995), compassion fatigue (Figley, 1995), and vicarious traumatization (McCann & Pearlman, 1990). These terms all refer to the potentially negative outcomes that the emotional pressure of working in a trauma setting and with traumatized individuals can have on helpers. These may not only lead to personal and professional costs for the caregiver and even their family members, but also may potentially limit their effectiveness in assisting trauma survivors. This aspect of trauma work necessitates that professional training include the development of finely tuned self-care and coping abilities to recognize and ameliorate the stressful impact of responding to this population.

The stressors of working with trauma survivors make it particularly important that training programs generate an atmosphere of safety for trainees (Chard & Hansel, 2006). In the absence of such an environment, students are unlikely to share the difficulties and self-questioning that inevitably arise in the course of the services they provide with their teachers and supervisors. Trauma faculty and supervisors need to make it clear to trainees that these types of reactions are to be expected and that expressing and addressing them is a welcomed and responsible part of functioning in this arena. Being able to recognize and acknowledge one's own responses is an indispensable component of effective trauma work (Giller, Vermilyea, & Steele, 2006).

In keeping with this approach, several authors have strongly recommended that training for trauma practitioners take place within a relational framework (see, e.g., Bacigalupe, 2002; Wells, Trad, & Alves, 2003; Saakvitne et al., 2000). Among other things, this perspective

recognizes the importance of having instructors and supervisors model humanness and openness. It encompasses, for example, acknowledging their own struggles with the stressors and the countertransference challenges of working with trauma survivors (Dalenberg, 2000). Only in such a context can trainees approach the level of knowledge and resilience needed to engage with traumatized individuals in a way that allows for a reasonable measure of appreciation for what they have been through and are grappling with. The relational approach to training explicitly acknowledges that a great deal of trauma occurs in a relational context and is thus a relational experience, thus, its resolution best occurs in a relational matrix (Wells et al., 2003).

An associated issue is that it is important for trainers to understand that attaining expertise as a trauma practitioner is a developmental process (Loneragan, O'Halloran, & Crane, 2004; Wells et al., 2003). One cannot achieve an adequate understanding of trauma on an intellectual level only; it is absolutely essential to comprehend trauma and its impact on an experiential level as well, in order to be of help to those who have lived through catastrophic circumstances resolve and cope with what they confronted. This achievement can only occur if the apprentice professional undergoes a personal transformation, and it is incumbent upon trainers to be attuned to and to foster this process.

Also consistent with a relational model of trauma training is emphasis on fostering cultural competency (Bacigalupe, 2002; Boehnlein, 2002; Brown, 2008). The impact and experience of, and response to trauma are shaped largely by the unique perspective of culture, ethnicity, gender, sexual orientation, and disability/ability status of the individual upon encountering the traumatic event (Brown, 2008), as well as personal characteristics and previous history of the individual. Trainees must be oriented to the importance of these factors in forming a working alliance with and understanding the perceptual and experiential framework through which the survivor makes sense of and reacts to the trauma. Training in cultural competency as well as the variable adaptations to traumatization is therefore an indispensable component of trauma training. In a related vein, helpers must also appreciate that the crisis of trauma and its resultant suffering may result not only in damage and demoralization, but, for

some, result in increases in resilience, personal meaning-making and transformation, and post-traumatic growth (Tedeschi & Calhoun, 1995).

One approach to trauma training that does justice to its scope while attending to some of its specific dimensions is to recognize the importance of combining generalist professional training with particular aspects of trauma training (Courtois, 2002; Gold, 2004; Yutzenka & Naifeh, 2008). The territory of trauma practice can only be adequately mastered if training in trauma is grounded in the fundamental and generalist curriculum of a profession. The extensive nature of the field of trauma make it a “specialty” for which those with high quality professional training are particularly well suited (Gold, 2004).

### Conclusion

This article has highlighted the ubiquity of trauma in human experience and the variety of posttraumatic reactions and disorders identified as occurring in its aftermath. It has also discussed the lacuna in professional training regarding trauma that has followed from its historical denial and disavowal across cultures, often after a period of acknowledgment and study. The unfortunate result of this lacuna has been the extension rather than the amelioration of the suffering of the traumatized, at individual, family, community, society, and global levels.

Given the advances in the scientific understanding of trauma and the development of the field of traumatic stress studies, the time has clearly come to include training in all dimensions of trauma across all professions. Psychology has a unique opportunity to take the lead in this endeavor, in that its influence expands across all of the medical, helping, human service, legal/criminal justice, journalism/media, and religious professions. Although we were able to find several models for trauma training in the psychological literature, the field as a whole is so extensive that none of them approaches a comprehensive overview of the various facets of the topic (although the original ISTSS task force report provides a model that could be built upon; Society for Traumatic Stress Studies, 1989). There is a pressing need for the development of a framework for educa-

tional and training in trauma that provides a holistic perspective.

We recommend the inclusion of trauma-related information and topics from the undergraduate level onward and that trauma be given presented as a normal and frequent occurrence in human history and as an influential, but as yet not fully recognized, factor in human development. This pertains, in particular, to the deleterious effects of trauma and its role as a contributor to psychopathology; however, this should not be the only focus, since trauma has also been influential in the development of human resilience and has been found to result in post-traumatic growth in many cases. This is one example of the type of perspective that would be needed in order to construct a comprehensive trauma curriculum.

Another recommendation is for graduate training programs across professions to pursue incorporation of trauma-related material across the entire curriculum in more detailed and sophisticated ways. We have identified and discussed some specific core competencies as the foundation of all professional training. Subspecializations across a variety of trauma-related topics and types of practice can also be offered and, over time, there might be entire curricula devoted to trauma studies and intervention. A trauma-informed perspective can also greatly enrich academic disciplines such as history and literature. In the applied professions, education and training will allow a much more adequate response to individuals who have been exposed to or experienced trauma and suffered distress in its aftermath and will also assist those practitioners whose job it is to offer them assistance and solace. To do any less than this is to be remiss in our professional and ethical responsibilities.

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