BACKGROUND MATERIALS

EDNY ADR Department
Columbia Law School Ethics Colloquium:
Power Imbalance in the Wake of Trauma
November 2018

Additional Readings

Types of Trauma

1. Trauma Awareness
    - This chapter describes the different kinds of traumatic events that can impact the behavioral health of individuals, families, and communities.
2. Types of Traumas & Violence
    - This article highlights key characteristics of traumatic experiences and explores several main elements that influence why people respond differently to trauma.

Effects of Trauma

3. Common Reactions after Trauma
    - This article discusses the common reactions to trauma.
4. Psychology of Mediation
    - This article helps in identifying several of the physiological symptoms a traumatized party may display during the course of mediation.
5. Understanding the Impact of Trauma
    - This chapter discusses the common experiences and responses to trauma along with advice for professionals working with traumatized individuals.
6. When terrible things happen
    - This article covers a wide variety of positive and negative reactions that survivors can experience during and immediately after a disaster, and what may or may not help when working with survivors.

Power Imbalance

7. Balance of Power
    - This article highlights if a power imbalance in mediation is problematic and speaks to the decision to correct the imbalance.
8. Managing and Imbalance of Power
    - This article describes the different skills that can be used in order to even the playing field when there is a power imbalance.
9. Power Imbalances in Mediation
    - This paper discusses research on power, the many types and how it changes a mediation.

Best Practices for Mediators

10. Three E's of Trauma
    - This article puts forth a framework for understanding trauma: event(s), experience of event(s), and effect.
11. Tips on Coping with Trauma
    - This article offers several suggestions for helping survivors of disasters and other traumatic events.
12. Trauma Informed Mediation
    - This article describes how to have a trauma sensitive and trauma informed approach to mediation.
13. When Should a Mediator Withdraw
    - This article discusses when and how a mediator should withdraw in situations that they deem appropriate.

A TREATMENT IMPROVEMENT PROTOCOL

Trauma-Informed Care in Behavioral Health Services

TIP 57

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

2 Trauma Awareness

IN THIS CHAPTER

- Types of Trauma
- Characteristics of Trauma
- Individual and Sociocultural Features

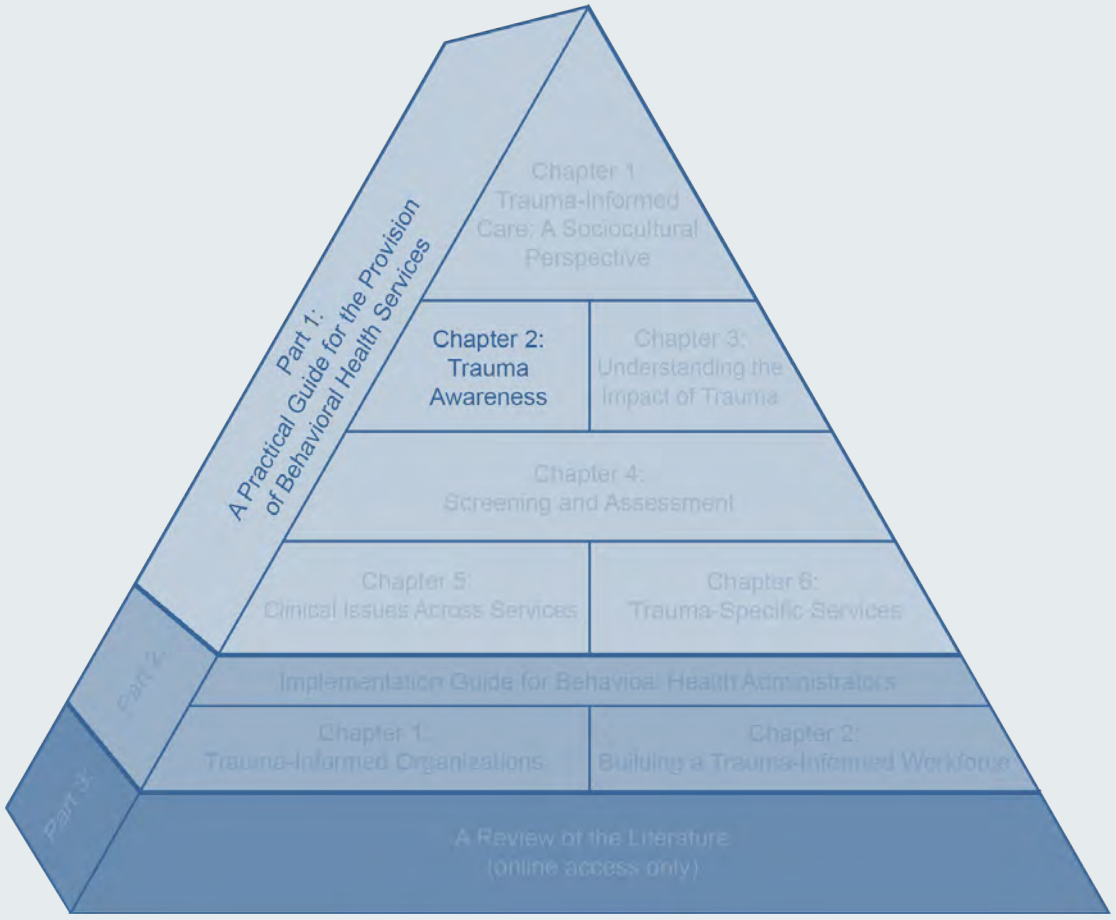
Traumatic experiences typically do not result in long-term impairment for most individuals. It is normal to experience such events across the lifespan; often, individuals, families, and communities respond to them with resilience. This chapter explores several main elements that influence why people respond differently to trauma. Using the social-ecological model outlined in Part 1, Chapter 1, this chapter explores some of the contextual and systemic dynamics that influence individual and community perceptions of trauma and its impact. The three main foci are: types of trauma, objective and subjective characteristics of trauma, and individual and sociocultural features that serve as risk or protective factors.

This chapter's main objective is to highlight the key characteristics of traumatic experiences. Trauma-informed behavioral health service providers understand that many influences shape the effects of trauma among individuals and communities—it is not just the event that determines the outcome, but also the event's context and the resultant interactions across systems.

Types of Trauma

The following section reviews various forms and types of trauma. It does not cover every conceivable trauma that an individual, group, or community may encounter. Specific traumas are reviewed only once, even when they could fit in multiple categories of trauma. Additionally, the order of appearance does not denote a specific trauma's importance or prevalence, and there is no lack of relevance implied if a given trauma is not specifically addressed in this Treatment Improvement Protocol (TIP). The intent is to give a broad perspective of the various categories and types of trauma to behavioral health workers who wish to be trauma informed.

TIC Framework in Behavioral Health Services—Trauma Awareness



Natural or Human-Caused Traumas

The classification of a trauma as natural or caused by humans can have a significant impact on the ways people react to it and on the types of assistance mobilized in its aftermath (see Exhibit 1.2-1 for trauma examples). Natural traumatic experiences can directly affect a small number of people, such as a tree falling on a car during a rainstorm, or many people and communities, as with a hurricane. Natural events, often referred to as "acts of God," are typically unavoidable. Human-caused traumas are caused by human failure (e.g., technological catastrophes, accidents, malevolence) or by human design (e.g., war). Although multiple factors contribute to the severity of a natural or human-caused trauma, traumas perceived as intentionally harmful often make the event more traumatic for people and communities.

For information on resources to prepare States, Territories, and local entities to deliver effective mental health and substance abuse responses during disasters, contact the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Disaster Technical Assistance Center:

4350 East West Hwy, Suite 1100
Bethesda, MD 20814 6233
Phone: 1 800 308 3515
Fax: 1 800 311 7691
Email: DTAC@samhsa.hhs.gov

Exhibit 1.2-1: Trauma Examples

Caused Naturally	Caused by People	
	Accidents, Technological Catastrophes	Intentional Acts
Tornado	Train derailment	Arson
Lightning strike	Roofing fall	Terrorism
Wildfire	Structural collapse	Sexual assault and abuse
Avalanche	Mountaineering accident	Homicides or suicides
Physical ailment or disease	Aircraft crash	Mob violence or rioting
Fallen tree	Car accident due to malfunction	Physical abuse and neglect
Earthquake	Mine collapse or fire	Stabbing or shooting
Dust storm	Radiation leak	Warfare
Volcanic eruption	Crane collapse	Domestic violence
Blizzard	Gas explosion	Poisoned water supply
Hurricane	Electrocution	Human trafficking
Cyclone	Machinery-related accident	School violence
Typhoon	Oil spill	Torture
Meteorite	Maritime accident	Home invasion
Flood	Accidental gun shooting	Bank robbery
Tsunami	Sports-related death	Genocide
Epidemic		Medical or food tampering
Famine		
Landslide or fallen boulder		

How survivors of natural trauma respond to the experience often depends on the degree of devastation, the extent of individual and community losses, and the amount of time it takes to reestablish daily routines, activities, and services (e.g., returning to school or work, being able to do laundry, having products to buy in a local store). The amount, accessibility, and duration of relief services can significantly influence the duration of traumatic stress reactions as well as the recovery process.

Alongside the disruption of daily routines, the presence of community members or outsiders in affected areas may add significant stress or create traumatic experiences in and of themselves. Examples include the threat of others stealing what remains of personal property, restrictions on travel or access to property or living quarters, disruption of privacy within shelters, media attention, and subsequent exposure to repetitive images reflecting the devastation. Therefore, it isn't just the natural disaster or event that can challenge an individual or community; often, the consequences of the event and behavioral responses from others within and outside the community play a role in pushing survivors away from effective coping or toward resilience and recovery.

Human-caused traumas are fundamentally different from natural disasters. They are either intentional, such as a convenience store robbery at gunpoint, or unintentional, such as the technological accident of a bridge collapse (as occurred in Minneapolis, Minnesota, in 2007; U.S. Fire Administration, 2007). The subsequent reactions to these traumas often depend on their intentionality. However, a person or group of people is typically the target of the survivors' anger and blame. Survivors of an unintentionally human-caused traumatic event may feel angry and frustrated because of the lack of protection or care offered by the responsible party or government, particularly if there has been a perceived act of omission. After intentional human-caused acts, survivors often struggle to understand the

Case Illustrations: Quecreek Mine Flood and Greensburg's Tornado

Quecreek Mine Flood

The year following the rescue of nine miners from the Quecreek mine in western Pennsylvania in 2002 was a difficult one for residents of Somerset County. The dazzle of publicity surrounding a handful of workers from a small town, tension between miners and rescuers, and animosity over money for movie and book deals, in addition to the trauma itself, resulted in a rescuer's suicide, a number of miners having trauma-related symptoms, and several rescuers needing to seek treatment for posttraumatic stress disorder (PTSD; Goodell, 2003).

Greensburg's Tornado

Greensburg, a small town in southern Kansas, was hit by a large tornado in 2007 that killed 11 residents and leveled 95 percent of the town while causing severe damage to the remaining 5 percent. Families and community members experienced significant grief and traumatic stress after the disaster. Yet today, Greensburg is rebuilding with a focus on being "green"—that is, environmentally responsible—from design to construction and all the way through demolition. This town has the highest number of Leadership in Energy and Environmental Design–certified buildings in the world. A reality television show about the town's reinvention ran for three seasons, demonstrating the town's residents and business owners working with local government and various corporations to make their home an even better place than it was before the tornado.

motives for performing the act, the calculated or random nature of the act, and the psychological makeup of the perpetrator(s).

Individual, Group, Community, and Mass Traumas

In recognizing the role of trauma and understanding responses to it, consider whether the trauma primarily affected an individual and perhaps his or her family (e.g., automobile accident, sexual or physical assault, severe illness); occurred within the context of a group (e.g., trauma experienced by first responders or those who have seen military combat) or community (e.g., gang-related shootings); transpired within a certain culture; or was a large-scale disaster (e.g., hurricane, terrorist attack). This context can have significant implications for whether (and how) people experience shame as a result of the trauma, the kinds of support and compassion they receive, whether their experiences are normalized or diminished by others, and even the kinds of services they are offered to help them recover and cope.

Individual trauma

An individual trauma refers to an event that only occurs to one person. It can be a single event (e.g., mugging, rape, physical attack, work-related physical injury) or multiple or prolonged events (e.g., a life-threatening illness, multiple sexual assaults). Although the trauma directly affects just one individual, others who know the person and/or are aware of the trauma will likely experience emotional repercussions from the event(s) as well, such as recounting what they said to the person before the event, reacting in disbelief, or thinking that it could just as easily have happened to them, too.

Survivors of individual trauma may not receive the environmental support and concern that members of collectively traumatized groups and communities receive. They are less likely to reveal their traumas or to receive validation of their experiences. Often, shame distorts their perception of responsibility for the trauma. Some survivors of individual traumas, especially those who have kept the trauma secret, may not receive needed comfort and

Advice to Counselors: Working With Clients Who Have Experienced Individual Traumas

In working with clients who have histories of individual trauma, counselors should consider that:

- Empathy, or putting oneself in the shoes of another, is more potent than sympathy (expressing a feeling of sorrow for another person).
- Some clients need to briefly describe the trauma(s) they have experienced, particularly in the early stages of recovery. Strategies that focus on reexperiencing the trauma, retrieving feelings related to the trauma, and bringing past experiences to the forefront should only be implemented if trauma-specific treatment planning and services are available.
- Understanding the trauma, especially in early recovery, should begin with educating the client about and normalizing trauma-related symptoms, creating a sense of safety within the treatment environment, and addressing how trauma symptoms may interfere with the client's life in the present.
- It is helpful to examine how the trauma affects opportunities to receive substance abuse and/or mental health treatment as well as treatment for and recovery from the trauma itself (e.g., by limiting one's willingness to share in or participate in group counseling).
- Identifying and exploring strengths in the client's history can help the client apply those strengths to his or her ability to function in the present.

acceptance from others; they are also are more likely to struggle with issues of causation (e.g., a young woman may feel unduly responsible for a sexual assault), to feel isolated by the trauma, and to experience repeated trauma that makes them feel victimized.

Physical injuries

Physical injuries are among the most prevalent individual traumas. Millions of emergency room (ER) visits each year relate directly to physical injuries. Most trauma patients are relatively young; about 70 percent of injury-related ER cases are people younger than 45 years old (McCaig & Burt, 2005). Dedicated ER hospital units, known as "trauma centers," specialize in physical traumas such as gunshot wounds, stabbings, and other immediate physical injuries. The term "trauma" in relation to ERs does not refer to psychological trauma, which is the focus of this TIP, yet physical injuries can be associated with psychological trauma. Sudden, unexpected, adverse health-related events can lead to extensive psychological trauma for patients and their families.

Excessive alcohol use is the leading risk factor for physical injuries; it's also the most promising target for injury prevention. Studies consistently connect injuries and substance use (Gentilello, Ebel, Wickizer, Salkever, & Rivara, 2005); nearly 50 percent of patients admitted to trauma centers have injuries attributable to alcohol abuse and dependence (Gentilello et al., 1999). One study found that two thirds of ambulatory assault victims presenting to an ER had positive substance use urinalysis results; more than half of all victims had PTSD 3 months later (Roy-Byrne et al.,

Acute stress disorder (ASD) prevalence among patients at medical trauma centers is very high, making trauma related disorders some of the most common complications seen in physically injured patients. Clients who have sustained serious injuries in car crashes, fires, stabbings, shootings, falls, and other events have an increased likelihood of developing trauma related mental disorders. Research suggests that PTSD and/or problem drinking is evident in nearly 50 percent of patients 1 year after discharge from trauma surgical units.

(Zatzick, Jurkovich, Gentilello, Wisner, & Rivara, 2002)

2004). Nearly 28 percent of patients whose drinking was identified as problematic during an ER visit for a physical injury will have a new injury within 1 year (Gentilello et al., 2005). For further information, see TIP 16, *Alcohol and Other Drug Screening of Hospitalized Trauma Patients* (Center for Substance Abuse Treatment [CSAT], 1995a).

Group trauma

The term "group trauma" refers to traumatic experiences that affect a particular group of people. This TIP intentionally distinguishes group trauma from mass trauma to highlight the unique experiences and characteristics of trauma-related reactions among small groups. These groups often share a common identity and history, as well as similar activities and concerns. They include vocational groups who specialize in managing traumas or who routinely place themselves in harm's way—for example, first responders, a group including police and emergency medical personnel. Some examples of group trauma include crews and their families who lose members from a commercial fishing accident, a gang whose members experience multiple deaths and injuries, teams of firefighters who lose members in a roof collapse, responders who attempt to save flood victims, and military service members in a specific theater of operation.

Survivors of group trauma can have different experiences and responses than survivors of individual or mass traumas. Survivors of group trauma, such as military service members and first responders, are likely to experience repeated trauma. They tend to keep the trauma experiences within the group, feeling that others outside the group will not understand; group outsiders are generally viewed as intruders. Members may encourage others in the group to shut down emotionally and repress their traumatic experiences—and there are some occupational roles that necessitate the repression of reactions to complete a mission or to be attentive to the needs at hand. Group members may not want to seek help and may discourage others from doing so out of fear that it may shame the entire group. In this environment, members may see it as a violation of group confidentiality when a member seeks assistance outside the group, such as by going to a counselor.

Group members who have had traumatic experiences in the past may not actively support traumatized colleagues for fear that acknowledging the trauma will increase the risk of repressed trauma-related emotions surfacing. However, groups with adequate resources for helping group members can develop a stronger and more supportive environment for handling subsequent traumas. These main group features influence the course of short- and long-term adjustments, including the development of traumatic stress symptoms associated with mental and substance use disorders.

Certain occupational groups are at greater risk of experiencing trauma—particularly multiple traumas. This TIP briefly reviews two main groups as examples in the following sections: first responders and military service members. For more detailed information on the impact of trauma and deployment, refer to the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (SAMHSA, planned f).

First responders

First responders are usually emergency medical technicians, disaster management personnel, police officers, rescue workers, medical and behavioral health professionals, journalists, and volunteers from various backgrounds. They also include lifeguards, military personnel, and clergy. Stressors associated with the kinds of traumatic events and/or disasters first responders are likely to experience include

exposure to toxic agents, feeling responsible for the lives of others, witnessing catastrophic devastation, potential exposure to gruesome images, observing human and animal suffering and/or death, working beyond physical exhaustion, and the external and internal pressure of working against the clock.

Military service members

Military personnel are likely to experience numerous stressors associated with trauma. Service members who have repeatedly deployed to a war zone are at a greater risk for traumatic stress reactions (also known as combat stress reaction or traumatic stress injury), other military personnel who provide support services are also at risk for traumatic stress and secondary trauma (refer to the glossary portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP). So too, service members who anticipate deployment or redeployment may exhibit psychological symptoms associated with traumatic stress. Some stressors that military service members may encounter include working while physically exhausted, exposure to gunfire, seeing or knowing someone who has been injured or killed, traveling in areas known for roadside bombs and rockets, extended hypervigilance, fear of being struck by an improvised explosive device, and so forth.

Trauma affecting communities and cultures

Trauma that affects communities and cultures covers a broad range of violence and atrocities that erode the sense of safety within a given community, including neighborhoods, schools, towns, and reservations. It may involve violence in the form of physical or sexual assaults, hate crimes, robberies, workplace or gang-related violence, threats, shootings, or stabbings—for example, the school shooting at Virginia Polytechnic Institute and State University in 2007. It also includes actions that attempt to dismantle systemic cultural practices, resources, and identities, such as making boarding school attendance mandatory for Native American children or placing them in non-Native foster homes. Cultural and/or community-based trauma can also occur via indifference or limited responsiveness to specific communities or cultures that are facing a potential catastrophe. Cultural traumas are events that, whether intentionally or not, erode the heritage of a culture—as with prejudice, disenfranchisement, and health inequities (e.g., late prenatal care, inability to afford medications, limited access to culturally appropriate health education, vicinity and quality of affordable medical services), among other examples.

"The excitement of the season had just begun, and then, we heard the news, oil in the water, lots of oil killing lots of water. It is too shocking to understand. Never in the millennium of our tradition have we thought it possible for the water to die, but it is true."

—Chief Walter Meganack, Port Graham, 1989

Of all the groups negatively affected by the Exxon Valdez oil spill, in many ways Alaska Natives were the most devastated. The oil spill destroyed more than economic resources; it shook the core cultural foundation of Native life. Alaska Native subsistence culture is based on an intimate relationship with the environment. Not only does the environment have sacred qualities for Alaska Natives; their survival also depends on the well-being of the ecosystem and the maintenance of cultural norms of subsistence. The spill directly threatened the well-being of the environment, disrupted subsistence behavior, and severely disturbed the sociocultural milieu of Alaska Natives.

Source: Gill & Picou, 1997, pp. 167–168.

Historical trauma

Historical trauma, known also as generational trauma, refers to events that are so widespread as to affect an entire culture; such events also have effects intense enough to influence generations of the culture beyond those who experienced them directly. The enslavement, torture, and lynching of African Americans; the forced assimilation and relocation of American Indians onto reservations; the extermination of millions of Jews and others in Europe during World War II; and the genocidal policies of the Hutus in Rwanda and the Khmer Rouge in Cambodia are examples of historical trauma.

In the past 50 years, research has explored the generational effects of the Holocaust upon survivors and their families. More recent literature has extended the concept of historical or generational trauma to the traumatic experiences of Native Americans. Reduced population, forced relocation, and acculturation are some examples of traumatic experiences that Native people have endured across centuries, beginning with the first European presence in the Americas. These tragic experiences have led to significant loss of cultural identity across generations and have had a significant impact on the well-being of Native communities (Whitbeck, Chen, Hoyt, & Adams, 2004). Data are limited on the association of mental and substance use disorders with historical trauma among Native people, but literature suggests that historical trauma has repercussions across generations, such as depression, grief, traumatic stress, domestic violence, and substance abuse, as well as significant loss of cultural knowledge, language, and identity (Gone, 2009). Historical trauma can increase the vulnerability of multiple generations to the effects of traumas that occur in their own lifetimes.

Mass trauma

Mass traumas or disasters affect large numbers of people either directly or indirectly. It is beyond the scope of this TIP to cover any specific disaster in detail; note, however, that mass traumas include large-scale natural and human-caused disasters (including intentional acts and accidents alike). Mass traumas may involve significant loss of property and lives as well as the widespread disruption of normal routines and services. Responding to such traumas often requires immediate and extensive resources that typically exceed the capacity of the affected communities, States, or countries in which they occur. Recent examples of such large-scale catastrophes include:

- In January 2010, a massive earthquake hit Haiti, killing hundreds of thousands of people and leaving over a million homeless.
- A nuclear reactor meltdown in the Ukraine in 1986 resulted in a technological and environmental disaster that affected tens of millions of people.
- The tsunami in the Indian Ocean in 2005 left hundreds of thousands dead in nine countries.

One factor that influences an individual's response to trauma is his or her ability to process one trauma before another trauma occurs. In mass traumas, the initial event causes considerable destruction, the consequences of which may spawn additional traumas and other stressful events that lead to more difficulties and greater need for adjustments among survivors, first responders, and disaster relief agencies. Often, a chain reaction occurs. Take, for example, Hurricane Katrina and its impact on the people of Louisiana and other coastal States. After the initial flooding, people struggled to obtain basic needs, including food, drinking water, safe shelter, clothing, medicines, personal hygiene items, and so forth, all as concern mounted about the safety of children and

other relatives, friends, and neighbors. In this and similar cases, the destruction from the initial flooding led to mass displacement of families and communities; many people had to relocate far from New Orleans and other badly affected areas, while also needing to gain financial assistance, reinitiate work to generate income, and obtain stable housing. People could not assimilate one stressor before another appeared.

Nevertheless, mass traumas can create an immediate sense of commonality—many people are "in the same boat," thus removing much of the isolation that can occur with other types of trauma. People can acknowledge their difficulties and receive support, even from strangers. It is easier to ask for help because blame is often externalized; large-scale disasters are often referred to as "acts of God" or, in cases of terrorism and other intentional events, as acts of "evil." Even so, survivors of mass trauma often encounter an initial rally of support followed by quickly diminishing services and dwindling care. When the disaster fades from the headlines, public attention and concern are likely to decrease, leaving survivors struggling to reestablish or reinvent their lives without much outside acknowledgment.

The experience of mass trauma can lead to the development of psychological symptoms and substance use at either a subclinical or a diagnostic level (refer to Part 3 of this TIP, available online, for more information highlighting the relationship between trauma and behavioral health problems). Likewise, one of the greatest risks for traumatic stress reactions after a mass tragedy is the presence of preexisting mental and co-occurring disorders, and individuals who are in early recovery from substance use disorders are at greater risk for such reactions as well. Nonetheless, people are amazingly resilient, and most will not develop long-term mental or substance use disorders after an event; in fact, most trauma-related symptoms will resolve in a matter of months (Keane & Piwowarczyk, 2006).

Interpersonal Traumas

Interpersonal traumas are events that occur (and typically continue to reoccur) between people who often know each other, such as spouses or parents and their children. Examples include physical and sexual abuse, sexual assault, domestic violence, and elder abuse.

Intimate partner violence

Intimate partner violence (IPV), often referred to as domestic violence, is a pattern of actual or threatened physical, sexual, and/or emotional abuse. It differs from simple assault in that multiple episodes often occur and the perpetrator is an intimate partner of the victim. Trauma associated with IPV is normally ongoing. Incidents of this form of violence are rarely isolated, and the client may still be in contact with and encountering abuse from the perpetrator while engaged in treatment.

Intimate partners include current and former spouses, boyfriends, and girlfriends. The majority of all nonfatal acts of violence and intimate partner homicides are committed against women; IPV accounts for over 20 percent of nonfatal violence against women but only 3.6 percent of that committed against men (Catalano, 2012). Children are the hidden casualties of IPV. They often witness the assaults or threats directly, within earshot, or by being exposed to the aftermath of the violence (e.g., seeing bruises and destruction of property, hearing the pleas for it to stop or the promises that it will never happen again).

Substance abuse, particularly involving alcohol, is frequently associated with IPV. It is the presence of alcohol-related problems in either partner, rather than the level of alcohol consumption itself, that is the important factor.

Drinking may or may not be the cause of the violence; that said, couples with alcohol-related disorders could have more tension and disagreement within the relationship in general, which leads to aggression and violence. The consumption of alcohol during a dispute is likely to decrease inhibitions and increase impulsivity, thus creating an opportunity for an argument to escalate into a physical altercation. More information on domestic violence and its effects on partners and families, as well as its connection with substance use and trauma-related disorders, is available in TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b), and from the National Online Resource Center on Violence Against Women (http://www.vawnet.org/).

Developmental Traumas

Developmental traumas include specific events or experiences that occur within a given developmental stage and influence later development, adjustment, and physical and mental health. Often, these traumas are related to adverse childhood experiences (ACEs), but they can also result from tragedies that occur outside an expected developmental or life stage (e.g., a child dying before a parent, being diagnosed with a life-threatening illness as a young adult) or from events at any point in the life cycle that create significant loss and have life-altering consequences (e.g., the death of a significant other in the later years that leads to displacement of the surviving partner).

Adverse childhood experiences

Some people experience trauma at a young age through sexual, physical, or emotional abuse and neglect. The Adverse Childhood Experiences Study (Felitti et al., 1998) examined the effects of several categories of ACEs on adult health, including physical and emotional abuse; sexual abuse; a substance-dependent parent; an incarcerated, mentally ill, or suicidal household member; spousal abuse between parents; and divorce or separation that meant one parent was absent during childhood. The National Comorbidity Studies examined the prevalence of trauma and defined childhood adversities as parental death, parental divorce/separation, life-threatening illness, or extreme economic hardship in addition to the childhood experiences included in the Adverse Childhood Experiences Study (Green et al., 2010).

ACEs can negatively affect a person's well-being into adulthood. Whether or not these experiences occur simultaneously, are time-limited, or recur, they set the stage for increased vulnerability to physical, mental, and substance use disorders and enhance the risk

Child Neglect

Child neglect occurs when a parent or caregiver does not give a child the care he or she needs according to his or her age, even though that adult can afford to give that care or is offered help to give that care. Neglect can mean not providing adequate nutrition, clothing, and/or shelter. It can mean that a parent or caregiver is not providing a child with medical or mental health treatment or is not giving prescribed medicines the child needs. Neglect can also mean neglecting the child's education. Keeping a child from school or from special education can be neglect. Neglect also includes exposing a child to dangerous environments (e.g., exposure to domestic violence). It can mean poor supervision for a child, including putting the child in the care of someone incapable of caring for children. It can mean abandoning a child or expelling him or her from home. Lack of psychological care, including emotional support, attention, or love, is also considered neglect—and it is the most common form of abuse reported to child welfare authorities.

Source: dePanfilis, 2006.

for repeated trauma exposure across the life span. Childhood abuse is highly associated with major depression, suicidal thoughts, PTSD, and dissociative symptoms. So too, ACEs are associated with a greater risk of adult alcohol use. When a person experiences several adverse events in childhood, the risk of his or her heavy drinking, self-reported alcohol dependence, and marrying a person who is alcohol dependent is two to four times greater than that of a person with no ACEs (Dube, Anda, Felitti, Edwards, & Croft, 2002).

A detailed examination of the issues involved in providing substance abuse treatment to survivors of child abuse and neglect is the subject of TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT, 2000b).

Political Terror and War

Political terror and war are likely to have lasting consequences for survivors. In essence, anything that threatens the existence, beliefs, well-being, or livelihood of a community is likely to be experienced as traumatic by community members. Whether counselors are working with an immigrant or refugee enclave in the United States or in another country, they should be aware of local events, local history, and the possibility that clients have endured trauma. (For international information about the clinical, historical, and theoretical aspects of trauma and terrorism, see Danieli, Brom, & Sills, 2005.) Terrorism is a unique subtype of human-caused disasters. The overall goal of terrorist attacks is to maximize the uncertainty, anxiety, and fear of a large community, so the responses are often epidemic and affect large numbers of people who have had direct or indirect exposure to an event (Silver et al., 2004; Suvak, Maguen, Litz, Silver, & Holman, 2008). Terrorism has a variety of results not common to other disasters, such as reminders of the unpredictability of terrorist acts; increases in security measures for the general population; intensified suspicion about a particular population, ethnicity, or culture; and heightened awareness and/or arousal.

Refugees

According to the World Refugee Survey, there are an estimated 12 million refugees and asylum seekers, 21 million internally displaced people, and nearly 35 million uprooted people (U.S. Committee for Refugees and Immigrants, 2006). Many of these people have survived horrendous ordeals with profound and lasting effects for individuals and whole populations. In addition to witnessing deaths by execution, starvation, or beatings, many survivors have experienced horrific torture.

Refugees are people who flee their homes because they have experienced or have a reasonable fear of experiencing persecution. They

Torture and Captivity

Torture traumatizes by taking away an individual's personhood. To survive, victims have to give up their sense of self and will. They become the person the torturer designs or a nonperson, simply existing. Inevitably, the shame of the victim is enormous, because the focus of torture is to humiliate and degrade. As a result, victims often seek to hide their trauma and significant parts of their selfhood long after torture has ended and freedom has been obtained. According to Judith Herman, "the methods of establishing control over another person are based upon the systematic, repetitive infliction of psychological trauma. They are organized techniques of disempowerment and disconnection. Methods of psychological control are designed to instill terror and helplessness and to destroy the victim's sense of self in relation to others."

Source: Herman, 1997, p. 77.

differ from immigrants who willingly leave their homes or homeland to seek better opportunities. Although immigrants may experience trauma before migrating to or after reaching their new destination, refugees will often have greater exposure to trauma before migration. Refugees typically come from war-torn countries and may have been persecuted or tortured. Consequently, greater exposure to trauma, such as torture, before migrating often leads to more adjustment-related difficulties and psychological symptoms after relocation (Steel et al., 2009).

Refugees typically face substantial difficulties in assimilating into new countries and cultures. Moreover, the environment can create a new set of challenges that may include additional exposure to trauma and social isolation (Miller et al., 2002). These as well as additional factors influence adjustment, the development of mental illness (including PTSD), and the occurrence of substance use disorders. Additional factors that influence outcomes after relocation include receptivity of the local community, along with opportunities for social support and culturally responsive services.

Among refugee populations in the United States, little research is available on rates of mental illness and co-occurring substance use disorders and traumatic stress among refugee populations. Substance use patterns vary based on cultural factors as well as assimilation, yet research suggests that trauma increases the risk for substance use among refugees after war-related experiences (Kozarić-Kovačić, Ljubin, & Grappe, 2000). Therefore, providers should expect to see trauma-related disorders among refugees who are seeking treatment for a substance use disorder and greater prevalence of substance use disorders among refugees who seek behavioral health services.

Vietnamese Refugees

"Wars always have consequences, both immediate and remote, and the consequences are often tragic. One tragic circumstance often caused by war is the forceful, disorganized, and uncontrollable mass movement of both civilians and soldiers trying to escape the horrors of the wars or of an oppressive regime.…

"Vietnamese communists, by taking power in the North in 1954 and then in the South in 1975, caused two major upheavals in the Land of the Small Dragon, as Vietnam was once called. The first Vietnam War led to the 1954 exodus during which 1 million people fled from the North to the South. The second Vietnam War resulted in the dispersion, from 1975-1992, of approximately 2 million Vietnamese all over the world. These significant, unplanned, and uncoordinated mass movements around the world not only dislocated millions of people, but also caused thousands upon thousands of deaths at sea.…

"The second and third wave of refugees from 1976 onward went through a more difficult time. They had to buy their way out and to hide from soldiers and the police who hunted them down. After catching them, the police either asked for brides or threw the escapees into jails. Those who evaded police still had to face engine failures, sea storms, pirates…They then had to survive overcrowded boats for days or weeks, during which food and water could not be replenished and living conditions were terrible… Many people died from exhaustion, dehydration, and hunger. Others suffered at the hands of terrifying pirates… After the sea ordeal came the overcrowded camps where living conditions were most often substandard and where security was painfully lacking.…

"In the United States, within less than 3 decades, the Vietnamese population grew from a minority of perhaps 1,000 persons to the second largest refugee group behind Cubans."

Source: Vo, 2006, pp. 1–4.

System-Oriented Traumas: Retraumatization

Retraumatization occurs when clients experience something that makes them feel as though they are undergoing another trauma. Unfortunately, treatment settings and clinicians can create retraumatizing experiences, often without being aware of it, and sometimes clients themselves are not consciously aware that a clinical situation has actually triggered a traumatic stress reaction. Agencies that anticipate the risk for retraumatization and actively work on adjusting program policies and procedures to remain sensitive to the histories and needs of individuals who have undergone past trauma are likely to have more success in providing care, retaining clients, and achieving positive outcomes.

Staff and agency issues that can cause retraumatization include:

- Being unaware that the client's traumatic history significantly affects his or her life.
- Failing to screen for trauma history prior to treatment planning.
- Challenging or discounting reports of abuse or other traumatic events.
- Using isolation or physical restraints.
- Using experiential exercises that humiliate the individual.
- Endorsing a confrontational approach in counseling.
- Allowing the abusive behavior of one client toward another to continue without intervention.
- Labeling behavior/feelings as pathological.
- Failing to provide adequate security and safety within the program.
- Limiting participation of the client in treatment decisions and planning processes.
- Minimizing, discrediting, or ignoring client responses.
- Disrupting counselor–client relationships by changing counselors' schedules and assignments.
- Obtaining urine specimens in a nonprivate setting.

Advice to Counselors: Addressing Retraumatization

- Anticipate and be sensitive to the needs of clients who have experienced trauma regarding program policies and procedures in the treatment setting that might trigger memories of trauma, such as lack of privacy, feeling pushed to take psychotropic medications, perceiving that they have limited choices within the program or in the selection of the program, and so forth.
- Attend to clients' experiences. Ignoring clients' behavioral and emotional reactions to having their traumatic memories triggered is more likely to increase these responses than decrease them.
- Develop an individual coping plan in anticipation of triggers that the individual is likely to experience in treatment based on his or her history.
- Rehearse routinely the coping strategies highlighted in the coping plan. If the client does not practice strategies prior to being triggered, the likelihood of being able to use them effectively upon triggering is lessened. For example, it is far easier to practice grounding exercises in the absence of severe fear than to wait for that moment when the client is reexperiencing an aspect of a traumatic event. (For more information on grounding exercises, refer to *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*; Najavits, 2002a, pp. 125–131.)
- Recognize that clinical and programmatic efforts to control or contain behavior in treatment can cause traumatic stress reactions, particularly for trauma survivors for whom being trapped was part of the trauma experience.
- Listen for the specific trigger that seems to be driving the client's reaction. It will typically help both the counselor and client understand the behavior and normalize the traumatic stress reactions.
- Make sure that staff and other clients do not shame the trauma survivor for his or her behavior, such as through teasing or joking about the situation.
- Respond with consistency. The client should not get conflicting information or responses from different staff members; this includes information and responses given by administrators.

- Having clients undress in the presence of others.
- Inconsistently enforcing rules and allowing chaos in the treatment environment.
- Imposing agency policies or rules without exceptions or an opportunity for clients to question them.
- Enforcing new restrictions within the program without staff–client communication.
- Limiting access to services for ethnically diverse populations.
- Accepting agency dysfunction, including lack of consistent, competent leadership.

Characteristics of Trauma

The following section highlights several selected characteristics of traumatic experiences that influence the effects of traumatic stress. Objective characteristics are those elements of a traumatic event that are tangible or factual; subjective characteristics include internal processes, such as perceptions of traumatic experiences and meanings assigned to them.

Objective Characteristics

Was it a single, repeated, or sustained trauma?

Trauma can involve a single event, numerous or repeated events, or sustained/chronic experiences. A *single trauma* is limited to a single point in time. A rape, an automobile accident, the sudden death of a loved one—all are examples of a single trauma. Some people who experience a single trauma recover without any specific intervention. But for others—especially those with histories of previous trauma or mental or substance use disorders, or those for whom the trauma experience is particularly horrific or overwhelming—a single trauma can result in traumatic stress symptoms and trauma- and stress-related disorders. Single traumas do not necessarily have a lesser psychological impact than repeated traumas. After the terrorist attacks on September 11, 2001—a significant single trauma—many Manhattan residents experienced intrusive memories and sleep disruption whether they were at the site of the attacks or watched television coverage of it (Ford & Fournier, 2007; Galea et al., 2002).

A series of traumas happening to the same person over time is known as *repeated trauma*. This can include repeated sexual or physical assaults, exposure to frequent injuries of others, or seemingly unrelated traumas. Military personnel, journalists covering stories of mass tragedies or prolonged conflicts, and first responders who handle hundreds of cases each year typify repeated trauma survivors. Repetitive exposure to traumas can have a cumulative effect over one's lifetime. A person who was assaulted during adolescence, diagnosed with a life-threatening illness in his or her thirties, and involved in a serious car accident later in life has experienced repeated trauma.

Some repeated traumas are sustained or chronic. Sustained trauma experiences tend to wear down resilience and the ability to adapt. Some examples include children who endure ongoing sexual abuse, physical neglect, or emotional abuse; people who are in violent relationships; and people who live in chronic poverty. Individuals in chronically stressful, traumatizing environments are particularly susceptible to traumatic stress reactions, substance use, and mental disorders.

Bidirectional relationships exist between trauma and substance use as well as trauma and mental illness. For example, abuse of alcohol and drugs increases the risk of a traumatic experience and creates greater vulnerability to the effects of trauma; substance abuse reduces a person's ability to take corrective and remedial actions that might reduce the impact of the trauma. Likewise, traumatic stress leads to a greater likelihood of

Case Illustration: Yourself

Think of a time that was particularly stressful (but not traumatic) in your life. Revisit this period as an observer watching the events unfold and then ask yourself, "What made this time particularly stressful?" It is likely that a part of your answer will include the difficulty of managing one situation before another circumstance came along demanding your time. Stressful times denote being bombarded with many things at one time, perceived or actual, without sufficient time or ability to address them emotionally, cognitively, spiritually, and/or physically. The same goes for trauma—rapid exposure to numerous traumas one after another lessens one's ability to process the event before the next onslaught. This creates a cumulative effect, making it more difficult to heal from any one trauma.

substance abuse that, in turn, increases the risk for additional exposure to trauma. Paralleling this bidirectional relationship, mental illness increases vulnerability to the effects of trauma and raises the risk for substance use disorders and for encountering additional traumatic events. So too, early exposure to ACEs is associated with traumatic stress reactions and subsequent exposure to trauma in adult years.

People who have encountered multiple and longer doses of trauma are at the greatest risk for developing traumatic stress. For example, military reservists and other military service members who have had multiple long tours of duty are at greater risk for traumatic stress reactions (see the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families;* SAMHSA, planned f). In addition, people are more likely to encounter greater impairment and distress from trauma if that trauma occurs with significant intensity and continues sporadically or unceasingly for extended periods.

Was there enough time to process the experience?

A particularly severe pattern of ongoing trauma, sometimes referred to as "cascading trauma," occurs when multiple traumas happen in a pattern that does not allow an individual to heal from one traumatic event before another occurs. Take, for example, California residents—they repeatedly face consecutive and/or simultaneous natural disasters including fires, landslides, floods, droughts, and earthquakes. In other cases, there is ample time to process an event, but processing is limited because people don't have supportive relationships or environments that model preventive practices. This can lead to greater vulnerability to traumas that occur later in life.

How many losses has the trauma caused?

Trauma itself can create significant distress, but often, the losses associated with a trauma have more far-reaching effects. For instance, a child may be forced to assume adult responsibilities, such as serving as a confidant for a parent who is sexually abusing him or her, and lose the opportunity of a childhood free from adult worries. In another scenario, a couple may initially feel grateful to have escaped a house fire, but they may nevertheless face significant community and financial losses months afterward. In evaluating the impact of trauma, it is helpful to access and discuss the losses associated with the initial trauma. The number of losses greatly influences an individual's ability to bounce back from the tragedy.

In the case illustration on the next page, Rasheed's losses cause him to disconnect from his wife, who loves and supports him. Successful confrontation of losses can be difficult if the losses compound each other, as with Rasheed's loss of his friend, his disability, his employment struggles, and the threats to his marriage and liberty. People can cite a specific

Case Illustration: Rasheed

Rasheed was referred to an employee assistance program by his employer. He considered quitting his job, but his wife insisted he talk to a counselor. He is a 41-year-old auto mechanic who, 4 years ago, caused a head-on collision while attempting to pass another vehicle. A close friend, riding in the passenger's seat, was killed, and two young people in the other vehicle were seriously injured and permanently disabled. Rasheed survived with a significant back injury and has only been able to work sporadically. He was convicted of negligent homicide and placed on probation because of his physical disability. He is on probation for another 4 years, and if he is convicted of another felony during that time, he will have to serve prison time for his prior offense.

While still in the hospital, Rasheed complained of feeling unreal, numb, and disinterested in the care he received. He did not remember the crash but remembers waking up in the hospital 2 days later. He had difficulty sleeping in the hospital and was aware of feelings of impending doom, although he was unaware of the legal charges he would later face. He was diagnosed with ASD.

He was discharged from the hospital with a variety of medications, including pain pills and a sleep aid. He rapidly became dependent on these medications, feeling he could not face the day without the pain medication and being unable to sleep without sleep medicine in larger doses than had been prescribed. Within 3 months of the accident, he was "doctor shopping" for pain pills and even had a friend obtain a prescription for the sleeping medication from that friend's doctor. In the 4 intervening years, Rasheed's drug use escalated, and his blunted emotions and detachment from friends became more profound. He became adept at obtaining pain pills from a variety of sources, most of them illegal. He fears that if he seeks treatment for the drug problem, he will have to admit to felony offenses and will probably be imprisoned. He also does not believe he can manage his life without the pain pills.

In the past 2 years, he has had recurring dreams of driving a car on the wrong side of the road and into the headlights of an oncoming vehicle. In the dream, he cannot control the car and wakes up just before the vehicles crash. At unusual times—for instance, when he is just awakening in the morning, taking a shower, or walking alone—he will feel profound guilt over the death of his friend in the accident. He becomes very anxious when driving in traffic or when he feels he is driving faster than he should. His marriage of 18 years has been marked by increasing emotional distance, and his wife has talked about separating if he does not do something about his problem. He has been unable to work consistently because of back pain and depression. He was laid off from one job because he could not concentrate and was making too many mistakes.

The counselor in the employee assistance program elicited information on Rasheed's drug use, although she suspected Rasheed was minimizing its extent and effects. Knowledgeable about psychological trauma, the counselor helped Rasheed feel safe enough to talk about the accident and how it had affected his life. She was struck by how little Rasheed connected his present difficulties to the accident and its aftermath. The counselor later commented that Rasheed talked about the accident as if it had happened to someone else. Rasheed agreed to continue seeing the counselor for five additional visits, during which time a plan would be made for Rasheed to begin treatment for drug dependence and PTSD.

event as precipitating their trauma, or, in other cases, the specific trauma can symbolize a series of disabling events in which the person felt his or her life was threatened or in which he or she felt emotionally overwhelmed, psychologically disorganized, or significantly disconnected from his or her surroundings. It will be important for Rasheed to understand how his losses played a part in his abuse of prescription medications to cope with symptoms associated with traumatic stress and loss, (e.g., guilt, depression, fear). If not addressed, his trauma could increase his risk for relapse.

Was the trauma expected or unexpected?

When talking about a trauma, people sometimes say they didn't see it coming. Being unprepared, unaware, and vulnerable often increases the risk of psychological injury, but these are common components of most traumas, given that most traumatic events do occur without warning (e.g., car crashes, terrorist attacks, sexual assaults). People with substance use disorders, mental illness, and/or cognitive disabilities may be especially vulnerable in that they may attend less or have competing concerns that diminish attention to what is going on around them, even in high-risk environments. However, most individuals attempt to gain some control over the tragedy by replaying the moments leading up to the event and processing how they could have anticipated it. Some people perseverate on these thoughts for months or years after the event.

Sometimes, a trauma is anticipated but has unexpected or unanticipated consequences, as in the case of Hurricane Katrina. Learning about what is likely to happen can reduce traumatization. For instance, training military personnel in advance of going to combat overseas prepares them to handle traumas and can reduce the impact of trauma.

Were the trauma's effects on the person's life isolated or pervasive?

When a trauma is isolated from the larger context of life, a person's response to it is more likely to be contained and limited. For instance, military personnel in combat situations can be significantly traumatized by what they experience. On return to civilian life or noncombat service, some are able to isolate the traumatic experience so that it does not invade ordinary, day-to-day living. This does not mean that the combat experience was not disturbing or that it will not resurface if the individual encounters an experience that triggers memories of the trauma; it just means that the person can more easily leave the trauma in the past and attend to the present.

Conversely, people who remain in the vicinity of the trauma may encounter greater challenges in recovery. The traumatic event intertwines with various aspects of the person's daily activities and interactions, thus increasing the possibility of being triggered by surrounding cues and experiencing subsequent psychological distress. However, another way to view this potential dilemma for the client is to reframe it as an opportunity—the repetitive exposure to trauma-related cues may provide vital guidance as to when and which treatment and coping techniques to use in the delivery of trauma-informed and trauma-specific behavioral health services.

Who was responsible for the trauma and was the act intentional?

If the severity of a trauma is judged solely by whether the act was intentional or not, events that reflect an intention to harm would be a primary indicator in predicting subsequent difficulties among individuals exposed to this form of trauma. For most survivors, there is an initial disbelief that someone would conceivably intend to harm others, followed by considerable emotional and, at times, behavioral investment in somehow making things right again or in making sense of a senseless, malicious act. For instance, in the wake of the World Trade Center attacks in New York City, people responded via renewed patriotism, impromptu candlelight vigils, attacks on people of Arab and Muslim descent, and unprecedented donations and willingness to wait in long lines to donate blood to the Red Cross. Each example is a response that in some way attempts to right the perceived wrong or attach new meaning to the event and subsequent consequences.

When terrible things happen, it is human nature to assign blame. Trauma survivors can become heavily invested in assigning blame or finding out who was at fault, regardless of the type of trauma. Often, this occurs as an attempt to make sense of, give meaning to, and reestablish a sense of predictability, control, and safety after an irrational or random act. It is far easier to accept that someone, including oneself, is at fault or could have done something different than it is to accept the fact that one was simply in the wrong place at the wrong time.

For some trauma survivors, needing to find out why a trauma occurred or who is at fault can become a significant block to growth when the individual would be better served by asking, "What do I need to do to heal?" Behavioral health professionals can help clients translate what they have learned about responsibility in recovery to other aspects of their lives. For instance, someone in treatment for co-occurring disorders who has internalized that becoming depressed or addicted was not his or her fault, but that recovery *is* a personal responsibility, can then apply the same principle to the experience of childhood abuse and thereby overcome negative judgments of self (e.g., thinking oneself to be a bad person who deserves abuse). The individual can then begin to reassign responsibility by attaching the blame to the perpetrator(s) while at the same time assuming responsibility for recovery.

Was the trauma experienced directly or indirectly?

Trauma that happens to someone directly seems to be more damaging than witnessing trauma that befalls others. For example, it is usually more traumatic to be robbed at gunpoint than to witness someone else being robbed or hearing someone tell a story about being robbed. Yet, sometimes, experiencing another's pain can be equally traumatic. For instance, parents often internalize the pain and suffering of their children when the children are undergoing traumatic circumstances (e.g., treatments for childhood cancer).

There are two ways to experience the trauma of others. An individual may witness the event, such as seeing someone killed or seriously injured in a car accident, or may learn of an event that happened to someone, such as a violent personal assault, suicide, serious accident, injury, or sudden or unexpected death. For many people, the impact of the trauma will depend on a host of variables, including their proximity to the event as eyewitnesses, the witnesses' response in the situation, their relationship to the victims, the degree of helplessness surrounding the experience, their exposure to subsequent consequences, and so on.

Case Illustration: Frank

Frank entered substance abuse treatment with diagnoses of co-occurring PTSD and substance use disorder. While on a whitewater kayak trip with his wife, her kayak became pinned on a rock, and Frank could only watch helplessly as she drowned. His drinking had increased markedly after the accident. He acknowledged a vicious cycle of sleep disturbance with intrusive nightmares followed by vivid memories and feelings of terror and helplessness after he awoke. He drank heavily at night to quiet the nightmares and memories, but heavy alcohol consumption perpetuated his trouble sleeping. He withdrew from contact with many of his old "couple friends" and his wife's family, with whom he had been close. At treatment entry, he described his life as "going to work and coming home." The trauma occurred 3 years before he sought treatment, but Frank continued to feel numb and disconnected from the world. His only emotion was anger, which he tried to keep in check. Integrated treatment for PTSD and substance abuse helped him sleep and taught him coping skills to use when the memories arose; it fostered his engagement and retention in long-term care for both disorders.

The effects of traumas such as genocide and internment in concentration camps can be felt across generations—stories, coping behaviors, and stress reactions can be passed across generational lines far removed from the actual events or firsthand accounts. Known as historical trauma, this type of trauma can affect the functioning of families, communities, and cultures for multiple generations.

What happened since the trauma?

In reviewing traumatic events, it is important to assess the degree of disruption after the initial trauma has passed, such as the loss of employment, assets, community events, behavioral health services, local stores, and recreational areas. There is typically an initial rally of services and support following a trauma, particularly if it is on a mass scale. However, the reality of the trauma's effects and their disruptiveness may have a more lasting impact. The deterioration of normalcy, including the disruption of day-to-day activities and the damage of structures that house these routines, will likely erode the common threads that provide a sense of safety in individual lives and communities. Hence, the degree of disruption in resuming normal daily activities is a significant risk factor for substance use disorders, subclinical psychological symptoms, and mental disorders. For example, adults displaced from their homes because of Hurricanes Katrina or Rita had significantly higher rates of past-month cigarette use, illicit drug use, and binge drinking than those who were not displaced (Office of Applied Studies, 2008).

Subjective Characteristics

Psychological meaning of trauma

An important clinical issue in understanding the impact of trauma is the meaning that the survivor has attached to the traumatic experience. Survivors' unique cognitive interpretations of an event—that is, their beliefs and assumptions—contribute to how they process, react to, cope with, and recover from the trauma. Does the event represent retribution for past deeds committed by the individual or his or her family? How does the individual attach meaning to his or her survival? Does he or she believe that it is a sign of a greater purpose not yet revealed? People who attempt to share their interpretation and meaning of the event can feel misunderstood and sometimes alienated (Paulson & Krippner, 2007; Schein, Spitz, Burlingame, & Muskin, 2006).

> It is important to remember that what happened is not nearly as important as what the trauma means to the individual.

People interpret traumatic events in vastly different ways, and many variables shape how an individual assigns meaning to the experience (framing the meaning through culture, family beliefs, prior life experiences and learning, personality and other psychological features, etc.). Even in an event that happens in a household, each family member may interpret the experience differently. Likewise, the same type of event can occur at two different times in a person's life, but his or her interpretation of the events may differ considerably because of developmental differences acquired between events, current cognitive and emotional processing skills, availability of and access to environmental resources, and so forth.

Disruption of core assumptions and beliefs

Trauma often engenders a crisis of faith (Frankl, 1992) that leads clients to question basic assumptions about life. Were the individual's core or life-organizing assumptions (e.g., about safety, perception of others, fairness, purpose of life, future dreams) challenged or disrupted during or after the traumatic event? (See the seminal work,

Resilience: Connection and Continuity

Research suggests that reestablishing ties to family, community, culture, and spiritual systems is not only vital to the individual, but it also influences the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) studied the descendants of survivors of Joseph Stalin's purge. They found that families who were able to maintain a sense of connection and continuity with grandparents directly affected by the purge experienced fewer negative effects than those who were emotionally or physically severed from their grandparents. Whether the grandparents survived was less important than the connection the grandchildren felt to their pasts.

Shattered Assumptions, by Janoff-Bulman, 1992.) For example, some trauma survivors see themselves as irreparably wounded or beyond the possibility of healing. The following case illustration (Sonja) explores not only the importance of meaning, but also the role that trauma plays in altering an individual's core assumptions—the very assumptions that provide meaning and a means to organize our lives and our interactions with the world and others.

Cultural meaning of trauma

Counselors should strive to appreciate the cultural meaning of a trauma. How do cultural interpretations, cultural support, and cultural responses affect the experience of trauma? It is critical that counselors do not presume to understand the meaning of a traumatic experience without considering the client's cultural context. Culture strongly influences the perceptions of trauma. For instance, a trauma involving shame can be more profound for a person from an Asian culture than for someone from a European culture. Likewise, an Alaska Native individual or community, depending upon their Tribal ancestry, may believe that the traumatic experience serves as a form of retribution. Similarly, the sudden death of a family member or loved one can be less traumatic in a culture that has a strong belief in a positive afterlife. It is important for counselors to recognize that their perceptions of a specific trauma could be very different from their clients' perceptions. Be careful not to judge a client's beliefs in light of your own value system. For more information on culture and how to achieve cultural competence in providing behavioral health services, see SAMHSA's planned TIP, *Improving Cultural Competence* (SAMHSA, planned c).

Individual and Sociocultural Features

A wide variety of social, demographic, environmental, and psychological factors influence a person's experience of trauma, the severity of traumatic stress reactions following the event, and his or her resilience in dealing with the short- and long-term environmental, physical, sociocultural, and emotional consequences. This section addresses a few known factors that influence the risk of trauma along with the development of subclinical and diagnostic traumatic stress symptoms, such as mood and anxiety symptoms and disorders. It is not meant to be an exhaustive exploration of these factors, but rather, a brief presentation to make counselors and other behavioral health professionals aware that various factors influence risk for and protection against traumatic stress and subsequent reactions. (For a broader perspective on such factors, refer to Part 1, Chapter 1.)

Individual Factors

Several factors influence one's ability to deal with trauma effectively and increase one's risk for traumatic stress reactions. Individual factors pertain to the individual's genetic, biological, and psychological makeup and history as they influence the person's experience and

Case Illustration: Sonja

Sonja began to talk about how her life was different after being physically assaulted and robbed in a parking lot at a local strip mall a year ago. She recounts that even though there were people in the parking lot, no one came to her aid until the assailant ran off with her purse. She sustained a cheekbone fracture and developed visual difficulties due to the inflammation from the fracture. She recently sought treatment for depressive symptoms and reported that she had lost interest in activities that typically gave her joy. She reported isolating herself from others and said that her perception of others had changed dramatically since the attack.

Sonja had received a diagnosis of major depression with psychotic features 10 years earlier and received group therapy at a local community mental health center for 3 years until her depression went into remission. She recently became afraid that her depression was becoming more pronounced, and she wanted to prevent another severe depressive episode as well as the use of psychotropic medications, which she felt made her lethargic. Thus, she sought out behavioral health counseling.

As the sessions progressed, and after a psychological evaluation, it was clear that Sonja had some depressive symptoms, but they were subclinical. She denied suicidal thoughts or intent, and her thought process was organized with no evidence of hallucinations or delusions. She described her isolation as a reluctance to shop at area stores. On one hand, Sonja was self-compassionate about her reasons for avoidance, but on the other hand, she was concerned that the traumatic event had altered how she saw life and others. "I don't see people as very caring or kind, like I used to prior to the event. I don't trust them, and I feel people are too self-absorbed. I don't feel safe, and this bothers me. I worry that I'm becoming paranoid again. I guess I know better, but I just want to have the freedom to do what I want and go where I want."

Two months after Sonja initiated counseling, she came to the office exclaiming that things can indeed change. "You won't believe it. I had to go to the grocery store, so I forced myself to go the shopping center that had a grocery store attached to a strip mall. I was walking by a coffee shop, quickly browsing the items in the front window, when a man comes out of the shop talking at me. He says, 'You look like you need a cup of coffee.' What he said didn't register immediately. I looked at him blankly, and he said it again. 'You look like you need a cup of coffee. I'm the owner of the shop, and I noticed you looking in the window, and we have plenty of brewed coffee left before we close the shop. Come on in, it's on the house.' So I did! From that moment on, I began to see people differently. He set it right for me—I feel as if I have myself back again, as if the assault was a sign that I shouldn't trust people, and now I see that there is some goodness in the world. As small as this kindness was, it gave me the hope that I had lost."

For Sonja, the assault changed her assumptions about safety and her view of others. She also attached meaning to the event. She believed that the event was a sign that she shouldn't trust people and that people are uncaring. Yet these beliefs bothered her and contradicted how she saw herself in the world, and she was afraid that her depressive symptoms were returning.

For an inexperienced professional, her presentation may have ignited suspicions that she was beginning to present with psychotic features. However, it is common for trauma survivors to experience changes in core assumptions immediately after the event and to attach meaning to the trauma. Often, a key ingredient in the recovery process is first identifying the meaning of the event and the beliefs that changed following the traumatic experience. So when you hear a client say "I will never see life the same," this expression should trigger further exploration into how life is different, what meaning has been assigned to the trauma, and how the individual has changed his or her perception of self, others, and the future.

(Continued on the next page.)

Case Illustration: Sonja (continued)

Sometimes, reworking the altered beliefs and assumptions occurs with no formal intervention, as with Sonja. In her situation, a random stranger provided a moment that challenged an assumption generated from the trauma. For others, counseling may be helpful in identifying how beliefs and thoughts about self, others, and the world have changed since the event and how to rework them to move beyond the trauma. It is important to understand that the meaning that an individual attaches to the event(s) can either undermine the healing process (e.g., believing that you should not have survived, feeling shame about the trauma, continuing to engage in high-risk activities) or pave the road to recovery (e.g., volunteering to protect victim rights after being sexually assaulted). The following questions can help behavioral health staff members introduce topics surrounding assumptions, beliefs, interpretations, and meanings related to trauma:

- In what ways has your life been different since the trauma?
- How do you understand your survival? (This is an important question for clients who have been exposed to ACEs or cumulative trauma and those who survived a tragedy when others did not.)
- Do you believe that there are reasons that this event happened to you? What are they?
- What meaning does this experience have for you?
- Do you feel that you are the same person as before the trauma? In what ways are you the same? In what ways do you feel different?
- How did this experience change you as a person? Would you like to return to the person you once were? What would you need to do, or what would need to happen, for this to occur?
- Did the traumatic experience change you in a way that you don't like? In what ways?
- How do you view others and your future differently since the trauma?
- What would you like to believe now about the experience?

interpretation of, as well as his or her reactions to, trauma. However, many factors influence individual responses to trauma; it is not just individual characteristics. Failing to recognize that multiple factors aside from individual attributes and history influence experiences during and after trauma can lead to blaming the victim for having traumatic stress.

History of prior psychological trauma

People with histories of prior psychological trauma appear to be the most susceptible to severe traumatic responses (Nishith, Mechanic, & Resick, 2000; Vogt, Bruce, Street, & Stafford, 2007), particularly if they have avoided addressing past traumas. Because minimization, dissociation, and avoidance are common defenses for many trauma survivors, prior traumas are not always consciously available, and when they are, memories can be distorted to avoid painful affects. Some survivors who have repressed their experiences deny a history of trauma or are unable to explain their strong reactions to present situations.

Remember that the effects of trauma are cumulative; therefore, a later trauma that outwardly appears less severe may have more impact upon an individual than a trauma that occurred years earlier. Conversely, individuals who have experienced earlier traumas may have developed effective coping strategies or report positive outcomes as they have learned to adjust to the consequences of the trauma(s). This outcome is often referred to as posttraumatic growth or psychological growth.

Clients in behavioral health treatment who have histories of trauma can respond negatively to or seem disinterested in treatment efforts. They may become uncomfortable in groups that emphasize personal sharing; likewise, an individual who experiences brief bouts of dissociation (a reaction of some trauma survivors) may be misunderstood by others in treatment and seen as uninterested. Providers need to

attend to histories, adjust treatment to avoid retraumatization, and steer clear of labeling clients' behavior as pathological.

History of resilience

Resilience—the ability to thrive despite negative life experiences and heal from traumatic events—is related to the internal strengths and environmental supports of an individual. Most individuals are resilient despite experiencing traumatic stress. The ability to thrive beyond the trauma is associated with individual factors as well as situational and contextual factors. There are not only one or two primary factors that make an individual resilient; many factors contribute to the development of resilience. There is little research to indicate that there are specific traits predictive of resilience; instead, it appears that more general characteristics influence resilience, including neurobiology (Feder, Charney, & Collins, 2011), flexibility in adapting to change, beliefs prior to trauma, sense of self-efficacy, and ability to experience positive emotions (Bonanno & Mancini, 2011).

History of mental disorders

The correlations among traumatic stress, substance use disorders, and co-occurring mental disorders are well known. According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (American Psychiatric Association, 2013a), traumatic stress reactions are linked to higher rates of mood, substance-related, anxiety, trauma, stress-related, and other mental disorders, each of which can precede, follow, or emerge concurrently with trauma itself. A co-occurring mental disorder is a significant determinant of whether an individual can successfully address and resolve trauma as it emerges from the past or occurs in the present. Koenen, Stellman, Stellman, and Sommer (2003) found that the risk of developing PTSD following combat trauma was higher for individuals with preexisting conduct disorder, panic disorder, generalized anxiety disorder, and/or major depression than for those without preexisting mental disorders. For additional information on comorbidity of trauma and other mental disorders, see TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c).

Sociodemographic Factors

Demographic variables are not good predictors of who will experience trauma and subsequent traumatic stress reactions. Gender, age, race and ethnicity, sexual orientation, marital status, occupation, income, and education can all have some influence, but not enough to determine who should or should not receive screening for trauma and traumatic stress symptoms. The following sections cover a few selected variables. (For more information, please refer to Part 3 of this TIP, the online literature review.)

Gender

In the United States, men are at greater risk than women for being exposed to stressful events. Despite the higher prevalence among men, lifetime PTSD occurs at about twice the rate among women as it does in men. Less is known about gender differences with subclinical traumatic stress reactions. There are also other gender differences, such as the types of trauma experienced by men and women. Women are more likely to experience physical and sexual assault, whereas men are most likely to experience combat and crime victimization and to witness killings and serious injuries (Breslau, 2002; Kimerling, Ouimette, & Weitlauf, 2007; Tolin & Foa, 2006). Women in military service are subject to the same risks as men and are also at a greater risk for military sexual trauma. Men's traumas often occur in public; women's are more likely to take place in private settings. Perpetrators of traumas against men are often strangers, but women are more likely to know the perpetrator.

Age

In general, the older one becomes, the higher the risk of trauma—but the increase is not dramatic. Age is not particularly important in predicting exposure to trauma, yet at no age is one immune to the risk. However, trauma that occurs in the earlier and midlife years appears to have greater impact on people for different reasons. For younger individuals, the trauma can affect developmental processes, attachment, emotional regulation, life assumptions, cognitive interpretations of later experiences, and so forth (for additional resources, visit the National Child Traumatic Stress Network; http://www.nctsn.org/). For adults in midlife, trauma may have a greater impact due to the enhanced stress or burden of care that often characterizes this stage of life—caring for their children and their parents at the same time. Older adults are as likely as younger adults to recover quickly from trauma, yet they may have greater vulnerabilities, including their ability to survive without injury and their ability to address the current trauma without psychological interference from earlier stressful or traumatic events. Older people are naturally more likely to have had a history of trauma because they have lived longer, thus creating greater vulnerability to the effects of cumulative trauma.

Race, ethnicity, and culture

The potential for trauma exists in all major racial and ethnic groups in American society, yet few studies analyze the relationship of race and ethnicity to trauma exposure and/or traumatic stress reactions. Some studies show that certain racial and ethnic groups are at greater risk for specific traumas. For example, African Americans experienced higher rates of overall violence, aggravated assault, and robbery than Whites but were as likely to be victims of rape or sexual assault (Catalano, 2004). Literature reflects that diverse ethnic, racial, and cultural groups are more likely to experience adverse effects from various traumas and to meet criteria for posttraumatic stress (Bell, 2011).

Sexual orientation and gender identity

Lesbian, gay, bisexual, and transgender individuals are likely to experience various forms of trauma associated with their sexual orientation, including harsh consequences from families and faith traditions, higher risk of assault from casual sexual partners, hate crimes, lack of legal protection, and laws of exclusion (Brown, 2008). Gay and bisexual men as well as transgender people are more likely to experience victimization than lesbians and bisexual women. Dillon (2001) reported a trauma exposure rate of 94 percent among lesbian, gay,

Resilience: Cultural, Racial, and Ethnic Characteristics

The following list highlights characteristics that often nurture resilience among individuals from diverse cultural, racial, and ethnic groups:

- Strong kinship bonds
- Respect for elders and the importance of extended family
- Spirituality and religious practices (e.g., shrine visitations or the use of traditional healers)
- Value in friendships and warm personal relationships
- Expression of humor and creativity
- Instilling a sense of history, heritage, and historical traditions
- Community orientation, activities, and socialization
- Strong work ethic
- Philosophies and beliefs about life, suffering, and perseverance

"Fortune owes its existence to misfortune, and misfortune is hidden in fortune."

–Lao-Tzu teaching, Taoism (Wong & Wong, 2006)

and bisexual individuals; more than 40 percent of respondents experienced harassment due to their sexual orientation. Heterosexual orientation is also a risk for women, as women in relationships with men are at a greater risk of being physically and sexually abused.

People who are homeless

Homelessness is typically defined as the lack of an adequate or regular dwelling, or having a nighttime dwelling that is a publicly or privately supervised institution or a place not intended for use as a dwelling (e.g., a bus station). The U.S. Department of Housing and Urban Development (HUD) estimates that between 660,000 and 730,000 individuals were homeless on any given night in 2005 (HUD, 2007). Two thirds were unaccompanied persons; the other third were people in families. Adults who are homeless and unmarried are more likely to be male than female. About 40 percent of men who are homeless are veterans (National Coalition for the Homeless, 2002); this percentage has grown, including the number of veterans with dependent children (Kuhn & Nakashima, 2011).

Rates of trauma symptoms are high among people who are homeless (76 to 100 percent of women and 67 percent of men; Christensen et al., 2005; Jainchill, Hawke, & Yagelka, 2000), and the diagnosis of PTSD is among the most prevalent non-substance use Axis I disorders (Lester et al., 2007; McNamara, Schumacher, Milby, Wallace, & Usdan, 2001). People who are homeless report high levels of trauma (especially physical and sexual abuse in childhood or as adults) preceding their homeless status; assault, rape, and other traumas frequently happen while they are homeless. Research suggests that many women are homeless because they are fleeing domestic violence (National Coalition for the Homeless, 2002). Other studies suggest that women who are homeless are more likely to have histories of childhood physical and sexual abuse and to have experienced sexual assault as adults. A history of physical and/or sexual abuse is even more common among women who are homeless and have a serious mental illness.

Youth who are homeless, especially those who live without a parent, are likely to have experienced physical and/or sexual abuse. Between 21 and 42 percent of youth runaways report having been sexually abused before leaving their homes; for young women, rates range from 32 to 63 percent (Administration on Children, Youth and Families, 2002). Additionally, data reflect elevated rates of substance abuse for youth who are homeless and have histories of abuse.

More than half of people who are homeless have a lifetime prevalence of mental illness and substance use disorders. Those who are homeless have higher rates of substance abuse (84 percent of men and 58 percent of women), and substance use disorders, including alcohol and drug abuse/dependence, increase with longer lengths of homelessness (North, Eyrich, Pollio, & Spitznagel, 2004).

For more information on providing trauma-informed behavioral health services to clients who are homeless, and for further discussion of the incidence of trauma in this population, see TIP 55-R, *Behavioral Health Services for People Who Are Homeless* (SAMHSA, 2013b).

Types of Trauma and Violence

Learn about the different kinds of traumatic events that can impact the behavioral health of individuals, families, and communities.

Traumatic events can include physical and sexual abuse, neglect, bullying, community-based violence, disaster, terrorism, and war.

SAMHSA's TIP 57: Trauma-Informed Care in Behavioral Health Services – 2014 and SAMHSA's National Child Traumatic Stress Network's Types of Traumatic Stress webpage provide in-depth information about the many different kinds of trauma and violence.

Sexual Abuse or Assault

Sexual abuse or assault includes unwanted or coercive sexual contact, exposure to age-inappropriate sexual material or environments, and sexual exploitation. The Department of Justice's (DOJ) Office on Violence Against Women defines sexual assault as "any type of sexual contact or behavior that occurs without the explicit consent of the recipient."

Physical Abuse or Assault

Physical abuse or assault is defined as the actual or attempted infliction of physical pain (with or without the use of an object or weapon), including the use of severe corporeal punishment. Federal law defines child abuse as any act, or failure to act, which results in death, serious physical or emotional harm, sexual abuse, or exploitation of a child.

Emotional Abuse or Psychological Maltreatment

Emotional abuse and psychological maltreatment are considered acts of commission (other than physical or sexual abuse) against an individual. These kinds of acts, which include verbal abuse, emotional abuse, and excessive demands or expectations, may cause an individual to experience conduct, cognitive, affective, or other mental disturbances. These acts also include acts of omission against a minor such as emotional neglect or intentional social deprivation, which cause, or could cause, a child to experience conduct, cognitive, affective, or other mental disturbances.

Neglect

Neglect is the most common form of abuse reported to child welfare authorities. However, it does not occur only with children. It can also happen when a primary caregiver fails to give an adult the care they need, even though the caregiver can afford to, or has the help to do so. Neglect also includes the failure to

provide an individual with basic needs such as food, clothing, or shelter. It can also mean not providing medical or mental health treatment or prescribed medicines. Neglect also includes exposing someone to dangerous environments, abandoning a person, or expelling them from home.

Serious Accident, Illness, or Medical Procedure

Trauma can occur when a person experiences an unintentional injury or accident, a physical illness, or medical procedures that are extremely painful and/or life threatening.

Victim or Witness to Domestic Violence

According to DOJ's Office on Violence Against Women, domestic violence is defined as: "a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone." Domestic violence includes violence and abuse by current or former intimate partners, parents, children, siblings, and other relatives.

For information on the Department of Health and Human Services' (HHS) work with domestic violence, visit the Administration for Children and Families' Family and Youth Services Bureau.

Victim or Witness to Community Violence

Extreme violence in the community, including exposure to gang-related violence, interracial violence, police and citizen altercations, and other forms of destructive individual and group violence is a recognized form of trauma.

Historical Trauma

Historical trauma is a form of trauma that impacts entire communities. It refers to the cumulative emotional and psychological wounding, as a result of group traumatic experiences, that is transmitted across generations within a community. Unresolved grief and anger often accompany this trauma and contribute to physical and behavioral health disorders. This type of trauma is often associated with racial and ethnic population groups in the United States who have suffered major intergenerational losses and assaults on their culture and well-being.

School Violence

School violence is described as violence that occurs in a school setting and includes, but is not limited to, school shootings, bullying, interpersonal violence among classmates, and student suicide. Youth violence is a serious problem that can have lasting harmful effects on victims and their families, friends, and communities

Bullying

Bullying is unwanted, aggressive behavior among school-aged children that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Both kids who are bullied and who bully others may experience serious, lasting problems. Trauma can be a consequence

of bullying, which can lead to mental health issues, substance use, and suicide, particularly if there is a prior history of depression or delinquency.

Natural or Manmade Disasters

Trauma can result from a major accident or disaster that is an unintentional result of a manmade or natural event. Disasters can occur naturally (such as tornadoes, hurricanes, earthquakes, floods, wildfires, mudslides, or drought) or be human-caused (such as mass shootings, chemical spills, or terrorist attacks).

Forced Displacement

Forced displacement is a traumatic event that occurs when people face political persecution and are forced to relocate to a new home (as an immigrant or through political asylum) or become a refugee.

War, Terrorism, or Political Violence

Exposure to acts of war-, terrorism-, or political-related violence such as bombing, shooting, and looting can cause trauma in an individual.

Military Trauma

Military trauma refers to both the impact of deployment and trauma-related stress on people who are deployed and their families. Significant numbers of returning service men and women experience mental and/or substance use disorders associated with military trauma and/or military sexual trauma.

Victim or Witness to Extreme Personal or Interpersonal Violence

This type of trauma includes extreme violence by or between individuals including exposure to homicide, suicide, and other extreme events.

Traumatic Grief or Separation

Traumatic grief and/or separation may include the death of a parent, primary caretaker, or sibling; abrupt and/or unexpected, accidental, or premature death or homicide of a close friend, family member, or other close relative; abrupt, unexplained and/or indefinite separation from a parent, primary caretaker, or sibling due to uncontrollable circumstances.

System-Induced Trauma and Retraumatization

Many systems that are designed to help individuals and families can actually cause trauma. For example, in child welfare systems, abrupt removal from the home, foster placement, sibling separation, or multiple placements in a short amount of time can retraumatize children. In mental health systems, the use of seclusion and restraint on previously traumatized individuals can revive memories of trauma. Further, invasive medical procedures on a trauma victim can re-induce traumatic reactions.

Last Updated: 03/02/2016

Disaster Distress Helpline

1-800-985-5990

NCTSN The National Child Traumatic Stress Network

Data and Statistics

» Adverse Childhood Experiences (ACE) Study – Centers for Disease Control and Prevention (CDC)

» CDC Data Sources on Intimate Partner Violence

» Department of Health and Human Services (HHS) Report on Child Maltreatment — 2012

» Mental Health Screenings and Trauma-Related Counseling in Substance Abuse Treatment Facilities — 2010

PTSD: National Center for PTSD

After going through a trauma, survivors often say that their first feeling is relief to be alive. This may be followed by stress, fear, and anger. Trauma survivors may also find they are unable to stop thinking about what happened. Many survivors will show a high level of arousal, which causes them to react strongly to sounds and sights around them.

Reactions to a trauma may include:

- Feeling hopeless about the future
- Feeling detached or unconcerned about others
- Having trouble concentrating or making decisions
- Feeling jumpy and getting startled easily at sudden noises
- Feeling on guard and constantly alert
- Having disturbing dreams and memories or flashbacks
- Having work or school problems

You may also experience more physical reactions such as:

- Stomach upset and trouble eating
- Trouble sleeping and feeling very tired
- Pounding heart, rapid breathing, feeling edgy
- Sweating
- Severe headache if thinking of the event
- Failure to engage in exercise, diet, safe sex, regular health care
- Excess smoking, alcohol, drugs, food
- Having your ongoing medical problems get worse

You may have more emotional troubles such as:

- Feeling nervous, helpless, fearful, sad
- Feeling shocked, numb, and not able to feel love or joy
- Avoiding people, places, and things related to the event

- Being irritable or having outbursts of anger
- Becoming easily upset or agitated
- Blaming yourself or having negative views of oneself or the world
- Distrust of others, getting into conflicts, being over-controlling
- Being withdrawn, feeling rejected, or abandoned
- Loss of intimacy or feeling detached

Recovery from stress reactions

Turn to your family and friends when you are ready to talk. They are your personal support system. Recovery is an ongoing gradual process. It doesn't happen through suddenly being "cured" and it doesn't mean that you will forget what happened. Most people will recover from trauma naturally. If your stress reactions are getting in the way of your relationships, work, or other important activities, you may want to talk to a counselor or your doctor. Good treatments are available.

Common problems that can occur after a trauma

Posttraumatic Stress Disorder (PTSD). PTSD is a condition that can develop after you have gone through a life-threatening event. If you have PTSD, you may have trouble keeping yourself from thinking over and over about what happened to you. You may try to avoid people and places that remind you of the trauma. You may feel numb. Lastly, if you have PTSD, you might find that you have trouble relaxing. You may startle easily and you may feel on guard most of the time.

Depression. Depression involves feeling down or sad more days than not. If you are depressed, you may lose interest in activities that used to be enjoyable or fun. You may feel low in energy and be overly tired. You may feel hopeless or in despair, and you may think that things will never get better. Depression is more likely when you have had losses such as the death of close friends. If you are depressed, at times you might think about

hurting or killing yourself. For this reason, getting help for depression is very important.

Self-blame, guilt and shame. Sometimes in trying to make sense of a traumatic event, you may blame yourself in some way. You may think you are responsible for bad things that happened, or for surviving when others didn't. You may feel guilty for what you did or did not do. Remember, we all tend to be our own worst critics. Most of the time, that guilt, shame, or self-blame is not justified.

Suicidal thoughts. Trauma and personal loss can lead a depressed person to think about hurting or killing themselves. If you think someone you know may be feeling suicidal, you should directly ask them. You will NOT put the idea in their head. If someone is thinking about killing themselves, call the Suicide Prevention Lifeline 1-800-273-TALK (8255) http://www.suicidepreventionlifeline.org. You can also call a counselor, doctor, or 911.

Anger or aggressive behavior. Trauma can be connected with anger in many ways. After a trauma, you might think that what happened to you was unfair or unjust. You might not understand why the event happened and why it happened to you. These thoughts can result in intense anger. Although anger is a natural and healthy emotion, intense feelings of anger and aggressive behavior can cause problems with family, friends, or co-workers. If you become violent when angry, you just make the situation worse. Violence can lead to people being injured, and there may be legal consequences.

Alcohol/Drug abuse. Drinking or "self-medicating" with drugs is a common, and unhealthy, way of coping with upsetting events. You may drink too much or use drugs to numb yourself and to try to deal with difficult thoughts, feelings, and memories related to the trauma. While using alcohol or drugs may offer a quick solution, it can actually lead to more problems. If someone close begins to lose control of drinking or drug use,

you should try to get them to see a health care provider about managing their drinking or drug use.

Summing it all up

Right after a trauma, almost every survivor will find himself or herself unable to stop thinking about what happened. Stress reactions, such as increased fear, nervousness, jumpiness, upsetting memories, and efforts to avoid reminders, will gradually decrease over time for most people.

Use your personal support systems, family and friends, when you are ready to talk. Recovery is an ongoing gradual process. It doesn't happen through suddenly being "cured" and it doesn't mean that you will forget what happened. Most people will recover from trauma naturally over time. If your emotional reactions are getting in the way of your relationships, work, or other important activities, you may want to talk to a counselor or your doctor. Good treatments are available.

THE PSYCHOLOGY AND NEUROBIOLOGY OF MEDIATION

*Elizabeth E. Bader**

I. INTRODUCTION

This article grew out of a moment in mediation when a party became furious with me after receiving the opening offer from the other side. As I tried to understand what was happening, I suddenly realized it was not about the offer at all. It was about *him.* He feared a loss of "face" in front of the other parties.

Treating him with utmost respect, I took him through what the admittedly complex offer actually said. After about fifteen minutes, he was fine with it. We moved on.

From this point on, I began to look at mediation through the lens of "face," self-esteem, and self-identity. I was struck by a repeating pattern. At the outset of a mediation, parties often had unrealistically optimistic hopes for resolution in their own favor, and on their own terms. This was also coupled with an attitude of "I am a winner, and I can do this!"

Mediation was, I found, in large measure the process of helping parties, and often their attorneys, work through their initially exaggerated sense of themselves and the possibilities for settlement in order to arrive at a realistic resolution of the dispute. Some level of deflation was endemic to this process. In my publications on the psychology of mediation, I called this cycle of *inflation*, *deflation*, and *realistic resolution* the IDR cycle.[1]

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[1] *See* Elizabeth E. Bader, *The Psychology of Mediation: Issues of Self and Identity and the IDR Cycle*, 10 PEPP. DISP. RESOL. L.J. 183 (2010) [hereinafter *Psychology of Mediation*]; Elizabeth E. Bader, *Self, Identity and the IDR Cycle: Understanding the Deeper Meaning of "Face" in Mediation*, 8 INT'L J. APPLIED PSYCHOANALYTIC STUD. 301 (2011) [hereinafter *Deeper Meaning of "Face"*].

pate on an equal level in face-to-face communications with adversaries, even with a skilled intermediary. Thus, a number of factors, including the extent to which a person has been or is traumatized, must be considered. Considering these factors when deciding how to structure a mediation may, indeed, be useful whether or not separate caucusing is used.

1. The Role of Trauma

The problem of trauma is hard to overestimate because trauma is so prevalent in the population. Some studies show that almost ninety percent of the people in this country have experienced at least one traumatic event in their lifetime.[48] A very large percentage of these people experienced traumatizing events when they were children, when it is most devastating.[49]

Trauma can impact parties in mediation indirectly as well as directly. For example, even a simple case, such as a rear-end car accident, can invoke residues of earlier childhood abuse for some people.[50] Thus, from a psychological point of view, the mediation of even a simple whiplash case can implicate deeper trauma.

Some people who have suffered acute trauma may be predisposed to react or overreact aggressively in the face of threat.[51] These people are more likely to experience sympathetic arousal or hyperarousal during the mediation.

However, as Peter Levine has emphasized, other seriously traumatized people, especially those dominated by the immobilization/freeze response, will have trouble mobilizing the sympathetic nervous system.[52] As a result, they may not be able to arouse

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48 Dean G. Kilpatrick et al., *National Estimates of Exposure to Traumatic Events and PTSD Prevalence Using DSM-IV and DSM-5 Criteria*, 26:5 J. TRAUMATIC STRESS 537–47 (2013) ("Traumatic event exposure using *DSM-5* criteria was high (89.7%), and exposure to multiple traumatic event types was the norm.").

49 BESSEL VAN DER KOLK, THE BODY KEEPS THE SCORE: BRAIN, MIND, AND BODY IN THE HEALING OF TRAUMA 145 (Viking 2014) (noting that in one very large study, even though the respondents were "mostly white, middle aged, well-educated, and financially secure enough to have good medical insurance", only one third reported having no adverse (traumatic) childhood experiences).

50 Robert Scaer, a neurologist, interviewed 250 whiplash patients about their backgrounds. He found that childhood physical and sexual abuse were the most powerful predictors of the number, severity, and duration of post-whiplash complaints. ROBERT SCAER, THE TRAUMA SPECTRUM: HIDDEN WOUNDS AND HUMAN RESILIENCY 228 (W.W. Norton & Company 2005).

51 "The traumatic experience functionally retunes neuroception to conservatively detect risk when there is no risk." PORGES, *supra* note 2, at 253.

52 LEVINE, *supra* at note 3, at 105–06 (chronically traumatized people, those trapped in shutdown, have difficulty activating the sympathetic nervous system).

healthy, active forms of self-protection.[53] They thus may enter the mediation in a state of deflation, not inflation, which puts them at a disadvantage.

A theory advanced by Blascovich and colleagues, known as the Biopsychosocial Model of Challenge and Threat, analyzes this issue from a somewhat different angle. According to the theory, people have a tendency to experience challenges to self-related goals as *threats* not *challenges* when they recognize the task, but do not feel their resources, internal or external, are up to the task. People who are threatened are more likely to have problems with self-esteem, and to withdraw or feel defeated during a task that others would find challenging, even exhilarating.[54]

i. Mediating in the Shadow of Trauma

Learning to read simple signs of sympathetic arousal, hyperarousal, or freeze/immobility can help provide important information about whether people are capable of negotiating face-to-face or even in separate caucuses. Again, there will be variations depending upon whether a full-on fight-or-flight or freeze/immobilization response is involved, or, more commonly, something less severe. This is not an exhaustive list.

Healthy sympathetic arousal: As Blascovich and colleagues have noted, a healthy sympathetic arousal in response to a challenge that does not feel overwhelming produces effects similar to aerobic exercise.[55] The sympathetic nervous system is aroused, but the blood vessels do not constrict, and the blood pressure is not high.[56] My experience is that the person actually looks something

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53 *Id.*

54 Jim Blascovich & Wendy Berry Mendes, *Social Psychology and Embodiment*, *in* HANDBOOK OF SOCIAL PSYCHOLOGY 195, 207–08 (Susan T. Fiske, Daniel T. Gilbert, Gardner Lindzey eds. 5th ed. 2010). The Biopsychosocial model, which is based on neuroendocrine responses to challenge and threat, is a fascinating model, one well worth an article of its own. It argues that although both threat and challenge result in sympathetic arousal; during threat, there is vasoconstriction due to changes in cardiovascular responses. Thus, among other things, blood pressure increases during threat but not challenge. This a complex theory. The best review of the basic principles for lay people can be found on Psychlopedia, an internet encyclopedia. *See The distinction between challenge and threat appraisals*, PSYCHLOPEDIA, http://www.psych-it.com.au/Psychlopedia/article.asp?id=281 (last visited July 30, 2015).

55 Jim Blascovich et al., *Social "Facilitation" as Challenge and Threat*, 77 J. PERS. SOC. PSYCHOL. 68, 70 (1999) (in response to a challenge, "sympathetic neural stimulation of the myocardium enhances cardiac performance . . . . This pattern mimics cardiovascular performance during aerobic exercise and represents the efficient mobilization of energy for coping.").

56 *Cf. id.*

like a person who has been exercising. There is a lot of energy and perhaps redness in the face and skin.

Sympathetic hyperarousal: Sympathetic *hyperarousal* can be indicative of a person locked in fight-or-flight response as a result of previous acute trauma, or simply a result of what is happening in the mediation. Peter Levine's list of physical signs of sympathetic hyperarousal includes: tightening of the muscles in the front of the neck, stiff posture, darting eyes, increased heart rate, dilation of the pupils, choppy quick breathing, and coldness in the hands.[57]

Freeze/immobilization: Again, physical signs of freeze/shut-down or dissociation will vary, depending upon the severity of the condition. According to Levine, the physical signs include fixed or spaced-out eyes, a physical posture of collapse or slumping, constriction of the pupils, and reduced breathing. The skin may turn pasty or even gray.[58]

An important warning signal occurs when a party seems to lack focus or to gaze off into the distance ("the thousand yard stare"), or shows other signs of disassociation.

ii. Case Example

In one case I mediated, I was struck by the fact that even in separate sessions, both parties avoided eye contact, and spent the entire time looking out the window. One of the parties, in particular, was sitting in a collapsed posture.

Since I felt his postural collapse was an expression of utter hopelessness, I emphasized the possibility of getting the case over with, and moving on. I also made a point of touching him lightly on his shoulder in an encouraging way.

While I think these were appropriate interventions when dealing with a person in freeze/immobility, the reality of the situation was that he was facing several lawsuits from different parties, most of whom were not a part of the lawsuit at issue in the mediation. He did not significantly come out of his immobility/freeze. However, the attorneys were quite active in the process, which, I felt, meant the mediation should not be discontinued.

2. The Role of Gender

A new model of the human threat response argues that, in addition to fight, flight, and immobilization/freeze, our responses to

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[57] LEVINE, *supra* note 3, at 105.

[58] *Id.* at 105.

3 Understanding the Impact of Trauma

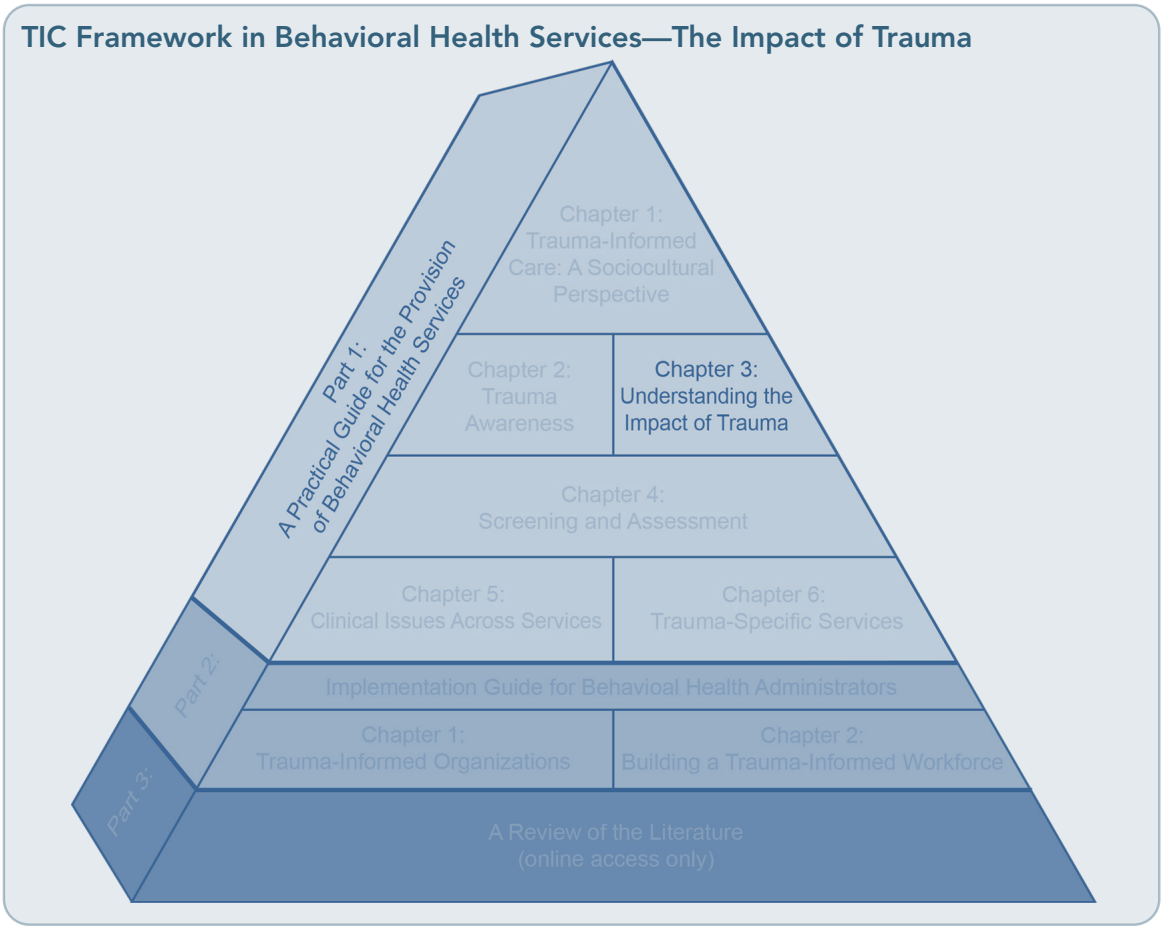
IN THIS CHAPTER

- Sequence of Trauma Reactions
- Common Experiences and Responses to Trauma
- Subthreshold Trauma Related Symptoms
- Specific Trauma Related Psychological Disorders
- Other Trauma Related and Co Occurring Disorders

Trauma-informed care (TIC) involves a broad understanding of traumatic stress reactions and common responses to trauma. Providers need to understand how trauma can affect treatment presentation, engagement, and the outcome of behavioral health services. This chapter examines common experiences survivors may encounter immediately following or long after a traumatic experience.

Trauma, including one-time, multiple, or long-lasting repetitive events, affects everyone differently. Some individuals may clearly display criteria associated with posttraumatic stress disorder (PTSD), but many more individuals will exhibit resilient responses or brief subclinical symptoms or consequences that fall outside of diagnostic criteria. The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors.

This chapter begins with an overview of common responses, emphasizing that traumatic stress reactions are normal reactions to abnormal circumstances. It highlights common short- and long-term responses to traumatic experiences in the context of individuals who may seek behavioral health services. This chapter discusses psychological symptoms not represented in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (DSM-5; American Psychiatric Association [APA], 2013a), and responses associated with trauma that either fall below the threshold of mental disorders or reflect resilience. It also addresses common disorders associated with traumatic stress. This chapter explores the role of culture in defining mental illness, particularly PTSD, and ends by addressing co-occurring mental and substance-related disorders.



Sequence of Trauma Reactions

Survivors' immediate reactions in the aftermath of trauma are quite complicated and are affected by their own experiences, the accessibility of natural supports and healers, their coping and life skills and those of immediate family, and the responses of the larger community in which they live. Although reactions range in severity, even the most acute responses are natural responses to manage trauma—they are not a sign of psychopathology. Coping styles vary from action oriented to reflective and from emotionally expressive to reticent. Clinically, a response style is less important than the degree to which coping efforts successfully allow one to continue necessary activities, regulate emotions, sustain self-esteem, and maintain and enjoy interpersonal contacts. Indeed, a past error in traumatic stress psychology, particularly regarding group or mass traumas, was the assumption that all survivors need to express emotions associated with trauma and talk about the trauma; more recent research indicates that survivors who choose not to process their trauma are just as psychologically healthy as

Foreshortened future: Trauma can affect one's beliefs about the future via loss of hope, limited expectations about life, fear that life will end abruptly or early, or anticipation that normal life events won't occur (e.g., access to education, ability to have a significant and committed relationship, good opportunities for work).

those who do. The most recent psychological debriefing approaches emphasize respecting the individual's style of coping and not valuing one type over another.

Initial reactions to trauma can include exhaustion, confusion, sadness, anxiety, agitation, numbness, dissociation, confusion, physical arousal, and blunted affect. Most responses are normal in that they affect most survivors and are socially acceptable, psychologically effective, and self-limited. Indicators of more severe responses include continuous distress without periods of relative calm or rest, severe dissociation symptoms, and intense intrusive recollections that continue despite a return to safety. Delayed responses to trauma can include persistent fatigue, sleep disorders, nightmares, fear of recurrence, anxiety focused on flashbacks, depression, and avoidance of emotions, sensations, or activities that are associated with the trauma, even remotely. Exhibit 1.3-1 outlines some common reactions.

Common Experiences and Responses to Trauma

A variety of reactions are often reported and/or observed after trauma. Most survivors exhibit immediate reactions, yet these typically resolve without severe long-term consequences. This is because most trauma survivors are highly resilient and develop appropriate coping strategies, including the use of social supports, to deal with the aftermath and effects of trauma. Most recover with time, show minimal distress, and function effectively across major life areas and developmental stages. Even so, clients who show little impairment may still have subclinical symptoms or symptoms that do not fit diagnostic criteria for acute stress disorder (ASD) or PTSD. Only a small percentage of people with a history of trauma show impairment and symptoms that meet criteria for trauma-related stress disorders, including mood and anxiety disorders.

The following sections focus on some common reactions across domains (emotional, physical, cognitive, behavioral, social, and developmental) associated with singular, multiple, and enduring traumatic events. These reactions are often normal responses to trauma but can still be distressing to experience. Such responses are not signs of mental illness, nor do they indicate a mental disorder. Traumatic stress-related disorders comprise a specific constellation of symptoms and criteria.

Emotional

Emotional reactions to trauma can vary greatly and are significantly influenced by the individual's sociocultural history. Beyond the initial emotional reactions during the event, those most likely to surface include anger, fear, sadness, and shame. However, individuals may encounter difficulty in identifying any of these feelings for various reasons. They might lack experience with or prior exposure to emotional expression in their family or community. They may associate strong feelings with the past trauma, thus believing that emotional expression is too dangerous or will lead to feeling out of control (e.g., a sense of "losing it" or going crazy). Still others might deny that they have any feelings associated with their traumatic experiences and define their reactions as numbness or lack of emotions.

Emotional dysregulation

Some trauma survivors have difficulty regulating emotions such as anger, anxiety, sadness, and shame—this is more so when the trauma occurred at a young age (van der Kolk, Roth, Pelcovitz, & Mandel, 1993). In individuals who are older and functioning well

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma

Immediate Emotional Reactions	Delayed Emotional Reactions
Numbness and detachment Anxiety or severe fear Guilt (including survivor guilt) Exhilaration as a result of surviving Anger Sadness Helplessness Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself) Disorientation Feeling out of control Denial Constriction of feelings Feeling overwhelmed	Irritability and/or hostility Depression Mood swings, instability Anxiety (e.g., phobia, generalized anxiety) Fear of trauma recurrence Grief reactions Shame Feelings of fragility and/or vulnerability Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
Immediate Physical Reactions	**Delayed Physical Reactions**
Nausea and/or gastrointestinal distress Sweating or shivering Faintness Muscle tremors or uncontrollable shaking Elevated heartbeat, respiration, and blood pressure Extreme fatigue or exhaustion Greater startle responses Depersonalization	Sleep disturbances, nightmares Somatization (e.g., increased focus on and worry about body aches and pains) Appetite and digestive changes Lowered resistance to colds and infection Persistent fatigue Elevated cortisol levels Hyperarousal Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
Immediate Cognitive Reactions	**Delayed Cognitive Reactions**
Difficulty concentrating Rumination or racing thoughts (e.g., replaying the traumatic event over and over again) Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as minutes) Memory problems (e.g., not being able to recall important aspects of the trauma) Strong identification with victims	Intrusive memories or flashbacks Reactivation of previous traumatic events Self-blame Preoccupation with event Difficulty making decisions Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma Belief that feelings or memories are dangerous Generalization of triggers (e.g., a person who experiences a home invasion during the daytime may avoid being alone during the day) Suicidal thinking
Immediate Behavioral Reactions	**Delayed Behavioral Reactions**
Startled reaction Restlessness Sleep and appetite disturbances Difficulty expressing oneself Argumentative behavior Increased use of alcohol, drugs, and tobacco Withdrawal and apathy Avoidant behaviors	Avoidance of event reminders Social relationship disturbances Decreased activity level Engagement in high-risk behaviors Increased use of alcohol and drugs Withdrawal

(Continued on the next page.)

Exhibit 1.3-1: Immediate and Delayed Reactions to Trauma (continued)

Immediate Existential Reactions	Delayed Existential Reactions
Intense use of prayer	Questioning (e.g., "Why me?")
Restoration of faith in the goodness of others (e.g., receiving help from others)	Increased cynicism, disillusionment
Loss of self-efficacy	Increased self-confidence (e.g., "If I can survive this, I can survive anything")
Despair about humanity, particularly if the event was intentional	Loss of purpose
Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)	Renewed faith
	Hopelessness
	Reestablishing priorities
	Redefining meaning and importance of life
	Reworking life's assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)

Sources: Briere & Scott, 2006b; Foa, Stein, & McFarlane, 2006; Pietrzak, Goldstein, Southwick, & Grant, 2011.

prior to the trauma, such emotional dysregulation is usually short lived and represents an immediate reaction to the trauma, rather than an ongoing pattern. Self-medication—namely, substance abuse—is one of the methods that traumatized people use in an attempt to regain emotional control, although ultimately it causes even further emotional dysregulation (e.g., substance-induced changes in affect during and after use). Other efforts toward emotional regulation can include engagement in high-risk or self-injurious behaviors, disordered eating, compulsive behaviors such as gambling or overworking, and repression or denial of emotions; however, not all behaviors associated with self-regulation are considered negative. In fact, some individuals find creative, healthy, and industrious ways to manage strong affect generated by trauma, such as through renewed commitment to physical activity or by creating an organization to support survivors of a particular trauma.

Traumatic stress tends to evoke two emotional extremes: feeling either too much (overwhelmed) or too little (numb) emotion. Treatment can help the client find the optimal level of emotion and assist him or her with appropriately experiencing and regulating difficult emotions. In treatment, the goal is to help clients learn to regulate their emotions without the use of substances or other unsafe behavior. This will likely require learning new coping skills and how to tolerate distressing emotions; some clients may benefit from mindfulness practices, cognitive restructuring, and trauma-specific desensitization approaches, such as exposure therapy and eye movement desensitization and reprocessing (EMDR; refer to Part 1, Chapter 6, for more information on trauma-specific therapies).

Numbing

Numbing is a biological process whereby emotions are detached from thoughts, behaviors, and memories. In the following case illustration, Sadhanna's numbing is evidenced by her limited range of emotions associated with interpersonal interactions and her inability to associate any emotion with her history of abuse. She also possesses a belief in a foreshortened future. A prospective longitudinal study (Malta, Levitt, Martin, Davis, & Cloitre, 2009) that followed the development of PTSD in disaster workers highlighted the importance of understanding and appreciating numbing as a traumatic stress reaction. Because numbing

Case Illustration: Sadhanna

Sadhanna is a 22-year-old woman mandated to outpatient mental health and substance abuse treatment as the alternative to incarceration. She was arrested and charged with assault after arguing and fighting with another woman on the street. At intake, Sadhanna reported a 7-year history of alcohol abuse and one depressive episode at age 18. She was surprised that she got into a fight but admitted that she was drinking at the time of the incident. She also reported severe physical abuse at the hands of her mother's boyfriend between ages 4 and 15. Of particular note to the intake worker was Sadhanna's matter-of-fact way of presenting the abuse history. During the interview, she clearly indicated that she did not want to attend group therapy and hear other people talk about their feelings, saying, "I learned long ago not to wear emotions on my sleeve."

Sadhanna reported dropping out of 10th grade, saying she never liked school. She didn't expect much from life. In Sadhanna's first weeks in treatment, she reported feeling disconnected from other group members and questioned the purpose of the group. When asked about her own history, she denied that she had any difficulties and did not understand why she was mandated to treatment. She further denied having feelings about her abuse and did not believe that it affected her life now. Group members often commented that she did not show much empathy and maintained a flat affect, even when group discussions were emotionally charged.

symptoms hide what is going on inside emotionally, there can be a tendency for family members, counselors, and other behavioral health staff to assess levels of traumatic stress symptoms and the impact of trauma as less severe than they actually are.

Physical

Diagnostic criteria for PTSD place considerable emphasis on psychological symptoms, but some people who have experienced traumatic stress may present initially with physical symptoms. Thus, primary care may be the first and only door through which these individuals seek assistance for trauma-related symptoms. Moreover, there is a significant connection between trauma, including adverse childhood experiences (ACEs), and chronic health conditions. Common physical disorders and symptoms include somatic complaints; sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders.

Somatization

Somatization indicates a focus on bodily symptoms or dysfunctions to express emotional distress. Somatic symptoms are more likely to occur with individuals who have traumatic stress reactions, including PTSD. People from certain ethnic and cultural backgrounds may initially or solely present emotional distress via physical ailments or concerns. Many individuals who present with somatization are likely unaware of the connection between their emotions and the physical symptoms that they're experiencing. At times, clients may remain resistant to exploring emotional content and remain focused on bodily complaints as a means of avoidance. Some clients may insist that their primary problems are physical even when medical evaluations and tests fail to confirm ailments. In these situations, somatization may be a sign of a mental illness. However, various cultures approach emotional distress through the physical realm or view emotional and physical symptoms and well-being as one. It is important not to assume that clients with physical complaints are using somatization as a means to express emotional pain; they may have specific conditions or disorders that require medical attention. Foremost, counselors need to refer for medical evaluation.

Advice to Counselors: Using Information About Biology and Trauma

- Educate your clients:
  - Frame reexperiencing the event(s), hyperarousal, sleep disturbances, and other physical symptoms as physiological reactions to extreme stress.
  - Communicate that treatment and other wellness activities can improve both psychological and physiological symptoms (e.g., therapy, meditation, exercise, yoga). You may need to refer certain clients to a psychiatrist who can evaluate them and, if warranted, prescribe psychotropic medication to address severe symptoms.
  - Discuss traumatic stress symptoms and their physiological components.
  - Explain links between traumatic stress symptoms and substance use disorders, if appropriate.
  - Normalize trauma symptoms. For example, explain to clients that their symptoms are not a sign of weakness, a character flaw, being damaged, or going crazy.
- Support your clients and provide a message of hope—that they are not alone, they are not at fault, and recovery is possible and anticipated.

Biology of trauma

Trauma biology is an area of burgeoning research, with the promise of more complex and explanatory findings yet to come. Although a thorough presentation on the biological aspects of trauma is beyond the scope of this publication, what is currently known is that exposure to trauma leads to a cascade of biological changes and stress responses. These biological alterations are highly associated with PTSD, other mental illnesses, and substance use disorders. These include:

- Changes in limbic system functioning.
- Hypothalamic–pituitary–adrenal axis activity changes with variable cortisol levels.
- Neurotransmitter-related dysregulation of arousal and endogenous opioid systems.

As a clear example, early ACEs such as abuse, neglect, and other traumas affect brain development and increase a person's vulnerability to encountering interpersonal violence as an adult and to developing chronic diseases and other physical illnesses, mental illnesses, substance-related disorders, and impairment in other life areas (Centers for Disease Control and Prevention, 2012).

Hyperarousal and sleep disturbances

A common symptom that arises from traumatic experiences is hyperarousal (also called hypervigilance). Hyperarousal is the body's way of remaining prepared. It is characterized by sleep disturbances, muscle tension, and a lower threshold for startle responses and can persist years after trauma occurs. It is also one of the primary diagnostic criteria for PTSD.

Hyperarousal is a consequence of biological changes initiated by trauma. Although it

Case Illustration: Kimi

Kimi is a 35-year-old Native American woman who was group raped at the age of 16 on her walk home from a suburban high school. She recounts how her whole life changed on that day. "I never felt safe being alone after the rape. I used to enjoy walking everywhere. Afterward, I couldn't tolerate the fear that would arise when I walked in the neighborhood. It didn't matter whether I was alone or with friends—every sound that I heard would throw me into a state of fear. I felt like the same thing was going to happen again. It's gotten better with time, but I often feel as if I'm sitting on a tree limb waiting for it to break. I have a hard time relaxing. I can easily get startled if a leaf blows across my path or if my children scream while playing in the yard. The best way I can describe how I experience life is by comparing it to watching a scary, suspenseful movie—anxiously waiting for something to happen, palms sweating, heart pounding, on the edge of your chair."

serves as a means of self-protection after trauma, it can be detrimental. Hyperarousal can interfere with an individual's ability to take the necessary time to assess and appropriately respond to specific input, such as loud noises or sudden movements. Sometimes, hyperarousal can produce overreactions to situations perceived as dangerous when, in fact, the circumstances are safe.

Along with hyperarousal, sleep disturbances are very common in individuals who have experienced trauma. They can come in the form of early awakening, restless sleep, difficulty falling asleep, and nightmares. Sleep disturbances are most persistent among individuals who have trauma-related stress; the disturbances sometimes remain resistant to intervention long after other traumatic stress symptoms have been successfully treated. Numerous strategies are available beyond medication, including good sleep hygiene practices, cognitive rehearsals of nightmares, relaxation strategies, and nutrition.

Cognitive

Traumatic experiences can affect and alter cognitions. From the outset, trauma challenges the just-world or core life assumptions that

Cognitions and Trauma

The following examples reflect some of the types of cognitive or thought-process changes that can occur in response to traumatic stress.

Cognitive errors: Misinterpreting a current situation as dangerous because it resembles, even remotely, a previous trauma (e.g., a client overreacting to an overturned canoe in 8 inches of water, as if she and her paddle companion would drown, due to her previous experience of nearly drowning in a rip current 5 years earlier).

Excessive or inappropriate guilt: Attempting to make sense cognitively and gain control over a traumatic experience by assuming responsibility or possessing survivor's guilt, because others who experienced the same trauma did not survive.

Idealization: Demonstrating inaccurate rationalizations, idealizations, or justifications of the perpetrator's behavior, particularly if the perpetrator is or was a caregiver. Other similar reactions mirror idealization; traumatic bonding is an emotional attachment that develops (in part to secure survival) between perpetrators who engage in interpersonal trauma and their victims, and Stockholm syndrome involves compassion and loyalty toward hostage takers (de Fabrique, Van Hasselt, Vecchi, & Romano, 2007).

Trauma-induced hallucinations or delusions: Experiencing hallucinations and delusions that, although they are biological in origin, contain cognitions that are congruent with trauma content (e.g., a woman believes that a person stepping onto her bus is her father, who had sexually abused her repeatedly as child, because he wore shoes similar to those her father once wore).

Intrusive thoughts and memories: Experiencing, without warning or desire, thoughts and memories associated with the trauma. These intrusive thoughts and memories can easily trigger strong emotional and behavioral reactions, as if the trauma was recurring in the present. The intrusive thoughts and memories can come rapidly, referred to as flooding, and can be disruptive at the time of their occurrence. If an individual experiences a trigger, he or she may have an increase in intrusive thoughts and memories for a while. For instance, individuals who inadvertently are retraumatized due to program or clinical practices may have a surge of intrusive thoughts of past trauma, thus making it difficult for them to discern what is happening now versus what happened then. Whenever counseling focuses on trauma, it is likely that the client will experience some intrusive thoughts and memories. It is important to develop coping strategies before, as much as possible, and during the delivery of trauma-informed and trauma-specific treatment.

help individuals navigate daily life (Janoff-Bulman, 1992). For example, it would be difficult to leave the house in the morning if you believed that the world was not safe, that all people are dangerous, or that life holds no promise. Belief that one's efforts and intentions can protect oneself from bad things makes it less likely for an individual to perceive personal vulnerability. However, traumatic events—particularly if they are unexpected—can challenge such beliefs.

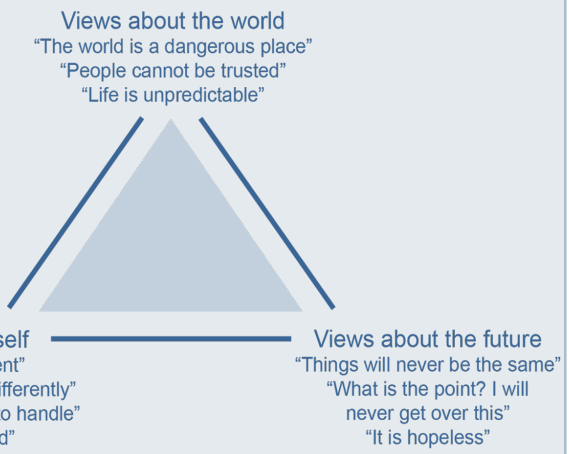
Let's say you always considered your driving time as "your time"—and your car as a safe place to spend that time. Then someone hits you from behind at a highway entrance. Almost immediately, the accident affects how you perceive the world, and from that moment onward, for months following the crash, you feel unsafe in any car. You become hypervigilant about other drivers and perceive that other cars are drifting into your lane or failing to stop at a safe distance behind you. For a time, your perception of safety is eroded, often leading to compensating behaviors (e.g., excessive glancing into the rearview mirror to see whether the vehicles behind you are stopping) until the belief is restored or reworked. Some individuals never return to their previous belief systems after a trauma, nor do they find a way to rework them—thus leading to a worldview that life is unsafe. Still, many other individuals are able to return to organizing core beliefs that support their perception of safety.

Many factors contribute to cognitive patterns prior to, during, and after a trauma. Adopting Beck and colleagues' cognitive triad model (1979), trauma can alter three main cognitive patterns: thoughts about self, the world (others/environment), and the future. To clarify, trauma can lead individuals to see themselves as incompetent or damaged, to see others and the world as unsafe and unpredictable, and to see the future as hopeless—believing that personal suffering will continue, or negative outcomes will preside for the foreseeable future (see Exhibit 1.3-2). Subsequently, this set of cognitions can greatly influence clients' belief in their ability to use internal resources and external support effectively. From a cognitive–behavioral perspective, these cognitions have a bidirectional relationship in sustaining or contributing to the development of depressive and anxiety symptoms after trauma. However, it is possible for cognitive patterns to help protect against debilitating psychological symptoms as well. Many factors contribute to cognitive patterns prior to, during, and after a trauma.

Feeling different

An integral part of experiencing trauma is feeling different from others, whether or not the trauma was an individual or group experience. Traumatic experiences typically feel surreal and challenge the necessity and value of mundane activities of daily life. Survivors

Exhibit 1.3-2: Cognitive Triad of Traumatic Stress



often believe that others will not fully understand their experiences, and they may think that sharing their feelings, thoughts, and reactions related to the trauma will fall short of expectations. However horrid the trauma may be, the *experience* of the trauma is typically profound.

The type of trauma can dictate how an individual feels different or believes that they are different from others. Traumas that generate shame will often lead survivors to feel more alienated from others—believing that they are "damaged goods." When individuals believe that their experiences are unique and incomprehensible, they are more likely to seek support, if they seek support at all, only with others who have experienced a similar trauma.

Triggers and flashbacks

Triggers

A trigger is a stimulus that sets off a memory of a trauma or a specific portion of a traumatic experience. Imagine you were trapped briefly in a car after an accident. Then, several years later, you were unable to unlatch a lock after using a restroom stall; you might have begun to feel a surge of panic reminiscent of the accident, even though there were other avenues of escape from the stall. Some triggers can be identified and anticipated easily, but many are subtle and inconspicuous, often surprising the individual or catching him or her off guard. In treatment, it is important to help clients identify potential triggers, draw a connection between strong emotional reactions and triggers, and develop coping strategies to manage those moments when a trigger occurs. A trigger is any sensory reminder of the traumatic event: a noise, smell, temperature, other physical sensation, or visual scene. Triggers can generalize to any characteristic, no matter how remote, that resembles or represents a previous trauma, such as revisiting the location where the trauma occurred, being alone, having your children reach the same age that you were when you experienced the trauma, seeing the same breed of dog that bit you, or hearing loud voices. Triggers are often associated with the time of day, season, holiday, or anniversary of the event.

Flashbacks

A flashback is reexperiencing a previous traumatic experience as if it were actually happening in that moment. It includes reactions that often resemble the client's reactions during the trauma. Flashback experiences are very brief and typically last only a few seconds, but the emotional aftereffects linger for hours or longer. Flashbacks are commonly initiated by a trigger, but not necessarily. Sometimes, they occur out of the blue. Other times, specific physical states increase a person's vulnerability to reexperiencing a trauma, (e.g., fatigue, high

Advice to Counselors: Helping Clients Manage Flashbacks and Triggers

If a client is triggered in a session or during some aspect of treatment, help the client focus on what is happening in the here and now; that is, use grounding techniques. Behavioral health service providers should be prepared to help the client get regrounded so that they can distinguish between what is happening now versus what had happened in the past (see Covington, 2008, and Najavits, 2002b, 2007b, for more grounding techniques). Offer education about the experience of triggers and flashbacks, and then normalize these events as common traumatic stress reactions. Afterward, some clients need to discuss the experience and understand why the flashback or trigger occurred. It often helps for the client to draw a connection between the trigger and the traumatic event(s). This can be a preventive strategy whereby the client can anticipate that a given situation places him or her at higher risk for retraumatization and requires use of coping strategies, including seeking support.

Source: Green Cross Academy of Traumatology, 2010.

stress levels). Flashbacks can feel like a brief movie scene that intrudes on the client. For example, hearing a car backfire on a hot, sunny day may be enough to cause a veteran to respond as if he or she were back on military patrol. Other ways people reexperience trauma, besides flashbacks, are via nightmares and intrusive thoughts of the trauma.

Dissociation, depersonalization, and derealization

Dissociation is a mental process that severs connections among a person's thoughts, memories, feelings, actions, and/or sense of identity. Most of us have experienced dissociation—losing the ability to recall or track a particular action (e.g., arriving at work but not remembering the last minutes of the drive). Dissociation happens because the person is engaged in an automatic activity and is not paying attention to his or her immediate environment. Dissociation can also occur during severe stress or trauma as a protective element whereby the individual incurs distortion of time, space, or identity. This is a common symptom in traumatic stress reactions.

Dissociation helps distance the experience from the individual. People who have experienced severe or developmental trauma may have learned to separate themselves from distress to survive. At times, dissociation can be very pervasive and symptomatic of a mental disorder, such as dissociative identity disorder (DID; formerly known as multiple personality disorder). According to the DSM-5, "dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior" (APA, 2013a, p. 291). Dissociative disorder diagnoses are closely associated with histories of severe childhood trauma or pervasive, human-caused, intentional trauma, such as that experienced by concentration camp survivors or victims of ongoing political imprisonment, torture, or long-term isolation. A mental health professional, preferably with significant training in working with dissociative disorders and with trauma, should be consulted when a dissociative disorder diagnosis is suspected.

Potential Signs of Dissociation

- Fixed or "glazed" eyes
- Sudden flattening of affect
- Long periods of silence
- Monotonous voice
- Stereotyped movements
- Responses not congruent with the present context or situation
- Excessive intellectualization

(Briere, 1996a)

The characteristics of DID can be commonly accepted experiences in other cultures, rather than being viewed as symptomatic of a traumatic experience. For example, in non-Western cultures, a sense of alternate beings within oneself may be interpreted as being inhabited by spirits or ancestors (Kirmayer, 1996). Other experiences associated with dissociation include depersonalization—psychologically "leaving one's body," as if watching oneself from a distance as an observer or through derealization, leading to a sense that what is taking place is unfamiliar or is not real.

If clients exhibit signs of dissociation, behavioral health service providers can use grounding techniques to help them reduce this defense strategy. One major long-term consequence of dissociation is the difficulty it causes in connecting strong emotional or physical reactions with an event. Often, individuals may believe that they are going crazy because they are not in touch with the nature of their reactions. By educating clients on the resilient qualities of dissociation while also emphasizing that it prevents them from addressing or

validating the trauma, individuals can begin to understand the role of dissociation. All in all, it is important when working with trauma survivors that the intensity level is not so great that it triggers a dissociative reaction and prevents the person from engaging in the process.

Behavioral

Traumatic stress reactions vary widely; often, people engage in behaviors to manage the aftereffects, the intensity of emotions, or the distressing aspects of the traumatic experience. Some people reduce tension or stress through avoidant, self-medicating (e.g., alcohol abuse), compulsive (e.g., overeating), impulsive (e.g., high-risk behaviors), and/or self-injurious behaviors. Others may try to gain control over their experiences by being aggressive or subconsciously reenacting aspects of the trauma.

Behavioral reactions are also the consequences of, or learned from, traumatic experiences. For example, some people act like they can't control their current environment, thus failing to take action or make decisions long after the trauma (learned helplessness). Other associate elements of the trauma with current activities, such as by reacting to an intimate moment in a significant relationship as dangerous or unsafe years after a date rape. The following sections discuss behavioral consequences of trauma and traumatic stress reactions.

Reenactments

A hallmark symptom of trauma is reexperiencing the trauma in various ways. Reexperiencing can occur through reenactments (literally, to "redo"), by which trauma survivors repetitively relive and recreate a past trauma in their present lives. This is very apparent in children, who play by mimicking what occurred during the trauma, such as by pretending to crash a toy airplane into a toy building after seeing televised images of the terrorist attacks on the World Trade Center on September 11, 2001. Attempts to understand reenactments are very complicated, as reenactments occur for a variety of reasons. Sometimes, individuals reenact past traumas to master them. Examples of reenactments include a variety of behaviors: self-injurious behaviors, hypersexuality, walking alone in unsafe areas or other high-risk behaviors, driving recklessly, or involvement in repetitive destructive relationships (e.g., repeatedly getting into romantic relationships with people who are abusive or violent), to name a few.

Self-harm and self-destructive behaviors

Self-harm is any type of intentionally self-inflicted harm, regardless of the severity of injury or whether suicide is intended. Often, self-harm is an attempt to cope with emotional or physical distress that seems overwhelming or to cope with a profound sense of dissociation or being trapped, helpless, and "damaged" (Herman, 1997; Santa Mina & Gallop, 1998). Self-harm is associated with past childhood sexual abuse and other forms of trauma as well as substance abuse. Thus,

Resilient Responses to Trauma

Many people find healthy ways to cope with, respond to, and heal from trauma. Often, people automatically reevaluate their values and redefine what is important after a trauma. Such resilient responses include:

- Increased bonding with family and community.
- Redefined or increased sense of purpose and meaning.
- Increased commitment to a personal mission.
- Revised priorities.
- Increased charitable giving and volunteerism.

Case Illustration: Marco

Marco, a 30-year-old man, sought treatment at a local mental health center after a 2-year bout of anxiety symptoms. He was an active member of his church for 12 years, but although he sought help from his pastor about a year ago, he reports that he has had no contact with his pastor or his church since that time. Approximately 3 years ago, his wife took her own life. He describes her as his soulmate and has had a difficult time understanding her actions or how he could have prevented them.

In the initial intake, he mentioned that he was the first person to find his wife after the suicide and reported feelings of betrayal, hurt, anger, and devastation since her death. He claimed that everyone leaves him or dies. He also talked about his difficulty sleeping, having repetitive dreams of his wife, and avoiding relationships. In his first session with the counselor, he initially rejected the counselor before the counselor had an opportunity to begin reviewing and talking about the events and discomfort that led him to treatment.

In this scenario, Marco is likely reenacting his feelings of abandonment by attempting to reject others before he experiences another rejection or abandonment. In this situation, the counselor will need to recognize the reenactment, explore the behavior, and examine how reenactments appear in other situations in Marco's life.

addressing self-harm requires attention to the client's reasons for self-harm. More than likely, the client needs help recognizing and coping with emotional or physical distress in manageable amounts and ways.

Among the self-harm behaviors reported in the literature are cutting, burning skin by heat (e.g., cigarettes) or caustic liquids, punching hard enough to self-bruise, head banging, hair pulling, self-poisoning, inserting foreign objects into bodily orifices, excessive nail biting, excessive scratching, bone breaking, gnawing at flesh, interfering with wound healing, tying off body parts to stop breathing or blood flow, swallowing sharp objects, and suicide. Cutting and burning are among the most common forms of self-harm.

Self-harm tends to occur most in people who have experienced repeated and/or early trauma (e.g., childhood sexual abuse) rather than in those who have undergone a single adult trauma (e.g., a community-wide disaster or a serious car accident). There are strong associations between eating disorders, self-harm, and substance abuse (Claes &Vandereycken, 2007; for discussion, see Harned, Najavits, & Weiss, 2006). Self-mutilation is also associated with (and part of the diagnostic criteria for) a number of personality disorders, including borderline and histrionic, as well as DID, depression, and some forms of schizophrenia; these disorders can co-occur with traumatic stress reactions and disorders.

It is important to distinguish self-harm that is suicidal from self-harm that is not suicidal and to assess and manage both of these very serious dangers carefully. Most people who engage in self-harm are not doing so with the intent to kill themselves (Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003)—although self-harm can be life threatening and can escalate into suicidality if not managed therapeutically. Self-harm can be a way of getting attention or manipulating others, but most often it is not. Self-destructive behaviors such as substance abuse, restrictive or binge eating, reckless automobile driving, or high-risk impulsive behavior are different from self-harming behaviors but are also seen in clients with a history of trauma. Self-destructive behaviors differ from self-harming behaviors in that there may be no immediate negative impact of the behavior on the individual; they differ from suicidal behavior in that there is no intent to cause death in the short term.

Advice to Counselors: Working With Clients Who Are Self-Injurious

Counselors who are unqualified or uncomfortable working with clients who demonstrate self-harming, self-destructive, or suicidal or homicidal ideation, intent, or behavior should work with their agencies and supervisors to refer such clients to other counselors. They should consider seeking specialized supervision on how to manage such clients effectively and safely and how to manage their feelings about these issues. The following suggestions assume that the counselor has had sufficient training and experience to work with clients who are self-injurious. To respond appropriately to a client who engages in self-harm, counselors should:

- Screen the client for self-harm and suicide risk at the initial evaluation and throughout treatment.
- Learn the client's perspective on self-harm and how it "helps."
- Understand that self-harm is often a coping strategy to manage the intensity of emotional and/or physical distress.
- Teach the client coping skills that improve his or her management of emotions without self-harm.
- Help the client obtain the level of care needed to manage genuine risk of suicide or severe self-injury. This might include hospitalization, more intensive programming (e.g., intensive outpatient, partial hospitalization, residential treatment), or more frequent treatment sessions. The goal is to stabilize the client as quickly as possible, and then, if possible, begin to focus treatment on developing coping strategies to manage self-injurious and other harmful impulses.
- Consult with other team members, supervisors, and, if necessary, legal experts to determine whether one's efforts with and conceptualization of the self-harming client fit best practice guidelines. See, for example, Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (Center for Substance Abuse Treatment [CSAT], 2005c). Document such consultations and the decisions made as a result of them thoroughly and frequently.
- Help the client identify how substance use affects self-harm. In some cases, it can increase the behavior (e.g., alcohol disinhibits the client, who is then more likely to self-harm). In other cases, it can decrease the behavior (e.g., heroin evokes relaxation and, thus, can lessen the urge to self-harm). In either case, continue to help the client understand how abstinence from substances is necessary so that he or she can learn more adaptive coping.
- Work collaboratively with the client to develop a plan to create a sense of safety. Individuals are affected by trauma in different ways; therefore, safety or a safe environment may mean something entirely different from one person to the next. Allow the client to define what safety means to him or her.

Counselors can also help the client prepare a safety card that the client can carry at all times. The card might include the counselor's contact information, a 24-hour crisis number to call in emergencies, contact information for supportive individuals who can be contacted when needed, and, if appropriate, telephone numbers for emergency medical services. The counselor can discuss with the client the types of signs or crises that might warrant using the numbers on the card. Additionally, the counselor might check with the client from time to time to confirm that the information on the card is current.

TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a), has examples of safety agreements specifically for suicidal clients and discusses their uses in more detail. There is no credible evidence that a safety agreement is effective in preventing a suicide attempt or death. Safety agreements for clients with suicidal thoughts and behaviors should only be used as an adjunct support accompanying professional screening, assessment, and treatment for people with suicidal thoughts and behaviors. Keep in mind that safety plans or agreements may be perceived by the trauma survivor as a means of controlling behavior, subsequently replicating or triggering previous traumatic experiences.

All professionals—and in some States, anyone—could have ethical and legal responsibilities to those clients who pose an imminent danger to themselves or others. Clinicians should be aware of the pertinent State laws where they practice and the relevant Federal and professional regulations.

However, as with self-harming behavior, self-destructive behavior needs to be recognized and addressed and may persist—or worsen—without intervention.

Consumption of substances

Substance use often is initiated or increased after trauma. Clients in early recovery—especially those who develop PTSD or have it reactivated—have a higher relapse risk if they experience a trauma. In the first 2 months after September 11, 2001, more than a quarter of New Yorker residents who smoked cigarettes, drank alcohol, or used marijuana (about 265,000 people) increased their consumption. The increases continued 6 months after the attacks (Vlahov, Galea, Ahern, Resnick, & Kilpatrick, 2004). A study by the Substance Abuse and Mental Health Services Administration (SAMHSA, Office of Applied Studies, 2002) used National Survey on Drug Use and Health data to compare the first three quarters of 2001 with the last quarter and reported an increase in the prevalence rate for alcohol use among people 18 or older in the New York metropolitan area during the fourth quarter.

Interviews with New York City residents who were current or former cocaine or heroin users indicated that many who had been clean for 6 months or less relapsed after September 11, 2001. Others, who lost their income and could no longer support their habit, enrolled in methadone programs (Weiss et al., 2002). After the Oklahoma City bombing in 1995, Oklahomans reported double the normal rate of alcohol use, smoking more cigarettes, and a higher incidence of initiating smoking months and even years after the bombing (Smith, Christiansen, Vincent, & Hann, 1999).

Self-medication

Khantzian's self-medication theory (1985) suggests that drugs of abuse are selected for their specific effects. However, no definitive pattern has yet emerged of the use of particular substances in relation to PTSD or trauma symptoms. Use of substances can vary based on a variety of factors, including which trauma symptoms are most prominent for an individual and the individual's access to particular substances. Unresolved traumas sometimes lurk behind the emotions that clients cannot allow themselves to experience. Substance use and abuse in trauma survivors can be a way to self-medicate and thereby avoid or displace difficult emotions associated with traumatic experiences. When the substances are withdrawn, the survivor may use other behaviors to self-soothe, self-medicate, or avoid emotions. As likely, emotions can appear after abstinence in the form of anxiety and depression.

Avoidance

Avoidance often coincides with anxiety and the promotion of anxiety symptoms. Individuals begin to avoid people, places, or situations to alleviate unpleasant emotions, memories, or circumstances. Initially, the avoidance works, but over time, anxiety increases and the perception that the situation is unbearable or dangerous increases as well, leading to a greater need to avoid. Avoidance can be adaptive, but it is also a behavioral pattern that reinforces perceived danger without testing its validity, and it typically leads to greater problems across major life areas (e.g., avoiding emotionally oriented conversations in an intimate relationship). For many individuals who have traumatic stress reactions, avoidance is commonplace. A person may drive 5 miles longer to avoid the road where he or she had an accident. Another individual may avoid crowded places in fear of an assault or to circumvent strong emotional memories about an earlier assault that took place in a crowded area. Avoidance can come in many forms. When people can't tolerate strong affects associated with traumatic memories, they avoid, project,

deny, or distort their trauma-related emotional and cognitive experiences. A key ingredient in trauma recovery is learning to manage triggers, memories, and emotions without avoidance—in essence, becoming desensitized to traumatic memories and associated symptoms.

Social/Interpersonal

A key ingredient in the early stage of TIC is to establish, confirm, or reestablish a support system, including culturally appropriate activities, as soon as possible. Social supports and relationships can be protective factors against traumatic stress. However, trauma typically affects relationships significantly, regardless of whether the trauma is interpersonal or is of some other type. Relationships require emotional exchanges, which means that others who have close relationships or friendships with the individual who survived the trauma(s) are often affected as well—either through secondary traumatization or by directly experiencing the survivor's traumatic stress reactions. In natural disasters, social and community supports can be abruptly eroded and difficult to rebuild after the initial disaster relief efforts have waned.

Survivors may readily rely on family members, friends, or other social supports—or they may avoid support, either because they believe that no one will be understanding or trustworthy or because they perceive their own needs as a burden to others. Survivors who have strong emotional or physical reactions, including outbursts during nightmares, may pull away further in fear of being unable to predict their own reactions or to protect their own safety and that of others. Often, trauma survivors feel ashamed of their stress reactions, which further hampers their ability to use their support systems and resources adequately.

Many survivors of childhood abuse and interpersonal violence have experienced a significant sense of betrayal. They have often encountered trauma at the hands of trusted caregivers and family members or through significant relationships. This history of betrayal can disrupt forming or relying on supportive relationships in recovery, such as peer supports and counseling. Although this fear of trusting others is protective, it can lead to difficulty in connecting with others and greater vigilance in observing the behaviors of others, including behavioral health service providers. It is exceptionally difficult to override the feeling that someone is going to hurt you, take advantage of you, or, minimally, disappoint you. Early betrayal can affect one's ability to develop attachments, yet the formation of supportive relationships is an important antidote in the recovery from traumatic stress.

Developmental

Each age group is vulnerable in unique ways to the stresses of a disaster, with children and the elderly at greatest risk. Young children may display generalized fear, nightmares, heightened arousal and confusion, and physical symptoms, (e.g., stomachaches, headaches). School-age children may exhibit symptoms such as aggressive behavior and anger, regression to behavior seen at younger ages, repetitious traumatic play, loss of ability to concentrate, and worse school performance. Adolescents may display depression and social withdrawal, rebellion, increased risky activities such as sexual acting out, wish for revenge and action-oriented responses to trauma, and sleep and eating disturbances (Hamblen, 2001). Adults may display sleep problems, increased agitation, hypervigilance, isolation or withdrawal, and increased use of alcohol or drugs. Older adults may exhibit increased withdrawal and isolation, reluctance to leave home, worsening of chronic illnesses, confusion, depression, and fear (DeWolfe & Nordboe, 2000b).

Neurobiological Development: Consequences of Early Childhood Trauma

Findings in developmental psychobiology suggest that the consequences of early maltreatment produce enduring negative effects on brain development (DeBellis, 2002; Liu, Diorio, Day, Francis, & Meaney, 2000; Teicher, 2002). Research suggests that the first stage in a cascade of events produced by early trauma and/or maltreatment involves the disruption of chemicals that function as neurotransmitters (e.g., cortisol, norepinephrine, dopamine), causing escalation of the stress response (Heim, Mletzko, Purselle, Musselman, & Nemeroff, 2008; Heim, Newport, Mletzko, Miller, & Nemeroff, 2008; Teicher, 2002). These chemical responses can then negatively affect critical neural growth during specific sensitive periods of childhood development and can even lead to cell death.

Adverse brain development can also result from elevated levels of cortisol and catecholamines by contributing to maturational failures in other brain regions, such as the prefrontal cortex (Meaney, Brake, & Gratton, 2002). Heim, Mletzko et al. (2008) found that the neuropeptide oxytocin—important for social affiliation and support, attachment, trust, and management of stress and anxiety—was markedly decreased in the cerebrospinal fluid of women who had been exposed to childhood maltreatment, particularly those who had experienced emotional abuse. The more childhood traumas a person had experienced, and the longer their duration, the lower that person's current level of oxytocin was likely to be and the higher her rating of current anxiety was likely to be.

Using data from the Adverse Childhood Experiences Study, an analysis by Anda, Felitti, Brown et al. (2006) confirmed that the risk of negative outcomes in affective, somatic, substance abuse, memory, sexual, and aggression-related domains increased as scores on a measure of eight ACEs increased. The researchers concluded that the association of study scores with these outcomes can serve as a theoretical parallel for the effects of cumulative exposure to stress on the developing brain and for the resulting impairment seen in multiple brain structures and functions.

The National Child Traumatic Stress Network (http://www.nctsn.org) offers information about childhood abuse, stress, and physiological responses of children who are traumatized. Materials are available for counselors, educators, parents, and caregivers. There are special sections on the needs of children in military families and on the impact of natural disasters on children's mental health.

Subthreshold Trauma-Related Symptoms

Many trauma survivors experience symptoms that, although they do not meet the diagnostic criteria for ASD or PTSD, nonetheless limit their ability to function normally (e.g., regulate emotional states, maintain steady and rewarding social and family relationships, function competently at a job, maintain a steady pattern of abstinence in recovery). These symptoms can be transient, only arising in a specific context; intermittent, appearing for several weeks or months and then receding; or a part of the individual's regular pattern of functioning (but not to the level of DSM-5 diagnostic criteria). Often, these patterns are termed "subthreshold" trauma symptoms. Like PTSD, the symptoms can be misdiagnosed as depression, anxiety, or another mental illness. Likewise, clients who have experienced trauma may link some of their symptoms to their trauma and diagnose themselves as having PTSD, even though they do not meet all criteria for that disorder.

Combat Stress Reaction

A phenomenon unique to war, and one that counselors need to understand well, is combat stress reaction (CSR). CSR is an acute anxiety reaction occurring during or shortly after participating in military conflicts and wars as well as other operations within the war zone, known as the theater. CSR is not a formal diagnosis, nor is it included in the DSM-5 (APA, 2013a). It is similar to acute stress

Case Illustration: Frank

Frank is a 36-year-old man who was severely beaten in a fight outside a bar. He had multiple injuries, including broken bones, a concussion, and a stab wound in his lower abdomen. He was hospitalized for 3.5 weeks and was unable to return to work, thus losing his job as a warehouse forklift operator. For several years, when faced with situations in which he perceived himself as helpless and overwhelmed, Frank reacted with violent anger that, to others, appeared grossly out of proportion to the situation. He has not had a drink in almost 3 years, but the bouts of anger persist and occur three to five times a year. They leave Frank feeling even more isolated from others and alienated from those who love him. He reports that he cannot watch certain television shows that depict violent anger; he has to stop watching when such scenes occur. He sometimes daydreams about getting revenge on the people who assaulted him.

Psychiatric and neurological evaluations do not reveal a cause for Frank's anger attacks. Other than these symptoms, Frank has progressed well in his abstinence from alcohol. He attends a support group regularly, has acquired friends who are also abstinent, and has reconciled with his family of origin. His marriage is more stable, although the episodes of rage limit his wife's willingness to commit fully to the relationship. In recounting the traumatic event in counseling, Frank acknowledges that he thought he was going to die as a result of the fight, especially when he realized he had been stabbed. As he described his experience, he began to become very anxious, and the counselor observed the rage beginning to appear.

After his initial evaluation, Frank was referred to an outpatient program that provided trauma-specific interventions to address his subthreshold trauma symptoms. With a combination of cognitive–behavioral counseling, EMDR, and anger management techniques, he saw a gradual decrease in symptoms when he recalled the assault. He started having more control of his anger when memories of the trauma emerged. Today, when feeling trapped, helpless, or overwhelmed, Frank has resources for coping and does not allow his anger to interfere with his marriage or other relationships.

reaction, except that the precipitating event or events affect military personnel (and civilians exposed to the events) in an armed conflict situation. The terms "combat stress reaction" and "posttraumatic stress injury" are relatively new, and the intent of using these new terms is to call attention to the unique experiences of combat-related stress as well as to decrease the shame that can be associated with seeking behavioral health services for PTSD (for more information on veterans and combat stress reactions, see the planned TIP, *Reintegration-Related Behavioral Health Issues for Veterans and Military Families*; SAMHSA, planned f).

Although stress mobilizes an individual's physical and psychological resources to perform more effectively in combat, reactions to the stress may persist long after the actual danger has ended. As with other traumas, the nature of the event(s), the reactions of others, and the survivor's psychological history and resources affect the likelihood and severity of CSR. With combat veterans, this translates to the number, intensity, and duration of threat factors; the social support of peers in the veterans' unit; the emotional and cognitive resilience of the service members; and the quality of military leadership. CSR can vary from manageable and mild to debilitating and severe. Common, less severe symptoms of CSR include tension, hypervigilance, sleep problems, anger, and difficulty concentrating. If left untreated, CSR can lead to PTSD.

Common causes of CSR are events such as a direct attack from insurgent small arms fire or a military convoy being hit by an improvised explosive device, but combat stressors encompass a diverse array of traumatizing events, such as seeing grave injuries, watching others

Advice to Counselors: Understanding the Nature of Combat Stress

Several sources of information are available to help counselors deepen their understanding of combat stress and postdeployment adjustment. Friedman (2006) explains how a prolonged combat-ready stance, which is adaptive in a war zone, becomes hypervigilance and overprotectiveness at home. He makes the point that the "mutual interdependence, trust, and affection" (p. 587) that are so necessarily a part of a combat unit are different from relationships with family members and colleagues in a civilian workplace. This complicates the transition to civilian life. *Wheels Down: Adjusting to Life After Deployment* (Moore & Kennedy, 2011) provides practical advice for military service members, including inactive or active duty personnel and veterans, in transitioning from the theater to home.

The following are just a few of the many resources and reports focused on combat-related psychological and stress issues:

- *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Tanielian & Jaycox, 2008)
- *On Killing* (Grossman, 1995), an indepth analysis of the psychological dynamics of combat
- *Haunted by Combat* (Paulson & Krippner, 2007), which contains specific chapters on Reserve and National Guard troops and female veterans
- *Treating Young Veterans: Promoting Resilience Through Practice and Advocacy* (Kelly, Howe-Barksdale, & Gitelson, 2011)

die, and making on-the-spot decisions in ambiguous conditions (e.g., having to determine whether a vehicle speeding toward a military checkpoint contains insurgents with explosives or a family traveling to another area). Such circumstances can lead to combat stress. Military personnel also serve in noncombat positions (e.g., healthcare and administrative roles), and personnel filling these supportive roles can be exposed to combat situations by proximity or by witnessing their results.

Specific Trauma-Related Psychological Disorders

Part of the definition of trauma is that the individual responds with intense fear, helplessness, or horror. Beyond that, in both the short term and the long term, trauma comprises a range of reactions from normal (e.g., being unable to concentrate, feeling sad, having trouble sleeping) to warranting a diagnosis of a trauma-related mental disorder. Most people who experience trauma have no long-lasting disabling effects; their coping skills and the support of those around them are sufficient to help them overcome their difficulties, and their ability to function on a daily basis over time is unimpaired. For others, though, the symptoms of trauma are more severe and last longer. The most common diagnoses associated with trauma are PTSD and ASD, but trauma is also associated with the onset of other mental disorders—particularly substance use disorders, mood disorders, various anxiety disorders, and personality disorders. Trauma also typically exacerbates symptoms of preexisting disorders, and, for people who are predisposed to a mental disorder, trauma can precipitate its onset. Mental disorders can occur almost simultaneously with trauma exposure or manifest sometime thereafter.

Acute Stress Disorder

ASD represents a normal response to stress. Symptoms develop within 4 weeks of the trauma and can cause significant levels of distress. Most individuals who have acute stress reactions never develop further impairment or PTSD. Acute stress disorder is highly associated with the experience of one specific trauma rather than the experience of long-term exposure to chronic traumatic stress. Diagnostic criteria are presented in Exhibit 1.3-3.

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD

A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse). **Note:** This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks), during which the individual feels or acts as if the traumatic event(s) were recurring. Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings. **Note:** In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood:
   5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms:
   6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
   7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors, such as head injury, alcohol, or drugs).

Avoidance Symptoms:
   8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   9. Efforts to avoid external reminders (e.g., people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms:
   10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
   11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
   12. Hypervigilance.
   13. Problems with concentration.
   14. Exaggerated startle response.

(Continued on the next page.)

Exhibit 1.3-3: DSM-5 Diagnostic Criteria for ASD (continued)

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure. **Note:** Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

Source: APA, 2013a, pp. 280–281.

The primary presentation of an individual with an acute stress reaction is often that of someone who appears overwhelmed by the traumatic experience. The need to talk about the experience can lead the client to seem self-centered and unconcerned about the needs of others. He or she may need to describe, in repetitive detail, what happened, or may seem obsessed with trying to understand what happened in an effort to make sense of the experience. The client is often hypervigilant and avoids circumstances that are reminders of the trauma. For instance, someone who was in a serious car crash in heavy traffic can become anxious and avoid riding in a car or driving in traffic for a finite time afterward. Partial amnesia for the trauma often accompanies ASD, and the individual may repetitively question others to fill in details. People with ASD symptoms sometimes seek assurance from others that the event happened in the way they remember, that they are not "going crazy" or "losing it," and that they could not have prevented the event. The next case illustration demonstrates the time-limited nature of ASD.

Differences between ASD and PTSD

It is important to consider the differences between ASD and PTSD when forming a diagnostic impression. The primary difference is the amount of time the symptoms have been present. ASD resolves 2 days to 4 weeks after an event, whereas PTSD continues beyond the 4-week period. The diagnosis of ASD can change to a diagnosis of PTSD if the condition is noted within the first 4 weeks after the event, but the symptoms persist past 4 weeks.

ASD also differs from PTSD in that the ASD diagnosis requires 9 out of 14 symptoms from five categories, including intrusion, negative mood, dissociation, avoidance, and arousal. These symptoms can occur at the time of the trauma or in the following month. Studies indicate that dissociation at the time of trauma is a good predictor of subsequent PTSD, so the inclusion of dissociative symptoms makes it more likely that those who develop ASD will later be diagnosed with PTSD (Bryant & Harvey, 2000). Additionally, ASD is a transient disorder, meaning that it is present in a person's life for a relatively short time and then passes. In contrast, PTSD typically becomes a primary feature of an individual's life. Over a lengthy period, PTSD can have profound effects on clients' perceptions of safety, their sense of hope for the future, their relationships with others, their physical health, the appearance of psychiatric symptoms, and their patterns of substance use and abuse.

There are common symptoms between PTSD and ASD, and untreated ASD is a possible predisposing factor to PTSD, but it is unknown whether most people with ASD are likely to develop PTSD. There is some suggestion that, as with PTSD, ASD is more

Case Illustration: Sheila

Two months ago, Sheila, a 55-year-old married woman, experienced a tornado in her home town. In the previous year, she had addressed a long-time marijuana use problem with the help of a treatment program and had been abstinent for about 6 months. Sheila was proud of her abstinence; it was something she wanted to continue. She regarded it as a mark of personal maturity; it improved her relationship with her husband, and their business had flourished as a result of her abstinence.

During the tornado, an employee reported that Sheila had become very agitated and had grabbed her assistant to drag him under a large table for cover. Sheila repeatedly yelled to her assistant that they were going to die. Following the storm, Sheila could not remember certain details of her behavior during the event. Furthermore, Sheila said that after the storm, she felt numb, as if she was floating out of her body and could watch herself from the outside. She stated that nothing felt real and it was all like a dream.

Following the tornado, Sheila experienced emotional numbness and detachment, even from people close to her, for about 2 weeks. The symptoms slowly decreased in intensity but still disrupted her life. Sheila reported experiencing disjointed or unconnected images and dreams of the storm that made no real sense to her. She was unwilling to return to the building where she had been during the storm, despite having maintained a business at this location for 15 years. In addition, she began smoking marijuana again because it helped her sleep. She had been very irritable and had uncharacteristic angry outbursts toward her husband, children, and other family members.

As a result of her earlier contact with a treatment program, Sheila returned to that program and engaged in psychoeducational, supportive counseling focused on her acute stress reaction. She regained abstinence from marijuana and returned shortly to a normal level of functioning. Her symptoms slowly diminished over a period of 3 weeks. With the help of her counselor, she came to understand the link between the trauma and her relapse, regained support from her spouse, and again felt in control of her life.

prevalent in women than in men (Bryant & Harvey, 2003). However, many people with PTSD do not have a diagnosis or recall a history of acute stress symptoms before seeking treatment for or receiving a diagnosis of PTSD.

Effective interventions for ASD can significantly reduce the possibility of the subsequent development of PTSD. Effective treatment of ASD can also reduce the incidence of other co-occurring problems, such as depression, anxiety, dissociative disorders, and compulsive behaviors (Bryant & Harvey, 2000). Intervention for ASD also helps the individual develop coping skills that can effectively prevent the recurrence of ASD after later traumas.

Although predictive science for ASD and PTSD will continue to evolve, both disorders are associated with increased substance use and mental disorders and increased risk of relapse; therefore, effective screening for ASD and PTSD is important for all clients with these disorders. Individuals in early recovery—lacking well-practiced coping skills, lacking environmental supports, and already operating at high levels of anxiety—are particularly susceptible to ASD. Events that would not normally be disabling can produce symptoms of intense helplessness and fear, numbing and depersonalization, disabling anxiety, and an inability to handle normal life events. Counselors should be able to recognize ASD and treat it rather than attributing the symptoms to a client's lack of motivation to change, being "dry drunk" (for those in substance abuse recovery), or being manipulative.

Posttraumatic Stress Disorder

The trauma-related disorder that receives the greatest attention is PTSD; it is the most

Case Illustration: Michael

Michael is a 62-year-old Vietnam veteran. He is a divorced father of two children and has four grandchildren. Both of his parents were dependent on alcohol. He describes his childhood as isolated. His father physically and psychologically abused him (e.g., he was beaten with a switch until he had welts on his legs, back, and buttocks). By age 10, his parents regarded him as incorrigible and sent him to a reformatory school for 6 months. By age 15, he was using marijuana, hallucinogens, and alcohol and was frequently truant from school.

At age 19, Michael was drafted and sent to Vietnam, where he witnessed the deaths of six American military personnel. In one incident, the soldier he was next to in a bunker was shot. Michael felt helpless as he talked to this soldier, who was still conscious. In Vietnam, Michael increased his use of both alcohol and marijuana. On his return to the United States, Michael continued to drink and use marijuana. He reenlisted in the military for another tour of duty.

His life stabilized in his early 30s, as he had a steady job, supportive friends, and a relatively stable family life. However, he divorced in his late 30s. Shortly thereafter, he married a second time, but that marriage ended in divorce as well. He was chronically anxious and depressed and had insomnia and frequent nightmares. He periodically binged on alcohol. He complained of feeling empty, had suicidal ideation, and frequently stated that he lacked purpose in his life.

In the 1980s, Michael received several years of mental health treatment for dysthymia. He was hospitalized twice and received 1 year of outpatient psychotherapy. In the mid-1990s, he returned to outpatient treatment for similar symptoms and was diagnosed with PTSD and dysthymia. He no longer used marijuana and rarely drank. He reported that he didn't like how alcohol or other substances made him feel anymore—he felt out of control with his emotions when he used them. Michael reported symptoms of hyperarousal, intrusion (intrusive memories, nightmares, and preoccupying thoughts about Vietnam), and avoidance (isolating himself from others and feeling "numb"). He reported that these symptoms seemed to relate to his childhood abuse and his experiences in Vietnam. In treatment, he expressed relief that he now understood the connection between his symptoms and his history.

commonly diagnosed trauma-related disorder, and its symptoms can be quite debilitating over time. Nonetheless, it is important to remember that PTSD symptoms are represented in a number of other mental illnesses, including major depressive disorder (MDD), anxiety disorders, and psychotic disorders (Foa et al., 2006). The DSM-5 (APA, 2013a) identifies four symptom clusters for PTSD: presence of intrusion symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity. Individuals must have been exposed to actual or threatened death, serious injury, or sexual violence, and the symptoms must produce significant distress and impairment for more than 4 weeks (Exhibit 1.3-4).

Certain characteristics make people more susceptible to PTSD, including one's unique personal vulnerabilities at the time of the traumatic exposure, the support (or lack of support) received from others at the time of the trauma and at the onset of trauma-related symptoms, and the way others in the person's environment gauge the nature of the traumatic event (Brewin, Andrews, & Valentine, 2000).

People with PTSD often present varying clinical profiles and histories. They can experience symptoms that are activated by environmental triggers and then recede for a period of time. Some people with PTSD who show mostly psychiatric symptoms (particularly depression and anxiety) are misdiagnosed and go untreated for their primary condition. For many people, the trauma experience and diagnosis

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see the DSM-5 section titled "Posttraumatic Stress Disorder for Children 6 Years and Younger" (APA, 2013a).

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
   4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
   5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
   2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
   3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
   4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
   5. Markedly diminished interest or participation in significant activities.
   6. Feelings of detachment or estrangement from others.
   7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

(Continued on the next page.)

Exhibit 1.3-4: DSM-5 Diagnostic Criteria for PTSD (continued)

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
   2. Reckless or self-destructive behavior.
   3. Hypervigilance.
   4. Exaggerated startle response.
   5. Problems with concentration.
   6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:
   1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
   2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify whether:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Source: APA, 2013a, pp. 271–272.

are obscured by co-occurring substance use disorder symptoms. The important feature of PTSD is that the disorder becomes an orienting feature of the individual's life. How well the person can work, with whom he or she associates, the nature of close and intimate relationships, the ability to have fun and rejuvenate, and the way in which an individual goes about confronting and solving problems in life are all affected by the client's trauma experiences and his or her struggle to recover.

Posttraumatic stress disorder: Timing of symptoms

Although symptoms of PTSD usually begin within 3 months of a trauma in adulthood, there can be a delay of months or even years before symptoms appear for some people. Some people may have minimal symptoms after a trauma but then experience a crisis later in life. Trauma symptoms can appear suddenly, even without conscious memory of the original trauma or without any overt provocation. Survivors of abuse in childhood can have a delayed response triggered by something that happens to them as adults. For example, seeing a movie about child abuse can trigger symptoms related

Advice to Counselors: Helping Clients With Delayed Trauma Responses

Clients who are experiencing a delayed trauma response can benefit if you help them to:

- Create an environment that allows acknowledgment of the traumatic event(s).
- Discuss their initial recall or first suspicion that they were having a traumatic response.
- Become educated on delayed trauma responses.
- Draw a connection between the trauma and presenting trauma-related symptoms.
- Create a safe environment.
- Explore their support systems and fortify them as needed.
- Understand that triggers can precede traumatic stress reactions, including delayed responses to trauma.
- Identify their triggers.
- Develop coping strategies to navigate and manage symptoms.

to the trauma. Other triggers include returning to the scene of the trauma, being reminded of it in some other way, or noting the anniversary of an event. Likewise, combat veterans and survivors of community-wide disasters may seem to be coping well shortly after a trauma, only to have symptoms emerge later when their life situations seem to have stabilized. Some clients in substance abuse recovery only begin to experience trauma symptoms when they maintain abstinence for some time. As individuals decrease tension-reducing or self-medicating behaviors, trauma memories and symptoms can emerge.

Culture and posttraumatic stress

Although research is limited across cultures, PTSD has been observed in Southeast Asian, South American, Middle Eastern, and Native American survivors (Osterman & de Jong, 2007; Wilson & Tang, 2007). As Stamm and Friedman (2000) point out, however, simply observing PTSD does not mean that it is the "best conceptual tool for characterizing posttraumatic distress among non-Western individuals" (p. 73). In fact, many trauma-related symptoms from other cultures do not fit the DSM-5 criteria. These include somatic and psychological symptoms and beliefs about the origins and nature of traumatic events. Moreover, religious and spiritual beliefs can affect how a survivor experiences a traumatic event and whether he or she reports the distress. For example, in societies where attitudes toward karma and the glorification of war veterans are predominant, it is harder for war veterans to come forward and disclose that they are emotionally overwhelmed or struggling. It would be perceived as inappropriate and possibly demoralizing to focus on the emotional distress that he or she still bears. (For a review of cultural competence in treating trauma, refer to Brown, 2008.)

Methods for measuring PTSD are also culturally specific. As part of a project begun in 1972, the World Health Organization (WHO) and the National Institutes of Health (NIH) embarked on a joint study to test the cross-cultural applicability of classification systems for various diagnoses. WHO and NIH identified apparently universal factors of psychological disorders and developed specific instruments to measure them. These instruments, the Composite International Diagnostic Interview and the Schedules for Clinical Assessment in Neuropsychiatry, include certain criteria from the DSM (Fourth Edition, Text Revision; APA, 2000a) as well as criteria from the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10; Exhibit 1.3-5).

Exhibit 1.3-5: ICD-10 Diagnostic Criteria for PTSD

A. The patient must have been exposed to a stressful event or situation (either brief or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.

B. There must be persistent remembering or "reliving" of the stressor in intrusive "flashbacks," vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.

C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.

D. Either of the following must be present:
   1. Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor.
   2. Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
      a. Difficulty in falling or staying asleep.
      b. Irritability or outbursts of anger.
      c. Difficulty in concentrating.
      d. Exaggerated startle response.

E. Criteria B, C, and D must all be met within 6 months of the stressful event or at the end of a period of stress. (For some purposes, onset delayed more than 6 months can be included, but this should be clearly specified.)

Source: WHO, 1992.

Complex trauma and complex traumatic stress

When individuals experience multiple traumas, prolonged and repeated trauma during childhood, or repetitive trauma in the context of significant interpersonal relationships, their reactions to trauma have unique characteristics (Herman, 1992). This unique constellation of reactions, called complex traumatic stress, is not recognized diagnostically in the DSM-5, but theoretical discussions and research have begun to highlight the similarities and differences in symptoms of posttraumatic stress versus complex traumatic stress (Courtois & Ford, 2009). Often, the symptoms generated from complex trauma do not fully match PTSD criteria and exceed the severity of PTSD. Overall, literature reflects that PTSD criteria or subthreshold symptoms do not fully account for the persistent and more impairing clinical presentation of complex trauma. Even though current research in the study of traumatology is prolific, it is still in the early stages of development. The idea that there may be more diagnostic variations or subtypes is forthcoming, and this will likely pave the way for more client-matching interventions to better serve those individuals who have been repeatedly exposed to multiple, early childhood, and/or interpersonal traumas.

Other Trauma-Related and Co-Occurring Disorders

The symptoms of PTSD and other mental disorders overlap considerably; these disorders often coexist and include mood, anxiety,

The term "**co occurring disorders**" refers to cases when a person has one or more mental disorders as well as one or more substance use disorders (including sub stance abuse). Co occurring disorders are common among individuals who have a history of trauma and are seeking help.

Advice to Counselors: Universal Screening and Assessment

Only people specifically trained and licensed in mental health assessment should make diagnoses; trauma can result in complicated cases, and many symptoms can be present, whether or not they meet full diagnostic criteria for a specific disorder. Only a trained assessor can distinguish accurately among various symptoms and in the presence of co-occurring disorders. However, behavioral health professionals without specific assessment training can still serve an important role in screening for possible mental disorders using established screening tools (CSAT, 2005c; see also Chapter 4 of this TIP). In agencies and clinics, it is critical to provide such screenings systematically—for each client—as PTSD and other co-occurring disorders are typically underdiagnosed or misdiagnosed.

substance use, and personality disorders. Thus, it's common for trauma survivors to be underdiagnosed or misdiagnosed. If they have not been identified as trauma survivors, their psychological distress is often not associated with previous trauma, and/or they are diagnosed with a disorder that marginally matches their presenting symptoms and psychological sequelae of trauma. The following sections present a brief overview of some mental disorders that can result from (or be worsened by) traumatic stress. PTSD is not the only diagnosis related to trauma nor its only psychological consequence; trauma can broadly influence mental and physical health in clients who already have behavioral health disorders.

People With Mental Disorders

MDD is the most common co-occurring disorder in people who have experienced trauma and are diagnosed with PTSD. A well-established causal relationship exists between stressful events and depression, and a prior history of MDD is predictive of PTSD after exposure to major trauma (Foa et al., 2006).

Many survivors with severe mental disorders function fairly well following trauma, including disasters, as long as essential services aren't interrupted. For others, additional mental health supports may be necessary. For more information, see *Responding to the Needs of People With Serious and Persistent Mental Illness in Times of Major Disaster* (Center for Mental Health Services, 1996).

Co-occurrence is also linked with greater impairment and more severe symptoms of both disorders, and the person is less likely to experience remission of symptoms within 6 months.

Generalized anxiety, obsessive–compulsive, and other anxiety disorders are also associated with PTSD. PTSD may exacerbate anxiety disorder symptoms, but it is also likely that preexisting anxiety symptoms and anxiety disorders increase vulnerability to PTSD. Preexisting anxiety primes survivors for greater hyperarousal and distress. Other disorders, such as personality and somatization disorders, are also associated with trauma, but the history of trauma is often overlooked as a significant factor or necessary target in treatment.

The relationship between PTSD and other disorders is complex. More research is now examining the multiple potential pathways among PTSD and other disorders and how various sequences affect clinical presentation. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c), is valuable in understanding the relationship of substance use to other mental disorders.

People With Substance Use Disorders

There is clearly a correlation between trauma (including individual, group, or mass trauma) and substance use as well as the presence of posttraumatic stress (and other trauma-related disorders) and substance use disorders. Alcohol and drug use can be, for some, an effort to

Co-Occurring PTSD and Other Mental Disorders

- Individuals with PTSD often have at least one additional diagnosis of a mental disorder.
- The presence of other disorders typically worsens and prolongs the course of PTSD and complicates clinical assessment, diagnosis, and treatment.
- The most common co-occurring disorders, in addition to substance use disorders, include mood disorders, various anxiety disorders, eating disorders, and personality disorders.
- Exposure to early, severe, and chronic trauma is linked to more complex symptoms, including impulse control deficits, greater difficulty in emotional regulation and establishing stable relationships, and disruptions in consciousness, memory, identity, and/or perception of the environment (Dom, De, Hulstijn, & Sabbe, 2007; Waldrop, Back, Verduin, & Brady, 2007).
- Certain diagnostic groups and at-risk populations (e.g., people with developmental disabilities, people who are homeless or incarcerated) are more susceptible to trauma exposure and to developing PTSD if exposed but less likely to receive appropriate diagnosis and treatment.
- Given the prevalence of traumatic events in clients who present for substance abuse treatment, counselors should assess all clients for possible trauma-related disorders.

manage traumatic stress and specific PTSD symptoms. Likewise, people with substance use disorders are at higher risk of developing PTSD than people who do not abuse substances. Counselors working with trauma survivors or clients who have substance use disorders have to be particularly aware of the possibility of the other disorder arising.

Timeframe: PTSD and the onset of substance use disorders

Knowing whether substance abuse or PTSD came first informs whether a causal relationship exists, but learning this requires thorough assessment of clients and access to complete data on PTSD; substance use, abuse, and dependence; and the onset of each. Much current research focuses solely on the age of onset of substance use (not abuse), so determining causal relationships can be difficult.

The relationship between PTSD and substance use disorders is thought to be bidirectional and cyclical: substance use increases trauma risk, and exposure to trauma escalates substance use to manage trauma-related symptoms. Three other causal pathways described by Chilcoat and Breslau's seminal work (1998) further explain the relationship between PTSD and substance use disorders:

1. The "self-medication" hypothesis suggests that clients with PTSD use substances to manage PTSD symptoms (e.g., intrusive memories, physical arousal). Substances such as alcohol, cocaine, barbiturates, opioids, and amphetamines are frequently abused in attempts to relieve or numb emotional pain or to forget the event.
2. The "high-risk" hypothesis states that drug and alcohol use places people who use substances in high-risk situations that increase their chances of being exposed to events that lead to PTSD.
3. The "susceptibility" hypothesis suggests that people who use substances are more susceptible to developing PTSD after exposure to trauma than people who do not. Increased vulnerability may result from failure to develop effective stress management strategies, changes in brain chemistry, or damage to neurophysiological systems due to extensive substance use.

PTSD and substance abuse treatment

PTSD can limit progress in substance abuse recovery, increase the potential for relapse, and complicate a client's ability to achieve success in various life areas. Each disorder can mask or hide the symptoms of the other, and both need

Case Illustration: Maria

Maria is a 31-year-old woman diagnosed with PTSD and alcohol dependence. From ages 8 to 12, she was sexually abused by an uncle. Maria never told anyone about the abuse for fear that she would not be believed. Her uncle remains close to the family, and Maria still sees him on certain holidays. When she came in for treatment, she described her emotions and thoughts as out of control. Maria often experiences intrusive memories of the abuse, which at times can be vivid and unrelenting. She cannot predict when the thoughts will come; efforts to distract herself from them do not always work. She often drinks in response to these thoughts or his presence, as she has found that alcohol can dull her level of distress. Maria also has difficulty falling asleep and is often awakened by nightmares. She does not usually remember the dreams, but she wakes up feeling frightened and alert and cannot go back to sleep.

Maria tries to avoid family gatherings but often feels pressured to go. Whenever she sees her uncle, she feels intense panic and anger but says she can usually "hold it together" if she avoids him. Afterward, however, she describes being overtaken by these feelings and unable to calm down. She also describes feeling physically ill and shaky. At these times, she often isolates herself, stays in her apartment, and drinks steadily for several days. Maria also reports distress pertaining to her relationship with her boyfriend. In the beginning of their relationship, she found him comforting and enjoyed his affection, but more recently, she has begun to feel anxious and unsettled around him. Maria tries to avoid sex with him, but she sometimes gives in for fear of losing the relationship. She finds it easier to have sex with him when she is drunk, but she often experiences strong feelings of dread and disgust reminiscent of her abuse. Maria feels guilty and confused about these feelings.

to be assessed and treated if the individual is to have a full recovery. There is a risk of misinterpreting trauma-related symptoms in substance abuse treatment settings. For example, avoidance symptoms in an individual with PTSD can be misinterpreted as lack of motivation or unwillingness to engage in substance abuse treatment; a counselor's efforts to address substance abuse–related behaviors in early recovery can likewise provoke an exaggerated response from a trauma survivor who has profound traumatic experiences of being trapped and controlled. Exhibit 1.3-6 lists important facts about PTSD and substance use disorders for counselors.

Sleep, PTSD, and substance use

Many people have trouble getting to sleep and/or staying asleep after a traumatic event; consequently, some have a drink or two to help them fall asleep. Unfortunately, any initially helpful effects are likely not only to wane quickly, but also to incur a negative rebound effect. When someone uses a substance before going to bed, "sleep becomes lighter and more easily disrupted," and rapid eye movement sleep (REM) "increases, with an associated increase in dreams and nightmares," as the effects wear off (Auerbach, 2003, p. 1185).

People with alcohol dependence report multiple types of sleep disturbances over time, and it is not unusual for clients to report that they cannot fall asleep without first having a drink. Both REM and slow wave sleep are reduced in clients with alcohol dependence, which is also associated with an increase in the amount of time it takes before sleep occurs, decreased overall sleep time, more nightmares, and reduced sleep efficiency. Sleep during withdrawal is "frequently marked by severe insomnia and sleep fragmentation…a loss of restful sleep and feelings of daytime fatigue. Nightmares and vivid dreams are not uncommon" (Auerbach, 2003, pp. 1185–1186).

Confounding changes in the biology of sleep that occur in clients with PTSD and substance use disorders often add to the problems of

Exhibit 1.3-6: PTSD and Substance Use Disorders: Important Treatment Facts

Profile Severity

- PTSD is one of the most common co-occurring mental disorders found in clients in substance abuse treatment (CSAT, 2005c).
- People in treatment for PTSD tend to abuse a wide range of substances, including opioids, cocaine, marijuana, alcohol, and prescription medications.
- People in treatment for PTSD and substance abuse have a more severe clinical profile than those with just one of these disorders.
- PTSD, with or without major depression, significantly increases risk for suicidality (CSAT, 2009a).

Gender Differences

- Rates of trauma-related disorders are high in men and women in substance abuse treatment.
- Women with PTSD and a substance use disorder most frequently experienced rape or witnessed a killing or injury; men with both disorders typically witnessed a killing or injury or were the victim of sudden injury or accident (Cottler, Nishith, & Compton, 2001).

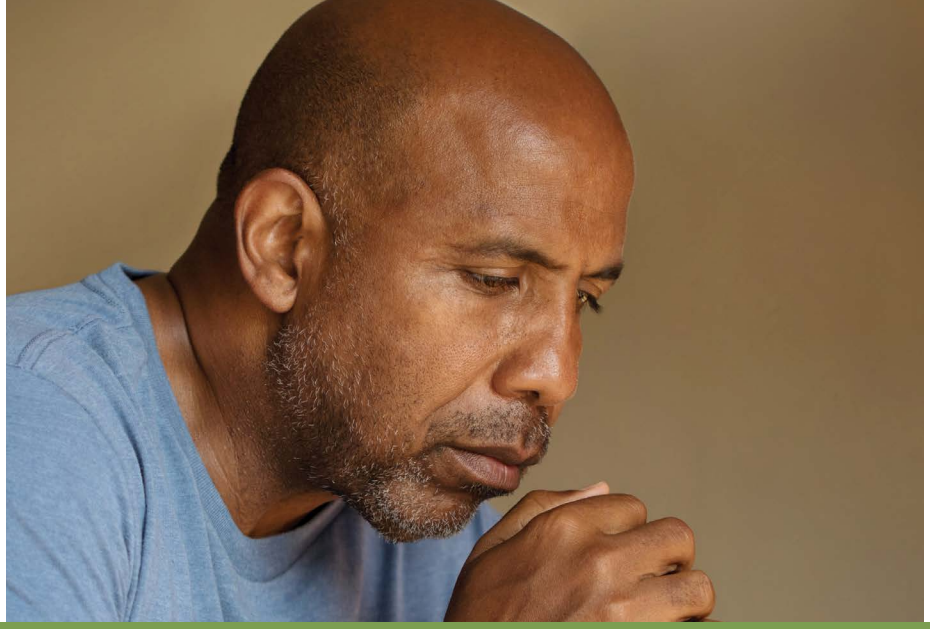
Risk of Continued Cycle of Violence

- While under the influence of substances, a person is more vulnerable to traumatic events (e.g., automobile crashes, assaults).
- Perpetrators of violent assault often are under the influence of substances or test positive for substances at the time of arrest.

Treatment Complications

- It is important to recognize and help clients understand that becoming abstinent from substances does not resolve PTSD; in fact, some PTSD symptoms become worse with abstinence for some people. Both disorders must be addressed in treatment.
- Treatment outcomes for clients with PTSD and a substance use disorder are worse than for clients with other co-occurring disorders or who only abuse substances (Brown, Read, & Kahler, 2003).

recovery. Sleep can fail to return to normal for months or even years after abstinence, and the persistence of sleep disruptions appears related to the likelihood of relapse. Of particular clinical importance is the vicious cycle that can also begin during "slips"; relapse initially improves sleep, but continued drinking leads to sleep disruption. This cycle of initial reduction of an unpleasant symptom, which only ends up exacerbating the process as a whole, can take place for clients with PTSD as well as for clients with substance use disorders. There are effective cognitive–behavioral therapies and nonaddictive pharmacological interventions for sleep difficulties.



WHEN TERRIBLE THINGS HAPPEN

What You May Experience

Immediate Reactions

There are a wide variety of positive and negative reactions that survivors can experience during and immediately after a disaster. These include:

Domain	Negative Responses	Positive Responses
Cognitive	Confusion, disorientation, worry, intrusive thoughts and images, self-blame	Determination and resolve, sharper perception, courage, optimism, faith
Emotional	Shock, sorrow, grief, sadness, fear, anger, numb, irritability, guilt and shame	Feeling involved, challenged, mobilized
Social	Extreme withdrawal, interpersonal conflict	Social connectedness, altruistic helping behaviors
Physiological	Fatigue, headache, muscle tension, stomachache, increased heart rate, exaggerated startle response, difficulties sleeping	Alertness, readiness to respond, increased energy

Common negative reactions that may continue include:

- Intrusive reactions
- Distressing thoughts or images of the event while awake or dreaming
- Upsetting emotional or physical reactions to reminders of the experience
- Feeling like the experience is happening all over again ("flashback")

Avoidance and withdrawal reactions

- Avoid talking, thinking, and having feelings about the traumatic event
- Avoid reminders of the event (places and people connected to what happened)
- Restricted emotions; feeling numb
- Feelings of detachment and estrangement from others; social withdrawal
- Loss of interest in usually pleasurable activities

Physical arousal reactions

- Constantly being "on the lookout" for danger, startling easily, or being jumpy
- Irritability or outbursts of anger, feeling "on edge"
- Difficulty falling or staying asleep, problems concentrating or paying attention

Reactions to trauma and loss reminders

- Reactions to places, people, sights, sounds, smells, and feelings that are reminders of the disaster
- Reminders can bring on distressing mental images, thoughts, and emotional/physical reactions
- Common examples include: sudden loud noises, sirens, locations where the disaster occurred, seeing people with disabilities, funerals, anniversaries of the disaster, and television/radio news about the disaster

Positive changes in priorities, worldview, and expectations

- Enhancedappreciation that family and friends are precious and important
- Meetingthe challenge of addressing difficulties (by taking positive action steps, changing the focus of thoughts, using humor, acceptance)
- Shiftingexpectations about what to expect from day to day and about what is considered a "good day"
- Shifting priorities to focus more on quality time with family or friends
- Increased commitment to self, family, friends, and spiritual/religious faith

When a Loved One Dies, Common Reactions Include:

- Feeling confused, numb, disbelief, bewildered, or lost
- Feeling angry at the person who died or at people considered responsible for the death
- Strong physical reactions such as nausea, fatigue, shakiness, and muscle weakness
- Feeling guilty for still being alive
- Intense emotions such as extreme sadness, anger, or fear
- Increased risk for physical illness and injury
- Decreased productivity or difficulties making decisions
- Having thoughts about the person who died, even when you don't want to
- Longing, missing, and wanting to search for the person who died
- Children and adolescents are particularly likely to worry that they or a parent might die
- Children and adolescents may become anxious when separated from caregivers or other loved ones

What Helps

- Talking to another person for support or spending time with others
- Engaging in positive distracting activities (sports, hobbies, reading)
- Getting adequate rest and eating healthy meals
- Trying to maintain a normal schedule
- Scheduling pleasant activities
- Taking breaks
- Reminiscing about a loved one who has died
- Focusing on something practical that you can do right now to manage the situation better
- Using relaxation methods (breathing exercises, meditation, calming self-talk, soothing music)
- Participating in a support group
- Exercising in moderation
- Keeping a journal
- Seeking counseling

What Doesn't Help

- Using alcohol or drugs to cope
- Extreme withdrawal from family or friends
- Overeating or failing to eat
- Withdrawing from pleasant activities
- Working too much
- Violence or conflict
- Doing risky things (driving recklessly, substance abuse, not taking adequate precautions)
- Blaming others
- Extreme avoidance of thinking or talking about the event or a death of a loved one
- Not taking care of yourself
- Excessive TV or computer games

Do mediators have an obligation to correct power imbalances between parties? (No, and for many reasons ...)

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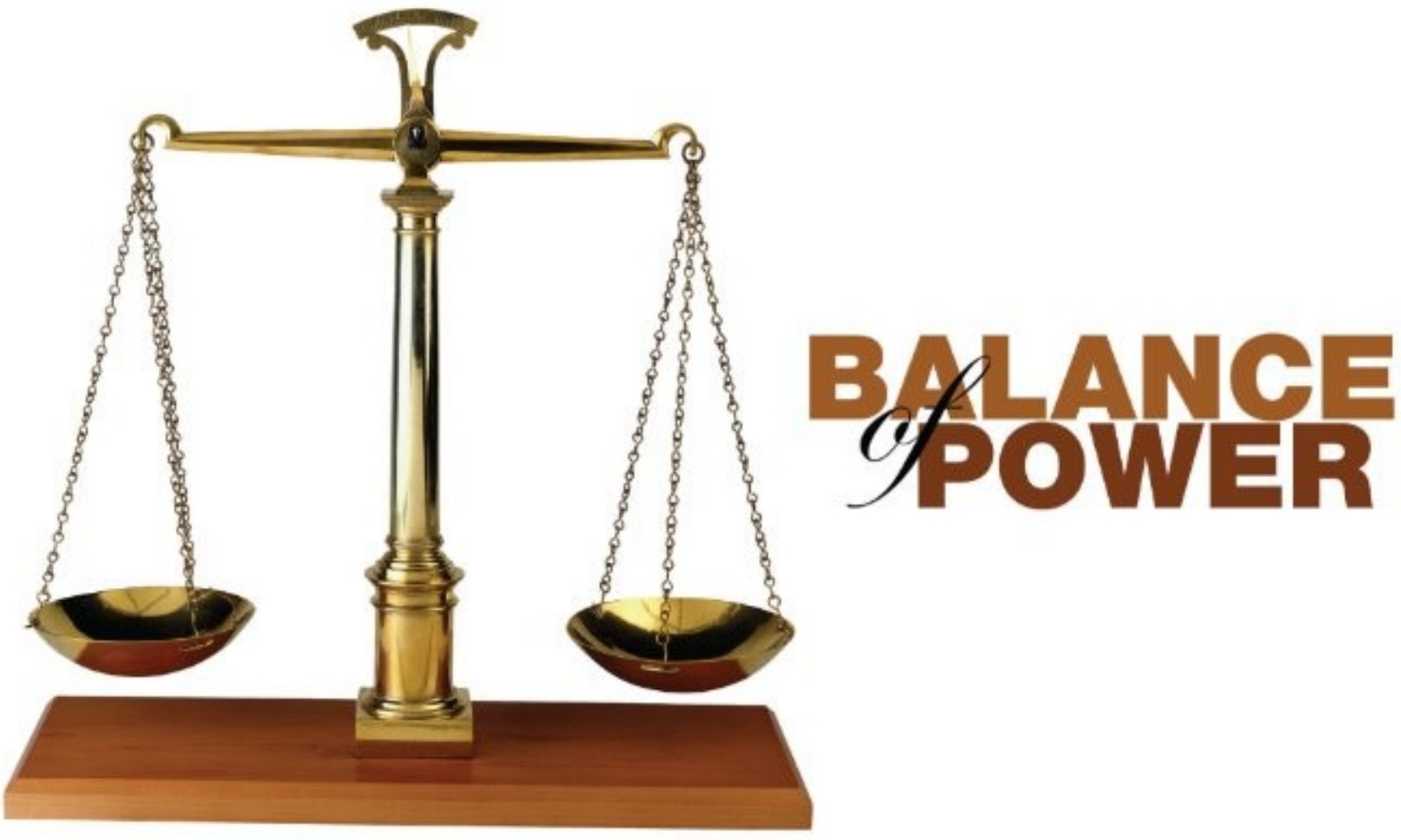

Where the parties to the mediation have unequal power, should the mediator exercise his or her power to affect the substantive outcome of the mediation? In other words, should mediators use their power to attempt to correct imbalances of power between parties? Instinctively, many people think that the answer is yes. But the reality is more complicated.

My conclusion, for the reasons in this post, is that a mediator should ***not*** attempt to balance up the parties' power. Instead, the mediator's task can be seen as helping each party understand what power it has and how and when it should use its power, and to understand what power the other party

has and how and when it might use it. Not only is this task consistent with being neutral and impartial; it helps the parties to participate effectively in the mediation and facilitates settlement of their dispute.

What do we mean by an imbalance of power between the parties? There are lots of different types of power that a party may possess in mediation.

Types of party power in a mediation:

1. ***Financial power:*** Big Bank v. Freddie Farmer: huge financial resources vs. not very much at all.
2. ***Forensic power:*** Silk, junior, partner and solicitor vs. suburban practitioner or no lawyer at all.
3. ***Substantive power:*** Party A's case is strong to overwhelming. Party B's case is weak to hopeless.
4. ***Negotiating power:*** Party A is a sophisticated and experienced negotiator. Party B is an first-time participant in mediation. Party A has invested significant resources in preparing for the mediation. Party B has skimped on preparation in the hope of an early settlement. Party A is realistic about its prospects. Party B is wildly optimistic about its prospects. Party A does all the talking. Party B is interrupted/cut short.
5. ***Moral power:*** Party A's position is in the public interest/promotes sobriety/will slow global warming. Party B's position cheats widows and orphans/promotes tax evasion by use of Panamanian shelf companies/threatens old-growth forests.
6. ***Gender power:*** Women do not ask for as much as men. (See Babcock & Laschever, "Women Don't Ask: Negotiation and the Gender Divide", Princeton University Press 2003).

How is party power relevant in mediation?

Power is relative. If two Big Banks face off against each other, there probably will not be much disparity in power. If both parties to the dispute are female, there is no disparity in gender power.

Power in mediation is the ability to get what you want from the other party. In the context of mediation, this probably means getting the other party to sign the settlement agreement that you want.

In mediation, the other party always has the right to end the mediation without agreeing to anything. Given a large disparity of power between the parties, however, this may not be a realistic alternative.

Theories of mediation that posit that mediators have a duty to correct imbalances of power must be based on the assumption that a mediator knows where power lies in a mediation. But is this assumption valid?

Does the mediator know where party power lies in a mediation?

1. The mediator has limited knowledge of the facts.
2. The mediator has limited knowledge of the relevant law.
3. The mediator has limited knowledge of the parties' interests and needs.
4. Financial power: Big Bank has to make a profit. Throwing good money after bad makes no more sense for Big Bank than for Freddie Farmer. Thus, having financial power does not necessarily mean that one will exercise it.
5. Forensic power: There are good senior counsel and not-so-good senior counsel. There are some brilliant suburban practitioners. And the forum is a mediation, not an adjudication.
6. Substantive power: Can the mediator, often with very limited information, know the respective strengths of the parties' cases?
7. Negotiating power: This is partly within the mediator's control.
8. Moral power: Opinions on moral issues differ.

To make things yet more complicated, power can move around during a mediation.

Party power is not static. It can and does move during a mediation.

Consider a farm debt mediation where the farm has been mortgaged to Big Bank and the mortgage has not been repaid. As long as the value of the farm exceeds the amount borrowed plus accrued interest and costs, Big Bank can be ruthless and will probably negotiate only about how much time the farmer has to repay the mortgage – failing which it will padlock the farm gate and put a "Mortgagee Sale" sign on it.

In this situation, there is no doubt where the power lies.

If, however, it transpires that the value of the farm is less than the amount secured over it, the power relationship is quite different. The bank's legal powers are the same, but exercising them will result in the bank's recovering only part of what it is owed. The farmer's personal covenant to repay the mortgage almost certainly is worthless. A large amount may have to be written off. Unless a solution to the problem is found, heads will roll in the Rural Lending Department of Big Bank .

In the second scenario, the bank may become interested in all sorts of settlements that:

- Require the willing participation of the farmer;
- Require the bank (at least for now) to forego recovery;
- Require the bank to lend ***more*** money; and
- In effect, require a joint venture between Big Bank and the farmer.

Possibilities include:

- Subdivision of the farm for sale as hobby farms;
- Novel crops with high value like blueberries; and
- Investing in irrigation, pasture improvement, new barns, new dams and new fencing in order to improve the productivity and value of the farm.

The important point is that, in the second scenario, the farmer's weakness has become a source of power.

Consider a simpler example: the mediation of a personal injury claim. The plaintiff, supported by comprehensive and credible medical reports, claims to have an incapacitating and permanent back injury sustained at work. Liability is not in dispute. The plaintiff is in an obviously powerful position.

Then the defendant insurer produces a surveillance video, showing the plaintiff lifting weights at a gym. Power instantly shifts to the defendant.

Then the plaintiff establishes that the video in fact shows his twin brother, not himself. Power instantly shifts back to the plaintiff.

The competing theories about party power in mediation:

Broadly speaking, there are two competing theories about the mediator's role vis-a-vis party power in mediation:

Theory One: The mediator has a duty to balance the parties' power. The reasoning in support of this theory is:

1. One party to a mediation may be significantly more powerful than the other.
2. A significant power difference between the parties may lead to one party dominating the process.
3. A significant power difference between the parties may lead to a settlement that largely favours the more powerful party's needs and interests. This is unfair. At the extreme, the result is coerced.
4. One of the functions of mediation is to redress unequal bargaining power
5. The mediator therefore has a duty to the process and/or to the parties to balance the parties' power in the mediation.

Theory Two: The mediator has a duty NOT to balance the parties' power. The reasoning in support of this theory is:

1. Mediation theory and most mediation agreements require the mediator

to be neutral and impartial towards the parties.

2. "Neutrality" means that the mediator is disinterested in the outcome of the dispute.
3. "Impartiality" means that the mediator treats the parties in an equal and even-handed way.
4. Disparities in bargaining power are a fact of life inside and outside the mediation.
5. If the mediator were to take steps to lessen the power of the more powerful party or to increase the power of the less powerful party (or both), in order to affect the outcome of the mediation, he or she would not be acting in a neutral or an impartial way.
6. Taking this a step further, if the mediator frankly acknowledged to the parties that his or her aim was to level up the parties in terms of power, the powerful party almost certainly would object. Why would they pay a mediator to dissipate advantages that they view as legitimate? Those advantages can include: being intelligent; being wealthy; having a strong case; having (at substantial cost) good lawyers; being (at substantial cost) well-prepared for the mediation.
7. While the mediator has a series of duties to the process and to the parties, those duties do not include balancing the parties' power in the mediation.

Can we resolve the conflict between the two approaches? I think that the conflict between the two approaches can be resolved.

1. Because the mediator probably does not know the relative power of the parties (and it might shift, anyway), the mediator probably has no realistic alternative to taking the parties as he or she finds them.
2. That does not mean the mediator has to ***leave*** the parties in the position in which he or she found them.
3. Reality testing of the parties' positions in private by the mediator may significantly affect their approach. Likewise, reality testing about the durability or enforceability of proposed settlement agreements may

affect their approach.

4. Is there a contradiction between taking the parties as you find them and attempting to shift the parties' positions towards each other so they can settle their dispute?
5. There is no contradiction here: It is the hallmark of legitimate reality testing that a mediator does ***not*** upset existing power imbalances by (for example) providing a party with legal knowledge that the party has not invested in ("There's a recent High Court decision on limitations that is right on point and which means that the other party is out of time.").
6. It is the hallmark of illegitimate reality testing that it ***does*** upset existing power imbalances. It is illegitimate because it is not neutral or impartial behaviour. Because the mediator is not acting in a neutral and impartial way, he or she risks losing credibility/losing influence/being fired.
7. Instead, the mediator should accept existing power imbalances and assist each party – given the imbalances – to analyse the strengths and weaknesses of its position and of the other side's position. Given this, the mediator can also help a party analyse whether offers received or contemplated are better or worse than a party's BATNA.
8. Women tend to value relationships more than men and thus, for fear of damaging a relationship between the parties, a woman may be inclined to ask for less (or offer to pay more) than a man who has the same BATNA. ("Women Don't Ask: Negotiation and the Gender Divide", above). The mediator can help a female party to understand that this is what she is doing. The mediator thereby helps the female party understand the nature and effect of gender power. By doing so, the mediator enables the female party to decide consciously whether she values the relationship more than the outcome of the dispute, rather than making this decision unconsciously.
9. The mediator can assist a party to make realistic concessions, or to capitalise on a strength it has. This is not balancing power; it is recognising realities.

10. Viewed this way, the mediator's task can be seen as helping each party understand what power it has and how and when it should use its power, and to understand what power the other party has and how and when it might use it. Not only is this task consistent with being neutral and impartial; it helps the parties to participate effectively in the mediation and facilitates settlement of their dispute.

Conclusions:

1. Viewing the mediator's task this way has the result that the patient, careful, earnest mediation of disputes remains a useful and important task.
2. Unless the mediator embraces a vision of mediation as transformative of the parties, practising mediators should be comforted by this acknowledgment of the validity of what they do for a living.

Robert Angyal SC

7 April 2016

Managing an Imbalance of Power

Introduction

One technique I often get requests to train on is managing an imbalance of power. There are effective techniques for handling power imbalance, however before we go too far, let's consider what is an imbalance of power?

Power Imbalance: So What!

My guess is you are reading this article because of the title. And about now you are hoping I did not use an attractive title to lure you into an article about some sad story about power abuse I suffered in graduate school or something. Graduate school is not always fair and just. Nobody said it would be. Life isn't fair. A lot of people suffer. Suffering the misuse of power does not create a position of privilege. Get over it! You are right. And that is why this is not a power imbalance story about one of my grad school experiences.

But wait a minute. You are right. Life isn't fair! Some people have more power than others and therefore the risk of being hurt by their power seems considerably high. In fact, I am willing to wager that many, no most, of you either have been or currently are in some relationship where the power is not equal and you too have a story to tell about the suffering this imbalance causes. If you do not have a personal painful power imbalance scar story, then I will bet you are a witness to power imbalance scarring.

Well, if power imbalance is such a natural state of affairs in so many areas of life, then why are we making such a big deal about it at the mediation table? Bluntly put: Why can't the technique simple be: "Life isn't fair. We all have to suffer an occasional power imbalance every now and again in life. So, get over it?"

I mean really, in some cases isn't an imbalance of power necessary,

preferable even? I want the boss to have the financial risk when the bottom falls out of the market. I want the university president to have more power than my grad school professor. I want the judge to have more power than the man I am suing. I certainly want the judge to have more power than me, because I want the judge to make him do what I want. I want more power than my 15-year-old daughter. So someone at the mediation table has more power. Big Deal! Why should the one with less power get special treatment? Why should this party be singled out? Why should a socialist philosophy be insinuated at the mediation table just because a few unrealistic bleeding heart mediators wish to escape from the real world? We do not live with a balance of power in everyday life--why the surprise it exists in our mediations as well?

Power Imbalance in Mediation: A Big Deal

The issue of power at the mediation table concerns Self-Determination and mediator's Neutrality. In fact, there is not anything to get excited about encountering an imbalance of power at the mediation table, unless it affects a party's ability to self-determine. A cornerstone of the mediation process is the protection of self-determination. If a party cannot self-determine their own future, then little difference exists between mediation and a judge or hearing officer deciding their fate for them. Empowering someone to determine for themselves the outcome of their conflict is part of the design of the mediation process and the skill set of talented mediators. Any challenge to a party's power to self-determine should be a concern of the talented mediator, requiring some serious attention and skill application. If a mediator does not recognize and address this challenge then the mediator could unwittingly become an accomplice or collaborator in undermining a party's power.

Imbalance in and of itself is not a problem. When an imbalance affects self-determination something needs to be done. There are many forms of imbalance. You could see informational imbalance; for example, when a

spouse does not disclose a hidden asset in divorce mediation. Self-determination is in jeopardy because your choice of outcomes is not real. Or the imbalance could be emotional where one party is overpowering or taking advantage of a meeker or less confident participant. Or a party might have better self-control in difficult situations. The imbalance could be intellectual, verbal, or an imbalance of experience (for example: managing the business or family checkbook or finances). The imbalance could be simply between the numbers of parties at the table. For example, it is not unusual for a Special Education mediation case to have many people on the side representing the school system, and only one or two on the parent's side of the table. These imbalances need not cause concern unless a party's self-determination is at risk.

Do eight against one create an imbalance? Yes. Does eight to one risk self-determination? Maybe. Maybe not. One does his or her homework and prepares extensively for the mediation or trial. The other sloughs off any preparation. Does this create imbalance? Yes. Does preparing versus not preparing risk self-determination. Maybe. Maybe not. Does a PhD. against a high school drop out create an imbalance? This is a trick question, isn't it? I would have to say, yes. However, I will reserve judgment on which way the imbalance goes. I know some PhDs who would not stand a chance against a high school... Sorry, slipping into the grad school stuff again. Moving on. Does a PhD against a high school drop out risk self-determination? Maybe. Maybe not. You get the point.

Therefore let's change the question a bit, rather than train mediators to recognize what an imbalance of power looks like. Let's learn to recognize when self-determination is at risk and consider possible actions. One of the reasons this shift is appealing is that it gets me away from having to suggest ways to rebalance power at a mediation table. I am not sure I know how to do that and I'm not sure it really needs to be done. I have skills for empowering self-determination. I'm pretty sure I cannot infuse power-less parties with more power. Let's look at a few available techniques capable of

addressing self-determination.

Communication Skills: Listening

One indication of an imbalance of power is verbal bullying. The first technique for addressing an imbalance of power is the talented mediator's superior communication skills. One effective way to support self-determination is to offer the party the one thing they are not getting: a complete hearing. For example: for the sake of avoiding harmful gender stereotyping, we will name the "victim" Jim. When Jim is continually cut off, you can slow down the verbal tempo by interrupting and asking a question. Asking the bully a question can take damaging attention off Jim. Asking Jim a question can stall the bully and give Jim a chance to speak. While the bully may not listen, may even attempt to cut Jim off again, you can simply interrupt again saying, "Excuse me for a moment. I was curious about what Jim was saying." Then turn back to Jim with, "Please continue." (Add words where needed).

Two things to notice about this technique: First, it does not matter if the bully hears Jim. In fact it is not important that the bully hear Jim at all. If the goal is to create a balance of power between the bully and Jim, then my concern could be about the level of respect Jim is not getting from the bully. But that is not my concern. Rather, my concern is that Jim has power enough for self-determination. I can do that by listening to Jim, by making sure Jim is heard (if no where else, then with me), by facilitating a process where Jim has a chance to think through all of his options. Which leads us to the second thing to notice about this technique: by showing interest in Jim's comments, I am communicating that Jim's comments are valuable. I am placing value where the bully will not. It is important to me, as the mediator, to hear Jim. Therefore, what Jim is saying is important. Where the design of the bully is to undermine value, I can counter-suggest if you will, value. Breaking the bullying tempo and inviting Jim to talk (to me) can create enough power for Jim's self-determination.

“Why are you spending so much time listening to what Jim says!” the Bully says. “You think Jim is more important than I am!” Ah, what about neutrality, or the perception of bias? The perception of lost neutrality should not keep me from doing my job. Is there a risk? Yes. But by not trying something, I risk collaboration with the bully. How about this: “I’m sorry if it looks like I am favoring Jim’s comments. I certainly do not mean to be giving that impression. I am equally interested in what you have to say on the matter and want to provide you with equal time. Was there something you wanted to add or can you tell me more about…” Managing the risk of an accusation of your imbalance (ironic, isn’t it), can be a matter of time management at the table. How much time are you spending with Jim? Are you having lengthy discussions and inquiries? Alternate your attention between the two. Turn back to the bully and ask a question or summarize the bully’s position. Pay attention to the flow and focus of the communication. Manage the tempo, manage your timing and your communication skills can empower self-determination.

Communication Skills: Question Asking

One way to manage timing is with question asking skills. Simply make sure you get a chance to hear Jim’s response to your questions. By asking general background questions in joint discussion both Jim and the bully get to respond. If the bully cuts Jim off with a tirade or patronizing discourse you can simply claim missing data from your information or fact gathering. “Excuse me. Looking at my notes I seem to be missing Jim’s comments on my question about leave policy. Jim, can you help me out and tell me how you understand the leave policy?” It appears you are filling in gaps. Filling out “forms,” or getting all the data, or fulfilling your mediator obligations requires Jim to speak and be heard (by you). Using these “excuses” to have Jim talk can take attention off any focus on Jim, keeping it innocent, maintaining balance, staying neutral.

Question asking in caucus can lead to reality testing. “What happens if you

decide to ‘cave-in,’ as you put it, Jim? What benefit is there for you, in an effort to avoid conflict here today, to pick a solution you are unhappy with?” “What could happen here today if you could select a solution that really makes you happy?” Realty testing with good question asking skills can be an effective way to get both bully and Jim considering potential outcomes, as well as the benefit/loss ratio (See the Benefit Matrix in “Discovering Benefits)to them for each potential solution. **Outside Resources**

Imbalance of power can also manifest itself via information. One party may have more information or experience than the other. Say, for example, one person in a marriage manages all of the finances for the home. If they are in your divorce mediation, then an ability to make financial decisions may be out of balance. A way to balance self-determining power could be appealing to the use of outside resources. Giving “homework” to the couple can be a good way to get information on the table. The “homework assignment” may require the party weak in financial experience to get help with the assignment in order to have it done for their next session. In reviewing the assignment, “Do you understand what you have to have ready for our next session? Do you have the resources and the help you will need to get this done? Is there anyone you can turn to assist you with this work?” There may be a pastor or minister who can help, a family member or a friend. Comparing results next session can bring to light areas for discussion, further explanation, or maybe further homework.

Another way to get information on the table is for the mediator to be as ignorant or inexperienced as the parties need. Asking for further clarification on a particular issue when you know one party is not getting the explanation or is overlooking a point can bring self-determining information to light. “Let me see if I understand family leave again.” You say that if… Is that right?” “So, does that mean if I…” Or, you can fill information gaps with experts not at the table: “Is there someone you can call to give you the information you need?” “Would the Personnel Director or HR Manager be someone you could turn to fill in the gaps we seem to have here today?”

These types of inquiry can aid the flow of information. Especially when the information impacts a party's ability of make an informed decision in his or her best interest. Information imbalance is similar to bullying. A special application of the type of questions you ask, i.e. appeals to an outside resource, and the way you facilitate the information flow and focus at the table can address information imbalance.

This requires some decision-making and judgment calls by you, the mediator. Remember, the issue is not equal power, but self-determining power. Parties have a right to be stupid and make poor choices (at least choices we might feel are stupid and poor). It is not our job to empower parties to make the "right" or "best" choice, whatever that might be, but to protect self-determination. That is why mediation is a skill set beyond just empathetic listening or therapeutic exploration. Empowering people to make informed decisions in their own best interest is the cornerstone of self-determination and the lifeblood of a master mediator.

Agenda Setting

Another technique for managing communication and information is agenda setting. First opportunity to create an agenda is during joint discussion using chart paper. It is easy to list items that come up during opening statements and joint discussion. While summarizing their opening statements list their topics. This creates focus and structure to their communication. By identifying topics, you can turn to each party for information or perspective on that topic. "Now that we have a list of topics important to both of you, let's talk about each of them in detail. Jim, tell me what is important to you about…."

A second agenda setting opportunity exists in caucus. Meeting privately with each party and developing an agenda for topics they each want to discuss when everyone gets back together assures Jim's agenda items equal exposure when we reconvene together. "Jim, one of the things you said you wanted to talk about was… Can you say more about this?" Be

careful not to speak for parties. The agenda assures topics are not forgotten. It is not your role to talk about the topic yourself. Get parties talking for themselves about what is important to them. Agenda setting can structure their communication in a way that is hard to perceive as bias attention toward Jim.

Roleplay Hypotheticals

Roleplying a hypothetical conversation during caucus can greatly increase the possibilities for self-determination. For example: “Jim, I have four items here you wish to discuss when we get back together with bully. Are you willing to discuss these items with bully?” “Yes? Good.” “Let’s talk about how that conversation might go. If you say XYZ, how do you think bully will respond? Let’s roleplay possible responses together: how would you respond if bully says…” Roleplaying hypotheticals can be a way to empower Jim’s ability to self-determine. Jim gets the chance to think through possible scenarios and how he might manage them. “If bully says, this; if bully says, that; if bully says, Yes; if bully says, No….” Assume it is impossible for you to think of every possible combination of potential responses. The exercise is enough to equip Jim with issues important to him, prioritizing them with him in such a way that he can apply his knowledge to whatever bully says.

Roleplaying hypotheticals can also be a useful technique with the bully. “I don’t know what Jim will say, but how do you think Jim might respond when you say XYZ? Let’s talk about how the conversation might go roleplaying possible responses together.” If bully’s response suggests an intimating tone, act it out. “If Jim’s agreement is the result of him feeling some kind of intimidation, how do you think this might influence Jim’s future behavior in the workplace? Would there be any benefit to you if Jim’s decision or agreement was not the result of intimidation?” And/or, “What benefit to you is there for Jim’s decision or agreement to be the result of some feeling of intimidation?” Roleplaying allows the consideration of “pretend” responses.

Bully may not consider the possibility that his or her communication may be causing intimidation.

Remember, intimidation, in itself is not your primary concern. It may be sad that Jim feels intimidated in his workplace or his relationships. Jim may simply be weak, feeling intimidation where there is none, unable to stand up for himself. It is not mediation's role to teach Jim assertiveness. His therapist can help him with that. Your role is to address Jim's ability to self-determine. And guess what, intimidated people can self-determine.

Need Exploration

The most powerful technique addressing an imbalance of power is need exploration. Working with Jim, identifying his self-interest(s) can empower negotiation. Helping Jim name his need(s), helping him structure a way to discuss his need(s), exploring possible options for meeting his need(s) can empower Jim. Identifying need can be the best antidote for power imbalance due to information, emotion, verbal ability, etc. Pretend for a moment that you do have the ability to balance power to the level of equality. Both bully and Jim have equal information, equal respect, equal power, equal verbal ability, and equal experience. Assume, too, for a moment, we ignore any process to identify Jim's need(s). What good is the balance? If Jim (or the bully, for that matter) is going to self-determine the outcome of this conflict, I would rather he do it around his need(s). All the power balance in the world will not help Jim's determination process more than his ability to speak to and negotiate around his need(s).

All the techniques above will work to address an imbalance of power at the mediation table. However, the two I rely upon most are my communication skills, facilitating the information flow and focus enough to hear Jim and my need exploration skills, uncovering Jim's self-interest. To the degree self-interest drives any of us, Jim is most likely to standup for his self-interest(s), especially if a process is available to identify them and to discuss them.

The bottom line is this. Knowing his need(s), Jim now has the choice to either negotiate a resolution addressing them, because they are important to him, or "cave-in" to a resolution knowing he is sacrificing his need(s) in the "cave-in." By choosing, Jim gets to practice self-determination. The mediation process, then, does what it is designed to do. I employ my skills to ensure mediation gets a chance to do what it is designed to do. No more, no less.

Terminating the Mediation

If a power imbalance is such that you determine that self-determination by one of the parties is unobtainable, then I recommend terminating the mediation. Not getting an agreement is better than getting a bad agreement. Understand what is at stake here. On the one hand: terminating the mediation, if self-determination is not possible, you end the chance for bully to determine Jim's future by offering the opportunity for a judge or hearing officer to decide Jim's future.

On the other hand: by terminating the mediation, if self-determination is not possible, you end the chance for bully to determine Jim's future and you becoming a collaborating perpetrator or a by-stander.

Conclusion

Since the question is not how much power does a party have, but rather does he or she have enough power for self-determination, an imbalance of power at the mediation table does not require a rebalancing act. Balance never has to be about creating equality at the table. It never has to be about taking someone else's power away from them and giving it to another.

There may be circumstances where power imbalance is inevitable, even preferable. Even so, empowering a self-determination process could be of immense value in many relationships, organizations, and teams. Learning and practicing these highly transferable skills promotes response-ability

and protects self-determination in the mediation process.

Richard Voyles, Ph.D. is the President of Conflict Resolution Academy, LLC a service company providing professional and personal development skills. Conflict Resolution Academy, LLC offers conflict prevention programs through Management and Leadership Training and resolution programs through Mediation Training and Mediation Services. Conflict Resolution Academy, LLC has developed 17 videos that focus on the mediation process steps, mediation techniques, legal and ethical issues, and a mediation roleplay. These training presentations specialize in facilitative mediation skills at every level. Dr. Voyles is a subject matter expert in the areas of Conflict Management and Dispute Resolution. He is a registered Neutral with the State of Georgia's Office of Dispute Resolution, and he has traveled the world, training people in conflict management and mediation skills. Dr. Voyles does extensive work in the areas of prejudice reduction, cross-cultural communication and conflict management. He is currently recognized internationally in Who's Who in 2002 in Business.

Power Imbalances in Mediation

By: Amrita Narine

Introduction

In recent years, mediation has become increasingly popular and now represents a viable option for parties in a variety of scenarios. Despite its rising popularity, mediation has received mixed responses because of the potential to entrench preexisting power imbalances. This paper will explore the usefulness of mediation when dealing with an imbalanced power dynamic. In part I, this paper will focus on defining power within mediation. Part II will explore the critiques of mediation in situations where there is an imbalanced power dynamic and specifically delve into gendered imbalances and employment imbalances. After exploring the critiques and responses to them, part III will focus on specific techniques that a mediator can use to help balance out the power dynamics at play and offer best practices for dealing with power imbalances.

I. Defining Power

"*Power is a word the meaning of which we do not understand*." – Leo Tolstoy

Power is a fluid word. Depending on the context, power can have a positive or a negative connotation. While some associate power with "coercion, a noncooperative spirit, and a breakdown in communication,"[1] it can also be associated with empowerment and strength. Within the context of mediation, "power can be defined as the ability of a person in a relationship to influence or modify an outcome."[2] To fully understand power, it is necessary to go beyond this definition and look at its features. Diane Neumann lists four defining features of

[1] Bernard Mayer, *The Dynamics of Power in Mediation and Negotiation*, 1987 CONFLICT RESOL. Q. 75, 75 (1987).

[2] Joan B. Kelly, *Power Imbalance in Divorce and Interpersonal Mediation: Assessment and Intervention*, 13 CONFLICT RESOL. Q. 85, 87 (1995).

power, each of which this paper will focus on individually: "(1) power is composed of many factors; (2) it is relative, situational, and shifting; (3) everyone has some degree of power; and (4) power is only effective when it is used."[3]

Oftentimes, we only focus on one or two different factors of power, when in reality there are a myriad of factors. When discussing power, we often tend to think of economic power and societal power (power based on genders or roles). By only focusing on one or two factors, we take away from the parties in mediation other forms of power that already exist. Neumann lists ten factors that contribute to the individual's power:

1. Belief system—a belief that one is on the side of right
2. Personality—the image one projects, how powerful one acts
3. Self-esteem—the internalized image of oneself, how powerful one feels
4. Gender—Western society grants men greater power than women
5. Selfishness—consistently putting oneself before others is a form of power
6. Force—willingness to use coercion or threats and the fear engendered in others is a form of power
7. Income/assets—power increases with income and the accumulation of assets
8. Knowledge—possessing information is a form of power
9. Status or age—increased status confers increased power, and power usually increases with age
10. Education—higher levels of education are associated with higher levels of power.[4]

While these are factors for an individual's power, another consideration includes factors that can create power inequities in mediation. Joan B. Kelly lists eight such factors, which are by no means meant to be an exhaustive list: (1) history and dynamics of disputant relationship; (2) personality and character traits; (3) cognitive style and capabilities; (4) knowledge base; (5) economic self-sufficiency; (6) gender and age differences; (7) cultural and societal stereotypes and training; and (8) institutionalized hierarchies.[5] While some of these overlap with Neumann's

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[3] Diane Neumann, *How Mediation Can Effectively Address the Male-Female Power Imbalance in Divorce*, 9 CONFLICT RESOL. Q. 227, 229 (1992).
[4] *Id*.
[5] *See* Kelly, *supra* note 2, at 89.

factors for individual power, it is important to acknowledge the ways that an individual has power *and* the factors that can create power inequities.

The second feature of power is that "it is relative, situational, and shifting."[6] Power does not reside with the same person all of the time and it is only relative to another person.[7] Even if someone seems all-powerful, that perception will vary from person to person. For example, in a traditional marriage a man might have more economic and gender power, but with regards to children the woman is given more deference. Even though the man might have power for deciding alimony, the woman might have power when deciding visitation rights. Depending on the topic and the situation, power can move from one party to the other and should not be based on surface level observations.

The third feature of power is that each person always has some degree of power. The above situation is a prime example of different degrees of power. Courts are more inclined to give women custody rights over men, which means that a man with children might not attempt to wield his economic power as much as he could. If he did, the woman could respond by attempting to restrict visitation rights knowing that the shadow of the law is on her side.

Finally, the fourth feature of power involves knowing that you have power. If a party does not know that s/he has power, oftentimes s/he is disadvantaged because s/he might not use this power effectively. An example of this would be in a mediation between a mistreated employee and his employer. The employee might not think that he has any power, especially because the employer has the ability to fire him. However, if the company were trying to maintain a good reputation, a lawsuit would not look good. The employee could talk to news outlets or post about the company on social media. If the employee is being treated unfairly,

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[6] *Id*. at 87.
[7] *See* Neumann, *supra* note 3, at 230.

there are a number of ways for him to get his story heard that could also harm the reputation of the company. This means that the employee does not have to agree to whatever the company wants simply because he does not think he can do better. If the employee does not know he has this power, then it is ineffective because the employee is more likely to give into the employer's demands.

II. Critiques of Mediation in Imbalanced Power Dynamics

"*The way to have power is to take it.*" – Boss Tweed

Many critics of mediation believe that power imbalances cannot lead to fair and equitable outcomes. They claim "mediation 'works best when equals are bargaining with one another and proves 'ineffective in cases of severe power imbalances between the parties.'"[8] This claim is known as the "oppression story."[9] The "oppression story" is the belief that mediation allows for stronger parties to impose their will on weaker parties because mediation emphasizes the power imbalances and the system does not provide effective checks and balances.[10] These critics focus purely on the stronger party's wealth, resources, and knowledge,[11] but do not give credit to the many benefits built into the mediation system that allow the process to be fair.

A. Gendered Imbalance

Many women advocates believe that women should not participate in mediation because they are generally considered the "weaker" party.[12] This rationale exists for a variety of reasons, including: (1) historically, "women have had less access to positions of power, and fewer

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[8] Jordi Agustí-Panareda, Power Imbalances in Mediation: *Questioning Some Common Assumptions*, 59 DISP. RESOL. J. 24, 26 (2004).
[9] *Id*.
[10] *Id*.
[11] *Id*.
[12] *See* Kelly, *supra* note 2, at 85.

external resources, including wealth";[13] (2) "women have not been socialized to ask for what they need and thus cannot bring an appropriate sense of entitlement to negotiations";[14] and (3) women are disadvantaged because "they prefer relational harmony to conflict."[15]

Further disadvantages experienced by women include disparity in economic power, disparity in information, and the credibility gap between men and women.[16] The assumption made with regards to disparity in economic power is that women are likely to have lower incomes than men.[17] The party with more resources, generally the man, can hire a lawyer, afford to wait out an extended delay, and can raise more issues than a party with fewer resources.[18] In addition, if a woman is in a weaker financial situation, she may be forced to accept an early settlement and ultimately settle for less than what she is entitled to by law.[19] The assumption for disparity in information is that in most traditional marital households, the husband will have more information about the family finances.[20] If the wife does not know what information to request or how to interpret the information, the husband is once again at an advantage.[21] Furthermore, the husband might have more access to information about the process as well, because he may be more likely to be able to afford to speak with a lawyer.[22] Finally, men tend to receive more credibility than women do.[23] In society, women are often treated with disbelief and are not taken seriously, oftentimes naturally and unintentionally.[24] Women have more features

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[13] *Id*.
[14] *Id*.
[15] *Id*.
[16] *See* Kathy Mack, *Alternative Dispute Resolution and Access to Justice for Women*, 17 ADEL. L. REV. 123, 124 (1995).
[17] *See id*. at 126.
[18] *See id*.
[19] *See id*.
[20] *See id*. at 127.
[21] *See id*.
[22] *See id*.
[23] *See id*. at 129.
[24] *See id*. at 130.

associated with powerlessness than men do, including the use of language features associated with powerlessness (such as superlatives or fillers), higher pitched voices, and smiling more frequently.[25] Since these factors are associated with powerlessness, women are perceived as having less credibility.[26]

Despite the concerns by advocates for women, "women in custody and divorce mediation have reported that mediation enable[s] them to have a voice and express their views, and they perceived that they had equal influence over the terms of the agreements."[27] Furthermore, it is the mediator's responsibility to ensure that the process is fair and equitable for both parties. If the mediator is unable to foster a collaborative environment and strongly believes that one party is being taken advantage of, the mediator can still choose to terminate the mediation.

a. Domestic Abuse

The use of mediation in domestic abuse cases has generated even more controversy than gender imbalance in general. On one side, "victim advocates assert that mediation is potentially unsafe and inherently unfair,"[28] while on the other side, "[m]ediation proponents counter that mediation can be a more empowering and effective process than such alternatives as lawyer-assisted negotiations, litigation, and adjudication."[29] One of the primary concerns victim advocates have is safety – mediation generally involves face-to-face communication, which gives the batterer access to the victim and potentially provides information that could jeopardize future safety.[30] Additionally, the mediated agreement could include terms that provide for ongoing communication between the batterer and the victim. Another concern is that while men

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[25] *See id*.
[26] *See id*.
[27] *See* Kelly, *supra* note 2, at 85.
[28] Peter Salem and Ann L. Milne, *Making Mediation Work in a Domestic Violence Case*, 17 FAM. ADVOC. 34, 34 (1995).
[29] *Id*. at 34-35.
[30] *Id*. at 36.

already have social and economic advantages over women, an abusive relationship is likely to exacerbate this problem, taking away the fairness and voluntariness that are central to mediation.

B. Employment Imbalance

Another imbalanced power dynamic occurs in the employment setting. When there is an employer and an employee, the employer is generally seen as having all of the power. Employers tend to have more wealth, more resources (including access to lawyers), and more experience. There is also a disparity between employers and employees because employers and their lawyers are usually repeat players—they might use the mediation system regularly to resolve employment disputes.[31] Employees, on the other hand, are usually one-shot disputants, meaning they only have one chance to resolve their employment dispute.[32] This problem is further exacerbated if the employee cannot afford legal counsel.[33]

However, the adjudicative system may not necessarily be a better option for employees. The same obstacles still apply in that the employer has more wealth, resources, and experience, and is still a repeat player. In addition, for employment discrimination cases, if the case does go to trial, "[employment discrimination plaintiffs] 'win less often than other [civil case] plaintiffs' and they prevail on their claims at 'only half the rate of other plaintiffs.'"[34] At least when dealing with employment discrimination, advocates have asserted that informal alternatives to the court system provide plaintiffs with a more realistic chance for a fair resolution.[35]

C. Mediation Benefits

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[31] Michael Z. Green, *Tackling Employment Discrimination with ADR: Does Mediation Offer a Shield for the Haves or Real Opportunity for the Have-Nots?*, 26 BERKELEY J. EMP. & LAB. L. 321, 339 (2005).
[32] *Id*.
[33] *Id*.
[34] *Id*. at 328.
[35] *Id*. at 329.

Mediation actually counteracts many of the claims of the "oppression story." Firstly, many of the assumptions made about power imbalance do not acknowledge that power comes from a number of different sources.[36] Even though wealth and resources are advantageous sources of power, they are not the only types of power. As previously mentioned, other types of power include personality and character traits, cognitive style and capabilities, and education.

Secondly, having equal power is not a necessity for a fair mediation.[37] Having equal power does not necessarily lead to a more effective negotiation because "symmetry in conflict situations tends to produce and reinforce hostility and prolong negotiations."[38] This suggests that equal power is not a prerequisite for a fair mediation.[39]

Thirdly, even though stronger parties have more power, this does not mean that they will abuse their power. There is an argument that "disproportionately greater power on the part of one party in a negotiation often reduces the likelihood of a favorable outcome for the power party."[40] Abuse of power could unintentionally cause the "weaker" party to be suspicious of the stronger party and reject the stronger party's proposals.[41] Since parties attend mediation with the hopes of settling their disputes, the stronger party will have to budge or listen to suggestions from the weaker party for the mediation to continue. Furthermore, even though a party might be perceived as having more power, they may not necessarily use this perception of power in a negative, repressive way.[42] The mediator can help to move the parties from a "power over" stance to a

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[36] *See* Agustí-Panareda, *supra* note 8, at 27.
[37] *Id*.
[38] *Id*.
[39] *Id*.
[40] *Id*.
[41] *Id*.
[42] *Id*. at 28.

"power with" approach, allowing the power to be "used as a creative force aimed at joint problem solving."[43]

Fourthly, the "oppression story" views power as a possession—something one party owns.[44] However, as previously mentioned, power is relational and constantly shifting.[45] The mediator can access these other power sources by speaking to the parties and finding out what is important to them. This can help even the playing field because, while wealth might not be the most important factor, it might be the only factor the parties are focusing on. This means the other party is not realizing their power and they are therefore, not able to use it. In litigation, the other party might not be able to determine where their power lies, but with the help of the mediator the interests of both parties can be addressed.

Finally, advocates who believe mediation is not right when there is a power imbalance also believe that the judicial process is the best tool parties have available to handle these types of disputes.[46] However, this is not necessarily true. As previously mentioned, the same issues of wealth, resources, and experience will have an impact in an adjudicative setting. The party that is wealthier will be able to hire a lawyer and can afford to go through the litigation process for a longer period of time. At least with mediation the timeline is often much shorter and the process is considerably less expensive than going through litigation. Additionally, "some critical legal thinkers question the adjudication process because they believe that the legal system is designed to preserve existing power imbalances in society."[47]

III. Mediation Techniques to Balance Power Dynamics

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[43] *Id*.
[44] *Id*.
[45] *See* Kelly, *supra* note 2, at 87.
[46] *See* Agustí-Panareda, *supra* note 8, at 28.
[47] *Id*.

"*An ounce of mediation is worth a pound of arbitration and a ton of litigation!*" — Joseph Grynbaum

A. Gendered Imbalances

While mediation can be an empowering opportunity for women in cases of divorce, "[e]mpowerment in mediation comes about from interactive participation."[48] When there is a history of domination and deference (as is the case in many traditional marriages), the mediator should concentrate on bringing the deferent party into the decision making process.[49] One way to do this is to engage the deferent party by actively encouraging evaluation of the ideas and proposals put forth by the more dominant party.[50] The mediator can also turn to the dominant party to explain how the proposal might work for both parties, thus converting the power to allow for mutual problem solving.[51]

Caucusing is also useful for parties that are more submissive. If parties fear conflict, they may not feel comfortable bringing up their feelings in front of a more dominant party. Furthermore, it can offer the mediator a chance to check in with the deferent party and probe for her feelings towards the proposal before bringing it up in the joint session. This offers the party a chance to explore and understand her feelings before bringing them up with the more dominant party. Tied into this idea might be an imbalance between the parties' ability to communicate. If they are unable to communicate their thoughts in an effective manner, they may be less willing to try. Encouragement from the mediator can help the deferent party get their ideas across without feeling flustered or rushed.[52] If the mediator is encouraging to the deferent party, this

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[48] *See* Kelly, *supra* note 2, at 87.
[49] *See id*. at 90.
[50] *See id*.
[51] *See id*. at 91.
[52] *See id*. at 92-93.

also takes power away from the dominant party because it expresses the notion that both parties will be heard and both parties are offering valuable communication.[53]

Cognitive style and capabilities, as well as knowledge, can also cause power imbalances. If a party gets confused by concepts in a mediation, for example complex financial issues, "interventions include slowing the pace, using a flipchart to record data, asking clients to take notes, reassuring that no agreement is final until everyone understands, instituting separate sessions, making referrals to outside consultants, and offering considerable help in structure and integrating the data, proposals, and tentative agreements."[54] Similar interventions can be implemented for a lack of knowledge. Additionally, the mediator can encourage questions and hold check-ins to make sure both parties are still on the same page.

a. Domestic Abuse

When handling domestic abuse situations, mediation should never be mandatory. However, mediation should still be available for parties that want the option. In Alaska, when victims of abuse were legislatively prohibited from mediating visitation issues, the victims expressed anger at being excluded.[55] When it comes to victims of abuse, they should be granted all the possible options to make them feel most comfortable.

Prior to mediation, screening should be conducted to determine whether the dispute and parties are appropriate for mediation.[56] The best type of screening is face-to-face, in private, and with someone of the same gender.[57] Since face-to-face is not always possible because of resource limitations, telephone sessions or questionnaires are also options.[58] Because victims of abuse are

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[53] *See id*. at 93.
[54] *Id*. at 93.
[55] Salem and Milne, *supra* note 17, at 36.
[56] *See id*. at 37.
[57] *See id*.
[58] *See id*.

not always aware they are being abused and do not always consider themselves victims, the screening should use ask about specific behaviors, such as "pushing, shoving, kicking, slapping, biting, punching, striking with an object, or threats with a weapon."[59] Along with questions about physical acts, the interviewers should also "ask about verbal abuse, such as intimidation and threats, whether the police have ever come to the home, patterns of decision making about specific topics, such as financial issues, patterns of conflict resolution, and other issues that may reveal an abusive relationship."[60] Screening does not end after the initial interview and mediators should continue to look for signs of domestic abuse throughout the mediation.[61]

Mediation should only occur with the consent of the parties and the mediators—meaning no mandatory court-ordered mediation. Furthermore, mediation may be inappropriate in the following scenarios: "(1) ongoing abuse; (2) batterer's use of or threats with a weapon; and (3) the victim's continuing to put the abuser's needs ahead of her own."[62] In these situations, the risk for the victim may be too high and the mediator should not attempt to resolve the dispute.

If mediation does go through with a domestic abuse case, there are a number of tools that mediators should use to ensure the victim's safety and to make sure the victim is heard. Firstly, private caucuses are a necessity.[63] Holding frequent caucuses are essential to check in with the victim during points of agreement and disagreement to ensure that she is not intimidated or coerced into an agreement.[64] If the victim is incapable or unwilling to be in the same room as the abuser, then shuttle mediation might be more appropriate, where the mediator is moving back and forth between the parties (they may be in separate rooms or have sessions at different

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[59] *Id*.
[60] *Id*.
[61] *See id*.
[62] *Id*.
[63] *See id*. at 38.
[64] *See id.*

times).[65] Being in different rooms will not only make the victim more comfortable, but there is also less of a chance for intimidation to occur. If it is unsafe for the victim to travel or for her abuser to know where she is, telephone mediation is another option and can be conducted either through a conference call or in a shuttle manner.[66] Providing the victim with "community resources and support services, such as a victim advocate, attorney, or counselor, may be effective in helping a client objectively assess options during a mediation session."[67] Furthermore, if a victim advocate can be present during the mediation, s/he can serve as another check on the power of the abuser and help to make sure the victim is not giving into proposals out of fear.[68] The mediator should also establish ground rules to restrict the agenda to specific issues.[69] For example, the victim might not be comfortable discussing reconciliation, dropping abuse charges, or modification of restraining orders, and ground rules can keep these topics off limits.[70] Finally, an attorney should be required to review the mediated agreement to assure informed decision-making.[71]

B. Employment Imbalances

When dealing with employers and employees, it is important to try to mitigate the advantages that the employers have as repeat players. The main advantage to being a repeat player is "the ability 'to choose and manipulate what process will be used to enforce substantive rights' because 'advantages . . . will flow to the repeat player who controls virtually all aspects of the disputing process.'"[72] One solution is to ensure that the employee also has legal counsel, who

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[65] *See id*.
[66] *See id.*
[67] *Id*.
[68] *See id*.
[69] *See id*.
[70] *See id*.
[71] *See id*.
[72] Green, *supra* note 20, at 340.

are generally also repeat players in mediation.[73] However, this is not always possible because affordable legal counsel might not be available to the party. One suggested solution is to ask the counsel for the employer to explain the law to the employee.[74] While the counsel might be unwilling to do this, it could also present a show of good faith on the part of the employer. Mediation is about coming up with suitable solutions for both parties and sharing information to get there. If the employer is serious about reaching a solution, then this could be a viable option.

Another option to make sure the employee understands the law is "to get the parties to agree that legal norms may play a role in reaching informed consent and to seek permission from the parties allowing the mediator to discuss those legal norms with either party, as requested."[75] The same logic applies here. If the employer is actually looking to putting forth a good faith effort, then having the employee be informed about the law will help the process. It is also helpful to inform both parties that there could be trouble with the mediated agreement later on if either party did not fully understand the terms when it was signed. Furthermore, if the mediator feels as though the employee really does not understand what is going on, then it is the mediator's duty to end the mediation because the process is no longer fair. Since the employer likely wants to come to an agreement in mediation, agreeing to at least one of these terms would be in the employer's best interest.

The employee should also be involved in the mediation process before it even begins. This suggestion needs to be implemented into the actual mediation system because the mediator cannot help with this. The employee should be ensured "fair and balanced selection processes for the mediators"[76] and provided "the opportunity to select diverse mediators who do not represent

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[73] *See id*. at 340-41.
[74] *See id*. at 350.
[75] *Id*.
[76] *Id*. at 341.

repeat player advantages for the employer."[77] This suggestion is hard to implement because as one-shot disputants, the employees might not know the procedures for setting up a mediation. This means that the process of selecting a mediator would need to have some extra regulations to protect the parties.

C. Comparison of Gender and Employment Imbalances

Techniques for correcting power imbalances for gender and employment mediations overlap in many places. For example, even though the following techniques are listed under correcting gender imbalance, they can still help with employment mediations: actively engaging the deferent party, caucusing, encouraging the deferent party, and slowing down and checking in to ensure that all parties are on the same page. Utilizing these techniques in employment mediation can also serve to level the playing field for employees who feel like they cannot share their ideas or for those who do not know how to share their thoughts. However, the techniques for balancing power in domestic abuse mediation do not translate as well because most of them are meant to keep the victim safe. While caucusing and checking in is important, solely conducting shuttle mediation in an employment scenario will hinder the collaborative atmosphere mediation strives to bring about.

Likewise, techniques for balancing employment power dynamics can also be applied to mediations with gender imbalances. Mediations with gender imbalances (specifically for divorce mediations) do not usually have the additional hurdle of repeat players versus one-shot disputants. However, these mediations do often have the economic disparity that gives an advantage to the employer. If this is the case and one side has a lawyer, while the other does not, it could be helpful to either have the lawyer explain the law or obtain permission for the mediator to be able to explain the law. Even though this might be less appealing to the advantaged side, it

[77] *Id*.

will help to create a collaborative environment. It will also help in the long run if both parties are fully aware of what they are getting into because this will leave both parties feeling satisfied and there is less of a chance of one party challenging the mediated agreement.

A final similarity revolves around the mediator's power. A mediator controls the mediation and can foster a collaborative environment instead of the typical adversarial atmosphere. Mediators should constantly remind the parties that mediation is a voluntary process and that the parties are in control of the mediation.[78] They have the opportunity to have input on the process, make their own proposals, and veto proposals. Mediators can also model the behavior they want the parties to exhibit (listening, being respectful, not interrupting) and monitor the parties to make sure they are adhering to the respectful communication model that was likely established at the beginning of the mediation.[79] Mediators can also make sure that all relevant documents and information have been produced and make sure there is understanding among the parties either by providing education themselves or referring parties to other sources.[80] They can also ensure the parties are not rushed into making any decisions and check in to make sure parties are comfortable with the mediation process.[81] Finally, mediators have the ultimate power to terminate the mediation if they do not believe the process is fair to both parties or they no longer feel comfortable with the situation.

IV. Conclusion

There are many ways to interpret power in mediation. Oftentimes when we think of power in mediation we think of economic power or societal power. However, power is multifaceted—it cannot be limited to just the obvious factors. Power has a number of different

[78] *See* Kelly, *supra* note 2, at 96.
[79] *See id*.
[80] *See id*.
[81] *See id*.

factors that are often ignored. Mediation can offer the chance to empower both parties and help them use this power to create a collaborative atmosphere. Empowerment comes from interactive participation, so it is up to the mediator to involve both parties in the mediation.

Power imbalances occur when one party has more wealth, resources, and experience. The assumption is that stronger parties will exert their wills onto the weaker parties, thus forcing the weaker parties to agree to less favorable terms. However, this ignores the basic understanding of mediation, which is that mediation is a voluntary process, both parties presumably want to reach an agreement and avoid the costs of litigation (both time and money), and an agreement cannot occur until both parties give their consent.

In cases of gender and employment imbalance, women and employees are often viewed as the weaker party. They do not have the same resources as men/employers and, because of the way they are viewed by society, they might be perceived as or even feel subservient to their respective counterparts. However, this does not mean that mediation is inappropriate for these parties. In order to achieve fairness, the mediator should actively engage these parties by using methods such as asking for their input, referring them to appropriate resources, and by caucusing to check-in and make sure they understand and are comfortable with the process. Power is not static and by engaging the perceived weaker parties, the mediator can empower them and help them find their voices.

Mediation is a powerful tool that should remain an option for all parties. Despite critiques of the system, mediation is ultimately a voluntary, confidential process. Even if the power dynamics seem imbalanced, either the parties or the mediator can always terminate mediation. It is only one option that is available to parties to help them achieve a fair and equitable outcome.

Mediation, if used effectively, can tackle these perceived power imbalances and offer parties a faster, more efficient way to resolve their disputes.

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

Prepared by

SAMHSA's Trauma and Justice Strategic Initiative

July 2014

THE THREE "E'S" OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

Events and circumstances may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. This element of SAMHSA's concept of trauma is represented in the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which requires all conditions classified as "trauma and stressor-related disorders" to include exposure to a traumatic or stressful event as a diagnostic criterion.

The individual's **experience** of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another (e.g., a child removed from an abusive home experiences this differently than their sibling; one refugee may experience fleeing one's country differently from another refugee; one military veteran may experience deployment to a war zone as traumatic while another veteran is not similarly affected). How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is experienced as traumatic. Traumatic events by their very nature set up a power differential where one entity (whether an individual, an event, or a force of nature) has power over another. They elicit a profound question of "why me?" The individual's experience of these events or circumstances is shaped in the context of this powerlessness and questioning. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. When a person experiences physical or sexual abuse, it is often accompanied by a sense of humiliation, which can lead the person to feel as though they are bad or dirty, leading to a sense of self blame, shame and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal, shattering a person's trust and leaving them feeling alone. Often, abuse of children and domestic violence are accompanied by threats that lead to silencing and fear of reaching out for help.

How the event is experienced may be linked to a range of factors including the individual's cultural beliefs (e.g., the subjugation of women and the experience of domestic violence), availability of social supports (e.g., whether isolated or embedded in a supportive family or community structure), or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, fifteen, or fifty).[1]

The long-lasting adverse **effects** of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. The duration of the effects can be short to long term. In some situations, the individual may not recognize the connection between the traumatic events and the effects. Examples of adverse effects include an individual's inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions. In addition to these more visible effects, there may be an altering of one's neurobiological make-up and ongoing health and well-being. Advances in neuroscience and an increased understanding of the interaction of neurobiological and environmental factors have documented the effects of such threatening events.[1,3] Traumatic effects, which may range from hyper-vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Tips for College Students:

AFTER A DISASTER OR OTHER TRAUMA

If you have experienced a disaster such as a hurricane or flood, or other traumatic event such as a car crash, you may have distressing reactions like feeling anxious or afraid. It's also pretty common to think about the event often, even if you were not directly affected and especially if you saw it on television. No reactions are wrong or right. Most responses are just normal ways of reacting to the situation.

Tips for Coping

- **Talk About It.**
  One of the most helpful things to do is to connect with others. Don't isolate yourself. Talk with someone about your sadness, anger, and other emotions, even though it may be difficult to get started. Find a peer who will understand and accept your feelings, or a trusted professor, counselor, or faith leader. Call home to talk with your parents or other caregivers (for example, your Resident Assistant if you are living on campus). Share your feelings and concerns with them, or visit the Student Health Center for any physical or emotional concerns.

- **Take Care of Yourself.**
  Rest when you need to. Eat healthy meals and snacks when they are available, and drink plenty of water.

- **Calm Yourself.**
  Move the stress hormones out of your body:

  – Deep breathing or breathing that emphasizes the exhale is really helpful in reducing stress.

  – Simple exercises like walking or gentle stretching such as yoga helps get rid of stress.

- **Give Yourself a Break—Turn Off the Television/Radio.**
  Take breaks from watching news coverage of the event or listening to radio reports.

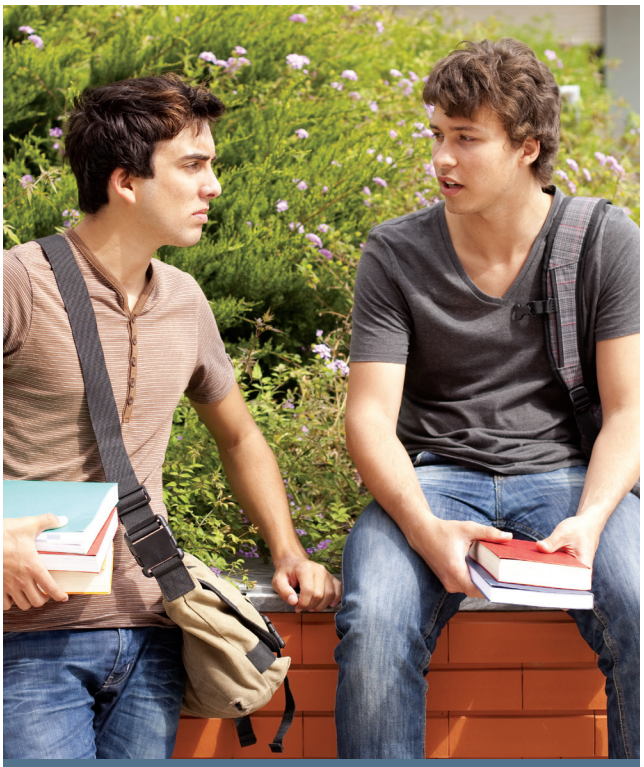
- **Avoid Using Alcohol, Drugs, and Tobacco.**
  They will not help you deal with stress, especially right after a traumatic event. They usually just make things worse.

- **Get Back to Your Daily Routines.**
  Do the things you would normally do, even if you don't feel like it. It's a good way to regain a sense of control and help you feel less anxious.

- **Get Involved in Your Community.**
  Engaging in positive activities like group discussions and candlelight vigils can help bring you comfort and promote healing. They also help you realize you are not alone. Volunteering is a great way to help and can create a sense of connectedness and meaning. Try something you think you'd like to do. For example, answer hotlines, distribute clothing, or join a food drive.

- **Help Others.**
  If you are trying to help a friend, make sure to listen attentively (for example, avoid looking at your cell phone) to find out where he or she is in the coping process. Others may have different responses from you, so try to accept their feelings. If you are concerned about them, contact one of the resources on this tip sheet for help.

- **Remember.**
  If a trauma was caused by a violent act, it is common to be angry at people who have caused great pain. Know that nothing good can come out of more violence or hateful acts.



We tend to remember traumatic events like disasters all our lives, but the pain will decrease over time, and even though it hurts, we usually do get stronger.

Be honest with yourself and accept your feelings—even if you have a sense of uncertainty. Things may seem off balance for a while, but most people start to feel differently after a week or two, especially if they get back to regular routines. Think about what you may have learned that might be helpful to you in the future. Do you feel this tragedy made you more adaptable or more self-reliant?

If you continue to experience emotional distress for 2–4 weeks after a disaster or other traumatic event, or if you just want to talk with a professional, see the **Helpful Resources** on the next page to help you or someone you know recover.

Common Reactions of Survivors of Disasters and Other Traumatic Events

- Having trouble falling asleep or staying asleep
- Feeling like you have no energy or like you are always exhausted
- Feeling sad or depressed
- Having stomachaches or headaches
- Feeling like you have too much energy or like you are hyperactive
- Feeling very irritable or angry—fighting with friends or family for no reason
- Being numb—not feeling at all
- Having trouble focusing on schoolwork
- Having periods of confusion
- Drinking alcohol or using illicit drugs or even legal medications to stop your feelings
- Not having any appetite at all, or just the opposite—finding that you are eating too much
- Thinking that no one else is having any of the same reactions and that you are alone in dealing with your feelings

Helpful Resources

Substance Abuse and Mental Health Services Administration Disaster Technical Assistance Center (SAMHSA DTAC)
Toll-Free: 1-800-308-3515
Website: http://www.samhsa.gov/dtac

Treatment Locators

Mental Health Treatment Facility Locator
Toll-Free: 1-800-789-2647 (English and español)
TDD: 1-866-889-2647
Website: http://findtreatment.samhsa.gov/MHTreatmentLocator

MentalHealth.gov
Website: http://www.mentalhealth.gov
MentalHealth.gov provides U.S. government information and resources on mental health.

Substance Abuse Treatment Facility Locator
Toll-Free: 1-800-662-HELP (1-800-662-4357)
(24/7 English and español); TDD: 1-800-487-4889
Website: http://www.findtreatment.samhsa.gov

**Note: Inclusion of a resource in this fact sheet does not imply endorsement by the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, or the U.S. Department of Health and Human Services.*

Hotlines

National Suicide Prevention Lifeline
Toll-Free: 1-800-273-TALK (1-800-273-8255)
TTY: 1-800-799-4TTY (1-800-799-4889)
Website: http://www.samhsa.gov
This resource can be found by accessing the Suicide Prevention Lifeline box once on the SAMHSA website.

National Dating Abuse Helpline*
Toll-Free: 1-866-331-9474 Text "loveis" to 77054

National Domestic Violence Hotline*
Toll-Free: 1-800-799-SAFE (7233); TTY: 1-800-787-3224

Office for Victims of Crime*
Toll-Free: 1-800-851-3420, or 301-519-5500
TTY: 301-947-8374
Website: http://www.ojp.usdoj.gov/ovc/ovcres/welcome.html

The Rape Abuse and Incest National Network (RAINN)*
operates the 24/7 confidential National Sexual Assault Hotline.
Toll-Free: 1-800-656-HOPE (1-800-646-4673)

Additional Behavioral Health Resources

National Child Traumatic Stress Network
Website: http://www.samhsa.gov/traumaJustice
This behavioral health resource can be accessed by visiting the SAMHSA website and then selecting the related link.

Administration for Children and Families
Website: http://www.acf.hhs.gov

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Trauma Informed Mediation - Guidance for Mediators and Ombuds Working In Traumatized Communities

Wendy Wood, PhD April 16, 2015

by Wendy Wood, PhD

For mediators and ombuds working in traumatized communities, it is critical to have an approach that is trauma sensitive and trauma informed. Trauma is extremely complex and multi-layered. For our purposes we will address only a few essential aspects. These include:

1. Basic understanding of the nature and effects of trauma
2. Basic understanding of vicarious or secondary trauma
3. Basic practices for self care

Trauma can be understood as the injury resulting from an experience that overwhelms one’s ability to protect oneself and stay safe. The injury can be physical, developmental, emotional, relational and/or spiritual. Sometimes people heal from the injury and recover healthy functioning. Sometimes functioning is altered in a manner that persists. Whether and how recovery of healthy functioning occurs depends on many factors including severity of the experience, age, innate characteristics, support within the environment, previous traumatic experience etc.

For our purposes, the persisting consequences of severe traumatization, beyond the physical injuries, can best be understood as alterations in the stress response systems which allow us to keep ourselves safe. These changes take place across all domains including in perception, processing, reactivity, cognition and self regulation. Traumatized individuals may literally perceive threat where no threat is intended from cues which are absolutely

neutral to others. Threat, actual or perceived, alters how we process auditory and visual clues.

When faced with danger our systems prepare for “fight, flight or freeze”. In fight or flight we undergo all the physiologic changes that prepare us to protect ourselves or escape – increased heart rate, respiration, etc. When we can neither defend ourselves nor escape, we freeze – our body prepares for injury. These two paths are described as hyperarousal and dissociation:

- Hyperarousal is pretty easy to recognize – it shows up as agitation, difficulty with focus, concentration and memory, high reactivity, anger and aggression.
- Dissociation may be harder to recognize in that it is inherently a form of withdrawal in which we are physically present but mentally disengaged. It is successful to the degree that one doesn’t draw attention to oneself. Individuals who defend themselves by dissociating don’t confront or antagonize and may be very passive and compliant but they are also not truly present.

When discussing developmental trauma it is said that “States become traits”. In childhood, the brain is organizing in response to experience and adapting for the world in which it finds itself. Persistent high levels of threat and activation of “fight, flight or freeze” will result in a brain which organizes for that environment. The hyper vigilance and/or dissociation will become persistent traits rather than transient states.

Our goal is to “First, do no harm”. Then, of course, we want to work in ways which are actually effective and useful. This means deliberately establishing and maintaining an environment of essential safety. Some key elements;

- Because we experience the novel and unfamiliar as potentially threatening systematically incorporating the “safe and familiar” from the very beginning can be very helpful. How to go about this in Rwanda can be determined collaboratively with our partners.

- The physical environment matters. For traumatized individuals an unobstructed path to the door is necessary. Enough room so that one's personal space is intact – our partners can guide us in terms of what this means in the countries and communities where we work.
- Shared agreements regarding how to deal with getting triggered – again, developed in collaboration with our partners.
- As a general principle, avoidance of retraumatization means awareness of and respect for personal boundaries. Any disclosure of personal information takes place at the discretion of the individual. Being pressured to tell the story of your trauma is not the same as being able to "tell your story" in your own way, at your own time.
- When working with others we have an ethical responsibility to be aware of what we, as individuals with our own personal histories may be bringing into the relationships. Our own trauma, unrecognized and unmanaged, can easily be activated and alter the dynamic in very significant ways.

Secondary or Vicarious Trauma

Those who bear witness to the suffering of others and are empathically engaged with victims of trauma may become traumatized themselves. Common signs that one is experiencing secondary trauma include changes in sleep and appetite, intrusive or repetitive disturbing thoughts and images, increased difficulty managing emotional states, emotional numbing, difficulty maintaining healthy boundaries, confusion, cynicism and feelings of hopelessness and loss of meaning.

The critical elements in managing vicarious trauma are awareness, balance and connection. Knowing the risks and recognizing the signs allow us to anticipate and cope with secondary trauma. Self care involves balancing the work with adequate rest, play, escape, exercise and proper nutrition. Caring for one another within the conflict management team is supported by developing practices that systematically sustain focus and awareness

and attunement. These include regular check-ins , doing “body scans”, breathing and other somatic practices which help with managing stress, scheduled debriefing and “decompression” times. It can be helpful to ritualize these activities so that they precede as well as follow interaction with traumatized individuals and groups.

We need to remember that while we do know, in a general sense, about the history and current conflict and trauma environments of the countries and communities where we are working, we do not know much at all about the individuals with whom we interact. It is crucial that we do not make assumptions, that we hold “Beginners Mind” as we engage with individuals and groups. The most important component of Beginners Mind is as it relates to ourselves. Self awareness is the necessary first step as we seek to “”do no harm”.

/Source

When Should a Mediator Withdraw?

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by Bill Eddy

Not all mediations go well. The parties are intransigent, or one is obviously a bully, or one is too weak to speak up for herself/himself, or the issues are beyond the knowledge-base of the mediator – or an assortment of other issues may prevent reaching an agreement. I am often asked whether I think that a particularly difficult couple will fail to reach an agreement and whether the mediator should withdraw – in other words "Should I fire my clients?" This article addresses some common issues, with my thoughts for how to deal with them, including comments about self-determination, which is *STANDARD I* of the APFM Standards of Practice. I encourage discussion on this topic, so feel free to send me your thoughts, long or short, to share with our readers. As with all ethical issues, it's not clear-cut.

Screening

Initial screening may help in determining whether the parties are good candidates for mediation in the first place. Domestic violence screening is the most common concern, and there are several approaches to consider, such as a written set of questions to be filled out in advance and/or a separate screening interview with each person. Several organizations, including APFM, have provided trainings on domestic violence screening. Our APFM trainers on screening, Hilary Linton and Claudette Reimer, have recommended several adaptations to the mediation process for safety, based on the mediator's assessment of the parties (See www.RiverdaleMediation.com for a good article about screening). After three decades of debate, most mediation programs agree that well-trained mediators can handle most domestic violence cases, with some exceptions that need to be screened out altogether. Of course, the mediator should stay alert to concerns about safety throughout the mediation process in all cases.

When there do not appear to be domestic violence issues present, I tend to favor taking any clients who are motivated to attend mediation, even if there are signs that they might not reach an agreement. I take a very optimistic approach to mediation. I believe that even high-conflict couples can reach agreements in mediation, and often do. There is no assessment tool that I know of that can predict, before a mediation begins, whether the parties will reach complete agreement or not.

I tell my couples that the vast majority of my cases do reach an agreement

even if they are far apart at the start of the process. But, of course, it's a voluntary process, so they can stop at any time, if either or both feel that it's necessary. After over thirty years as a provider of divorce mediations, I find that I cannot tell (even during the process) which people will reach a full agreement and which ones will get stuck and drop out of the mediation. So I favor hanging in there to give it my best efforts and help the couple calm the conflict, even if they don't reach a complete settlement.

Difficult Parties

Some mediation clients can be very resistant to reaching agreements, or even to discussing issues reasonably. However, it's important to know that some couples take longer to settle down, to comprehend the situation they are really in, to become open to compromise, and to fully understand their choices. There's no point at which a mediator should give up on the parties simply because they are not making progress. Many parties really do need more time. Instead, my approach has been to give this problem to the parties to resolve, with information about how it's going. I believe this is informed consent, which is part of self-determination—one of the pillars of mediation ethics:

"You both seem to be out of ideas at this point, and I'm out of ideas, too. We've looked at a lot of information and you've both made serious proposals. We just don't have agreements on everything yet. So let's look at your options at this point. We could take a break for a few weeks. You could talk to some experts on the unresolved issues. You could get written opinions from lawyers on these issues. I'm willing to keep working with you,

but I'm not sure that I can help you at this point. I certainly don't want to take your money if you're not making progress. Do you want to schedule another appointment, which you can cancel at least two business days in advance? Or do you want to discuss your options, if you stop mediation now? It's really up to the two of you."

With this approach, I have been fired a few times. But, I have had many more cases in which they come back after a break and are able to reach agreements. If I had fired them, I don't believe that this would have occurred. They like knowing that I am still sticking with them, even when they are frustrated – and frustrating!

Difficult Issues

Difficult issues are a different matter. Sometimes there are issues that would be better handled by another mediator or other professional(s). Keeping informed-consent and self-determination in mind, the mediator should openly say that his or her knowledge is limited on the subject at hand and another professional may be better able to deal with it. However, the mediator should also offer the idea of including another professional(s) in the mediation process, rather than transferring the case to someone else. This way, the parties can make their decision, informed of the limitations and alternatives by the mediator.

For example, inviting in a financial advisor to assist with a complicated financial issue has worked in several of my cases. Sometimes it's one of the party's accountant or financial advisor, and in others, they have jointly hired a neutral financial specialist. This can also work for parenting issues, if there is a need for outside information, such as how to deal with a child with special needs. Sometimes I have sent the parties to an outside therapist, but also having a therapist (who has worked with the children) on a speaker phone with both parties present is another alternative. All of these approaches avoid firing the clients, if possible.

How to Withdraw

For mental health reasons, we need to be very careful if we withdraw from a mediation case. One or both parties may be feeling very insecure in their lives at this hard time. This may be especially true if the case is not going well. Mediators develop a close relationship with their clients, similar to that of mental health professionals. We know that when a close relationship ends, it can be traumatic and trigger deep-seated emotions. For divorcing parties, such a relationship has already just ended with their spouse, so these feelings may be more likely to occur if a mediator seems to "reject" or "abandon" clients. This is why I prefer to stick with my clients unless they decide to fire me, as I suggested above.

I have only withdrawn in two cases out of about 2,000 mediations (that I can recall). In one case, the wife dumped a cup of water on the husband when he made a proposal she really didn't like. I knew that she had smashed his car window once, so I concluded that this was a pattern of impulsive behavior and I terminated the mediation on the spot. I told them they needed to each have their own lawyer and that the lawyers needed to help them resolve their issues while they were in separate rooms – or buildings.

The other case in which I withdrew was one that was occurring purely by phone conference call from two different cities. After about a year of conference calls the couple had made no progress on relatively simple issues. They didn't have new information or new proposals that they had prepared beforehand. I think that the distance had forced them to informally settle all the important issues (including parenting), so that there was no incentive to settle the remaining property and long-term support issues. I felt like they, equally, were doing nothing to move things forward, so I told them they needed to pick someone to make their decisions for them and to be done with it. They could have gone to court and quickly finished their case. I was no longer willing to participate in a process in which neither party was motivated to finish – even after a year of conference calls every

couple months.

Conclusion

For ethical, and for mental health reasons, I think we should be very reluctant to withdraw from the mediation process once we have begun. On the other hand, we need to remain alert to concerns about safety, difficult clients and difficult issues. To fulfill our obligations of self-determination with informed consent, we should give the parties as much information as possible about the limitations of the mediation process and of our own knowledge, so that they can decide whether to keep working with us and adding more professionals, or moving on to someone else or to another process. It needs to be up to them as much as possible, but up to us to recognize when withdrawing may be necessary and appropriate.

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