1 WHAT IS TRAUMA?

The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (*DSM-5*; American Psychiatric Association [APA], 2013) defines a *trauma* as

> 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). (https://www.ncbi.nlm.nih.gov/books/NBK207191/box/part1_ch3.box16/)

Although this definition is useful, and widely used in clinical and research contexts, some have questioned the requirement that trauma be limited to "exposure to actual or threatened death, serious injury, or sexual violence," since many events may lead to posttraumatic stress even if life threat or injury is not an issue (Anders et al., 2011). Because the *DSM-5* does not consider events to be traumatic if they are merely highly upsetting but not immediately life threatening—for example, chronic emotional abuse, potentially fatal chronic illnesses, severe social maltreatment, and major losses—it may underestimate the extent of actual trauma in the general population.

Our own view is that an event is traumatic if it is extremely upsetting, at least temporarily overwhelms the individual's internal resources, and produces lasting psychological distress. This broader definition, which includes sudden, severe emotional losses not involving death or injury (Carlson et al., 2013), is used throughout this book. This is because people who experience emotional traumas or extreme loss can suffer as much as those traumatized by physical injury or immediate life threat, and can respond equally well, we believe, to trauma-informed therapies. At the same time, this expanded definition is most relevant to case formulation and clinical interventions; when a formal diagnosis is being considered, clinicians must employ *DSM-5* trauma exposure criteria.

SINGLE VERSUS MULTIPLE TRAUMATIC EVENTS IN DSM-5

A notable, but frequently overlooked change to Criterion A in *DSM-5* is the abandonment of the single trauma requirements of previous DSMs (APA, 2013). Prior to *DSM-5*, all symptoms of posttraumatic stress disorder (PTSD) or acute stress disorder (ASD) had to be linked to the same adverse event, such as a single sexual assault, combat experience, or motor vehicle accident. As a result, PTSD or ASD could not be diagnosed if some posttraumatic symptoms, for example, hyperarousal or nightmares, arose from one trauma and others, for example, flashbacks or effortful avoidance, were related to a different traumatic event.

This approach was problematic because, as noted later in this chapter, stress disorders such as PTSD are far more common among those with a history of multiple traumas, and often appear to reflect the cumulative effects of these experiences. For this reasons, *DSM-5* Criterion A for PTSD now specifies traumatic "event(s)" [note parenthesized plural], in contrast to previous DSM's single trauma requirement. This transition from a single event to a potentially multi-trauma criterion highlights the notion often presented in this book that significant trauma-related symptoms are often the result of multiple, often complex, traumatic events that accumulate over time.

Major Types of Trauma

Surveys of the general population indicate that as many as 80 percent of adults living in the United States have experienced at least one major trauma (e.g., Benjet et al., 2016; Kilpatrick et al., 2013). Although traumatic stressors are common, their ability to produce significant psychological symptoms and disturbance is influenced by a number of other variables, as discussed in Chapter 2. The following pages detail most of the major types of traumatic events and adversities potentially experienced by those seeking mental health services. There are a myriad of ways in which an individual can be psychologically hurt, of course, not all of which are easy for the client to disclose in an initial clinical interview. This is important to keep in mind—frequently, clients will not report events they have experienced unless they are specifically asked about those events in a nonjudgmental, supportive context, or until trust has been established psychotherapeutically (see Chapter 3). Described briefly below are major traumas often experienced by mental health clients and others. See Eadie and Briere (in press) for a more detailed review of these and other adversities.

Child Maltreatment

Sexual abuse. *Childhood sexual abuse* can be defined as intentional sexual acts against a child under 18 years of age by an adult or a significantly older person. Research indicates that such experiences, ranging from fondling to rape, are retrospectively reported by approximately 25 percent of women and 5 percent of men (e.g., Finkelhor et al., 2014). Even these numbers may be underestimates, however. A recent study, for

example, found that over a third of women had experienced unwanted sexual contact at age 13 or younger (Briere, Runtz et al., 2020).

Physical abuse. Physical maltreatment involves injurious acts against a child by an adult, ranging from hits or blows that bruise or bleed to severe beatings and life-threatening assaults. Like sexual abuse, childhood physical abuse is common in North America, with between 10 to 22 percent of men and women reporting physical abuse, if asked (e.g., Briere & Elliott, 2003).

Psychological abuse. *Psychological abuse* can be defined as caregiver behaviors involving repetitive criticism, denigration, blaming, insults, and threats (e.g., Briere, Godbout et al., 2012; Hart et al., 2011). Several studies indicate that many, if not most, parents report engaging in at least some psychologically abusive behaviors toward their children (Daro & Gelles, 1992; Straus et al. 1998).

Psychological neglect and disattunement. Childhood psychological neglect involves inadequate or absent caretaker attention, protection, nurturance, and attunement, whereas disengaged caretaking refers to general parental inattentiveness and nonresponse to the child's proximity-seeking behavior. Although not meeting *DSM-5* trauma criteria, caretaker neglect and disattunement has been repeatedly implicated in children's subsequent insecure attachment and, in the long term, relational difficulties and psychological symptomatology (Briere et al., 2017; Sroufe et al., 2005).

Rape and Sexual Assault

Rape is defined as nonconsensual oral, anal, or vaginal sexual penetration (if the victim is a child, see *Child Sexual Abuse*) by virtue of threat or physical force, or when the victim is incapable of giving consent, for example, when under the influence of drugs or alcohol, or when otherwise cognitively impaired. The prevalence of rape against women in the United States is reported to be around 18 percent (Tjaden & Thoennes, 2000) and is even higher for racial and gender minorities (Littleton & DiLillo, 2021). The term *sexual assault* often refers to any forced sexual contact that does not involve sexual penetration, although some researchers and clinicians include rape in this definition. Peer sexual victimization of adolescent women is quite common; the National Survey of Adolescents suggests that approximately 12 to 13 percent of female adolescents in America have experienced sexual assault or rape (Elwood et al., 2011). The sexual assault rate for males is estimated to range between 2 and 5 percent (Black et al., 2011; Elliott et al., 2004).

Drug-facilitated sexual assault [DFSA]. DFSA involves the use of psychoactive substances to incapacitate potential victims, who are then sexually assaulted. The most common substances used in DFSA are alcohol, benzodiazepines, gamma-hydroxybutyrate (GHB), and ketamine (Fiorentin & Logan, 2019).

Military sexual trauma (MST). *MST* is defined as sexual coercion, inappropriate sexual behavior, and/or sexual assaults against active service people by their peers or command superiors (Ormerod & Steel, 2018). In a meta-analysis of 69 studies (Wilson, 2018), 24 percent of female military personnel and veterans report instances of sexual assault in the military and 53 percent report sexual harassment.

Sexual assault during war or immigration. Many people living in high conflict situations or war have experienced sexual assault, often perpetrated by opposing forces as a way to demoralize civilians, foster "ethnic cleansing" through impregnation, or reward soldiers (e.g., Berman et al., 2006; Human Rights Watch, 2009). In addition, significant numbers of women and children are raped or sexually assaulted during immigration into the United States (Fernandez, 2019; Infante et al., 2012).

Physical Assault

Physical assault includes physical aggression, beatings, stabbings, shootings, and other violent action against either someone who is known to the assailant or a stranger, as well as physical bullying or other violent acts specifically perpetrated against minoritized individuals, including people identifying as LBGTQ+. The U.S. Department of Justice estimated that stranger assaults, alone, accounted for approximately 38 percent of all incidents of nonfatal violence in 2010 (Harrell, 2012).

Intimate partner violence (IPV). *IPV* can be defined as physical or sexual assault that occurs in an intimate relationship. IPV is often accompanied by emotional abuse and coercive control, potentially including humiliation, extreme criticism, and/or threats toward or violence against children, pets, and/or property (Black et al., 2010; Dichter et al., 2018). It is estimated that that over 23 percent of women and 13 percent of men experience severe physical violence by an intimate partner at some point in their lives, whereas 16 percent of women 7 percent of men experience sexual violence at the hands of a partner (Smith et al., 2017).

Stalking

Stalking refers to intentionally and repeatedly following or harassing another person in such a way that they feel intimidated or threatened. Examples of stalking also include leaving unwanted notes or phone messages; cyber-stalking via computer; and vandalizing someone's property. Approximately 8 percent of women and 2 percent of men in the United States report having been stalked by someone known or unknown to them, and 81 percent of women who were stalked by a former intimate partner were physically assaulted by that person and 31 percent were sexually assaulted (Tjaden & Thoennes, 1998).

Sex Trafficking, Prostitution, and Sex Work

Sex trafficking involves the forced or coerced recruitment, transportation, transfer, harboring, or receipt of individuals for the purposes of commercial sexual exploitation (The Protection Project, 2011). Approximately 15,000 to 18,000 people are trafficked into the United States each year for sex or forced labor (U.S. Department of State, 2005).

Prostitution. Prostitution involves the exchange of sex for money, drugs, or other valued things. By virtue of the vulnerability associated with repeated sexual contact with strangers, prostitution is a serious risk factor for physical or sexual assault, and death (Farley, 2004). Many prostituted people are also marginalized by race, poverty, sexual identity, and/or low education (e.g., Butler, 2016; Farley, 2004), have histories

of sexual abuse (e.g., McClanahan et al., 1999), and are addicted to drugs (e.g., Young et al., 2000). In many cases, they are also minors (Barnert et al., 2017).

Sex work. Some consider engaging in sex for money to be *sex work*, emphasizing the stigma, criminalization, and physical danger associated with commercial sexual behavior (Bell, 2009; Open Society, 2019). Although opinions in this area differ (see Benoit et al., 2018 versus Moran & Farley, 2018), when such sexual contact is not free of exploitation, coercion, or the person is a minor, the neutral term *sex work* may be ill-placed because it implies a voluntary, freely chosen occupation

Torture

The United Nations Convention Against Torture defines *torture* as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him [*sic*] or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or a third person" (United Nations Treaty Collection, 1984). At least 112 nations sanction or allow torture (Amnesty International, 2013), and the Center for Victims of Torture estimate that 44 percent of refugees in the United States are either torture survivors or family members or close intimates of survivors (Higson-Smith, 2015).

War

War has been a common and powerful source of trauma and enduring psychological disturbance throughout history. Combat involves a wide range of violent and traumatic experiences, including immediate threat of death, grievous physical injury, witnessing injury and/or death of others, not to mention injuring or killing people (e.g., Gahm et al., 2007). Those captured during war may additionally undergo torture, rape, and prisoner-of-war experiences. Although the Veterans' Administration (VA) provides care for many U.S. war veterans with service-connected injuries in the United States, it is not uncommon for veterans to present to non-VA mental health centers and clinicians. Because the treatment of war trauma can require specialized information, we recommend additional reading, for example, Committee on the Assessment of Ongoing Efforts in the Treatment of Posttraumatic Stress Disorder (Board on the Health of Select Populations, & Institute of Medicine, 2014; Moore & Penk [2019], and material available from the VA's National Center for PTSD [https://www.ptsd.va.gov/]).

Moral injury. *Moral injury* can be defined as perpetrating, witnessing, or hearing about events that transgress or challenge deeply held moral beliefs about fairness and goodness (Litz et al., 2009; Shay, 1995). Morally injurious acts during war can include killing others, committing atrocities, giving or following immoral orders, and engaging in violence against civilians (e.g., Callaway & Spates, 2016). Moral injury also occurs outside of war settings, for example when health care workers are forced to make difficult triage decisions in the face of limited resources or overwhelming demand (Williamson et al., 2021).

Living with war. Beyond combat trauma, war can directly impact the people indigenous to where it takes place. Studies indicate that living in a war-torn area or armed-conflict zone is associated with significant—and sometimes culture-specific—adverse outcomes for both children and noncombatant adults (El Baba & Colucci, 2018; Eytan et al., 2011).

Incarceration

Over 2 million people in 2019 were incarcerated in prisons, jail, and other criminal detention facilities in the United States (Carson, 2020). A disproportionate number have low socioeconomic status and are racialized minorities, especially Black and Latinx men (e.g., Bishop et al., 2020; Jaggi et al., 2016), and many report extensive trauma histories (e.g., Briere, Agee et al., 2016). Not only is incarceration, itself, often traumatizing, it is also not uncommon for inmates to experience sexual and/or physical assaults by other inmates or staff (e.g., Daquin et al., 2016).

Extended Homelessness

Homelessness involves not only the potential trauma of dislocation and of not having a safe place to stay, it also elevates the risk of physical and sexual assaults, loss or theft of personal possessions, and inadequate medical care (Bassuk et al., 2001;Wiewel & Hernandez, 2021). Many unhoused people also suffer from prior traumas (Grey et al., 2019), as well as ongoing racism and other forms of social marginalization and maltreatment (Fusaro et al., 2018).

Witnessing or Being Confronted With the Homicide or Suicide of Another Person

As described in the *DSM-5* criteria for PTSD and ASD, trauma can involve witnessing or learning about violent or accidental death or injury of another person, including exposure to the murder or suicide of a friend, family member, or partner. The Federal Bureau of Investigation (2010) estimates that there were over 14,000 homicides in the United States in 2010 alone. In many cases, multiple closely associated individuals (e.g., friends, spouses, parents, offspring) are affected by the crime, either by directly witnessing it or learning of it soon after it occurs. Similarly, witnessing or being confronted with death by suicide can be traumatic, particularly for children or youth exposed to suicide of a parent (Hung & Rabin, 2009), but also for friends, partners, or family members (e.g., Ogata et al., 2011).

Mass Causality Events

Traumatic events that occur on a large scale and involve multiple fatalities can have widespread psychological impacts on individuals in a specific community or geographic area. Some of these events can be interpersonal in nature, as is the case with a terrorist attack, or noninterpersonal in origin, for example a natural disaster.

Interpersonal violence. Intentional violence that involves multiple injuries or casualties—but does not occur in the context of war—is a newer category in the trauma field, although such events have existed throughout human history. Examples of recent mass interpersonal trauma in the United States include the 9/11/01 attacks on the World Trade Center and the Pentagon; the Las Vegas and Sandy Hook mass shootings in 2012 and 2017; and the shootings in Parkland, Florida, in 2018. There is an unfortunately large number of other examples, including terrorist attacks, school shootings, and human rights abuses in North America and throughout the world.

Natural disasters. Natural disasters are large-scale, not human-caused, potentially injurious or deadly environmental events that impact a significant number of people. Surveys indicate that between 13 and 30 percent of individuals have been exposed to at least one major earthquake, large fire, flood, severe storm (e.g., a hurricane or tornado), tsunami, or other major adverse natural event in their lifetimes (Briere & Elliott, 2000).

Large-scale transportation accidents. Transportation accidents involve events such as airplane crashes, train derailments, and maritime accidents often involve multiple victims and high fatality rates (Maeda & Higa, 2006). Although less common than most other major traumas, these events can nevertheless result in significant, sometimes lasting, psychological distress (Gouweloos et al., 2016; Lundin, 1995).

Fire and Burns

Even though large-scale fires are often considered to be disasters, many people have been burned by smaller fires, often caused by smoking in bed, electrical shorts, or malfunctioning stoves or heaters. In other cases, major burns arise from automobile accidents, fireworks, barbecue accidents, illegal drug manufacturing, or intentional burning by others. The American Burn Association (2016) reports that approximately 40,000 people are hospitalized for severe burns each year in the United States. The potential physical effects of serious burns can include extreme pain, a long recovery period, multiple surgeries (including amputations), and visible and/or painful scars.

Motor Vehicle Accidents

In 2020, at least 5 million police-reported traffic accidents occurred in the United States, over 42,000 of which involved fatalities (National Center for Statistics and Analysis, 2024). Accidents involving electrical bicycles have escalated over the last decade, with a concomitant rise in serious injuries and fatalities (U.S. Consumer Products Safety Commission, 2023, September).

Life-Threatening Medical Conditions

Many serious illnesses or medical issues (e.g., cancer or heart attacks), are no longer necessarily considered Criterion A-level traumas in *DSM-5*. This contrasts with *DSM-IV-TR*, which included any serious "threat to physical integrity" (APA, 2013, p. 274). Specifically, the *DSM-5* notes that "a life-threatening illness or debilitating medical

condition is not necessarily considered a traumatic event. Medical incidents that qualify as traumatic events involve sudden, catastrophic events" (p. 274). In our view, this narrowing of medical trauma criteria is potentially problematic, as it can inappropriately limit the extent to which PTSD or ASD can be applied to symptomatic people in severe (but not immediately catastrophic) medical contexts such as heart attacks, cancer, AIDS, severe burns, or a stroke, or as a result of medical procedures such as extensive surgery, amputations, or treatment in intensive care units.

Pregnancy Loss and Stillbirth

At least 12 to 20 percent of all pregnancies end in miscarriages (e.g., Jeve & Davies, 2014), and stillbirth is estimated to occur in one in 175 births (Hoyert & Gregory, 2023). These events can be traumatic for both the survivor and their partner (Due et al., 2017). Although some people affected by pregnancy loss appear to return to earlier levels of functioning within a year or two, recovery may be more extended for others (Janssen et al., 1997), especially those struggling with infertility or a history of previous miscarriages (Blackmore et al., 2011).

Emergency Worker Trauma

Because first responders and emergency workers often encounter fatal events, grotesque injury, and extreme victim distress, it is not surprising that those who help the traumatized can become traumatized themselves. In fact, the *DSM-5 trauma* definition includes reference to "experiencing repeated or extreme exposure to aversive details of the traumatic event(s)" (p. 271). Among those known to be at risk are firefighters, rescue workers, paramedics and other emergency medical personnel, individuals involved in the identification and handling of deceased trauma victims, emergency mental health workers, those whose occupation entails exposure to explicit details of child abuse or sexual violence, and law enforcement personnel (American Psychological Association, 2013; LaFauci & Marotta, 2011).

Social Discrimination and Maltreatment (SDM)

Exposure to racism, sexism, antisemitism, Islamophobia, cisheterosexism (anti-LGBQT+ behaviors), and other forms of social maltreatment can be traumatic for many (Brown, 2008; Mooney, 2017; Polanco-Roman et al., 2021). SDM is pervasive in the lives of many minoritized people, can include physical violence, and may lead to lasting posttraumatic symptoms and responses (Briere et al. 2024a; Nadal & Mendoza, 2014; Robinson & Rubin, 2016).

Micro- and macroaggressions. Microaggression refers to "comment(s) or action(s) that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group" (https://www.merriam-webster.com/dictionary). In other instances, the aggression is not "micro," subtle, or unconscious, including hate crimes, threats, stalking, bullying, and violence at the hands of authorities or others.

Historical trauma. Historical trauma involves collective maltreatment by a dominant culture of a specific group of people that extends over generations. Especially egregious examples in the United States include, but are not limited to, over two centuries of enslavement of Black people (e.g., Hannah-Jones, 2021); massacres, forced relocation, and near genocide of Native Americans (Brave Heart & DeBruyn, 1998); arrests, family separation, and deportation of Hispanic immigrants by U.S. authorities (e.g., Venta et al., 2024); antisemitism directed against Jewish people (e.g., Lipstadt, 2019); and the widespread internment of people of Asian descent during and after World War II (Brockell, 2021).

Gender and historical trauma. Women and girls have a long history of gender-based maltreatment, generally meeting the definition of historical trauma presented above. The tendency for women to report higher rates of depression, anxiety, suicide attempts, posttraumatic stress disorder, and eating disorders than men (American Psychiatric Association, 2017) has been linked to their experience of sexual trauma throughout the life span; gender-based discrimination in the workplace and social contexts; restrictions on career advancement; and adverse gender socialization (e.g., Haahr-Pedersen et al., 2020; Rees et al., 2011; Silove et al., 2017; Vigod & Rochon, 2020).

Combined and Cumulative Traumas

The intersection of different traumas and social adversities—and the symptoms and difficulties they cause over a given person's lifespan—can be complex. As noted earlier, child abuse and social maltreatment is associated with a greater likelihood of violent victimization and exposure to community violence and may produce symptoms and maladaptive behaviors in adolescence and adulthood that, in turn, increase the likelihood of additional interpersonal victimization. These later traumas may then lead to further behaviors and responses that are additional risk factors for new trauma and potentially even more complex mental health outcomes. Multiple traumas may not only lead to a range of diverse outcomes, they also can increase the likelihood of a stress disorder in response to a later trauma (e.g., Karam et al., 2014). In fact, despite the assumptions of previous *DSM*s, those exposed to a single trauma in their lives are relatively unlikely to develop PTSD as compared to those with a history of multiple traumas (Briere et al., 2016).

The specific role of accumulated traumas in the genesis of a stress disorder may involve one or more of several pathways:

- the cumulative effects of multiple traumas and adversities over time may summate to meet the criteria for a stress disorder, with the most proximal event serving as a "tipping point" for diagnosed PTSD or ASD (Briere, Dias et al., 2017),
- cumulative trauma may neurobiologically or psychologically sensitize the trauma survivor over time (Smith et al., 2007), leading to heightened

peritraumatic distress following a new trauma, thereby increasing the likelihood of a stress disorder, and/or

- prior traumas may have already produced a stress disorder, which is only identified when a new trauma exacerbates symptoms or causes the client to come to the attention of mental health or medical practitioners.

This mixture of multiple traumas, multiple risks, social maltreatment, and multiple symptomatic responses is well known to trauma-focused clinicians, who may find it difficult to connect certain symptoms to certain traumas, and other symptoms to other traumas, or, in fact, to discriminate trauma-related symptoms from less trauma-specific ones. Although this task is often daunting, the remaining chapters of this book describe assessment and treatment approaches that clarify these various trauma-symptom connections and, in some cases, provide alternative ways of approaching multitrauma-multisymptom presentations.

2 THE PSYCHOLOGICAL EFFECTS OF TRAUMA

John Briere, Catherine Scott, & Janelle Jones

This chapter is divided into two sections. The first discusses those individual, social, and trauma-specific variables most associated with the development of trauma-related symptoms in older adolescents and adults. These various contributors to posttraumatic outcomes are relevant to clinical practice because, as it turns out, any two people exposed to a similar trauma may respond in remarkably different ways—for example, one may present with only mild, transient symptoms, whereas the other may develop a full-blown stress disorder that endures for months or years.

Research indicates that only a minority of adults exposed to a Criterion A trauma go on to develop a posttraumatic stress disorder (Bisson et al., 2015)—the rest either are less affected or respond with other symptoms, such as depression or anxiety. The specific extent and type of symptom expression is associated with a range of variables or factors. In some cases, intervention aimed at these factors may lead to decreased posttraumatic responses and less risk for future disorders.

The second section of this chapter describes the major forms that posttraumatic symptomatology can take. Clinical outcomes include not only the three major trauma-specific disorders (acute stress disorder [ASD], posttraumatic stress disorder [PTSD], and brief psychotic disorder with marked stressor [BPDMS]), but also the dissociative disorders, adjustment disorder, and a number of other, more generic, responses or disorders.

WHAT MAKES TRAUMA RESPONSES MORE LIKELY, MORE INTENSE, OR MORE COMPLICATED?

The amount and type of posttraumatic symptomatology an individual experiences are a function of at least three domains: (1) variables specific to the survivor, (2) characteristics of the stressor, and (3) how those around the survivor respond to them.

Survivor Variables

Survivor variables refer to those aspects of the survivor that were in place before the relevant trauma but that nevertheless are associated with an increased likelihood of

posttraumatic difficulties. Many of these variables (e.g., gender, race, ethnicity, and sexual orientation) are risk factors largely because they are associated with social maltreatment and marginalization. Others may arise from earlier trauma or abuse, leading to psychological disturbance and problematic coping associated with revictimization. Major survivor-specific risk factors include the following:

- Female gender (e.g., Lehavot et al., 2018)
- Racial or sexual minority status, including identification as lesbian, gay, bisexual, transgender, queer, and other (LGBTQ+) (e.g., Littleton & DiLillo, 2021; Steenkamp et al., 2017)
- Living in poverty, low socioeconomic status, and housing insecurity (e.g., Hopper, 2010; Kim et al., 2010)
- Intergenerational oppression and marginalization (Mohatt et al., 2014)
- Refugee or immigration status (e.g., Bronstein et al., 2012)
- Dysfunctional coping styles (e.g., Karstoft et al., 2015)
- Previous trauma exposure (e.g., Karam et al., 2014)
- Dysregulated neurobiology (McFarlane et al., 2011)
- Genetic predisposition (Duncan et al., 2018)
- Peritraumatic or persistent distress or dissociation (e.g., Andrews et al., 2000; Nobakht et al., 2019)

Peritraumatic distress is a major predictor of risk for PTSD. In fact, in the prior *Diagnostic and Statistical Manual* (*DSM-IV-TR*), a stressful event was not considered to be traumatic unless the individual reported feelings of horror, fear, or helplessness at the time it happened or soon thereafter. Although this criterion (A2) no longer exists in *DSM-5*, peritraumatic distress is still considered an important risk factor, and is included in a separate symptom cluster in current PTSD criteria.

Other peritraumatic responses, such as anger, shame, and guilt at the time of the event, are also likely to increase the risk of posttraumatic reactions (Andrews et al., 2000). Although sometimes considered a trauma characteristic (as implied by the prior *DSM-IV*), peritraumatic distress (and peritraumatic dissociation) is probably as much a survivor variable as it is an index of trauma severity. Those who experience especially high levels of distress at the time of a trauma are more at risk for posttraumatic difficulties for a variety of reasons, including preexisting problems in stress tolerance and emotional regulation, prior trauma exposure, and a cognitive predisposition to view life events as outside of their control or as potential threats.

Characteristics of the Stressor

In addition to survivor variables, various trauma characteristics are associated with posttraumatic outcome. The most important of these include

- Interpersonal violence, as opposed to noninterpersonal events (e.g., Green et al., 1990)
- Life threat (e.g., DiGrande et al., 2010)
- In war,
  - the extent of direct combat exposure (e.g., Adams et al., 2016)—although see Kelley et al. (2021) for the effects of trauma exposure on remote intelligence, surveillance, and reconnaissance personnel
  - involvement in the killing others (e.g., Maguen et al., 2009)
  - exposure to moral injury (Shay, 1995)
- Witnessing death (e.g., Phillips et al., 2010)
- In cases of victimization, degree of relationship to the perpetrator (Goldsmith et al., 2012)
- Acutely life-threatening illness and especially painful medical events and procedures (Bienvenu & Neufeld, 2011)
- Unpredictability and uncontrollability (Carlson & Dalenberg, 2000)
- Sexual victimization (Kang et al., 2005)
- Traumas of greater duration, frequency, and/or complexity (Courtois, 2004)

The impact of these trauma characteristics on the development of posttraumatic stress is significant. Irrespective of survivor variables, certain traumatic events (e.g., rape) are known to produce a much greater likelihood of PTSD than others (e.g., natural disasters). Thus, just as it is erroneous to consider only trauma variables when attempting to predict posttraumatic stress in an individual, it is also a mistake to assume that posttraumatic reactions are solely due to individual or demographic variables.

The specific role of child maltreatment. Although many adult traumas are extreme in nature and can be associated with severe psychological outcomes, research suggests that, on average, childhood abuse and neglect is even more related to lasting psychosocial difficulties (see a review by Teicher et al., 2021). This is likely because childhood traumas occur at the most vulnerable point in human development, typically involve relational maltreatment by parents and other caregivers, tend to result in insecure attachment styles, and may continue over a long period of time, involving multiple, separate victimization experiences (Cook et al., 2005; Courtois, 2010).

As a result, child abuse and neglect can result not only in the disturbed mood, cognitive distortions, posttraumatic stress, and related symptoms sometimes found in survivors of adult traumas, but also the disturbed self-organization more specific to childhood victimization and disrupted parent–child attachment. These include problems with emotional regulation, identity disturbance, and in forming positive and lasting relationships with others (Bachem et al., 2021; Bigras et al., 2015; Briere & Rickards, 2007). Unfortunately, research indicates that not only is child maltreatment implicated in a range of serious psychological outcomes, but it is also associated with poorer response to both psychotherapy and psychiatric medication (e.g., Nemeroff et al., 2003).

Because, as noted earlier, childhood trauma and neglect are also risk factors for additional victimization in adolescence and adulthood, a significant proportion of child abuse survivors have experienced both earlier and later interpersonal violence, resulting in especially complex clinical outcomes (see Complex Posttraumatic Presentations, later in this chapter). This may involve not only the accumulation and summation of trauma effects over the life span (e.g., Briere et al., 2008; Ford & Courtois, 2020), but also instances when earlier trauma exacerbate subsequent responses to later trauma (Breslau et al., 2008). Thus, even though no one should discount the often-major effects of sexual assault, torture, or other violence committed against adults, it is important that these more recent traumas be evaluated and treated in the context of the client's earlier history of childhood maltreatment as well. As will be described in this and later chapters, these compound child–adult trauma effects may make treatment a more complicated endeavor, since a range of symptoms and problems may be present simultaneously, each potentially requiring different approaches and strategies.

Social Response, Support, and Resources

Psychological support from family members, friends, and others is known to reduce the severity of posttraumatic outcomes. Such support includes nonblaming, caring, and nurturing responses from loved ones, and the availability of helpers, peers, and support or aid agencies after a traumatic event (Godbout et al., 2014; Won et al., 2021). Social response to the survivor is not independent of trauma characteristics or survivor variables, however. Some traumatic events are often deemed more socially acceptable than others (e.g., the survivor of a hurricane or earthquake may be viewed as more innocent and worthy of compassion than a rape survivor), and certain trauma survivors (e.g., racial and gender minorities, undocumented immigrants, those who abuse drugs, and individuals experiencing commercial sexual exploitation) are more likely to receive prejudicial treatment than others (L.S. Brown & Pantalone, 2011; Chang & Singh, 2018). Above and beyond these complexities, most studies suggest that social support is one of the most powerful determinants of the ultimate effects of trauma. This fact highlights the social/relational aspect of trauma recovery, including, as we will see, the importance of the therapeutic relationship in trauma treatment.

TYPES OF POSTTRAUMATIC RESPONSE

As noted previously, potentially traumatic events vary in type and frequency, and their psychological effects are moderated by a host of survivor-specific and social/cultural variables. It is not surprising, therefore, that a wide range of symptoms and disorders have been associated with exposure to traumatic events. The most significant of these are described in the following pages.

Not all psychological impacts can be encompassed by a list of specific symptoms or disorders, however. Trauma can alter the very meaning we give to our lives and can produce feelings and experiences that are not easily categorized in diagnostic manuals. These more existential impacts can include a loss of meaning, a sense of being alone in the world, a realization of the fragility of life, loss of connection with one's spirituality or morality, and disruption in one's ability to hope, trust, or care about oneself or others (Drescher et al., 2011; Shay, 1995). For this reason, rarely will a diagnosis or set of psychological test results encompass the full breadth of trauma impacts.

TRAUMA- AND STRESSOR-RELATED DISORDERS

The hallmarks of extreme traumatization are often considered to be PTSD or ASD, each of which is categorized as a *trauma- and stressor-related disorder* in *DSM-5*—as opposed to their designations as anxiety disorders in *DSM-IV*. Although these responses represent only a subset of the symptoms that can arise from trauma, they are obviously quite prevalent among the trauma exposed. Also contained within this category are the adjustment disorders. An additional trauma response, albeit not included in *DSM-5*, is complex PTSD, described at the end of this chapter.

Posttraumatic Stress Disorder (PTSD)

PTSD is the best-known trauma-specific diagnosis in *DSM-5*. As presented in Table 2.1, its symptoms are divided into four clusters: (A) reexperiencing of the traumatic event; (B) avoidance of trauma-relevant stimuli; (C) numbing, negative cognitions and mood; and (D) hyperarousal and hyperreactivity. Typically, reexperiencing presents as flashbacks and intrusive thoughts and/or memories of the trauma, as well as distress and autonomic reactivity upon exposure to reminiscent stimuli. Avoidance symptoms may be cognitive, such as avoiding or suppressing upsetting thoughts, feelings, or memories, or involve effortful avoidance, for example avoiding people, places, activities, or conversations that might trigger memories of the trauma. Numbing and negative cognitions and mood include diminished interest, emotional detachment, psychogenic memory loss, as well as persistent negative beliefs and emotional states. Hyperarousal and hyperreactivity, on the other hand, may present as jumpiness (a lowered startle threshold), irritability, sleep disturbance, risky behavior, or problems with attention and concentration. The reexperiencing symptoms of PTSD are often the first

to fade over time, whereas avoidant and hyperarousal symptoms typically are more enduring (e.g., Abbas et al., 2009).

In contrast to ASD (described next), PTSD can only be diagnosed once 30 days have elapsed since the stressor. The symptoms do not have to appear within a certain time period after the trauma; the *DSM-5* has an option for "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)" (p. 272).

TABLE 2.1 ■ *DSM-5* Diagnostic Criteria for Posttraumatic Stress Disorder (for adults, adolescents, and children older than 6 years)

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 effect 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).

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.

(*Continued*)

TABLE 2.1 ■ *DSM-5* Diagnostic Criteria for Posttraumatic Stress Disorder (for adults, adolescents, and children older than 6 years) (*Continued*)

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 if:

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).

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As is noted more extensively later in this chapter, *DSM-5* acknowledges several associated features of PTSD that are especially prevalent following interpersonal victimization. These include cognitive distortions and more "personality disorder"—like difficulties in areas such as relatedness and emotional regulation. In addition, up to 80 percent of those with PTSD have at least one other psychological disorder (Kessler et al., 1995). Common comorbidities include major depression, substance abuse, suicidality, and the various anxiety disorders (e.g., Dorrington et al., 2014; Fox et al., 2020). For this reason, a detailed assessment for PTSD should consider these sequelae as well.

Acute Stress Disorder (ASD)

The diagnosis of acute stress disorder first appeared in *DSM-IV*. The primary function of this category was to recognize and codify those intrusive, avoidant (especially dissociative), and hyperarousal-related psychological reactions to a stressor that occur relatively immediately after the traumatic event has transpired, and to help identify those who will progress to later PTSD. In *DSM-5*, the relevant symptoms must last for at least 3 days but not exceed 4 weeks in duration.

ASD is similar to PTSD, except that it is diagnosed more acutely and there is no requirement that any given symptom cluster, *per se*, be represented in the client's distress; it is only necessary that a total of 9 or more out of 14 symptoms be present. Importantly, there is no one-to-one relationship between ASD and later PTSD. In *DSM-IV*, some individuals with severe acute responses, initially met criteria for ASD but failed to meet criteria for PTSD once 30 days had elapsed. Conversely, some individuals who did not meet criteria for *DSM-IV* ASD initially, often because they did not have dissociative symptoms, met criteria for PTSD at one-month posttrauma (Harvey & Bryant, 2002).

It is not yet clear whether the disjuncture between ASD and PTSD diagnoses ultimately will be as large in *DSM-5*, since ASD no longer prizes dissociation over other acute symptoms and PTSD now includes the possibility of depersonalization and/or derealization. An early comparison of the two sets of diagnostic criteria, however, found that *DSM-5* diagnostic criteria for ASD identified more ASD (14%) than did DSM-IV criteria (8%) (Bryant, Creamer et al., 2015). Similar proportions of people who were diagnosed with ASD went on to develop PTSD, irrespective of whether *DSM-IV* or *DSM-5* criteria were employed.

Some people diagnosed with acute stress reactions present with labile affect and psychomotor agitation or retardation, although these symptoms are not included in the *DSM-5* criteria. Psychotic or near-psychotic symptoms also may occur, especially when the stressor is severe, or the survivor is particularly vulnerable psychologically. When psychotic features are prominent, however, the appropriate diagnosis is usually *brief psychotic disorder with marked stressors*, as noted later in this chapter, or, if relevant, *major depression with psychotic features*.

Some have argued that there is insufficient evidence for the existence of *DSM-IV* ASD as a disorder separate from early PTSD, and that the dissociative symptoms emphasized by the earlier ASD diagnostic criterion set are not necessarily a regular part of early onset posttraumatic stress (Harvey & Bryant, 2002). Further, as noted in Chapter 12, some studies indicate that the dissociative components of *DSM-IV* ASD may be less powerful predictors of later PTSD than symptoms like early hypervigilance, sleep disturbance, and intrusive reexperiencing of the trauma (e.g., Dalgleish et al., 2008). For example, functional brain scans of survivors immediately following a trauma show that early amygdala hyperactivity, a correlate of hypervigilance, predicts the chronicity of PTSD symptoms up to a year later (Stevens et al. 2017).

Whether ASD is phenomenologically distinct from PTSD or not, it is a useful diagnosis for those suffering from severe symptoms immediately following a traumatic event. A major change in *DSM-5* ASD is to no longer require any given set of symptoms, including the overly restrictive dissociative ones emphasized in *DSM-IV*, thereby potentially increasing its applicability following acute trauma. Yet, a mere collection of symptoms that exceed a somewhat arbitrary threshold may reduce the validity of this criterion set. Since ASD may represent an early expression of PTSD

(Elklit & Brink, 2004), future DSMs may choose to settle on a common structure and diagnostic criteria for both diagnoses. In any event, just as *DSM-5* PTSD can be diagnosed with or without dissociative symptoms, future diagnostic criteria for ASD might benefit from a dissociation specifier, since some instances of ASD seem to involve considerably more dissociative symptoms than do others.

Adjustment Disorder (AD)

Newly relocated to the *trauma- and stressor-related disorder* section in *DSM-5* and found in the ICD-11 as one of the *disorders specifically associated with stress*, symptoms of AD involve unusually intense emotional or behavioral (but not normal bereavement) reactions that appear within 3 months of exposure to an adverse event. These symptoms are characterized by either marked distress that is out of proportion to what would be a "normal" response to the event or significant impairment in social, occupational, or other important areas of functioning (SAMHSA, 2016). Importantly, cultural and contextual factors must be considered before stressor-related symptoms can be considered sufficiently out of proportion to warrant an ASD diagnosis.

The AD diagnosis cannot be made if symptoms meet the criteria for another *DSM-5* disorder or involve an exacerbation of a preexisting disorder. Specified as *acute* (symptoms of less than 6 months duration) or *chronic* (symptoms that last 6 months or longer), the subtypes of adjustment disorder are

- *with depressed mood*
- *with anxiety*
- *with mixed anxiety and depressed mood*
- *with disturbance of conduct*
- *with mixed disturbance of emotions and conduct*
- *unspecified*

Adjustment disorders are not uncommon among those experiencing significant medical or mental health difficulties, as well as those who are unemployed or bereaved (O'Donnell et al., 2019). In study of hospitalized injury patients (O'Donnell et al., 2016), 19 percent were diagnosed with *DSM-5* AD at 3 months post-trauma versus 16% at 12 months, and PTSD symptoms were common at both points in time. These data suggest that AD may be well situated within the *trauma- and stressor-related disorder* category. Notably, O'Donnell et al. found that AD does not appear to be temporally stable, "with the majority of patients . . . at 12 months not having the diagnosis at 3 months, and two-thirds of those who had the disorder at 3 months no longer had the diagnosis at 12 months" (p. 1236).

DISORDERS AND SYMPTOMS TYPICALLY RELATED TO TRAUMA EXPOSURE

Dissociation

The *DSM-5* describes *dissociation* as "a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behavior" (p. 291). This response appears to involve a defensive alteration in normal consciousness that arises from reduced or altered access to one's thoughts, feelings, perceptions, and/or memories, often in response to a traumatic event, that is not attributable to an underlying medical disorder (Brand, 2023; Cardeña & Carlson, 2011; van der Hart et al., 2004).

The *DSM-5* lists three dissociative disorders, as well as the usual *DSM-5* residual disorders (in this case, *other specified dissociative disorder* and *unspecified dissociative disorder*):

1. *Depersonalization/derealization disorder,* involving persistent or recurring experiences of unreality or detachment from one's mind, self, or body, and/or from one's surroundings
2. *Dissociative amnesia*, consisting of psychogenic, clinically significant inability to recall autobiographic information (note that this diagnosis also includes the specifier *with dissociative fugue*, which was its own diagnosis in *DSM-IV*)
3. *Dissociative identity disorder (DID)*, involving the experience of having two or more personalities within oneself, with recurring memory "gaps" or episodes of amnesia. *DSM-5* also now includes culture-bound experiences of pathological possession as a potential DID criterion

Despite the range of dissociative symptoms, dissociative phenomena traditionally have been considered manifestations of a single underlying state, trait, or dimension whereby, for example, dissociative identity disorder or fugue states are considered to be a more severe dissociative response than, say, depersonalization (I. H. Bernstein et al., 2001; Dell, 2006). Other researchers note that dissociative symptoms tend to form a number of only moderately correlated clusters (Briere et al., 2005; Ross et al., 1991) that may each range in severity. These latter analyses suggest that *dissociation* may be a somewhat overly generalized term—the construct appears to refer to a cluster of diverse, phenomenologically distinct experiences that differ in form but ultimately may produce a similar outcome: mental avoidance of otherwise challenging or overwhelming emotional distress. From this perspective, it may not be sufficient merely to say that someone is dissociating, but also *how* they are doing so.

In most cases, dissociation is related to trauma (Brand, Dalenberg et al., 2018; Dalenberg et al., 2012). Among the events associated with this response are child abuse

(e.g., Dalenberg & Palesh, 2004), combat (e.g., Maguen et al., 2009), sexual and physical assaults (e.g., Elklit & Brink, 2004; Schalinski et al., 2011), and natural disasters (Koopman et al., 1996). This trauma–dissociation relationship probably explains the significant comorbidity between persistent dissociation and PTSD described earlier. However, one study suggests that, although most dissociative responses occur in those with a trauma history, the majority of those exposed to a trauma—in the absence of other risk factors—do not go on to report major dissociative symptomatology (Briere, 2013). Instead, for dissociation to occur, there may need to be (a) exposure to a highly aversive event or series of events, (b) associated peritraumatic distress, and (c) a relative inability to modulate that distress psychologically or neurobiologically.

Even though dissociation often can be linked to a trauma history, some dissociative responses appear to be associated with childhood neglect experiences and/or early insecure parent–child attachment. Especially associated with dissociation may be the individual's early *disorganized* attachment to caregivers, involving chaotic, shifting, and intrusive responses to grossly confusing, fear-inducing, and/or painful parental behaviors, which may persist into the long term (Brand et al., 2022; Briere, Runtz et al., 2019; Mayrand et al., 2024). Although such data might suggest that some dissociative symptomatology is not necessarily trauma related, insecure attachment is often a posttraumatic response, as witness *DSM-5*'s inclusion of attachment disorders in the *trauma- and stressor-related disorder* category. Attachment disturbance often arises from abusive events that occurred very early in the child's life (and that are therefore unavailable to later explicit recall), or neglect, loss, or disattunement of such severity that it was terror-inducing, painful, and developmentally disruptive (Ensink et al., 2020; Godbout et al., 2019). From this perspective, insecure attachment often may be a marker for early, unreportable abuse, loss, or severe neglect rather than an independent etiology.

Distress Reduction Behaviors (DRBs)

Not uncommon among those exposed to childhood maltreatment and attachment disturbance are a range of seemingly risky or dysfunctional, but persistent behaviors, including but not limited to the following:

- Deliberate nonsuicidal self-injury (e.g., Briere & Eadie, 2016)
- Compulsive or risky sexual behavior (e.g., Vaillancourt-Morel et al., 2016)
- Binge eating and purging (e.g., Rosenbaum & White, 2013)
- Reactive aggression (e.g., Ford et al., 2012)
- Triggered suicidal behavior (e.g., Briere, Kwon et al., 2019)
- Compulsive stealing (e.g., Caputo, 2009)

Regular involvement in DRBs often has been viewed as evidence of a psychological disorder—especially borderline personality disorder (discussed later in this chapter)

but also, in some cases, an impulse control disorder or behavioral addiction (American Psychiatric Association [APA], 2013). While not entirely dismissing these possibilities, we suggest that such responses may be understood phenomenologically as *distress reduction behaviors* (DRBs[1]). DRBs are thought to reflect attempts to distract, neutralize, numb, counteract, or otherwise avoid distress associated with triggered abuse or attachment memories, generally in the context of insufficient emotional regulation capacities (Briere, 2019). Slightly diverging from some approaches to behavioral avoidance (e.g., Hayes et al., 2011), this perspective is more specifically focused on insecure attachment and trauma exposure, suggesting that such behaviors typically arise when upsetting childhood memories (including preverbal schema involving early attachment insecurity) are triggered by current reminiscent stimuli which, in the absence of sufficient emotional regulation skills, are overwhelming and motivate behavioral avoidance. Supporting this perspective, each of the DRBs listed above have been associated with antecedent childhood abuse or neglect, attachment disturbance, and/or emotional dysregulation (Briere, 2019).

Although there is little research known to the authors on potential mediators of triggerability, clinical experience suggests that people are more likely to respond to a trigger with one or more DRBs if they are already challenged by other dysregulating events or processes, such as relational conflict, stress, substance abuse, new traumas, or physical issues such as insufficient sleep, hunger, illness, or pain. For this reason, as described in Chapters 4 and 8, interventions to decrease or eliminate DRBs often include immediate stabilization and stress reduction.

DRBs are thought to provide one or more of the following psychological functions (e.g., Briere, 2019; Klonsky, 2007; Yates, 2004 2004):

- Distraction from painful internal states
- Self-soothing
- Reduction of unwanted numbing or dissociation
- Distress-incompatible experiences
- Momentary interpersonal connection
- Self-punishment as a way to reduce guilt or shame
- Communication of emotional distress in the face of social disconnection
- An increased sense of control

Traumatic Brain Injury (TBI)

As clinicians and researchers have developed increasingly sensitive assessments of central nervous system functioning, and as modern medicine's ability to preserve life following severe injuries improves, the rates of TBI identified in trauma survivors have escalated. It is estimated that between 1.5 and 2 million Americans yearly suffer the effects of a traumatic

brain injury (e.g., Kim et al., 2007), primarily from falls, violence, and motor vehicle accidents (Faul et al., 2010). TBI is also prevalent among those in combat; in one study, 17 percent of over one thousand post-9/11 war veterans met criteria for TBI (Linquist et al., 2017).

Research has especially focused on mild TBI (mTBI)—typically defined as involving less than 30 minutes of loss of consciousness following the trauma, amnesia of 24 hours or less, and an initial Glasgow Coma Score (GCS) of 13–15[2] (American Congress of Rehabilitation Medicine, 1993). This is because, counter to what one might expect, mTBI has a greater association with PTSD, especially reexperiencing symptoms, than does moderate or severe TBI (Zatzick et al., 2010). Although the reasons for this finding are not entirely understood, more severe TBI is associated with greater brain damage and, consequently, more amnesia. As a result, the memory encoding and consolidation that otherwise might lead to PTSD may be interrupted.

Neurological Symptoms

The neurological effects of TBI often overlap with its psychological effects. Brain injury effects include reduced energy and motivation, poor attention and concentration, memory impairment, irritability, impulsivity, mood disturbance, and personality changes (e.g., McInnes et al., 2017; Vasterling et al., 2018). Sleep problems are especially common after head trauma, with almost half of TBI patients meeting criteria for either sleep apnea, posttraumatic hypersomnia, narcolepsy, or periodic limb movement disorder (Castriotta & Murthy, 2011).

Psychological Symptoms

Neurological injury and disability can produce sustained helplessness and hopelessness, anxiety, decreased functioning at work, relationship problems, and aggression (Gould et al., 2011; Silver & Nedelec, 2020). TBI and PTSD are frequently both present in head trauma survivors, often producing more complicated and extended clinical presentations (Vasterling et al., 2018). As a result, it is often difficult to separate the neurological and psychological effects of physically traumatic injury in a given client, leading to potential misdiagnosis in either direction.

GENERIC SYMPTOMS SOMETIMES ASSOCIATED WITH TRAUMA EXPOSURE

Depression

Exposure to traumatic events can produce a range of depressive symptoms. When posttraumatic and depressive symptoms arise concomitantly, survivors may report themes of loss, abandonment, and isolation. The comorbidity between posttraumatic stress, grief, and depression (Kersting et al., 2009; O'Connor et al., 2010), and the associated

risk of suicidality (Briere, 2019) highlights the importance of assessing for depression when working with trauma survivors.

Major Depression

Those who have been exposed to a major trauma are at risk of developing major depressive disorder; in fact, depression is one of the most common comorbid disorders for PTSD (e.g., El Baba & Colucci, 2018). Some symptoms of depression (e.g., insomnia, psychomotor agitation, loss of interest in formerly enjoyable events, and concentration problems) overlap with symptoms of PTSD (Gros et al., 2010). Significantly, some trauma survivors presenting with depressed mood do not initially report a history of trauma exposure. When depression is a significant component of an individual's posttraumatic picture, pharmacotherapy may be indicated in addition to psychotherapy (see Chapter 15), and specific treatment approaches may be more effective, for example, interpersonal therapy (IPT; Weissman et al., 2017).

Major depressive disorder with psychotic features (APA, 2013). Depression with psychotic features generally involves the copresence of both a relatively severe depressive episode and delusions and/or hallucinations. This confluence may be understandable since trauma is known to be associated with psychosis as well as with depression (Hardy, 2017; Schäfer & Fisher, 2011), and those diagnosed with major depression with psychotic features are more likely than others to report posttraumatic stress and PTSD (e.g., Franklin & Zimmerman, 2001).

The elevated risk of PTSD in those with psychotic depression may be explained in several ways:

- Major trauma can produce both psychosis and depression, such that some individuals present with both sets of symptoms simultaneously.
- Those with a predisposition to psychotic depression may be at risk for PTSD by virtue of a decreased capacity to downregulate stress.
- Some of the "psychotic" symptoms in those PTSD sufferers with comorbid depression in some cases represent severe intrusive or avoidant symptomatology associated with posttraumatic stress.

Complicated or Traumatic Grief

Grief is a normal human response that, in most instances, resolves naturally over time. Especially since the attacks on the World Trade Center in New York, clinicians and researchers have increasingly focused on posttraumatic grief or bereavement arising from the sudden, unexpected death of loved ones. When the stressor involves the traumatic death of a loved one or major loss in one's life, it may lead to grief responses that are more complicated, enduring, and associated with lasting mental health problems,

including depression, anxiety, PTSD, decreased social functioning, and substance abuse, as well as, in some cases, serious physical illness (Shear & Smith-Caroff, 2002; Kersting et al., 2009; O'Connor et al., 2010).

Prolonged grief disorder. The initial *DSM-5* approach to prolonged grief overlooked research suggesting that extended grief responses differ in significant ways from depression that arises from other etiologies (Boelen, 2021; Prigerson et al., 1999). In response, the *DSM-5-TR* (text revision; APA, 2022) introduced a new diagnosis, *prolonged grief disorder* (PGD), which discriminates extended grief from both depression and posttraumatic stress. Because a PGD diagnosis can only be made after a year of symptoms, and the diagnostic criteria are not focused on trauma, per se, it is less relevant to more acute grief responses.

Anxiety

Because trauma involves the experience of danger and vulnerability, posttraumatic outcomes often involve symptoms of anxiety. Such responses can be divided into three clusters: generalized anxiety, panic attacks, and posttraumatic phobias.

Generalized anxiety. Generalized anxiety disorder (GAD), which includes excessive anxiety and worry, concentration problems, irritability, and a variety of physical symptoms associated with autonomic arousal such as fatigue and muscle tension, is both a risk factor for developing posttraumatic stress in response to a trauma (Koenen et al., 2002) and a syndrome that may follow trauma exposure (Ayazi et al., 2014). Because GAD is not always trauma related, however, its presence does not necessarily mean that trauma is part of the underlying etiology. In traumatized individuals, however, such nonspecific anxiety often reflects the impact of threatening events and should be addressed in any comprehensive trauma therapy.

Panic. Historically, panic attacks (usually lasting from minutes to an hour, and characterized by symptoms such as overwhelming fear, palpitations, shortness of breath, sweating, cold extremities, and feelings of impending doom) and panic disorder have not been viewed as especially trauma-related phenomena. Yet, panic attacks can arise from especially stressful events and major losses, and many trauma survivors report episodes of panic (Cougle et al., 2010). In some cases, PTSD is associated with panic attacks, even when such attacks are not obviously attributable to trauma-related triggers.

Phobic anxiety. Most descriptions of phobia tend to stress conditioned fear responses to stimuli associated with prior adverse events, although some also note genetic aspects of phobia development (e.g., Kendler et al., 2002). Many of the avoidant symptoms of PTSD and ASD are implicitly phobic, involving efforts to avoid people, places, and situations that are reminiscent of a given trauma, primarily because painful emotions have become associated with those stimuli. Probably as a result, phobias have been found to be comorbid with posttraumatic stress (Carleton et al., 2011) and to be more prevalent among trauma survivors (e.g., Cougle et al., 2010).

Physical/Medical Symptoms and Related Psychological Disorders

Those exposed to interpersonal traumas are at risk for a range of health problems and symptoms (e.g., Cubbin et al., 2019; Eadie et al., 2008). The relationship between trauma exposure and physical symptomatology is often separated into two domains: physical disorders associated with the physiological impacts of trauma and physical symptoms thought to represent the psychological impacts of trauma.

In the former instance, somatic complaints may reflect underlying illness, immune disturbance, autonomic hyperarousal, and, in some cases, physiologic sensitivity to bodily distress associated with trauma (Paras et al., 2009; Videlock et al., 2009). PTSD sufferers, in particular, are more likely to experience back pain, hypertension, arthritis, lung disease, nervous system diseases, circulatory disease, cancer, stroke, seizures, digestive disorders, chronic pain, and endocrine disorders (Abouzeid et al., 2011; Myers et al., 2019).

In other cases, physical symptoms that are thought to arise from—or be complicated by—trauma-related psychological responses are referred to as *somatization*. However, the boundary between the solely physical effects of trauma and those thought to be mediated by psychological factors can be unclear or even misleading. Although somatization is a real issue for some trauma survivors, those with psychologically related physical complaints also can present with verifiable medical problems (Kendall-Tackett, 2009). For this reason, trauma survivors with significant medical concerns should be referred for a detailed medical work-up to rule out organic illness, as opposed to the clinician interpreting expressed somatic distress as solely psychological in nature.

Somatic symptom disorder (SSD). When individuals report significant and distressing somatic symptoms, but psychological issues are also contributory, a diagnosis of somatic symptom disorder is often applied. As described by the American Psychiatric Association (2022; https://www.psychiatry.org/patients-families/somatic-symptom-disorder/what-is-somatic-symptom-disorder), this disorder is diagnosed "when a person has a significant focus on physical symptoms, such as pain, weakness or shortness of breath, to a level that results in major distress and/or problems functioning . . . The physical symptoms may or may not be associated with a diagnosed medical condition." The severity of SSD depends on whether there are a wide variety of physical symptoms (in the *severe* form) or just one or two (*mild* or *moderate* forms, respectively). Although it can have multiple etiologies, SSD symptoms appear more prevalent among those exposed to child abuse and later trauma in several studies (e.g., Kealy et al., 2018; Morina et al., 2018).

Functional neurological symptom disorder (FNSD). *Often referred to as conversion* in the clinical literature, FNSD is defined as "symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition, but evidence reveals significant incompatibility with a recognized medical

disorder" (APA, 2013, p. 318). FNSD include at least partially psychogenic symptoms such as paralysis, loss of ability to speak, abnormal movements, deafness, weakness, blindness, and seizures. Conversion disorder was initially linked to guilt and conflict in the early psychoanalytic literature (Akagi & House, 2002). However, most empirically based analyses suggest stress and trauma factors. Traumas often implicated in FNSD include child abuse (e.g., Hailes et al., 2019), combat (e.g., van der Hart et al., 2001), and torture (e.g., Van Ommeren et al., 2001).

Problematic Substance Use

Substance use is relatively common among those exposed to traumatic events, perhaps especially those who have experienced interpersonal violence (Hedtke et al., 2008). Further, those with substance use problems are more likely than many other people to report symptoms of PTSD (e.g., Ullman et al., 2013). The comorbidity of trauma, PTSD, and substance use is widely discussed in both the substance abuse and trauma fields, primarily because such comorbidity can complicate assessment and interfere with treatment (Najavits, 2002).

There are at least three major reasons for the comorbidity between trauma, PTSD, and substance use. Substance use may (1) serve as a way to self-medicate posttraumatic distress; (2) increase vulnerability to victimization and trauma exposure; and (3) contribute, itself, to greater symptomatology (Briere, 2019; P. J. Brown & Wolfe, 1994). Chilcoat and Breslau (1998) found that individuals with PTSD were four times more likely to excessively use alcohol or drugs than those without PTSD (irrespective of trauma history), whereas substance use was not a predictor of subsequent trauma exposure or PTSD. On the other hand, some studies do suggest that major substance use increases the likelihood of interpersonal victimization (e.g., Logan et al., 2002), and exposure to other traumas, for example automobile accidents (Ursano et al., 1999). In fact, this research and clinical experience with substance-using survivors suggests a vicious circle:

- Child abuse and later traumas in adulthood may lead to posttraumatic stress and dysphoria and interfere with the development of emotional regulation skills.
- Posttraumatic stress and insufficiently modulated distress may motivate the use of drugs and alcohol that either numb, distract, or produce distress-incompatible euphoria.
- Drug and alcohol use can lead to decreased environmental awareness and involvement in risky behaviors.
- This lack of awareness may increase the likelihood of additional trauma and posttraumatic distress, potentially leading to more substance abuse.

Sexual Problems

Childhood sexual abuse, but also physical abuse, adult sexual assault, and combat are commonly associated with sexual difficulties in women and men. A review of the literature suggests there are likely multiple reasons for diminished or absent sexual interest, sexual anxiety, sexual dysfunction (including erectile dysfunction in men), painful sex, and involvement in risky sexual behavior. As described in the literature (e.g., Bentsen et al., 2015; Bigras et al., 2017; O'Loughlin & Brotto, 2020; Vaillancourt-Morel et al., 2015), these likely include

- Direct conditioning of sexual stimuli to danger and pain following sexual abuse or assault
- The development of abuse-related sexual compulsively as a way to distract from and reduce distress
- Negative responses to intimate relationships or connections based on prior victimization experiences in parental or partner relationships
- Abuse-related depression
- The effects of trauma-related dissociation on sexual arousal
- The impacts of childhood sexual abuse on survivors' relational functioning and self-esteem

Psychosis

Although not common in less severe or complex trauma populations, psychotic symptoms (typically hallucinations, delusions, loosened mental associations, and some instances of catatonic behavior) may follow exposure to an overwhelmingly traumatic event (Hardy & Mueser, 2017). It has been estimated that 30 to 40 percent of treatment-seeking Vietnam combat veterans with PTSD experience at least some hallucinations and/or delusions (David et al., 1999), and psychotic symptoms have been documented among assault survivors (Kilcommons et al., 2008) and those with histories of child abuse (Bebbington et al., 2011). The presence of childhood trauma is associated with more severe and varied psychotic symptoms as well as more disturbed behavior (Álvarez et al., 2011). In some cases, the type of trauma a person experiences may affect the content of their psychotic delusions and hallucinations (Bentall et al., 2012). In *DSM-5,* there is one psychotic disorder (BPDMS) and one mood disorder (major depressive disorder with psychotic features, described earlier) that have been associated with trauma and PTSD.

Brief psychotic disorder with marked stressor(s) (BPDMS). A *DSM-5* diagnosis of BPDMS requires at least one of four psychotic symptoms: delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior. *DSM-5* lists suicide

attempts as an associated feature and notes that those with this disorder may require close supervision. The duration of BPDMS ranges from 1 day to less than 1 month, although, as noted below, this time frame is somewhat questionable. Traumas linked to BPDMS include severe accidents, major losses, assaults, homelessness, and disasters (APA, 2013) and recently, the stress of COVID-19 (Valdez-Florido et al., 2022).

Importantly, not all psychotic episode that follows a traumatic stressor are, in fact, BPDMS. As noted in the prior *DSM-IV*, in some cases the psychosis may be trauma related but persists for several months or longer (APA, 2000, p. 331). Because these symptoms exceed the somewhat arbitrary 1-month limit required by *DSM-5*, they cannot be diagnosed as BPDMS—regardless of how trauma related they appear. In other instances, apparent psychotic responses to a stressor may represent the trauma-related activation of a latent predisposition toward psychosis, or the acute exacerbation of an already existing—but previously undetected—psychotic process It also is not uncommon for a severe trauma to produce or trigger depression with psychotic features—a diagnosis that takes precedence over BPDMS. As noted above, some chronic psychotic states are associated, at least in part, with childhood traumatic events, suggesting, again, that not all trauma-related psychosis is necessarily brief.

Some cases of severe posttraumatic stress may include psychotic symptoms (e.g., paranoid ideation, looseness of thought, or hallucinations) in the context of a more prominent ASD or PTSD presentation (Compean & Hamner, 2019). In such cases, BPDMS may not be a diagnostic option, since the 1-month period may have passed. Finally, although less common, there are reports of psychotic symptoms (e.g., vivid upsetting hallucinations) resulting in posttraumatic stress (e.g., Berry et al., 2013), suggesting that comorbid psychotic and posttraumatic symptomatology should be evaluated in terms of their relative chronology.

Trauma and schizophrenia. Although psychotic symptoms have been associated with trauma exposure, generally it has been assumed that the most common psychotic disorder, schizophrenia, does not have a significant trauma etiology. Instead, this disorder is often viewed as arising from genetic factors, with elevated rates found among identical twins and siblings whose parents suffer from schizophrenia (see a review by Sullivan, 2005).

In contrast to some models of schizophrenia, however, recent studies and analyses implicate trauma, especially severe childhood abuse (see a review by Popovic et al., 2019). In a meta-analysis of 20 studies examining the relationship between a diagnosis of schizophrenia and a reported history of childhood abuse, C. Morgan and Fisher (2007) reported that 50 percent of people suffering from schizophrenia, across gender, had histories of sexual or physical abuse.

Such studies do not demonstrate that schizophrenia necessarily arises directly from childhood trauma exposure, however. Some "hallucinations" identified in trauma survivors may actually reflect posttraumatic flashbacks, some "delusions" may, instead, involve trauma-based cognitive distortions and hypervigilance, and some of what

appear to be the negative signs of schizophrenia may reflect numbing or posttraumatic dissociation (see Chapter 3). Despite such potential misclassification, however, the neural diathesis-stress model of schizophrenia (Jones & Fernyhough, 2007) suggests that at least some individuals who ultimately develop schizophrenic symptoms do so because a genetic predisposition to psychosis is triggered by the stress effects of childhood trauma. The link between childhood abuse and a later diagnosis of schizophrenia may also reflect, in part, a neurodevelopmental interaction between the biology of posttraumatic stress (e.g., alterations in the hypothalamic-pituitary-adrenergic [HPA] axis, prefrontal and amygdaloid areas, and, more generally, the dopaminergic circuitry of the brain) and the presumed biological substrates of schizophrenia (Popovic et al., 2019; Read et al., 2001).

TRAUMA SYNDROMES IN NON-WESTERN CULTURES

As noted in this book, posttraumatic responses are influenced by a variety of individual, social, and environmental variables. People from different cultures or subcultures often experience trauma and express posttraumatic symptoms in ways that diverge from mainstream Western society (Kirmayer et al., 2010; Marsella et al., 1996). For example, it appears that individuals from non–Anglo-Saxon cultures "often fail to meet PTSD diagnostic criteria because they lack avoidant/numbing symptoms despite the presence of reexperiencing and arousal symptoms" (Marsella et al., 1996, p. 533). Further, in some cultures classic PTSD symptoms are accompanied by more somatic and dissociative symptoms than typically are found in North American groups (Marsella et al., 1996).

Cultural influences do not necessarily override or replace the etiologies described above. Instead, any given culturally variable symptom may represent "an index of disease or disorder, an indication of psychopathology, a symbolic condensation of intrapsychic conflict, a culturally coded expression of distress, a medium for expressing social discontent, and a mechanism through which patients attempt to reposition themselves within their local worlds" (Kirmayer & Young, 1998, p. 420).

Growing clinical awareness that not all posttraumatic stress responses are captured by the PTSD diagnosis, perhaps especially in some non-Anglo/European cultures, has led to the concept of *culture-bound* stress responses (Yamada & Marsella, 2013). It should be noted, however, that PTSD itself, is likely to be at least partially culture bound, since it likely best describes the posttraumatic symptomatology of those born or raised in Anglo/European countries (Marsella, 2010). *DSM-5* Appendix 3 (Cultural Concepts) lists several relatively culture-specific syndromes that involve what Western clinicians would consider to be potentially trauma-related dissociation, somatization, and/or anxiety responses, including *attaques de nervios, nervios, dhat, latah, pibloktoq, shin-byung*, and *susto.* Although sometimes overlooked as a diagnostic option, *DSM-5*

now allows the coding of culture-bound stress disorders under the rubric of *other specified trauma- and stressor-related disorder.*

The variation in the psychological impacts of trauma does not mean that individuals from other societies or cultures do not ever develop PTSD; symptoms of PTSD can be found among traumatized people to some extent regardless of culture or geographic locale (Wilson & Tang, 2007). Rather, the existing literature suggests that cultural variables can impact trauma perception and responses, and thus clinicians should be vigilant to the possibility of trauma syndromes above and beyond classic ASD, PTSD, or adjustment disorder when clients originate from other cultures or subcultures

COMPLEX POSTTRAUMATIC PRESENTATIONS

Complex Posttraumatic Stress Disorder

Complex posttraumatic stress disorder, C-PTSD, (Herman, 1992a) is frequently described in the modern trauma literature. Although not a *DSM-5* disorder, this diagnosis appears in the 11th edition of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11) (Karatzias et al., 2017; World Health Organization, 2019). C-PTSD often arises from early, severe, prolonged, and repeated traumas and adversities whose effects sustain into the long term (Ford & Courtois, 2020; Herman, 1992b). Reflecting its largely childhood etiology, including disrupted parent–child attachment (Godbout et al., 2019; Ford, 2021a), C-PTSD often includes somatic and dissociative symptoms, as well as disturbances in self-organization, including identity, boundary awareness, interpersonal functioning, emotional regulation, and avoidance responses (Bachem et al., 2021; Briere & Scott, 2015). These problems, in turn, may lead to a tendency to be involved in chaotic and maladaptive relationships and difficulties negotiating interpersonal boundaries (Briere & Runtz, 2002; Cloitre et al., 2014).

Most researchers and clinicians concur that C-PTSD is a valid and discrete disorder that is an appropriate addition to future *DSM*s (e.g., Ford & Courtois, 2021; Cyr et al., 2021). Although we challenged this notion to some extent in earlier editions of this text and elsewhere, current psychometric research is increasingly persuasive that C-PTSD represents, in fact, a real disorder, albeit one whose internal structure may vary significantly as a function of neurobiology; age of onset, type, and duration of trauma; early attachment disruption; sociocultural factors; and other variables described at the outset of this chapter.

Borderline Personality Disorder (BPD)

DSM-5 describes BPD as a chronic disturbance in which there is "a pervasive pattern of instability of interpersonal relationship, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts" (APA, 2013, p. 663). Per *DSM-5*, the symptoms of BPD are wide-ranging, and include

- Attempts to avoid perceived abandonment by others
- Unstable interpersonal relationships
- Identity disturbance
- Potentially self-endangering impulsivity
- Suicidality or self-injurious behavior
- Emotional instability
- Feelings of emptiness
- Inappropriate, intense anger
- Episodes of stress-related dissociation and, occasionally, psychotic symptomatology

Although there are several potential issues associated with this diagnosis, we include it here because—as will be seen—it is often linked to severe childhood maltreatment and attachment disturbance.

Borderline personality disorder was so named because it was thought to represent the borderline between neurosis and psychosis (Stern, 1938). Since then, the diagnosis, its presumed etiology, and its defining symptoms have gone through many iterations. Most prominently, theorists in the 1970s (e.g., Mahler et al., 1975) held that the etiology of BPD was rooted in dysfunctional maternal behavior in the first several years of the child's life. For example, it was posited that the soon-to-be-borderline child was rewarded for enmeshed dependency and punished—often through rejection or abandonment—for attempts to separate and individuate from the typically borderline mother (Mahler et al., 1975). The result was thought to be a nonspecific ego weakness in which there was significant reality distortion, immature defenses, and primitive or disorganized mental representations of self and others.

Although some clinicians adhere to versions of this view, research provides little support for early maternal punishment of autonomy in the genesis of this symptom pattern. Instead, most modern perspectives link BPD to severe and extended childhood abuse, neglect, and disattunement, and associated insecure attachment (e.g., Hailes et al., 2019; van Dijke et al., 2012). Also implicated is the neurobiological dysregulation frequently associated with trauma exposure, including in the hippocampus, frontal cortex, amygdala, and, more broadly, the hypothalamic-pituitary-adrenal (HPA) axis (Carrasco et al., Chapman & Gratz, 2007; Driessen et al, 2000).

As an example of the potential complexity of BPD, as well as its multivariate etiology, a structural equation model analysis (Godbout et al., 2018) found that childhood trauma and attachment predictors of BPD symptoms varied as a function of the attachment style and gender of the participants and that of their abusive or neglectful parents. Further, in women, child maltreatment by both mothers and fathers was directly

associated with borderline symptoms, whereas, in men, only maltreatment by fathers was so related. Finally, in women maltreatment by *fathers* was indirectly associated with symptoms via insecure attachment, whereas, in men, maltreatment by *mothers* indirectly predicted symptoms of BPD via insecure attachment.

Ultimately, the construct validity of BPD as a unitary phenomenon is subject to considerable methodological and theoretical debate (e.g., Lewis & Grenyer, 2009; New et al., 2008), with some questioning whether it represents a specific, unique disorder. For example, some researchers and clinicians suggest that what is referred to as BPD is a heterogeneous collection of symptoms and problems that vary according to a wide range of factors and that overlap with several other disorders—including those related to trauma and attachment disturbance (Briere & Scott, 2015; Kulkarni, 2017).

Further, there is an active debate about whether BPD is better viewed as complex PTSD, as described earlier. However, multivariate analyses (e.g., Cyr et al., 2021; Cloitre et al., 2014) suggest that BPD and complex PTSD are both correlated with trauma exposure but are likely different, albeit overlapping, phenomena (see a review by Ford & Courtois, 2021). Such findings suggest that BPD may represent a "real" entity, albeit not necessarily the one that earlier clinicians described.

In this vein, we approach BPD in this volume as a broad, multidimensional phenomenon that involves identity problems, emotional dysregulation (with associated DRBs), and interpersonal dysfunction, that has not been adequately characterized to date, and that—like complex PTSD—is variously related to gender, child abuse, psychological neglect, parental disattunement or disengagement, insecure attachment, and altered neurobiology. Importantly, the presence of DRBs like self-injury or compulsive behavior should not be seen as indicative of BPD in any given case; most who engage in such behaviors do not meet diagnostic criteria for BPD, and not all people diagnosed with BPD are equally prone to DRBs (Briere, 2019).