Beyond PTSD

An Evolving Relationship Between Trauma Theory and Family Violence Research

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During the past 20 years, we have learned how similarly harmful are experiences of terror, violence, and abuse, whether they occur on the combat field or at home. The field of family violence has gained much from the field of traumatic stress, and collaborations between these two previously separate fields have yielded important new answers, as well as new research questions. The field of traumatic stress is poised to integrate, more fully than in the past, a variety of aspects of trauma such as social betrayal, as well as outcomes of trauma such as depression, criminality, and physiological harm that go beyond posttraumatic stress. The field of family violence has much to offer in this process. We look forward to improved research designs that will further our knowledge of how trauma affects aspects of people's lives, including productivity, relationships, cognition, and emotions, in negative and positive ways.

Keywords: *trauma; family violence; betrayal*

WHAT IS THE MOST IMPORTANT THING WE HAVE LEARNED ABOUT VIOLENCE AND TRAUMA IN THE PAST 20 YEARS?

By the early 1980s, researchers and advocates had made great strides toward exposing the scope of the problem of family violence in this country. By this time, the National Center for Child Abuse and Neglect and the National Center for the Prevention and Control of Rape had been formed. The high prevalence of physical and sexual abuse within families was becoming widely understood for the first time (e.g., Finkelhor, 1980;

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Hanneke, Shields, & McCall, 1986; K. A. Miller & Miller, 1983; Russell, 1983).

Feminist researchers and advocates, in addition to exposing the high prevalence of sexual abuse and rape in the United States, were beginning to describe the effects of rape and other forms of abuse on women. The battered woman syndrome characterized for the first time the trauma symptoms of women in battered women's shelters (Walker, 1983). As understanding of posttraumatic stress disorder (PTSD) among Vietnam veterans grew, it was becoming clear that women exposed to violence and terror in their homes responded in much the same as Vietnam veterans exposed to the violence and terror of war. As Herman (1992) explained,

> Only after 1980, when the efforts of combat veterans had legitimized the concept of posttraumatic stress disorder, did it become clear that the psychological syndrome seen in survivors of rape, domestic battery, and incest was essentially the same as the syndrome seen in survivors of war. (p. 32)

Clearly, linking the effects of family violence with other forms of violence was instrumental in gaining awareness about the seriousness of family violence and for advancing theory of the causes and effects of family violence. We have a better understanding today of many forms of victimization, including child physical abuse, child sexual abuse, adult sexual assault, intimate partner violence, sibling abuse, and bullying because of the perspective of trauma theory (e.g., Black, Newman, Harris-Hendriks, & Mezey, 1997; Herman, 1992).

WHAT IS THE MOST IMPORTANT THING WE NEED TO LEARN IN THE NEXT 10 YEARS?

As we come to the end of the past 20 years, it is apparent that the trauma perspective that has brought us so far must be expanded if we are to fully understand the scope of interpersonal violence and its effects. In 2002, the topic of the meeting of the International Society for the Study of Traumatic Stress was *Complex Trauma: Its Correlates and Effects* (International Society for Traumatic Stress Studies, 2002). In 2003, the topic was *Fragmentation and Integration in the Wake of Psychological Trauma* (International Society for Traumatic Stress Studies, 2003). Both meetings featured numerous presentations on the complexity of traumatic experiences and effects, heralding a growing awareness of the need to move beyond a one-dimensional view of traumatic stressors and effects.

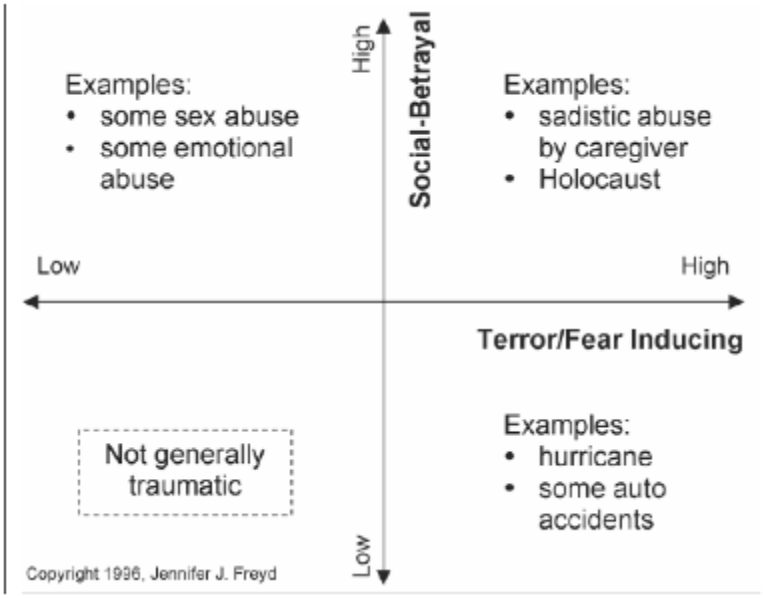

Figure 1: A Two-Dimensional Model of Trauma
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Clarifying our definition of trauma should be one of our primary goals for the next 10 years. At present, the *Diagnostic and Statistical Manual* (*DSM-IV*, American Psychiatric Association, 1994) criteria for PTSD drew heavily on aspects of terror. We now know that few traumatic events that cause long-lasting harm involve solely or even mostly terror. Sexual abuse can be highly terrifying, as in the case of most stranger rape, or involve virtually no immediate fear for life, as in the case of children who are groomed by perpetrators to view the abuse as acceptable. Social betrayal is a potent dimension of events that cause harm (see Figure 1) and very likely to be present in all forms of family violence (Freyd, 1996, 2001). DePrince (2001) found that the amount of betrayal in an event was more predictive of most negative symptoms than the amount of terror and fear. Even war combat may include significant elements of grief, shame, and betrayal (Shay, 1994).

Although betrayal and fear are core distinctions to be made when describing trauma, there are other aspects of family violence and some other interpersonal traumas that require further consideration. Many forms of victimization involve loss. Parental abandonment, foster care, or the loss of a

relationship with an abusive family with whom the child no longer has contact are common examples of traumatic grief facing children who are abused. Witnessing trauma and secondary trauma are also aspects of victimization for some people. Almost all family violence requires victims to keep secrets and limits opportunities for relationships with friends and others outside of the family (Herman, 1992). Overall, family violence is still highly stigmatized and difficult to prove in court (American Prosecutors Research Institute, 2003; Browne & Finkelhor, 1986). Survivors' experiences of loss, betrayal, shame, stigma, and isolation have yet to be considered as rigorously as terror.

Clarifying our definition of *trauma* will lead to a clarification and expansion of the effects of trauma. A whole class of difficulties following trauma have received relatively little research attention, including relationships with siblings, extended family, partners, and children. Sexual and sleep difficulties are common among survivors and may have implications for mental and physical well-being (e.g., Maltz, 2001; Matsakis, 1996). The effects of trauma on education, employment, and the accommodations schools should make for people suffering the effects of trauma have not been fully researched. With the possible exception of male batterers, survivors' experiences of anger, and particularly healthy anger, has received little empirical investigation.

Extant research on the effects of trauma tends to focus on negative effects that are treated as static conditions or traits rather than part of a process of survivors' moving toward new and more positive understanding of trauma, themselves, and the future. In an influential article titled *Scars That Won't Heal: The Neurobiology of Child Abuse* which provided new information, Teicher (2002) wrote in the concluding paragraph:

> Stress can set off a ripple of hormonal changes that permanently wire a child's brain to cope with a malevolent world. . . . Our stark conclusion is that we see the need to do much more to ensure that child abuse does not happen in the first place, because once these key brain alterations occur, there may be no going back. (p. 75)

On one hand, it is incredibly important to point to the potentially long-term harmful effects of child abuse, and it is imperative to focus our efforts on preventing that abuse in the first place. On the other hand, viewpoints that reify stereotypes of survivors of child abuse as damaged goods who will never recover are not helpful. In fact, other research suggests this view is not accurate. Fisher, Gunnar, Chamberlain, and Reid (2000) reported improvements in those areas of the nervous system damaged by abuse when children

who were abused receive high-quality foster care. We are just beginning to understand the ways this healing occurs; however, undoubtedly we will eventually understand the societal and neurological changes (including neurogenesis and the forging of alternative mechanisms) that underlie this healing.

Finally, it is becoming very clear that victimizations are not unrelated, and multiple forms of victimization must be taken into account when assessing the impact of victimization (Finkelhor, Ormrod, Turner, & Hamby, 2004). In a report on the victimization experiences of a national representative sample of 2,030 children, 288 (14%) reported experiencing between four and six kinds of victimization, and 118 (9%) reported experiencing seven or more kinds of victimization (Finkelhor, Ormrod, & Turner, 2004). Victimization kinds were defined as endorsing any of the items comprising the following scales: sexual victimization, physical assault, property victimization, maltreatment, peer or sibling victimization, and witnessing or indirect victimization. Controlling for several possible confounding variables, the number of different kinds of victimization predicted anger, depression, and anxiety better than chronic victimization of any one kind.

Future research is likely to further confirm that poly-victimization is related not only to mental health outcomes but also to a range of social and physical outcomes as well (e.g., Edwards, Anda, Felitti, & Dube, 2003; Felitti et al., 1998; Finkelhor & Kendall-Tackett, 1997; Kendall-Tackett, 2003; Widom, 1989). Furthermore, we are becoming aware that comorbidity in mental and physical health problems may be directly a function of underlying childhood victimizations that lead to multiple problems (Ross, 2000). And all this raises an important question for future research on the impact of family violence on societal behaviors such as the propensity to support military aggression (DeMause, 2002; Millburn & Conrad, 1996; A. Miller, 1980).

This finding has the potential to undermine the validity of studies that only assess one kind of victimization (e.g., sexual abuse or exposure to domestic violence). It is important to identify risk factors for experiencing single and multiple forms of trauma and identify factors that may influence outcomes associated with single and multiple forms of trauma.

Gender is one potentially very powerful risk factor for victimization. In general, men are more likely to be exposed to war combat, nonsexual assaults between strangers, and to be victimized in public places (Craven, 1997; U.S. Census Bureau, 2003), whereas women are more likely to be sexually abused, injured by an intimate partner, and victimized in a private home (Craven, 1997; Finkelhor, 1994; Straus, 2001). Thus, the scope of traumas

assessed and the categories used to produce categories of experiences that are added together to form a measure of multiplicity of trauma experiences make a great deal of difference.

A recent community survey revealed a number of gender differences in exposure to various kinds of trauma (Goldberg & Freyd, under review). Women were much more likely to report having been emotionally or psychologically mistreated by someone close as adults (approximately 40% compared to less than 12% of men) and as children (approximately 30% compared to less than 14%). Women also reported more sexual abuse in adulthood and in childhood than did men. However, men were much more likely to report having witnessed someone who they were not close to being killed, committing suicide, or being injured, in adulthood and childhood. Overall, women reported more events involving someone close to them, and men reported more events that did not involve other people, and events involving others who were not close to them.

These data suggest that victims of betrayal-related events are more likely to be women than men, whereas victims of nonbetrayal events are more likely to be men. Exposure to different types of trauma may be one form of gender-based socialization that affects a range of psychological, social, and physical health outcomes (DePrince & Freyd, 2002; Freyd, 1999).

Different kinds of traumas are associated with particular outcomes. Traumas that involve high levels of threat are often associated with PTSD while secretive, family violence is more likely to be associated with dissociative symptoms (Freyd, 1996; Herman, 1992). Thus, although the number of kinds of traumas may predict general mental health outcomes, exposure to particular kinds of victimization may predict memory difficulty, dissociation, and PTSD. To the extent that exposure to violence is gendered, and outcomes differ by type of trauma, trauma-related psychological, social, and physical outcomes will be gender related. Understanding gender may be highly important for designing prevention and intervention strategies.

WHAT IS THE MOST PROMISING METHODOLOGICAL INNOVATION IN THE PAST 20 YEARS FOR THE STUDY OR TREATMENT OF TRAUMA OR INTERPERSONAL VIOLENCE?

It is our view that the most valid and reliable information on trauma, and particularly family violence, comes from self-reports under conditions of complete confidentiality or anonymity, at least for older children and adults. Multi-informant methodologies could prove even more valuable, as under-

and overreporting are possible depending on the context and information source (e.g., Brody & Litrownik, 2004). Anonymous paper surveys and methodologies that provide clinical referrals in lieu of reporting abuse have been possible ways of collecting completely confidential information on abuse for years. New technologies, including Web surveys and computer-assisted interviewing software that allows participants to listen to questions through headphones and respond using a keyboard, are promising because of the ability to collect information directly from participants while protecting their privacy (e.g., Brody & Litrownik, 2004). Methodologies that allow participants to feel comfortable giving honest responses are important for two reasons. First, it is only though such techniques that we will be able to learn about hidden forms of abuse that are not reported to authorities and may be associated with particular kinds of outcomes. Second, such methodologies would make it easier for a wider range of studies, particularly longitudinal studies of children, to include measures of abuse. This would fill a critical gap in our understanding of the role of victimization in relatively common childhood difficulties including attention problems, learning disorders, depression, and conduct problems.

CONCLUSION

Trauma theory has provided an essential conceptual base for the development of family violence research during the past 20 years. In the coming years, family violence research will play an equally crucial role in the expansion of trauma theory as it grows to more fully include the many forms of victimization that occur between people and within families. In the past, trauma theory has led us to a deeper understanding of the substantially harmful sequelae of family violence. In the future, family violence research will help us to have a much broader and deeper understanding of the traumas that cause the most long lasting effects.

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