

Erin M. Eadie and John Briere have masterfully summarized the research and provided essential knowledge about psychological trauma and the assessment of its effects. This landmark book guides readers about assessing reactions to trauma ranging from one-time events to complex, developmental traumas, neglect, and social maltreatment. It is a must-have reference for all clinicians.

—**Bethany L. Brand, PhD**, Professor Emerit of Psychology, Towson University, Towson, MD, United States; author of *The Concise Guide to the Assessment and Treatment of Trauma-Related Dissociation*, and coauthor of *Finding Solid Ground: Overcoming Obstacles in Trauma Treatment* and *The Finding Solid Ground Program Workbook: Overcoming Obstacles in Trauma Recovery*

To call this book brilliant and revolutionary is an understatement. The authors are willing to state, clearly and unequivocally, that the domain of trauma includes many things not previously considered and that are not yet included in formal diagnostic manuals. It is solidly based in empirical data, and extremely useful for anyone assessing the effects of the widest possible range of traumas. The authors bring their authority to what is, in effect, a decolonizing of trauma assessment. I am so grateful for this work.

—**Laura S. Brown, PhD, ABPP**, Courtesy Clinical Professor, Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, United States; author of *Decolonizing Trauma Healing: Toward a Humble, Culturally Responsive Practice*

Eadie and Briere offer a thorough exploration of the intricate phenomenology of posttraumatic stress, and present a cutting-edge approach to the nuanced assessment of trauma-related symptoms. This is an essential read for clinicians working with individuals affected by trauma.

—**Ruth A. Lanius, MD, PhD**, Professor of Psychiatry, Harris-Woodman Chair, University of Western Ontario, London, ON, Canada

Since the publication of the first edition of *Psychological Assessment of Adult Posttraumatic States*, our understanding of the range and scope of traumatic stressors has expanded considerably. In this revised edition, Eadie and Briere provide a review of contemporary viewpoints regarding traumatic stressors and discuss their etiology and range of possible posttraumatic and other consequences, including the complications posed by repeated and cumulative forms of different types of trauma and those based on developmental and diversity issues. On this foundation, they then provide up-to-date information on the use of various instruments, interviews, and strategies—including telehealth methodologies—for assessing traumatized individuals. A very timely resource for those seeking approaches and methods for understanding and documenting a wide variety of posttraumatic consequences.

—**Christine A. Courtois, PhD, ABPP**, Delaware Licensed Psychologist, Board Certified Counseling Psychologist; author of *Healing the Incest Wound: Adult Survivors in Therapy*; coeditor of *Treating Complex Traumatic Stress Disorders in Adults* and coauthor of *Treatment of Complex Trauma: A Sequenced, Relationship-Based Approach*

This text offers an exceedingly rare combination of (a) deep clinical knowledge and extraordinary clinical sensitivity, (b) respect for and knowledge of the trauma literature, (c) solid methodology and statistical skill, and (d) compelling and readable prose. It would be hard to find a better resource for the trauma professional at any level of training. This is one of the very few books that should be both a requirement in a trauma psychology course and a staple in the library of any trauma-informed professional.

—**Constance Dalenberg, PhD**, Distinguished Professor, Alliant International University; Director, Trauma Research Institute, Claremont, CA, United States; Science Committee Chair, Division 56 (Trauma Psychology), American Psychological Association

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1 TRAUMA TYPES, CHARACTERISTICS, AND COMPLEXITY

Although the psychological literature indicates that trauma exposure is associated with a wide range of symptoms, problems, and disorders, these effects often vary according to the type of adverse experience as well as its severity, duration, onset, complexity, whether it was interpersonal, and other important characteristics. Furthermore, it turns out that many adverse events that do not meet the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* trauma criteria (American Psychiatric Association, 2022) can lead to posttraumatic symptomatology. In this chapter, we outline the issues associated with defining trauma, explore the various traumas and serious adverse events known to produce posttraumatic symptoms, and consider the various peri- and post-traumatic factors (e.g., immediate emotional and dissociative responses, social support, and responsiveness) that mediate or moderate psychological symptoms.

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Psychological Assessment of Adult Posttraumatic States: Phenomenology, Diagnosis, and Measurement, Third Edition, by E. Eadie and J. Briere

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DEFINING TRAUMA

Unlike most other diagnostic categories in the *DSM-5-TR*, the diagnoses of posttraumatic stress disorder (PTSD) and acute stress disorder (ASD) require a specific evaluation of etiology as well as symptomatology. Because the *DSM-5-TR* diagnostic criteria require the presence of a major stressor (referred to as *Criterion A*) before a diagnosis of PTSD can be made, the clinician must not only assess symptoms of stress but also evaluate the nature of the stressor, including when the stressor is sufficiently severe to warrant the term *trauma*.

Assessment of trauma exposure may appear to be a simple matter of listing those events known to produce posttraumatic stress; however, the wide variety of adverse experiences that might be included defies easy categorization. Furthermore, it is now clear that an event that produces posttraumatic stress in one individual may not do so in another. Perhaps most importantly, it is often not one discrete event that comprises the experience of trauma; in many cases, such as war, torture, or interpersonal violence, a series of linked events encompass the traumatic experience.

A notable change in the *DSM-5-TR* criteria for PTSD (and ASD), compared with previous editions, is the option to include posttraumatic symptoms that arise from, or are related to, different traumatic events (Briere & Scott, 2015). For example, in contrast to previous *DSM* editions, nightmares can now be related to one trauma (e.g., sexual assault) and effortful avoidance to another (e.g., motor vehicle accident) and both symptoms can count toward a diagnosis of PTSD. In the past, all symptoms of PTSD or ASD had to be linked to the same single traumatic event, potentially leading to underdiagnosis of individuals with histories of multiple traumas and symptoms arising from different traumatic events (Simpson et al., 2011). This change is a marked improvement because it recognizes, as discussed throughout this book, that posttraumatic symptoms often reflect the cumulative experiences of multiple, repeated, and often complex traumatic events.

The *DSM-5-TR* diagnostic criteria for PTSD and ASD define trauma as follows:

- Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
 - Directly experiencing the traumatic event(s).
 - Witnessing, in person (not through the media), the event(s) as it occurred to others.
 - 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.

- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) during work (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Of note, this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is occupationally related. (American Psychiatric Association, 2022, pp. 301 and 313–314)

One notable improvement in the *DSM-5-TR* is the expansion of the former *DSM-IV* definition (American Psychiatric Association, 1994) of what constitutes sexual violence. The *DSM-5-TR* definition now includes the following:

forced sexual penetration; alcohol/drug-facilitated nonconsensual sexual penetration; other unwanted sexual contact; and other unwanted sexual experiences not involving contact, such as being forced to watch pornography, exposure to the display of genitals by an exhibitionist, or being the victim of unwanted photography or videotaping of a sexual nature or the unwanted dissemination of these photographs or videos. (American Psychiatric Association, 2022, p. 305)

This expanded definition is consistent with the previous specification in the *DSM-IV* that in childhood, “sexually traumatic events may include developmentally inappropriate sexual experiences *without threatened or actual violence or injury*” (American Psychiatric Association, 2000, p. 464, emphasis added). Although there is some debate about what experiences should be considered abusive sexual contact or noncontact sexual abuse (e.g., Levin et al., 2014), the broadening of this criterion allows inclusion of victimization experiences that previously might not have been technically considered a trauma (e.g., drug-facilitated sexual contact with someone who could not render consent, or some cases of sexual harassment) but that can nevertheless result in posttraumatic stress or other adverse outcomes (Avina & O’Donohue, 2002; Gauntlett-Gilbert et al., 2004).

Using this or similar (i.e., *DSM-IV*) definitions, it is estimated that approximately 80% of adults in the United States have undergone, or will undergo, at least one major trauma in their lifetime (e.g., Benjet et al., 2016; Kilpatrick et al., 2013). Yet, as we will see, if threats not involving potential death or injury were included in the *DSM-5-TR* (or the prior edition), this percentage would be even higher. Prevalence data of this magnitude highlight the ubiquity of trauma exposure in North America—not just in clinical settings but in the general population as well.

Beyond Criterion A

Even with improvements made to *DSM-5-TR* Criterion A for PTSD and ASD, there are significant criticisms. Perhaps most importantly, the requirement

that a trauma involve “exposure to actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association, 2022, p. 301) is potentially problematic because many events seemingly can be traumatic even if life threat, injury, or violence is not present (Anders et al. 2011; Briere & Scott, 2014). In contrast, the *DSM-III-R* (American Psychiatric Association, 1987) included threats to psychological integrity (e.g., extreme emotional abuse, nonviolent loss of a loved one, or extended humiliation or degradation) as long as they were “outside the range of usual human experience and that would be markedly distressing to almost anyone” (p. 250). Threats to psychological integrity were removed in the *DSM-IV* definition and are not present in the *DSM-5* or *DSM-5-TR*. Yet by excluding events if they are highly upsetting but not life-threatening, the *DSM-5-TR* diagnostic criteria may underestimate the extent of actual trauma in the general population and reduce the availability of a stress disorder diagnosis for some individuals who would otherwise meet all other criteria for ASD or PTSD.

Given the potential limitations of *DSM-5-TR* Criterion A, some have suggested that the term *trauma* be broadened as it applies to modern clinical practice. When considering the broader effects of trauma and when assessing for the purposes of treatment planning, it may be helpful to consider a more inclusive definition. For example, Briere and Scott (2014) suggested that “[A]n event is traumatic if it is extremely upsetting, at least temporarily overwhelms the individual’s internal resources, and produces lasting psychological distress” (p. 4). This broader definition includes experiences such as sudden, severe emotional losses (see Carlson et al., 2013), extreme parental neglect or abandonment (Sroufe et al., 2005), and moral injury (Shay, 2014) and thus addresses the concerns of people who might benefit from trauma-informed therapies. It also reflects the fact that people who experience major challenges to psychological integrity can suffer as much as those traumatized by physical injury or immediate life threat. This is primarily a treatment issue, however; for the purpose of formally diagnosing a stress disorder, clinicians should adhere to the *DSM-5-TR* definition of trauma.

Complex and Cumulative Trauma

As noted earlier, the *DSM-5* (American Psychiatric Association, 2013) abandoned the single trauma requirement of previous *DSM* editions (Briere & Scott, 2015) and now specifies symptom criteria that arise from traumatic “event(s).” This transition from a single event to a potentially multitrauma criterion highlights a theme that we will return to throughout this book: Significant trauma-related symptoms are often the result of multiple additive or interactive stressors that accumulate and potentially operate synergistically

over time (Briere, Runtz, et al., 2020; Briggs et al., 2021). This change is especially relevant to some more commonly occurring traumas that tend to involve multiple events, contexts, and interactions, not all of which conform to *DSM-5-TR* Criterion A. These include not only severe interpersonal abuse, harassment, and related experiences but also social discrimination and maltreatment of marginalized groups and individuals, arising from systemic racism, sexism, transphobia, and xenophobia (Briere et al., 2024a; Russell & Fish, 2016; Sue et al., 2007; Williams, 2021).

As described later in this chapter, abuse and other childhood adversities may produce symptoms and maladaptive behaviors in adolescence and adulthood that increase the likelihood of later victimization. These later traumas may then lead to further behaviors and responses (e.g., substance abuse, gang activities) that are additional risk factors for further trauma exposure and potentially even more complex mental health outcomes. The accumulation of multiple, different forms of interpersonal trauma over the lifespan is sometimes referred to as *cumulative trauma* (e.g., Briere et al., 2008; Cloitre et al., 2009; Follette et al., 1996) and, when it results in multiple psychological symptoms and problems, *complex trauma* (Courtois, 2004; Herman, 1992a). Although cumulative childhood traumas appear to be, on average, more impactful than adult ones (Cloitre et al., 2009), multiple experiences of highly aversive adult traumas (e.g., torture, sustained relational violence, prisoner-of-war experiences) can also result in complex posttraumatic outcomes (e.g., Herman, 1992b). Studies indicate that cumulative interpersonal traumas are more likely than single ones to lead to a diagnosis of PTSD or ASD (Briere, Agee, & Dietrich, 2016; Briere, Dias, et al., 2017; Karam et al., 2014) and to produce more complex symptomatology (Briere et al., 2008; Cloitre et al., 2009; Felitti & Anda, 2003).

The fact that childhood and adult adversities and traumas can accumulate to produce a range of psychological difficulties has implications for the assessment of both trauma exposure and trauma outcomes. For example, current symptoms in an adult trauma survivor might represent the following:

- the lasting effects of childhood abuse and/or neglect, social maltreatment, and insecure attachment that have persisted into adulthood;
- the effects of more recent sexual or physical assaults, emotional abuse, social maltreatment, or other traumas;
- the additive/cumulative effects of childhood and adult traumas and adversities; and/or
- the exacerbation of earlier, childhood traumas as a function of more recent adult adversities.

In the latter instance, especially severe, regressed, dissociated, or self-destructive responses to an adult trauma may arise, in part, from its interaction with early adversities and trauma, such as when traumatic childhood memories are triggered by more recent mistreatment or trauma, resulting in more severe or complex symptom presentations.

The mixture of multiple traumas, multiple risks, endemic social maltreatment, and multiple symptomatic responses is well known to trauma-focused clinicians, who sometimes find it difficult (a) to connect certain symptoms to certain traumas and other symptoms to other traumas or (b) to discriminate trauma-related symptoms from less trauma-specific ones. The remaining chapters of this book describe assessment approaches that clarify these various trauma-symptom connections and, in some cases, provide alternative ways of conceptualizing complex trauma and multisymptom presentations.

SPECIFIC STRESSORS KNOWN TO PRODUCE POSTTRAUMATIC SYMPTOMS

Although there are many potentially traumatic events, a smaller subset of these is cited regularly in the literature as producing posttraumatic symptomatology. Several of these more common stressors are described briefly in terms of their incidence and potential posttraumatic effects. It is important to reiterate that these (and other) traumatic events are often well within the range of normal human experience. In fact, surveys suggest that up to 80% of people in the general population have experienced at least one major traumatic stressor (Benjet et al., 2016; Norris, 1992; Resnick et al., 1993). If major threats to psychological integrity are also counted, this proportion would be even higher. Although such traumatic stressors are common, their ability to produce significant posttraumatic disturbance varies as a function of a wide variety of other variables, as discussed in Chapter 2 (this volume).

Interpersonal Versus Noninterpersonal Traumas

One of the most significant of these variables is whether the event was due to nonhuman factors (e.g., earthquakes, floods, or tornadoes), resulted from unintended acts (e.g., motor vehicle accidents), or arose from intended interpersonal violence (e.g., rape or physical assault). In general, assault or abuse by another person is associated with substantially more posttraumatic disturbance than are natural disasters or unintended acts. In a study directly comparing the effects of disasters to interpersonal violence in the general population, Briere and Elliott (2000) found that interpersonal victimization

was associated with far greater symptomatology than was disaster exposure. The same study indicated, however, that disasters also were quite capable of producing negative, albeit less common, mental health outcomes that persisted for many years.

Developmental Trauma

Research over the last several decades indicates that although traumas experienced in adulthood can have major psychological effects, childhood traumas may be even more detrimental (Teicher et al., 2022). Such developmental traumas, which include the various forms of maltreatment outlined in this chapter, occur during the most vulnerable points in human development and tend to continue over long periods of time (Cook et al., 2005; Courtois, 2004). Developmental trauma can result not only in the posttraumatic symptoms sometimes found in survivors of adult traumas but also in altered self-capacities and disrupted parent–child attachment, including problems with emotional regulation, identity, and formation of stable interpersonal relationships (Bachem et al., 2021; Bigras et al., 2015; Briere & Rickards, 2007). Unfortunately, research indicates that early abuse and neglect may be associated with poorer response to both psychotherapy and psychiatric medication relative to adult-onset traumas (e.g., Nemeroff et al., 2003). Although most types of traumas can occur at any point in the human lifespan (e.g., a hurricane, a house fire, or a motor vehicle accident), these are typically not considered to be developmental traumas because they do not exclusively occur in childhood and do not inherently disrupt caregiver–child attachment relationships.

Sexual and Physical Abuse

Childhood sexual and physical maltreatment are quite prevalent in North American society. Retrospective self-report studies suggest that more than 20% of women and 5% of men in the United States describe being sexually abused as children or adolescents (e.g., Finkelhor et al., 2014). Briere, Runtz, and colleagues (2020) found that 36% of individuals in an online sample of North American women had experienced unwanted sexual contact at age 13 years or younger. When sexual abuse is defined as including non-contact victimization (e.g., sexual comments, propositions) during childhood or adolescence, the prevalence is roughly double that of contact sexual abuse alone (Briere et al., 2024b). Several meta-analyses indicate that childhood sexual abuse can be broadly impactful; it is associated with a variety of psychological and social symptoms and disorders (e.g., Hailes et al., 2019; Paolucci et al., 2001).

Similarly, between 10% and 22% of men and women report experiences of physical abuse in childhood (e.g., Briere & Elliott, 2003), minimally defined as caregiver behavior that resulted in injuries such as cuts, bruises, or broken bones. It should be noted, however, that retrospective self-reports of childhood trauma vary according to study, research methodology, geography, and participant willingness to disclose (Stoltenborgh et al., 2011), making it difficult to assess the exact prevalence of child maltreatment in North America or elsewhere.

Psychological Maltreatment

Psychological abuse, characterized by caregiver behaviors that involve excessive and continuing criticism, denigration, blaming, insults, and threats (e.g., Hart et al., 2011), is common in the general population. Rates vary widely depending on how inclusive a definition is used. For example, almost all individuals will endorse at least one item on a continuous measure of psychological abuse in childhood (e.g., “Did your parents criticize you?”) because these experiences are relatively common at low frequencies (Briere et al., 2012; Straus et al., 1998; Van Bruggen et al., 2006; Wolfe & McIsaac, 2011). However, assessments of repeated and persistent experiences of psychological or emotional abuse in childhood tend to yield estimates of 12% to 22% (e.g., Edwards et al., 2003; Finzi-Dottan & Karu, 2006). Psychological abuse is not always considered as serious as sexual or physical maltreatment, and because these experiences do not always involve immediate threats to life or physical integrity, they rarely meet *DSM-5-TR* trauma criteria. This assumption can be incorrect, however: Chronic psychological abuse is a major life stressor with a range of long-term psychological effects (Briere et al., 2012; Teicher et al., 2006; Yun et al., 2019). In some cases, psychological maltreatment is an even stronger predictor of adverse outcomes than other forms of maltreatment (e.g., Spinazzola et al., 2014).

Psychological Neglect, Disattunement, and Insecure Attachment

Although it is not included in *DSM-5-TR* Criterion A, early psychological neglect and disattunement can be powerfully adverse experiences that play a significant role in the psychosocial difficulties of many (Sroufe et al., 2005). *Psychological neglect* generally involves inadequate parental attention, protection, nurturance, and affection, whereas *disattunement* refers to disengaged parental caretaking, such as ignoring or not noticing the child’s needs, nonresponsiveness to the child’s proximity-seeking behavior, or, in some cases, dissociation or substance abuse that interferes with normal parental responsivity (Briere, Runtz, et al., 2017). Early neglect and disattunement can be potent sources of psychosocial difficulties involving

disturbances in self-organization (DSOs; Bachem et al., 2021)—primarily, difficulties with self-concept, relational functioning, and emotional regulation (Ford & Courtois, 2021; Levy et al., 2015)—as discussed in Chapter 2.

The relationship between childhood neglect or disattunement (as well as other forms of early maltreatment) and DSOs highlights the foundational nature of parent–child attachment. Early parent–child interactions that are characterized by neglect, disattunement, rejection, or significant loss often lead to insecure attachment (Simpson & Rholes, 2015). For this reason, modern theorists tend to view caregiver disattunement and neglect as potentially quite traumatic and harmful, even though they generally do not meet *DSM-5-TR* criteria for a traumatic event.

Witnessing Intimate Partner Violence

An additional form of psychological and health-related harm during childhood is witnessing household violence, particularly between parental figures (Forke et al., 2019; Wolfe et al., 2003). In the often-cited studies of adverse childhood experiences (ACEs), Felitti and colleagues (1998) found that approximately 12% of adults recalled being exposed to violence toward their mother or stepmother during their childhood. Long-term effects of witnessing intimate partner violence (IPV) include alcoholism, illicit drug use, and depression (Dube et al., 2002) as well as a variety of other symptoms and problems (Holt et al., 2008).

Child Maltreatment–Related Revictimization

Child maltreatment not only can produce enduring psychological dysfunction, it is also associated with a greater likelihood of being sexually or physically revictimized later in life (Duckworth & Follette, 2011). This association may be largest for childhood sexual abuse and later sexual assault (e.g., Van Bruggen et al., 2006). In one study, women who reported experiencing sexual abuse in childhood had twice the likelihood of later sexual assault (68%) than those without a history of sexual abuse (34%) (Briere, Runtz, et al., 2020). In that research, child abuse not only increased the likelihood of later trauma, but both childhood and adult traumas also additively contributed to elevated levels of psychological distress and dysfunction.

Adult Rape and Sexual Assault

Rape can be defined as nonconsensual oral, anal, or vaginal sexual penetration of an adolescent or adult with a body part or object, through the use of threat or physical force, or when the victim is incapable of giving consent. The term *sexual assault* sometimes refers to any forced sexual contact short

of rape, although we will define it more broadly in this book as any forced sexual contact, including rape.

The prevalence of sexual assault among adult women in the United States is reported to be between 15% and 22% (Black et al., 2011; Elliott et al., 2004; Tjaden & Thoennes, 2000). This statistic may be an underestimation for some groups, however. For example, research with university women often reveals higher rates (Eadie et al., 2008; Tansill et al., 2012), with one study finding that 19% of university women reported attempted or completed sexual assault since entering college alone (Krebs et al., 2009). When adolescent girls are included, the prevalence of sexual assault is generally higher. In one study, 32% of women had experienced unwanted sexual contact at age 14 or later (Briere, Runtz, et al., 2020). Sexual assault rates for men are less clear but are estimated to range between 2% and 5% (Black et al., 2011; Elliott et al., 2004).

Drug-Facilitated Sexual Assault

Drug-facilitated sexual assault (DFSA) involves the use of drugs or alcohol to incapacitate potential victims, who can then be sexually assaulted without resistance (Butler & Welch, 2009). The most frequently used substances in DFSA are alcohol, benzodiazepines, antihistamines, antidepressants, muscle relaxants, scopolamine, GHB (γ -hydroxybutyrate), and ketamine (Fiorentin & Logan, 2019). In some cases, perpetrators victimize already intoxicated people or coerce future victims into overusing alcohol or drugs. In others, the drug is administered covertly, such as in an unguarded drink at a bar.

Military Sexual Trauma

Clinicians and researchers have increasingly documented the phenomenon of military sexual trauma, involving sexual coercion and assaults against active-duty personnel by their peers or command superiors in the military (e.g., Ormerod & Steel, 2018). In a meta-analysis of 69 studies, Wilson (2018) found that 24% of female military personnel and veterans reported instances of sexual assault in the military and 53% reported sexual harassment.

Sexual Assault During War or Immigration

A significant number of women and children living in war-torn countries have experienced sexual assault, partially because sexual violence may be used by invading forces as a way to assert control, humiliate civilians, devastate morale, foster “ethnic cleansing” through impregnation, or “reward” soldiers (e.g., Berman et al., 2006; Sawyer, 2009). Women and children are also sometimes sexually assaulted during immigration—for example,

by traffickers who sexually assault people as they transport them across the Mexico–U.S. border (Fernandez, 2019).

Physical Assault

Physical assault refers to physical bullying, muggings, beatings, stabbings, shootings, attempted strangulations, and other violent actions against either someone who is known to the assailant or a stranger. Such assaults include violent acts against members of racial and ethnic minority groups and people identifying (or identified) as LGBTQ+, gang-related aggression, workplace violence, and peer assaults. When physical assaults occur within an intimate relationship, they are typically characterized as IPV (discussed next). Although many acts of violence in relationships are directed toward women rather than men, the reverse appears true for physical assaults by strangers (e.g., Currier & Briere, 2000). The U.S. Department of Justice estimated that stranger assaults accounted for approximately 38% of all incidents of nonfatal violence in the United States in 2010 (Harrell, 2012).

Intimate Partner Violence

IPV is usually defined as physically or sexually assaultive behavior by one person against another in an intimate and often cohabiting relationship. Although IPV is usually viewed as victimization of heterosexual women by heterosexual men, there are a number of studies documenting IPV within LGBTQ+ relationships as well as violence against heterosexual men by their partners (Decker et al., 2018; Godbout, Vaillancourt-Morel, et al., 2019). In many cases, there is also emotional abuse, including humiliation, degradation, extreme criticism, and coercive control involving dominance through intimidation, isolation, stalking, and terror-inducing violence or threats of violence (Black et al., 2011; Dichter et al., 2018; Kendall-Tackett, 2009). The U.S. Centers for Disease Control and Prevention National Intimate Partner and Sexual Violence Survey indicated that more than 23% of women and 13% of men have experienced severe physical violence by an intimate partner at some point in their lives, whereas 16% of women and 7% of men have experienced contact sexual violence from a partner (Smith et al., 2017).

Commercial Sexual Exploitation

Sexual exploitation for commercial purposes is similar in many ways to childhood and adult sexual assault, but with the abuser or trafficker benefitting financially or in some other commercial way. Often these traumas are multiple

and layered, involving extensive coercive control, force, or both, with the exploited individual treated as a commodity.

Sex Trafficking

Sex trafficking can be defined as the forced or coerced recruitment, transportation, transfer, harboring, or receipt of individuals, both children and adults, for the purposes of commercial sexual exploitation (The Protection Project, 2011). It is estimated that 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), whereupon they may be forced into prostitution, pornography, or work in massage parlors or for escort services (e.g., Ugarte et al., 2004).

Prostitution

Research indicates that most people engaged in prostitution are marginalized by race, poverty, gender identity, and low education (e.g., Monroe, 2005); frequently have histories of childhood trauma (e.g., McClanahan et al., 1999); and are more likely to be addicted to drugs (e.g., Young et al., 2000). In addition, a significant proportion are minors (Institute of Medicine & National Research Council, 2013). Studies suggest that those involved in prostitution have at least a 40% to 80% probability of being raped (Farley & Barkan, 1998; Valera et al., 2000) and undergo considerable physical and emotional abuse (Farley, 2017; Miller & Schwartz, 1995; Vanwesenbeeck et al., 1995). Prostitution is often injurious to physical and psychological health and is a substantial risk factor for homicide and serious injury (e.g., Farley, 2004a). Notably, some people eschew the label *prostitution*, instead using the less stigmatizing term *sex work* (Bell, 2009; Open Society, 2019). It should be noted, however, that when such activity occurs when the person is a minor or is under the control of another person or when sex acts occur in the context of nonconsent, force, or coercion, the term may be misleading because it falsely implies a freely chosen behavior or occupation (Moran & Farley, 2018). In instances involving minors, the term *commercial sexual exploitation of children* is more appropriate.

Torture

Torture can be defined as follows:

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)

Amnesty International (2015) reported that 141 nations sanction or tacitly allow the use of torture, and a meta-analysis suggested that more than 1 million torture-surviving refugees currently reside in the United States (Higson-Smith, 2015). Torture survivors are especially overrepresented among refugees, with the Center for Victims of Torture estimating that 44% of refugees in the United States are either torture survivors or family members or close intimates of survivors (Higson-Smith, 2015).

Mass Casualty Events

Large-scale events that cause widespread fear, terror, injury, and physical casualties can have significant psychological effects on many individuals in a specific venue, community, or geographic area. These events can be interpersonal in nature, as is the case with a terrorist attack or a mass shooting, or noninterpersonal in origin, such as a natural disaster or transportation accident.

Interpersonal Violence

Violence committed outside of war by one or more people and involving high numbers of injuries or casualties has existed throughout human history. Recent examples in the United States include the Oklahoma City bombing of 1995, the 9/11 attacks on the World Trade Center and the Pentagon in 2001, the Sandy Hook school shooting in 2012, the Las Vegas mass shooting in 2017, and the school shooting in Parkland, Florida, in 2018.

Natural Disasters

Natural disasters can be defined as large-scale, not directly human-caused, injury- or death-producing environmental events that adversely affect a significant number of people. They are relatively common in the United States, with 13% to 30% of individuals having experienced one or more natural disasters in their lifetime (Briere & Elliott, 2000; Green & Solomon, 1995). Typical disasters include earthquakes, large fires, floods, tsunamis, avalanches, hurricanes, and tornadoes.

Large-Scale Transportation Accidents

Transportation accidents include airplane crashes, train derailments, and maritime accidents that often involve multiple victims and high fatality rates (Maeda & Higa, 2006). Large-scale accidents can be especially traumatic to survivors because they frequently occur over a relatively extended period of time, during which the victims are exposed to ongoing terror and fear of death.

Fire and Burns

Beyond fire-related disasters, a significant number of survivors seen by trauma clinicians have experienced injury by smaller fires. These include house fires, often caused by smoking in bed, electrical short circuits, or leaking or malfunctioning propane tanks, stoves, or heaters, as well as fires that occur in recreational contexts, involving barbecues, firepits, and fireworks. Serious burns also may result from motor vehicle accidents, industrial fires, or even intentional attacks by others. In the United States alone, more than 32,000 people are hospitalized for severe burns each year (American Burn Association, 2024). The potential physical effects of serious burns—including extreme pain, a long recovery period, multiple surgeries, visible or painful scars (or both), disfigurement, amputation, and reduced mobility—mean that burn trauma can continue and repeat over time (Gilboa et al., 1994; Martin et al., 2017).

Motor Vehicle Accidents

It is estimated that approximately 20% of individuals in the United States have experienced a serious motor vehicle accident (Blanchard & Hickling, 2004). A substantial number develop psychological symptoms (e.g., Craig et al., 2016), especially if the accident involved major injuries or resulted in the death of others (Blanchard et al., 2003). When the driver is responsible for the accident, guilt and self-blame may increase subsequent psychological symptoms (Fitzharris et al., 2005). Survivors of a major motor vehicle accident may sustain traumatic brain injury, which can further complicate assessment and treatment (Harvey & Bryant, 2002).

War

War can involve a wide range of violent and traumatic experiences, including immediate threat of death, grievous physical injury, witnessing injury or death (or both) of others, and involvement in injuring or killing people (e.g., Gahm et al., 2007). For those captured, war sometimes includes extended confinement, torture, rape, and extreme physical deprivation. These traumas, in turn, can produce a variety of symptoms and disorders, perhaps especially PTSD (Institute of Medicine, 2010). Although the U.S. Department of Veterans Affairs (VA) provides care for many U.S. war veterans with service-connected injuries, others may not qualify for (or desire) such treatment, and it is not uncommon for veterans to present to non-VA mental health centers and clinicians. For this reason, we recommend (a) that all adult clients be queried regarding any military service and participation in war, and (b) that clinicians be prepared

to address war-related trauma in addition to the effects of other adversities. Because the assessment and treatment of combat veterans and others exposed to war can be complex, we recommend clinicians refer to specialized information (e.g., 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) in this area.

War also can profoundly affect the people indigenous to where it takes place, whether through direct military action against noncombatants, forced migration, or degraded social support systems. Living in a war-torn area or armed-conflict zone is associated with significant and lasting anxiety, depression, PTSD, and other adverse outcomes for both children and noncombatant adults (El Baba & Colucci, 2018; Eytan et al., 2011).

Moral Injury

First described by Shay (1995), moral injury involves “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Litz et al., 2009, p. 697). In addition to the grotesqueries of war, command malpractice, and betrayal by co-combatants, recent formulations of war-related moral injury include the act of torturing or killing others, committing or failing to prevent atrocities, using disproportionate violence, giving or following immoral orders, and engaging in violent crimes or accidentally deadly acts against civilians (e.g., Callaway & Spates, 2016).

Of late, the term *moral injury* also has been applied to the experiences of health care professionals, first responders, and others who have engaged in or observed immoral or unfair acts, inadequate care, and difficult ethical dilemmas (Koenig & Al Zaben, 2021). In a recent example, health care workers working with critically ill patients with coronavirus disease 2019 (COVID-19) may report moral injury associated with difficult triage decisions or relative helplessness to adequately treat dying individuals (D'Alessandro et al., 2022). Whatever its source, moral injury can lead to alienation from others or society, lack of trust, loss of meaning, shame, and disruption of religious or spiritual beliefs (Drescher et al., 2011; Koenig et al., 2018), along with more classically clinical outcomes such as anxiety, depression, guilt and self-blame, anger, suicidality, and substance abuse (e.g., Litz et al., 2018).

Traumatic Loss

Traumatic loss generally refers to exposure to the sudden, unexpected death of a loved one or close friend. This may involve witnessing a violent death at

the hands of family members, gangs, or police officers, or sudden loss of life associated with mass casualty events, major accidents, and medical events such as a fatal heart attack or sudden death by suicide or disease. Such events may lead to traumatic bereavement, involving extended grief, guilt, anxiety, depression, anger, suicidality, and posttraumatic stress (Boelen et al., 2019; Green et al., 2001; Prigerson et al., 1997). Extended responses to traumatic loss are described in Chapter 2 as part of the new *DSM-5-TR* diagnosis, prolonged grief disorder.

Elder Abuse

Elder abuse includes physical, emotional, or sexual abuse; and/or neglect, abandonment, or financial exploitation of an older person by a caregiver, family member, or other person in a position of trust (American Psychological Association, 2020c; Hall et al., 2016). It is estimated to affect 1 in 10 people aged 60 years or older in the United States (Acierno et al., 2010; Laumann et al., 2008; National Center on Elder Abuse, 2005). Although all forms of elder abuse can be psychologically devastating (Dong et al., 2013), clinical experience suggests that physical and sexual elder abuse are especially likely to result in classical symptoms of posttraumatic stress.

Stalking

Stalking involves repeatedly following or harassing another person in such a way that they feel terrorized, intimidated, or threatened. In one large study, 8% of women and 2% of men in the United States reported having been stalked by someone; 81% of women who were stalked by a former intimate partner were physically assaulted, and 31% were sexually assaulted (Tjaden & Thoennes, 1998). Although sometimes discounted in U.S. society, especially when no physical violence has transpired, stalking can be traumatizing and result in significant psychological symptomatology, including posttraumatic stress, anxiety, depression, and somatization (Amar, 2006; Hauch & Elklit, 2023).

Life-Threatening Medical Conditions

As opposed to the *DSM-IV*, the *DSM-5* no longer considers many illnesses or medical issues, such as cancer or heart attack, inevitably to be Criterion A–level traumas. It 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”

(American Psychiatric Association, 2013, p. 274). As a result, very upsetting medical experiences that might previously have been considered traumatic (e.g., a cancer diagnosis, heart attack, or HIV/AIDS) as well as medical procedures (e.g., heart surgery, invasive cancer treatment, and debridement for severe burns) are not necessarily considered traumatic in the *DSM-5-TR* (Norrholm et al., 2021; Pai et al., 2017). See Kilpatrick et al. (2013) for a discussion of the implications of this change.

Although the evaluator must always adhere to the current *DSM* criteria when making a diagnosis of medically related stress disorder, we suggest that the specifics of an adverse event be studied carefully in case a Criterion A trauma is actually present. For example, although COVID-19–related experiences often do not meet current criteria for a trauma designation, they would do so if the patient experienced “extreme anxiety/panic and fear of death during severe respiratory distress” (Norrholm et al., 2021, p. 1). Notably, even in cases in which a medical stressor does not rise to the level of a *DSM-5-TR* trauma, it can still underlie a variety of other disorders, including adjustment disorder, brief psychotic disorder with marked stressors, unspecified trauma- and stressor-related disorder, and some forms of depressive disorder.

Pregnancy and Infant Loss

Miscarriage occurs in up to 20% of all pregnancies (Blohm et al., 2008; Jevé & Davies, 2014), and stillbirth is estimated to occur in 1 of every 175 births in the United States (Gregory et al., 2023), with higher rates among racial and ethnic marginalized groups. Pregnancy and infant losses are widely experienced as traumatic, often resulting in sustained anxiety, grief, depression, posttraumatic stress, suicidality, or substance abuse (Farren et al., 2016; Weng et al., 2018). Effects are also found among partners of those who have miscarried (Due et al., 2017). Some people affected by pregnancy loss appear to recover within a year or two, whereas others may suffer for considerably longer (Janssen et al., 1997), especially those dealing with chronic infertility or previous miscarriages and stillbirths (Blackmore et al., 2011).

COVID-19

A dramatic example of medical trauma is the COVID-19 pandemic, which has resulted in widespread loss of life and a variety of serious and lasting health and mental health problems worldwide. In most cases, having severe COVID-19–related symptoms or being hospitalized for the disease would be insufficient to meet *DSM-5-TR* Criterion A for ASD or PTSD, even though the effects of COVID-19 infection often include symptoms consistent with post-traumatic stress (e.g., Bridgland et al., 2021).

Emergency Worker Trauma

First responders and other emergency personnel often encounter death, grotesque injury, and extreme victim distress. As a result, those who work with acutely traumatized people can become traumatized themselves. In fact, the *DSM-5-TR* trauma criteria refer to the experience of “repeated or extreme exposure to aversive details of the traumatic event(s)” (American Psychiatric Association, 2022, p. 301). Among those known to be at risk for such work-related traumas are firefighters, rescue workers, paramedics and other emergency medical personnel, emergency mental health workers, and law enforcement personnel (e.g., Berger et al., 2012; LaFauci Schutt & Marotta, 2011). Of late, extreme emotional distress has been documented in health care workers who were faced with unavoidable rationing and triage decisions during the COVID-19 pandemic (American Psychiatric Association, 2020).

Social Maltreatment

A strong case can be made that experiences of institutionalized maltreatment and oppression—such as racism, sexism, or discrimination against those identifying as LGBTQ+—constitute a major source of trauma for many in society (e.g., Allwood et al., 2022; Briere et al., 2024a; Mooney, 2017). Social maltreatment can lead to acute distress, trigger painful memories of previous social maltreatment, exacerbate the effects of other traumas, and accumulate to produce lasting posttraumatic symptoms and responses (Briere et al., 2024b; Nadal & Mendoza, 2014; Robinson & Rubin, 2016).

Microaggressions and Macroaggressions

Microaggressions, defined as “comment(s) or action(s) that subtly and often unconsciously or unintentionally express a prejudiced attitude toward a member of a marginalized group (such as a racial minority)” (Merriam-Webster, n.d.), can be acutely distressing and, as they accumulate, can lead to a range of negative psychological outcomes (Lui & Quezada, 2019; Sue et al., 2007). Macroaggressions, including hate crimes and related threats, stalking, bullying, and violence at the hands of authorities, are also obvious risk factors for psychological distress and disorder (Barnes & Ephross, 1994; Briere & Runtz, 2024).

Historical Trauma

Historical trauma can be defined as collective maltreatment by a dominant culture of a specific group of people that extends over generations. Examples of historical trauma in the United States include the enslavement of Black people for more than 250 years (DeGruy, 2017; Hannah-Jones, 2021); massacres, forced relocation, and near physical and cultural genocide of Native

Americans (Brave Heart & DeBruyn, 1998; Hartmann et al., 2019); and the widespread internment and maltreatment of people of Asian descent during and after World War II (Brockell, 2021; Nagata et al., 2019). Such adversities can have broad and ongoing social and cultural effects that are carried over the generations and tend to continue into the present in the form of systemic discrimination and social maltreatment.

Gender and Historical Trauma

Although those who identify as women and girls have often not been described as survivors of historical trauma, there is a centuries-long history of gender-based discrimination and victimization. Women and girls report higher rates of depression, anxiety, suicide attempts, PTSD, and eating disorders than men and boys (American Psychiatric Association, 2017; Briere & Scott, 2007; World Health Organization, 2000), which have been linked to their experience of more frequent sexual and domestic trauma throughout the lifespan, gender-based discrimination, restrictions on education and career advancement, and adverse gender socialization (e.g., Haahr-Pedersen et al., 2020; Rees et al., 2011; Silove et al., 2017; Vigod & Rochon, 2020).

Other Potentially Traumatic Adversities

Along with explicit experiences of maltreatment or victimization, there are adverse events or contexts that can be traumatizing by virtue of their inherent toxicity or because they increase the risk of victimization. These include the following:

- exposure to homelessness (Bassuk et al., 2001),
- extended poverty (Klest, 2012),
- living in communities characterized by violence and social marginalization (Fowler et al., 2009), and
- extended incarceration (Liem & Kunst, 2013).

Although they are generally not considered *DSM-5-TR*-level traumas, these adversities are associated with a range of negative outcomes, including post-traumatic stress (Ford et al., 2015).

STRESSOR AND RESPONSE CHARACTERISTICS

Psychological outcomes following trauma exposure vary according to aspects of both the stressor itself and the response to that stressor, both within the individual and in the external environment. Both aspects of the stressor and the types of responses to stressors are discussed next.

Aspects of the Stressor

A number of stressor characteristics appear to affect posttraumatic outcome. Together, these characteristics are thought to reflect a general construct sometimes referred to as *stressor magnitude* or *stressor intensity*.

Variables that appear to increase stressor magnitude, and thus the likelihood or severity of PTSD or related outcomes, include the following:

- intentional acts of violence (as opposed to noninterpersonal events; e.g., Briere & Elliott, 2000);
- presence of life threat (e.g., DiGrande et al., 2011);
- physical injury (e.g., Foy et al., 1987);
- extreme or frequent combat exposure during war (e.g., Adams et al., 2016);
- witnessing death (e.g., Phillips et al., 2010), especially when grotesque in nature (e.g., Epstein et al., 1998);
- loss of a friend or loved one (e.g., Green et al., 1990);
- unpredictability and uncontrollability (e.g., Carlson & Dalenberg, 2000);
- sexual (as opposed to nonsexual) victimization (e.g., Kang et al., 2005); and
- traumas of longer duration, greater frequency, or greater complexity (Briere, Agee, et al., 2016; Courtois, 2004).

Although in many cases there appears to be a linear relationship between the extent or severity of the stressors and the subsequent posttraumatic response, this association is not especially large in magnitude and applies more to group data than to specific individuals. For example, it is not uncommon to encounter two people who experienced the same stressor (e.g., an earthquake or fire) who differ significantly in terms of their posttraumatic response. One individual may develop ASD, followed by PTSD, whereas another may experience few short-term or long-term effects. In addition, two stressors may appear objectively equivalent (e.g., two assaults of seemingly equal severity) yet have remarkably different effects on those involved.

Peritraumatic Responses

Emotional distress and dissociation—at the time of a trauma or immediately afterward—can affect an individual's internal experience and processing of the event. As a result, different types of peritraumatic responses can be associated with different posttraumatic outcomes.

Peritraumatic Distress

The trauma survivor's emotional response at the time of the potential stressor was given substantial credence by the *DSM-IV*, to the point that the negative

event was not deemed a trauma if there was no report of concurrent horror, fear, or helplessness (Criterion A2). Although the *DSM-5-TR* PTSD criteria no longer include Criterion A2, there is little doubt that posttraumatic stress is more likely (and perhaps more intense) when the individual experiences one or more of these emotions peritraumatically (e.g., Brewin et al., 2000; Vance et al., 2018). Other negative emotional responses, such as anger, shame, and guilt, are also likely to increase the risk of posttraumatic reactions (e.g., Andrews et al., 2000; Bub & Lommen, 2017).

These findings imply that those who interpret a traumatic experience more negatively are at greater risk for posttraumatic difficulties, partially because of cognitive predispositions (e.g., the tendency to view life events as outside of one's control, or to perceive challenges as threats), partially as a function of preexisting stress intolerance, and partially because of the specific nature of the trauma (i.e., stressors vary according to the extent that they would motivate negative appraisal in most people). One individual may respond to an event with horror or helplessness because the event itself is horrific and overwhelming, whereas another might respond in a similar manner to a much lower magnitude stressor because of negative cognitive schema arising, for example, from previous child abuse experiences. To compound the complexity of subjective response, such attributions are almost always reported after the traumatic event and its effects have occurred (March, 1993). As a result, phenomena that occur after the event, such as the level of perceived support from others, subsequent negative or positive events, the effects of posttraumatic symptomatology, financial or interpersonal influences, or the results of professional intervention, are also important.

Peritraumatic Dissociation

Some research suggests that peritraumatic dissociative reactions (e.g., depersonalization or derealization around the time of the trauma) predict more extreme psychological outcomes, especially a greater likelihood of PTSD (e.g., Lensvelt-Mulders et al., 2008; Shalev et al., 1996). Such responses may interfere with the encoding and immediate processing of traumatic memories, thereby increasing the risk of more severe posttraumatic outcomes (e.g., Koopman et al., 1995). Although the correlation between peritraumatic dissociation and subsequent PTSD is substantial in some studies (Ozer et al., 2003), other researchers have failed to replicate this relationship (e.g., Marshall & Schell, 2002; Mellman et al., 2001) or report that the peritraumatic dissociation–PTSD connection disappears once other variables are taken into account (e.g., Holeva & Tarrier, 2001). In one study (Briere, Scott, et al., 2005), a measure of persistent and ongoing dissociation following a specific traumatic event was considerably more powerful in the prediction

of PTSD than was another scale measuring peritraumatic dissociative symptoms. In fact, peritraumatic dissociation ceased to be predictive of PTSD once sustained posttraumatic dissociation was taken into account through multiple regression analysis. These data suggest that whether one dissociates during a traumatic event may be less of a risk factor for PTSD than whether dissociation associated with the event (perhaps regardless of when it began) persists into the long term.

SOCIAL RESPONSE, SUPPORT, AND RESOURCES

As is especially reported in the interpersonal violence literature, posttraumatic states may vary in intensity as a function of the level of acceptance and support offered by others following the stressor. However, social response to the victim is not independent of trauma characteristics, victim variables, or environmental effects. Some traumatic events appear to be more socially acceptable than others. For example, a victim of a hurricane or earthquake may be seen as more innocent and worthy of compassion than a rape victim or someone targeted because of their sexual orientation. In addition, certain trauma survivors are more likely to receive prejudicial treatment than others, especially those living in poverty, members of racial and ethnic minority groups, those who identify as LGBTQ+, undocumented immigrants, women, people who have been trafficked or exploited (or both) by the sex industry, and those without housing (Bassuk et al., 2001; De Zulueta, 1998; Farley, 2004b; Goodman et al., 1991; Loo et al., 2001; West, 2002). This correlation between certain traumas, victims, and social variables may produce additional stigmatization and, as a result, reports of shame, guilt, or self-hatred (e.g., Hardesty & Greif, 1994; Herek et al., 1999).

Holding social prejudice constant, however, it appears that posttrauma support by family members, friends, helping professionals, and others can moderate the intensity of posttraumatic stress (Wang et al., 2021). Such support includes accepting (versus rejecting) responses after the trauma disclosure, nurturance from loved ones, an absence of stigmatization or blame by others, and availability of helpers and agencies after a traumatic experience. Importantly, Hobfoll (1988) noted that traumatic events not only produce stress, but they may also precipitate *loss spirals*, wherein the victim becomes more dependent on (and consuming of) social resources, eventually resulting in depletion of these resources, leading to additional stressors, greater vulnerability, and more stress responses. When the stressor affects an entire community (e.g., during a disaster), it may reduce social and physical resources at the same time that it traumatizes individuals, thereby producing more severe

reactions (Norris & Thompson, 1995). When the stressor is more confined to the individual level (e.g., a rape or miscarriage), initial social support may decrease as the victim fails to recover in a time span expected by the social milieu, leading to victim perceptions of abandonment and rejection and, ultimately, potentially more severe stress responses.

CONCLUSION

The notion of what constitutes a traumatic event is less straightforward than might be envisioned. The initial intent of the *DSM-III* (American Psychiatric Association, 1980) was to define stressor characteristics, relatively independent of the victim, that were of sufficient intensity to produce a posttraumatic response in almost anyone. However, recent research suggests that the extent to which an event is traumatic is governed by the interaction between trauma magnitude and a range of victim variables that serve as relative risk factors for the development of posttraumatic stress. This interaction is further moderated by concurrent and postevent variables such as peritraumatic responses, level of social support and resources, cultural beliefs and expectations, and postevent attributions regarding the stressor.

It is clear that the interactionist view of traumatic events has lent greater precision to a clinical understanding of posttraumatic states. Among other things, this perspective increases the likelihood that the clinician will consider the stressor, the person, and their social network when evaluating the etiology of posttraumatic states. As has been found in other areas of mental health, the interactionist model suggests that posttraumatic stress rarely exists in a vacuum, and that the individual's responses to upsetting events must be considered within the context of their environment, resources, and life history.

On the other hand, the growing awareness of predisposing and moderating victim variables in PTSD response should not be used to discount the inherently traumatic nature of many events. Regardless of moderating victim and environmental phenomena, some events are intrinsically traumatic—acts of tremendous intrusion that negatively affect almost all of those who experience them. If these stressors are only considered traumatic when they produce a formal *DSM-5-TR* diagnosis of PTSD, there is a danger that the pain and lasting distress of many trauma survivors (e.g., those whose symptoms do not fit precisely into existing PTSD criteria) will be discounted. In contrast, the broader view of posttraumatic disturbance offered in the following chapters takes into account various types of disturbance, including subthreshold posttraumatic stress, ASD, complex PTSD, dissociation, and interpersonal sequelae, and thus implicates a wider range of potentially traumatic events.