

## **Taxonomy of Trauma and Trauma Assessment**

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*A review of the theory of trauma as a special case of stress response theory, two different classifications / taxonomies of traumas emerge. Each taxonomy describes a different dimension of the traumatic event. The first taxonomy, areas of individual functioning, includes five types: Attachment trauma, autonomy or identity trauma, interdependence trauma, achievement or self-actualization trauma, and survival trauma. The second classification is based on experiential objective external criteria and includes two main categories: Factitious or trauma-like and real traumatic events. The first happens in one step transmission from one to one or more persons. The second get transmitted in multiple steps or cross-generationally. Traumas can get transmitted cross generationally in two venues: through family or collectively. Collective transmission of traumas happens in two contexts: historical and social structural. Direct traumas (person-made), on the other hand, is divided into two types: Simple (type I) and complex (type II, and type III). While type I is a single blow, type II is a unit of repeated and connected series of blows. Type III is the additive effect of the sequence of all direct, indirect, and factitious traumatic events on one or more of the different areas of functioning across life span. The latter section of the paper describes a Trauma Assessment Matrix to help identify the accumulation of traumatic events and its potentially additive effects in one or more of the five areas of functioning. The treatment implications are addressed.*

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**Key Words:** Taxonomy, trauma, trauma assessment, trauma transmission, trauma treatment.

### **Introduction**

The focus of this paper is to develop a plausible classification of traumatic events that impact individual functioning. To do that, I start by developing general understanding of the trauma dynamics, its mechanisms, and the different areas of functioning that traumas potentially impact.

Traumatogenic stimuli are events that are outside the range of the individual's usual experience, that constitute, for him, exceptional mental and physical stressors (compare ICD-10). That means, what is traumatic for an individual, may not be as traumatic for another. DSM VI limits the event criterion for PTSD diagnosis to only those kinds of traumatic events that cause "actual or threatened death or serious injury or a threat to the physical integrity of self or others". This limits the events that can cause PTSD to mostly survival traumas. However, the range of events that are traumatic to the individuals are more diverse than just survival traumas, and the trauma response is greater than simple PTSD. Trauma theory is a special case of stress response theory. Traumatic events are the ultimate or most severe stressors. Regular life stressors, in different areas of human experience, are ordinary and have high expectancy, probability of happening, and controllability. Traumas are the out of ordinary stressors that have low expectancy, probability, and controllability.

The outcome of stress response research applies to the effects of trauma. There is a wealth of research on the effects of chronic stress on physical, psychological, familial, and social functioning. Diathesis-stress model suggests that each person has a degree of vulnerability or threshold. A symptom may be triggered in a vulnerable person, by a relatively minor stressors or “hassles”, whereas only major catastrophic events might induce similar reaction in a non-vulnerable person (see e.g., Zuckerman, 1999). On the other side, the additive effects of multiple environmental stressors can produce trauma-like symptoms even in the less vulnerable person. The additive effects of multiple traumas can produce what I call type III trauma symptoms. Moreover, the effects of traumatogenic exposure, e.g. mother abandonment, on two years infant that did not develop adequate self processing structure, is different than the same exposure when he is child, teen, or adult. There is a great deal of controversy about the dynamics of stress response. For example, how much variance the genetic factors versus the environmental stressors contribute to the response. Research findings attribute 30-60% of the variance to each (see, for example, True et al, 1993). However, the interaction between genes and environment is far more complex.

Humans are value processors. They acquire through development a pre-event self or value processing system that control triggering the automatic signification or the unconscious appraisal of the event and the activation or inhibition of emotional and cognitive processing, as well as the arousal and action (compare Lazarus & Folkman, 1984; and Kira, I., 1997). Factorial studies of the structure of value processing that include values and morality found five factors that are replicated cross-culturally. These five factors that represent the area of human functioning are: Attachment, individuation, interdependence, performance, and flexibility/ survival (see, Kira, 1997, 2000). Theories and research on life span development and psychodynamics’ further add to the credibility of this empirical classification of individual functioning. Persons are biosocial organisms who possess unique genes, unique personal values, and self-structures that mediate the psycho-physiological reactions to environmental stressors and traumas. Trauma causes physiological changes in central and peripheral nervous system that regulate the whole physiological interactions and body functioning.

The ordinary human experience contributes to shaping the structures of individual’s value processing system through his development from infant to adult. However, the out of ordinary traumatic events contribute more to either the disturbance, or creation of a more developed self system that can process and cope with the out of ordinary experiences. Moreover, it can also disturb the course of value and self-system development in the childhood. A more developed or advanced self-processing system can handle the out of ordinary traumatic events. To sum up, this pre-event processing system, that include these five sub-systems, directs the interactive process between hard-wired genes, interactive flexibly wired two neurological systems (central nervous and peripheral nervous systems CNV and PNS), physiological, and hormonal processes on one side, and the environmental stressors and traumas on the other side.

The focus of this paper is to develop a plausible classification of the traumatic events that can either disturb, rebuild, or reinforce the existing, stable or developing, self-processing structures. It is of primary importance to assess the full range of types of traumas that yield different levels of trauma response.

### **Taxonomies of Traumas**

A comprehensive taxonomy of trauma can give the clinician an organizing pattern of the clients' traumatic exposures, and its specific and potential effects on different areas of functioning in different stages of development. Based on the previous analysis of trauma dynamics, as well as the research on child development, and on reviewing hundreds of cases from clinical practice especially with refugees, I propose a taxonomy that is based on two classifications of trauma. The first classification is based on the subjective experience, the processing mode, and the area of functioning that is impacted. The second classification is based more on the objective characteristics of the Traumatogenic events. The two classifications complement each other in assessing the client traumatic exposures across his life span.

#### **First classification:**

I classify traumatic events according to its impact on different area of individual functioning (see Kira, 1997) as follows:

##### **1. Attachment Trauma:**

Attachment or intimacy traumas impact the shared affective exchange with a companionship for the adult or with parents for the infant and child. It affects the feeling of warmth and connectedness for the adult and the feeling of security and trust for the young child who depends on the attachment figure for survival. Early childhood trauma that affects attachment can disturb the whole sequence of child emotional development. Examples of such traumas are abandonment, death of parents, or kidnapping of a baby, affairs, divorce, and loss of very close significant others. It can yield avoidant or disordered attachment style, or attachment disorders for infants and children. It can yield relationship and personality disorders for adults. This can shatter his /her assumptions and beliefs about self and objects and impact on emotional and cognitive processing, in the area of object relations.

##### **Case examples:**

Case 1: Maranda is 5 years old girl. Parents went through nasty divorce when she was 2 years old. Father gets custody of all the children including her. Maranda separated from her primary attachment figure (Mom). She developed ambivalent attachment style, nightmares and other symptoms that meet the criteria for PTSD.

Case 2: Mariam was 2.6 years old when child protective service took her from her parents, developed nightmares, avoidance of any adult figure, crying spells, refuse any touch or closeness, refuse to eat, and lack of sleep.

Case 3: Layla was 18 when married her first love, a police officer. They had a baby girl. One day she went home after shopping to find her husband with another woman in her bed. After this incident she refused to remarry or trust any man, till she was 52 years old when she came to therapy. This client continued to function well in all areas, except the relationship area, as she cannot keep a relationship. After the initial trauma, she had nightmares and other symptoms that meet the criteria for PTSD. Her beliefs, assumptions, and value system about relationships have been disturbed. After therapy she was able to remarry and start a new stable life.

## 2. Autonomy/ Identity / Individuation (personal, or collective) Trauma:

The formation of a sense of identity, agency, and self efficacy is a developmental landmark of late adolescent or early adulthood with positive consequences of individual's well being. Autonomy or identity trauma can shatter the behavioral and emotional independence of the individual or group or his / their sense of identity and leads to feelings of incompetence, inadequacy, alienation, and loss of control over self and destiny. Examples of such trauma are sexual and physical abuse, domestic violence, rape, slavery, prisoners of war, torture, and genocide. Such traumas in early childhood can disturb the development of a healthy autonomy and identity formation. It can cause, in adults, feelings of loss of self and helplessness.

## 3. Interdependence or Disconnectedness Trauma:

Social interaction is core to survival. The individual is interlocked within a network of connections that give him emotional, social, and material support. It gives him a sense of social embeddedness, belonging, and meaning in life. He develops a system of conditioned social contingencies that are rooted physiologically and emotionally and are basic to his feelings of safety, security, and community. Events that threaten these connected network and his embeddedness in it can traumatize the individual. Even moving from school to school, or from state to state for a child can be traumatizing in same examples, as it involves losing the long standing relationships and support system. Uprootedness, especially involuntarily uprootedness (e.g., refugees experience) loss of affiliation by suspension or forced out are examples of this kind of trauma.

## 4. Achievement/ Self-actualization trauma:

Tremendous amount of social behavior is motivated by the pursuit of personal goals that are central to the individual's perceived survival. There is a value-processing component to all goal-directed behavior that include valenced evaluations of prospective targets. The failure to achieve a target that is perceived essential to survival or progression can be traumatic. Examples of this kind are lay-off, demotion, and

substantial loss of money, health, or valuables, substantial failures to achieve life goals. Prolonged unemployment, for example, has been found to be a threat to the worker, the family and the community at large. In the United States, with a one percentage point rise in unemployment, homicides were found to increase 5.7%; suicides, 4.1%, admissions to mental hospitals, 4.3% for men and 2.3% for women; and deaths from stress related disorders, almost 2% (see Schwebel, M. 1998).

##### 5. Survival Trauma:

Survival trauma is an event that pose direct or indirect threat to self or significant others' lives, e.g., witnessing or participation in war, exposure to drive by shooting, attempted suicide, homicide or killing, car accident, violent crimes, natural or man made disasters. . Deep automatic activation of terror is particularly likely to result from death thoughts and perception of subtle or non-subtle threats (e.g., see Arndt, Greenberg, Solomon, Pyszczynski & Simon, 1997). A belief system about life, death, and destiny which may be part of religious, philosophical, or ideological value system contributes to regulating the processing of such traumas and managing the terrors activated be them. For example, traumatized individual can turn to be a suicide bomber if he develops a specific belief system about death, life, and destiny that justifies this action. However, he can cope in a different and positive way with his trauma using different belief systems about life, death, and survival.

There are some traumas that can affect more than one value processing subsystem. Incest trauma can disturb both attachment and autonomy subsystems. Genocide can disturb collective identity, interdependence, and survival subsystems, Survival trauma may hijack in emergency, all other value processing subsystems, and mobilizes the person's resources to respond to the worst case scenario. Survival can overrule all other sub-systems. A traumatic or survival threatening experience can shatter the schema, the beliefs, the assumptions, and judgments about the self and the world, and about the efficacy of the existing value processing (appraisal) mechanisms that the individual possesses in one or all of the five areas of functioning. This affects the value processing functions that are based on such beliefs, (compare, for example, Janoff-Bulman, 1992). Traumatic events can disturb the automatic functions that execute the automatic activation of schema. They may be beyond the existing repertoire of schemata that direct the adaptive response to such an event. This may put a demand for novelty toward new value processing structures. Furthermore, the traumatized person can commit behaviors that do not match his or her value system. Paradoxical morality, committing immoral acts to serve survival which is higher order moral goal, is one of the potential behavioral components of trauma response, for example, the case of Schindler's list controversy (see Kira, 1996). We can find this pattern of paradoxical morality rampant in refugees who suffered from multiple survival traumas.

### **The second Classification**

The second Classification is based on the objective or the external characteristics of the traumatic event. It starts with the factitious and indirect trauma and goes to the potentially most severe and direct ones. It classifies traumas into two categories:

Factitious and real or actual. Traumatogenic stimuli can be either internally induced, e.g., terminal illness, limb amputation, uncontrollable pain, panic attacks, or externally induced. Externally induced traumatogenic stimuli can be either nature-made, e.g., hurricanes, or man-made. Man-made traumatogenic stimuli can be either person-made (direct trauma) or society-made (indirect trauma transmission). Person-made or direct trauma can be single event (type I) or complex episode/episodes. Complex trauma can be either repeated episodes (type II), or sequence of trauma (type III) that has usually accumulative effects. Type III trauma take different sequences in each area of functioning. On the other hand society-made traumas that takes place through the transmission mechanisms is divided according to the steps of transmission. The first one is one step transmission like this that happens from child and parent and vice versa, from worker to coworker/ workers, and from client to service provider. The second kind happens when trauma is transmitted in more than one step (cross-generational transmission). There are two kinds of cross-generational transmission. The first happens within family, e.g., cross-generational family violence. The second happens in a collective setting and is divided into two kinds: Historical trauma, e.g., genocide, slavery, and social/ structural trauma. In the next section, I will define and explain each of these kinds.

### **1. Factitious trauma or trauma like events.**

The accumulation of non-traumatic cascade of stressors, ordeals, or predicaments in space and time can create trauma like experience (see for example: Scott, M. J. & Stradling, 1994 and Berk J. 1992). Accumulating or additive effects or such cascading unrelenting rapidly unfolding successive non-traumatic stressors can produce effects remarkably similar to other types of trauma and eventuate PTSD like symptoms. They can also add up to the real traumas and amplify their effects. Post trauma secondary traumatization is an example of factitious trauma. The negative socio-cultural attitudes and non-supportive responses toward the traumatized individual can create the chain of post trauma stressors that cause secondary traumatization.

### **2. Indirect or vicarious trauma.**

This is transmitted between persons or generations through different mechanisms. Examples of such mechanisms that channel transmission of trauma are symbiosis, empathy, attachment, enmeshment, personal or collective identification, projective identification, introjection, dependency, codependency, interdependency, parenting, and acculturation. Individual coexists in a system or a network of interlocking relationships that transmit the effects of different significant events horizontally and vertically within time and space. An extreme example that gives validity to this assumption is shared psychotic disorder (Folie a Deux). In this disorder a delusion develops in an individual in the context of a close relationship with another person(s) who has an already established delusion (DSM IV, 297.3). Traumas can have similar effects on persons in relationships, or within strong collective identity, even they did not suffer the trauma themselves. In

this context, trauma can happen not only to one person, but also to a social unit, to a community, or sometimes to a whole society, e.g., genocide. However, the transmission of trauma does not always occur. Moreover, the mere experience of the most extreme traumatic event does not necessarily result in a disorder (see Lomranz, 1990). We can find two main kinds within this category:

**(a) One step transmission of trauma.** The transmission can happen from one person to another or from an individual or individuals to a connected group. For example, domestic violence is a direct trauma to the parent and indirect trauma to the child or children. Sexual abuse of the child is direct trauma to the child and indirect trauma to parents. Studies reveal that many mothers and in some situations both parents scored high on post traumatic symptoms at the time of disclosure or discovery of sexual abuse of one of their children (for example, see DeYoung M., 1994; Davies, M., 1995). Other examples are clinicians, fire fighters, emergency workers, police personnel, and international relief personnel that deal, as part of their daily work, with a multitude of traumatized clients. This kind of exposure can cause them a burnout, empathetic traumatization or compassion fatigue (Figley, 1995). Wilson and Lindy, 1994, describe two major types of emotional strain experienced by therapists through countertransference. The first type of emotional strain comes from their tendency to avoid, or to engage in empathetic withdrawal. The second type is the tendency to overidentify and to engage in empathetic enmeshment. Erikson et al, 1998 found that approximately 30% of international relief worker surveyed reported symptoms that meet a full or partial diagnosis of PTSD. However, perceived social support for those “honorably wounded” staff is associated with fewer symptoms of PTSD. Other examples include critical incidents that happen in the work place. These critical incidents directly experienced by one or some of the group can traumatize indirectly the rest of the group. The trauma, in this situation, may get transmitted from an individual to a connected group of people.

**(b) Multiple steps indirect traumas that are transmitted cross generations can be sub-divided into two categories:**

**(1) Generational family trauma transmission:** In this kind, traumatic practices and their effects get transmitted within a family system across generations. Examples are the vicious cycles of violence, the physical abuse, and incest in some families. For example, Skowron, E. (1998) found that many of the traumatized women who have been exposed to domestic violence, left the violent family of their childhood, only to enter relationships with violent partners to reexperience and engage in defensive reenactment of their childhood traumas. Reexperiencing the nightmare may be part of their PTSD symptoms that may enhance mastery or recovery through life course. The intergenerational continuity of those family patterns often expressed by their young children as violent perpetrators, or victims repeating the intergenerational cycle of violence. A great deal of research substantiate the intergenerational transmission of violence (e.g., Davies, P. T. & Cummings, 1994; DeKlyen, M., 1996; Constantino, 1996). There are other mechanisms that may account for the transmission of trauma. The research has consistently shown a strong correspondence between parents’

attachment styles and corresponding internal working models of relationship on the one hand, and the child's security of attachment to that parent, on the other. Secure adults beget secure children, dismissive parents begets anxious-avoidant children, preoccupied parents beget anxious ambivalent children, and violence and trauma in the family will tend to create frightened disorganized children, e.g., see Skowron, 1998, Main & Goldwyn, 1984, Fonagy, Steele & Steele, 1991, Steele, Steele & Fonagy, 1996. Research shows that mothers of infants with disorganized attachment styles reported significantly greater levels of violence with their current partners than those mothers of infants who developed secure attachment styles, see Zeenah, Hirshberg, Danis, Brennan & Miller, 1994. Projective identification is another possible mechanism that can facilitate the transmission of unresolved traumatic experiences. Projective identification in the context of parent-child relationships involves the parent's enlistment of the child to perform a particular role for the parent's externalized unconscious fantasy, and is thought to harm a child by impairing his capacity to experience his or her own subjective perceptions and sensations as a legitimate reality. It appears that enlistment of a child in the parent's projective fantasies lead to a collapse of the potential space within the mother-child relationship that allow for the development of child's autonomy (Skowron, 1998; Ogden, 1979). However this transmission is not automatic. There are resiliency factors and family differences that help interrupt the transmission of trauma across generations (see, e.g., Fonagy et al, 1994). Assessing the presence of and breaking such cycles of traumatic practices across generation is very important clinical task.

(2) **Collective cross-generational trauma transmission:** In this kind, group trauma is transmitted across generations. I can divide this sort into two kinds of collective traumas:

(a) The first kind is the historical trauma, e.g., slavery of American Blacks, Armenian genocide in Turkey, Jewish experience of Holocaust, and American Indian experience of genocide. This type of trauma is more a collective complex trauma as it is inflicted on a group of people that have specific group identity or affiliation to ethnicity, color, national origin, or religion. Unfortunately, this kind of trauma tends to be ignored in most clinical assessment and treatment of the individual client. It is important to assess prior traumatization and the dose of traumatic exposure including the effects of historical trauma on the client as part of the accumulation of trauma effects. Historical trauma can predispose the individual to poorly respond to lifetime traumas. For example, Solomon, 1993, found that the incidence of PTSD in combat veterans second generation survivors of the Holocaust lasted much longer and were also more severe, than non-holocaust combat veterans. Ford, 1999 found that the Native American Vietnam Veterans have very high prevalence of PTSD and severe psychosocial impairment and disorders of extreme stress comparing to their Caucasian counterparts. Prior victimization is generally associated with more symptoms and longer recovery.

(b) The second kind is the multigenerational transmission of structural violence that constitutes extreme social disparities (compare Schwebel, 1998). The effects of the structure or social violence created by generating deprived social structures or classes are traumatic to the parents and their children. Poverty, biologically induced traumas such as hunger or prolonged malnutrition, inadequate and crowded shelter,



inadequate medical care, unemployment, underemployment or employment in temporary jobs without fringe benefits, all of those cause severe consequences. They can cause parental insecurity; overwork and fatigue and accompanying irritability, limited availability of parents to children because of overwork, fatigue, tension, and illness and chronic ongoing threats to security and well-being for parents and their children (see Schwebel, 1998). This can either stimulate or overwhelm their sense of survival. This can disturb their value processing in one or all areas of functioning. This can also contribute to the kinds of conduct problems that are more prevalent in such social structures. The effects of deprivation by poverty and demoralization go from parents to children. McLoyd (1998), reviewing of research on socioeconomic disadvantage and child development, found that family level of poverty, low SES, and residence in less economically advantaged neighborhood, each independently predicts lower scores on tests of intelligence and cognitive functioning, lower levels of school achievement, and increased level of socioemotional problems, controlling for various parent and family characteristics. Poverty translates into the arrest of intellectual development and into educational deprivation even for those who have no apparent organic limitations to learning. The direct and indirect cross-generational consequences of such structural violence are devastating and enduring. They can transmit this kind of traumatic conditions across generations. Unfortunately, people accustomed to see such traumatized others suffering from such structural traumas, and regard the state of those others as part of the natural order of society (see Schwebel, 1998). Challenging the system's structural violence is a formidable task that should be addressed by community leaders, activists, politicians, as well as clinicians. Systemic interdisciplinary interventions to reverse the structural violence and curb its effects on next generations are the needed task that can deal with this kind of chronic ongoing society made traumas.

### **3. Direct Traumas.**

This is the third type of trauma with two types that can affect any one or more areas of individual functioning:

- a. Single unexpected direct trauma (type I).** It constitutes a single sudden blow. Type I trauma can cause typical symptoms of PTSD (e.g., persistent reexperiencing, persistent avoidance, persistent increased arousal). It does not appear to breed alone the massive denials, psychic numbing, self-anesthesia, or personality disorders that characterize the effects of type II trauma (see Terr, 1991). This trauma can impair one or more of the five areas of human functioning discussed earlier.

- b. Complex traumas.** Complex traumas especially type III traumas yield the most severe effects on mental health, e.g., dissociation, somatization, personality disorders, disorders of extreme stress. We can identify two main kinds of complex traumas:

- (1) Type II which is a unit of related series of blows, or sustained and repeated ordeals that gained prolonged and sickening anticipation in one areas of human

functioning, e.g., combat (survival), ongoing physical or sexual abuse (autonomy); compare Terr, 1991. This kind can be divided into two kinds:

(a) Ongoing chronic traumatic conditions. Examples are poverty, hunger, illness and disease without accessibility to adequate medical care, and terminal illness, e.g., AID, or terminal cancer. Ongoing physical, sexual abuse, or wars are other examples.

(b) Past extended traumatic conditions that ceased at the present time. The first episode in such extended trauma creates surprise. But the subsequent unfolding of terrors creates a sense of anticipation. Such traumas creates massive defense mechanisms, e.g., massive denial, massive repression, dissociation, somatization, self-anesthesia, self-hypnosis, identification with the aggressor, and aggression against the self. The impairment in emotional processing includes the absence of feelings, a sense of rage, unremitting sadness and fear (see Terr L., 1991).

(2) Type III which is a cascade of traumatic events that each can be either direct or indirect trauma of either type I or II that affect one or more areas of person's functioning. Examples are refugees' experience (e.g., Iraqi refugees). The series of traumatic events can take different patterns or sequences in its longitudinal course over time (see Kira, 1999). Examples of sequence are as follows:

- (a) Type I- type II.      (b) Type II-type II
- (c) Type II-type I      (d) type I-type III

Every pattern or sequence of traumas can yield different kinds of symptoms. Type III trauma can be focused on one area of human functioning, e.g., attachment or survival or it can affect different or all areas of individual processing. Any single or complex direct trauma can occur with added indirect traumas, as well as factitious trauma. We can use this taxonomy to devise a trauma checklist that helps identify all the traumatic events that affected a client. Pre-trauma traumatic events from any kinds, as well as secondary victimization and factitious trauma should be assessed. Developing an assessment matrix can help visualizing the affects of this kind of traumas on person's functioning and to calculate the severity of the exposure in each area.

The following diagram summarizes the proposed taxonomy:

Type III Trauma Assessment Matrix

Type of Trauma	Attachment Traumas	Autonomy/ Identity Traumas	Interdependence Traumas	Achievement Traumas	Survival Traumas	Internal Traumas
Transmitted Structural, and Historical traumas						
Birth and Infancy traumas						
Early Childhood traumas						
Adolescent Age Traumas						
Early Adulthood Traumas						
Late Adulthood Traumas						
Elderly Traumas						

Specify if it is indirect trauma, direct trauma, or factitious trauma; if direct trauma specify Type I= 1, Type II= 2; for type II indicate: a= ongoing, b= ceased. If indirect trauma specify if it is one step or cross generational, if cross-generational trauma specify if it is family or collective; if collective specify if it is historical or

social / structural. Further, specify if it is nature made or man made; if it is man made, specify if it is person made or society made.

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