

## Lessons Learned in the Traumatic Stress Field and the Way Forward

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# Overview

- Exposure to potentially traumatic events (PTEs) has been an important part of human existence since before recorded history, and important work was done prior to the 1970s on how exposure to PTEs impacts physical and psychological health. However, the traumatic stress field as we now know it began to emerge in the 1970s.
- This webinar describes the tributaries that led to the field's development, our accomplishments over the past four decades, some key challenges the field faces, and “modest proposals” for how we can address these challenges.
- I am an “Old Buffalo” who started working in the traumatic stress field in 1974, so my take on our field’s accomplishments, challenges, and “lessons learned” reflects this perspective.

# Traumatic Stress “Old Buffalo” in Action at His Desk



# Why Should We Care about History?

## Important People Say We Should Learn the Lessons of History:

- “Those who cannot remember the past are condemned to repeat it.”  
George Santayana (1905)
- “Everyone who ever heard Santayana’s quotation is doomed to repeat it!” Alex Saunders (2002)
- “History repeats itself, first as tragedy, second as farce”.  
Karl Marx (1852)

# Other Reasons to Know and Learn from Our History

- To measure our progress as a field. If we know how things were and how they are now, we can determine how much progress we have made.
- To avoid re-inventing the wheel. If someone has already developed something that works, we don't need to re-invent it and can spend our time in more productive ways.
- Even more importantly, to avoid re-inventing the flat tire!!! If something was a bad idea that didn't work before, why would we expect it to be a good idea that would work now?
- As one of my old professors one said, "to recognize old wine in new bottles" (i.e. old concepts that are recycled and presented as if they were new). That new "shiny object" may not be as new as you think!

# Foundations of the Trauma Field Prior to PTSD Diagnosis in DSM-III (1980)

- Empirical observations of PTSD-like symptoms among Civil War, WWI, and WWII combatants and civilians, natural disaster survivors, train wreck victims, and child sexual assault victims (e.g. soldier's heart, shell shock, railway spine).
- Fundamental basic research on fear conditioning, stimulus generalization, avoidance behavior, and helplessness.
- Feminism and the Women's Rights movement (e.g. info from consciousness raising groups about rape and intimate partner violence experienced by women and advocacy for improved VAW prevention and services).
- Child abuse and neglect movement.
- Crime Victims Rights movement.
- The Vietnam War and Antiwar movement.

# The Status of the Traumatic Stress Field in Early 1970s

- DSM-II (APA,1968) had no way to capture responses to PTEs such as major accidents, child maltreatment, disasters, violence against women, or war. DSM-II had a diagnosis of **TRANSIENT SITUATIONAL DISTURBANCE** that gave following example of Adjustment Reaction in Adult Life: “Fear associated with military combat and manifested by trembling, running, and hiding”. This was the only thing remotely related to traumatic stress in the whole DSM-II.
- Mental health professionals got no training in how to understand or address PTE-related mental health problems. Evidence-based treatments for these problems did not exist.
- Research on the scope of exposure to PTEs, the mental health impact of such exposure, and effectiveness or safety of treatments for these problems was virtually nonexistent.

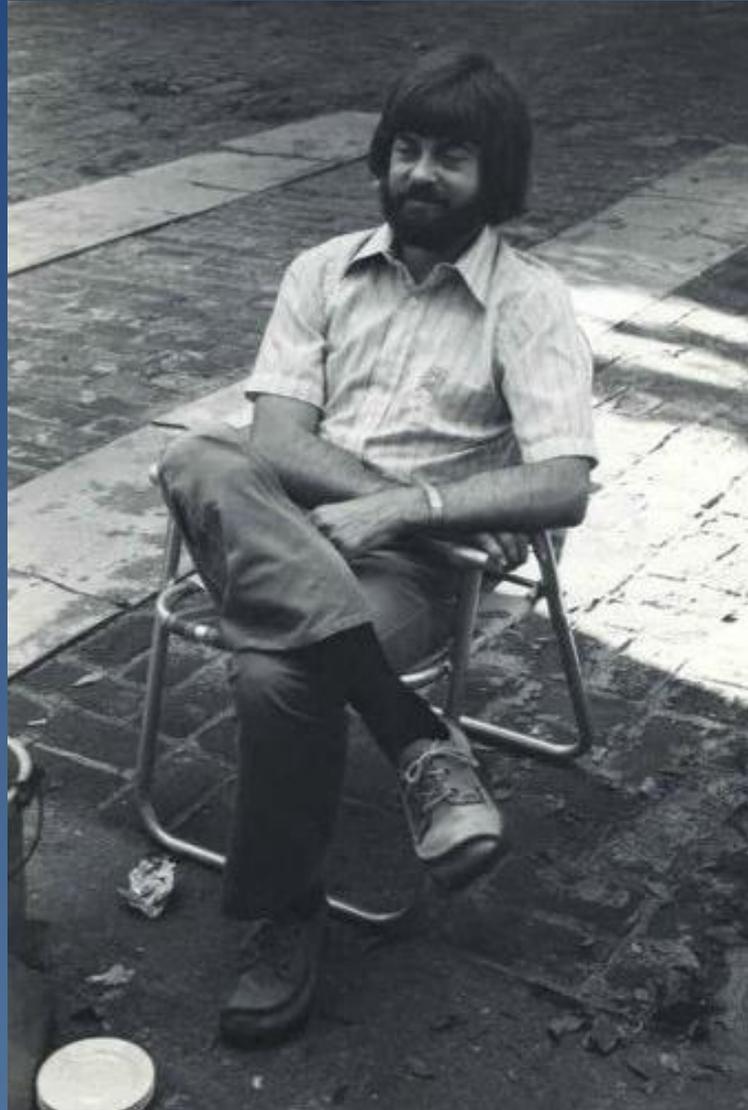
# Traumatic Stress Field in the Early '70s (Continued)

- Traumatic stress was not on the public policy, education, or professional practice radar screen.
- Traumatic stress was viewed as being so far out of the mental health mainstream that many colleagues thought you were risking professional suicide if you got involved.
- Children and adults who experienced PTEs had no chance of getting evidence-based trauma-focus treatment from a well-trained MH professional who understood the impact of trauma and how to treat people who had experienced it.
- In summary, there was no traumatic stress field in the early 1970s, only a few professionals working in isolation with different populations who had experienced various types of individual PTEs.

# This Is How I Got Involved in 1974

- In early 1974, the National Organization of Women sponsored public forum on rape. Everyone who attended was outraged, and a few of us signed up to figure out what to do about Charleston's rape problem. Shortly thereafter, we established People Against Rape (PAR), a feminist-oriented, grass-roots rape crisis center. I was the only man and the only mental health professional among the founders.
- PAR attracted terrific volunteers, some of whom were female psychology interns and research assistants, and many of those who got their start as PAR volunteers have gone on to make major contributions to the traumatic stress field (e.g. Drs. Connie Best, Patti Resick, Alma Dell Smith, and Lois Veronen).

# Dr. Dean Circa 1974



# My Journey as a Traumatic Stress Scientist/Practitioner/Policy Advocate

- I think that research is the best way to make progress because it keeps me honest by determining which of my wonderful ideas aren't supported by data! My best research ideas come from interacting with PTE survivors, and I also believe that research is of little value if it is not used to inform policy and improve services for those who have experienced PTEs.
- When we were training PAR volunteer, we thought they needed info about common concerns and problems experienced by rape victims, but there was no good research information about this. Consequently, Patti Resick, Lois Veronen, and I submitted a grant to NIMH in 1976 that was funded in early 1977 (i.e. Treatment of Fear and Anxiety in Victims of Rape) that involved longitudinal assessment of recent rape victims and non-victims as well as development and feasibility testing of SIT for rape-related fear and anxiety.

# Patti Resick and Yours Truly with Colleague John Roitzsch at AABT's First Poster Session in San Francisco, 1975



# My Journey (continued)

- Given the low rates of reporting to police and service seeking among female victims of violence, we conducted NIDA-funded epidemiological research assessing for exposure to PTE's and mental health consequences including PTSD, depression, and substance use problems. Subsequently, we expanded our epidemiological research to include adolescents, college women, and individuals exposed to natural disasters and terrorist attacks.
- To summarize a great deal of research, we found that exposure to PTEs is substantial across the lifespan and that most exposed individuals have experienced more than one PTE. We also found that number of PTE's experienced has a cumulative effect on the risk of PTSD and related disorders but that most PTE exposed individuals are resilient.

# My Journey (continued)

- Because I think that it is extremely important to increase public awareness about traumatic stress issues, I overcame my native shyness and shared research information about traumatic stress with the news media and public policy makers.
- One example of media and public policy outreach was a report we developed titled “Rape in America: A Report to the Nation” that was released in a press conference at the National Press Club in Washington. This report received widespread distribution in the media (i.e. over 108 million media impressions within 10 days) and also has been cited over 800 times in the research literature, the NRC, as well as by policymakers.

# Report Presented at National Press Club in Washington, D.C.

## **RAPE** IN AMERICA

A R E P O R T T O T H E N A T I O N

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# Traumatic Stress Field's Major Accomplishments in the Last 40 Years

Adding the PTSD diagnosis to DSM-III in 1980 was a huge accomplishment for several reasons that include:

- Increasing the credibility of MH responses to PTE exposure.
- Improving clinical assessment of common PTE-related problems.
- Identifying common responses to different PTEs.
- Stimulating development and evaluation of new treatments.
- Fostering an explosion in traumatic stress-related research.
- Providing a unifying language and conceptual framework that facilitated traumatic stress researchers and clinicians who were working with those exposed to different types of PTEs to recognize common responses to different events.

# Major Traumatic Stress Research Accomplishments in Last 40 Years

- Epidemiological studies that document the prevalence of exposure to PTEs and the extent to which exposure increases risk of PTSD and related disorders in probability samples of adults and adolescents.
- Studies that examine biopsychosocial risk and protective factors for PTSD and related disorders given exposure to PTEs.
- Randomized clinical trials comparing the efficacy of preventive interventions, medications, and psychotherapies for treatment of PTSD and related disorders.
- Studies that examine use of technology to provide new treatments and to augment existing treatments.
- Implementation science studies.

# Major Traumatic Stress Clinical Care Accomplishments in the Last 40 Years

- In contrast to 40 years ago, we now have several treatments for PTSD and related disorders with documented efficacy and effectiveness. They do not work with everyone and are not perfect, but we have much more to offer patients now than we did then.
- We have good assessment tools for measuring exposure to PTEs as well as PTSD and related disorders.
- Innovative work done developing online interventions based on SBIRT principles that provide screening, brief psychoeducational intervention, and referral to treatment. We are also delivering interventions via telehealth.

# Major Educational Accomplishments

- Traumatic stress research and clinical training is now a part of many Ph.D, Psy.D, internship, and postdoctoral training programs.
- You can obtain CEU credit for several online courses that provide baseline training in TF-CBT, PE, and CPT.
- New competency guidelines have been developed that provide a comprehensive framework for educational content and competencies in the trauma field.

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## A Consensus Statement on Trauma Mental Health: The New Haven Competency Conference Process and Major Findings

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### The New Haven Trauma Competency Group

Although the scientific literature on traumatic stress is large and growing, most psychologists have only a cursory knowledge of this science and have no formal training in, nor apply evidence-based psychosocial treatments for, trauma-related disorders. Thus, there exists a clear need for the development and dissemination of a comprehensive model of trauma-focused, empirically informed competencies (knowledge, skills, and attitudes). Therefore, the New Haven Competencies consensus conference was assembled. Sixty experts participated in a nominal group process delineating 5 broad foundational and functional competencies in the areas of trauma-focused and trauma-informed scientific knowledge, psychosocial assessment, psychosocial interventions, professionalism, and relational and systems. In addition, 8 cross-cutting competencies were voted into the final product. These trauma competencies can provide the basis for the future training of a trauma-informed mental health workforce.

*Keywords:* stress disorders, competencies, evidence-based practice, professional competence, professional training

# Major Public Policy Accomplishments

- Numerous laws have been passed that provide child maltreatment victims, rape victims, battered women, elder abuse victims, and other crime victims with increased rights and services. This includes the right to crime victims compensation which covers mental health care.
- Laws have been passed that established the Department of Veterans Affairs National Center for PTSD, which has been a tremendous resource for the traumatic stress field. Other laws provided veterans with greater access to evidence-based treatments for PTSD.
- The National Child Traumatic Stress Network was established and funded.
- There are now strengthened laws and policies against sexual harassment and sexual assault in the workplace, on campus, and in the military.

# Lessons Learned

- We have made a lot of progress, but we still have a long way to go to accomplish the mission of learning how to prevent PTE exposure when we can and insuring that all trauma victims have access to the best possible services until prevention efforts are a success.
- You can get a lot done if you are willing to be persistent , work hard and collaboratively with others, and overcome the reluctance most of us have to engage with nonprofits, the media, and public policy makers.

## Lessons Learned (continued)

- Professional and public policy interest in traumatic stress runs in cycles. Traumatic stress is hot and then it is not! We cannot assume that our field will remain a priority for funding because some new fad will come along.
- The good news is that our field has grown enormously. The bad news is that this growth has resulted in increased fragmentation, competition for resources, and failure to take a broader perspective on the importance of all types of PTEs occurring at all stages of the lifespan.
- The biggest lesson I have learned personally is to be careful about your hairstyle and how you dress! If not, pictures of you taken now may be VERY embarrassing in the future!!!!

- The field is fragmented by a narrow focus on single types of PTEs occurring during a single period in the lifespan. There is often mistrust and fragmentation between researchers and clinicians. Traumatic stress professionals, PTE survivors, and nonprofit groups often mistrust each other.
- We need a better trained trauma-informed work force of culturally competent researchers and clinicians.
- We need PTSD treatments that are even more effective, and we must figure out how to make effective interventions available at scale.

# Challenges for the Traumatic Stress Field (continued)

- More public awareness is needed about the causes and consequences of traumatic stress and the availability of effective treatment.
- Resources aren't adequate.
- There is an profound anti-science mood in the country and in some parts of the traumatic stress field.
- The “new shiny toy” in the research funding realm is an extreme biological and neuroscience reductionism that often focuses on a molecular level of analysis and that does not adequately value other important perspectives and levels of analysis.

# Dr. Dean 40 Years Later Circa 2014



# The Way Forward: Some Modest Proposals

- It is imperative that the traumatic stress field succeed in addressing its challenges not only for those of us in the field but more importantly, success will enable us to better meet the needs of those we supposed to be serving.
- Meeting these challenges will require us to collaborate, work hard, and work smart, but we owe those we are attempting to serve no less than doing our very best.

# Modest Proposals

- Find ways to decrease fragmentation. There is often mistrust between researchers and clinicians as well as between traumatic stress professionals, PTE survivors, and nonprofit groups. We need a more collaborative, unified approach that focuses more on what we have in common and our areas of agreement than our differences and disagreements.
- Increase public awareness and public policy efforts using the best data presented in the most user friendly way possible.
- Flesh out and implement the New Haven Competency guidelines to improve the knowledge, education, and skills of the traumatic stress workforce.

# Modest Proposals

- **Adopt a public health approach that emphasizes the importance of both prevention and treatment.**
- **Recognize that the whole traumatic stress field benefits from good research.**

# Farmer Dean in Clover, S.C.: He's Not Just a Pointy-Headed Intellectual!

