The Seven Core Losses Associated With[[1]](#footnote-1) Trauma[[2]](#footnote-2) and Traumatic Stress[[3]](#footnote-3)

**1. The actual experience of, exposure to, and/or observance of the actual or perceived loss[[4]](#footnote-4) of well-being[[5]](#footnote-5) in one’s life[[6]](#footnote-6) or the life of another.[[7]](#footnote-7)**

**2. The abrupt and/or chronic loss of choice.[[8]](#footnote-8)**

**3. The abrupt and/or chronic loss of control.**

**4. The loss of normal and routine feelings[[9]](#footnote-9) of safety[[10]](#footnote-10) and invulnerability.[[11]](#footnote-11)**

**5. The loss of a predictable[[12]](#footnote-12) and orderly world.[[13]](#footnote-13)**

**6. The loss of an adequate[[14]](#footnote-14) and positive self-perception.[[15]](#footnote-15)**

**7. The loss of trust in self, others,[[16]](#footnote-16) human systems,[[17]](#footnote-17) and/or God.[[18]](#footnote-18)**

As described above, “The Seven Core Losses Associated With Trauma” are assumed to be etic[[19]](#footnote-19) and, therefore, generalizable across cultures and trauma contexts.[[20]](#footnote-20) However, these seven losses are not intended to limit, confine, or simplify the normal but highly complex responses of individuals, families, communities, and societies to traumatic events and experiences. In addition, (to summarize footnote # 1), it should never be assumed that all people exposed to severe trauma experience these losses to their fullest extent emotionally, cognitively, behaviorally, and relationally. That is, trauma events[[21]](#footnote-21) are not deterministic predictors of individual, human reactions. The list is, however, intended to provide a relatively simple, straight-forward, easily understood working model that can help people begin or continue the process of integrating single or multiple traumatic experiences with real life and the development of new normal.[[22]](#footnote-22)

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1. Trauma as a term comes from the Greek language and means “injury or wound.” (Schauer, M., Neuner, F., & Elbert, T. (2005). *Narrative exposure therapy: A short-term intervention for traumatic stress disorders after war, terror, or torture.* Cambridge, MA: Hogrefe and Huber). Trauma, however, must be defined by distinguishing the event from both the consequences of—as well as the appraisal of—experiencing that event. For a traumatic event to result in a traumatic outcome in human beings (at a so-called ‘disorder’ level of impact, if you will), an enduring adverse response must exist for an individual, a group, a community, or a society. For example, Webster’s defines trauma as an intense mental, emotional, or physical disturbance due to stress. That is, the definition of trauma highlights the negative impact occurring to and within the individual who experienced a traumatic event. Normal disruptions in psychobiosocial functioning following a traumatic experience usually dissipate over time, relative to the volume, duration, type, and intensity of the initial disturbances. For complex reasons related to multiple vulnerability factors, however, some disruptions may remain chronic in certain individuals. (It must be noted that experiencing traumatic events in childhood—especially repetitively—can result in developmental patterns impacting relational attachments, mood presentation, physical well-being, and cognitive structures.) [↑](#footnote-ref-1)
2. Psychological trauma: “A circumstance in which an event overwhelms or exceeds a person’s capacity to protect his or her psychic well-being and integrity…a collision between an event and a person’s resources, where the power of the event is greater than the resources available for effective response and recovery.” (Cloiter, Cohen, and Koenen, 2006) A significant concern surfaces, however, when people realize that the human reactions to trauma are not uniform and similar. Questions, therefore, abound. For example, why do some people seem to display more resiliency than others? Are there better ways to cope and worse ways to cope? Can resiliency be learned and applied prophylactically? Is resiliency impacted by genetic factors more than by social and developmental ones? Why do some people develop PTSD from the same event while others do not? And so on. Keep in mind, too, that even resiliency/coping itself is not a quantifiable, standardized category. For some severely traumatized individuals, just sustaining the will to live one day at a time *is* resiliency. For this individual, using drugs or alcohol (for example) to numb the fear and deaden the pain *is* coping: so, for this person, the problem has become the solution. On a continuum from healthy to unhealthy these coping mechanisms may be unhealthy and unsustainable long-term, but even unhealthy coping is still a component of resiliency. Using the Vietnam War as a source of large-scale trauma, maybe that is why over 40,000 young American soldiers came back from Vietnam as heroin addicts. And who knows how many became full-fledged alcoholics as well? It is estimated that approximately 1.5 million soldiers experienced combat in Vietnam. Using a conservative approach, it is assumed that 10% developed diagnosable PTSD. Sixty to eighty percent of those with PTSD developed a substance abuse addiction. [See: <https://www.selfgrowth.com/articles/prevalence-of-addiction-and-alcoholism-in-vietnam-war-veterans> and <https://www.recoveryfirst.org/blog/addiction-and-alcoholism-in-vietnam-war-veterans>] Bremner (2002) confirms that alcohol, heroin, marijuana, and benzodiazepines attenuated the PTSD symptoms of hyperarousal and intrusive memories by dampening the noradrenergic system of the brain (p. 161). Self-medicating, though unhealthy, was a way for soldiers to cope with horrific images and relentless fear. [↑](#footnote-ref-2)
3. The human response to stress begins in the brain and is psychobiologically complex. As explained by McEwen and Lasley (2002), *allostasis* (from the Greek word *allo*, which means many variables) is a rapid, intricate communication throughout the body that is summarized in what is commonly known as the fight or flight response. Though the flight/fight response is usually associated with danger and threat, allostasis can be activated by the morning commute, the annual performance review scheduled for 10:00 AM, the argument with your stubborn spouse over the cost of lodging during your upcoming family vacation, and the multitasking required at 4:00 PM to settle a squabble between the kids, change a smelly diaper, pick up a few toys, get dinner started, and make sure Fido has a potty break before staining the carpet…again! *Allostatic load*, on the other hand, exists when the stress response system consistently fails to meet the challenges of the stressor and results in damage to the person physiologically. On the other hand, “…allostasis, when functioning smoothly, is what empowers us to handle and adapt to changes in our environment (p.26).” PTSD, therefore, is essentially an allostatic load condition due to experiencing a traumatic change in one’s environment that cannot be coped with effectively. [↑](#footnote-ref-3)
4. Of course, the ultimate loss is physical death that leads to spiritual death. Even the Bible clearly stipulates that death, even for those in Christ, is still the enemy yet to be destroyed (1 Corinthians 15:24-28). For an encouraging and comprehensive overview of eternity as a follower of Jesus, see Alcorn’s book, *Heaven.* [↑](#footnote-ref-4)
5. This first loss *must* occur and is the catalyst for the following cascade of losses. Traumatic loss is clinically associated with a physical threat of harm, specific injury, or death (see the DSM-5 Posttraumatic Stress Disorder—code 309.81 (F43.10)—description of a traumatic event in Criteria A). However, identical and typical psychobiosocial (and, by extension, neurological) responses of fear, helplessness, avoidance, numbing, arousal, hopelessness, and depression (for example) can and do occur in response to non-physical events such as the discovery of an affair, chronic racism and prejudice, the loss of a job, or the betrayal of a friend. As mentioned in footnote number 1, another confounding issue concerns frequent, repetitive, chronic (and, in some cases, less frequent but acute) exposure to traumatic events as a child. These experiences can become so commonplace as to be interwoven into the fabric of the child’s life in such a way that isolated memories of time-person-place events as an adult become difficult if not impossible to retrieve in any detail. Clinical terms for this childhood trauma exposure—though not officially utilized in the current diagnostic manuals—include “complex trauma,” “developmental trauma disorder,” and “disorders of extreme stress not otherwise specified” (DESNOS) (van der Kolk, 2014, p. 155-159). [↑](#footnote-ref-5)
6. People are generally hard-wired to pursue life (as noted, for example, by the automatic fight-flight response to a life-threatening event), but are simultaneously aware that death is ultimate and unavoidable. In human development, the emergence of self-consciousness at approximately age three also introduces the toddler to a life-time of death awareness and what that rudimentary awareness means regarding the eventual adult pursuit of security and significance. For a thorough view of what is called Terror Management Theory, see the following two works by Pyszczynski, Greenberg, and Solomon: *In the Wake of 9/11: The Psychology of Terror* and *The Worm at the Core: On the Role of Death in Life*. [These three authors are social psychologists. They seem to collectively agree that religious systems are a creative human antidote to the universal self-consciousness that evolutionary-directed survival is impossible and that death is always the outcome. Though they inadvertently expose and articulate some fascinating biblical principles, they do not actually believe in God, the death and resurrection of Jesus, nor the Bible as God’s communication to people. For an honest view of evolution, human consciousness and the development of morality and ethics from an atheist perspective, see Thomas Nagel’s *Mind and Cosmos: Why the Materialist Neo-Darwinian Conception of Nature Is Almost Certainly False.* Nagel (2012), a renowned philosopher, argues that evolution fails to adequately explain how natural selection; random, progressive genetic mutations; and universal common descentfrom an original single cell resulted in a moral-ethical human consciousness. [↑](#footnote-ref-6)
7. Those who witness traumatic losses sustained by others can experience what is called “emotional contagion.” This phenomenon is an “…affective process in which an individual observing another person, experiences emotional responses parallel to that person’s actual or *anticipated* emotions (Figley, 2002, p. 2-3).” Emotional contagion is essentially based on the open-loop limbic system that is activated through mirror neurons (Iacoboni, 2008). This is similar to what is called the “proximity effect.” On the other hand vicarious or secondary traumatization “…refers to a transformation in the therapist’s [or any care-giver’s, for that matter] inner experience resulting from empathic engagement with clients’ trauma material (Figley, 2002, p. 3).” Another term for the cumulative stress effects associated with chronic care-giving is compassion fatigue. Those who provide care for a family member with Alzheimer’s, hospice providers, or social services staff, for example, may experience a gradual change in their own cognitive, emotional, spiritual, physical, and/or relational presentations or symptoms as they attempt to cope with chronic exposure to the losses of others. [↑](#footnote-ref-7)
8. From a biblical perspective, a fundamental principle seems to be that people created in the image of God were (in their original primal condition) given control over their environments (see “rule”/”dominion” in Genesis 1:26 and Genesis 1:28), and given the freedom to choose (Genesis 2:16-17) a dependent long-term relationship with God…or not. The fact that our initial human ancestors chose to believe a lie, and the resulting natural consequence of death, should not diminish the importance God placed on human beings possessing choice and control in life. Though I do not fully understand choice and control within the complexity of the entire biblical record, as a follower of Christ I accept the proposition that God gifted human beings with dominion and power over what God had created (Genesis 1:26-28) as a component of His love for them. God also gave people freedom to choose within limits. He did not grant permission to people to choose to not trust Him. That is, God’s word “…never regards the choice to decline covenant as legitimate (Sanders, 1998, p. 45).” However, the threat of a natural outcome punishment—death as separation from God—implies that there was a possibility that humans could exceed their limits and choose to not trust God. Truly this was, as Sanders (p. 46) puts it, a “sovereign risk” implemented by God in his relationship with people (See Genesis 2:15-17.) Nowhere, however, does God, by granting choice and control, imply that humans could “lord it over” one another. Trauma tends by its very nature to abruptly, unexpectedly, and/or violently eliminate or reduce choice and control. And it becomes especially egregious when choice and control is traumatically eliminated by a fellow human being. [↑](#footnote-ref-8)
9. Emotionally, some posttraumatic reactions are literally overwhelming. People can be flooded and overwhelmed with fear and anxiety and become stuck in the memory as if the trauma was occurring all over again. This experience is called an *abreaction.* However, some people shut down emotionally. They are numb, unfeeling, blank, frozen, and emotionally flat-lined. This presentation moves from alexithymia (the absence of words for describing feelings) to depersonalization. Alexithymia almost becomes part of an individual’s personality whereas depersonalization represents a ‘disconnect’ between the traumatic event(s) and the feelings one would assume to be associated with those memories. The real problem with depersonalization is when it characterizes an individual’s routine state of being, not just an event or episode. Van der Kolk (2014) explains, “Knowing *what* we feel is the first step to knowing *why* we feel that way (p. 95-96).” In depersonalization (and alexithymia) the ‘what,’ and ‘why,’ as well as the words for feelings are (for the most part) simply absent. In a paradoxical sense, therefore, the inability to feel and communicate those feelings is a form of communication. Accessing the emotional brain and bringing the rational, analytical brain into a cooperative, healthy entailment with the limbic brain is a goal of any trauma therapy. It seems that the bridge, so to speak, between the executive, rational dorsolateral prefrontal cortex and the limbic system (especially the amygdala) is the medial prefrontal cortex, where self-awareness tends to reside (van der kolk, 2014, p. 206 et ff). It is fascinating to imagine that for a follower of Christ, having the Holy Spirit inside the brain, mind, and awareness of a one’s conscious awareness is a critical component of what Siegel (2012) describes as “mindsight.” So, for example, the application of Philippians 4:8 is not simply a cognitive, rote progression of factual examples of what is true, honest, just, pure, lovely, good report, virtue, and praise-worthy. Rather, for the believer in Jesus, it is the interactive analysis of one’s thoughts, emotions, attitudes, and values in a given moment with the living God. And, in that self-awareness, God the Holy Spirit may *then* bring specific aspects of Philippians 4:8 to mind that fit the occasion. Unfortunately, traumatic experiences can so imprint the brain that the limbic, emotional brain highjacks the circuitry and activates fight, flight, or freeze reactions (the amygdala’s instantaneous threat appraisal feedback) that are essentially void of input from either dorsolateral or medial prefrontal cortices. [↑](#footnote-ref-9)
10. This is why some people only find comfort and safety in the context of those who can also literally say “I’ve been there, done that, and got the T-shirt.”(For example, see: Marlantes, 2011; Ussher, Kirsten, Butow, & Sandoval, 2006) In fact, a sense of safe belonging can be the most elusive within the context of one’s closest family members and friends who have no first-hand idea as to what the trauma victim experienced. As one survivor of the Holocaust recounted her experience, “If you were not there, it’s difficult to describe and say how it was. How men function under such stress is one thing, and then how you communicate and express that to somebody who never knew that such a degree of brutality exists seems like a fantasy (van der Kolk, 2014, p. 195).” [↑](#footnote-ref-10)
11. This loss results in anxiety and fear—the dialectical opposites of safety and invulnerability—becoming predominant. This state is markedly internal and may, in general, be non-specific as to on-going causes. That is, even relatively benign, innocuous losses of choice and control can trigger anxiety and fear at a level perplexingly disproportionate to the situation. (This phenomenon is sometimes referred to as stimulus discrimination error.) Extreme emotional posttraumatic reactions can manifest on a continuum from hyperarousal to hypoarousal. Either one of these polarized triggered reactions means the person has been pushed beyond their window of acceptable tolerance, so to speak (van der Kolk, 2014, p. 205). The emotional brain has, in essence, highjacked the rational, analytical brain. There are few to no instantiated direct connections between the rational part of the human brain (the dorsolateral pre-frontal cortex) and the main structures of the limbic brain (especially the amygdala and the hippocampus). However, the medial pre-frontal cortex—where self awareness and mindful interoception take place—link the limbic system with the dorsolateral pre-frontal cortex. It’s at this juncture that emotional self-regulation can gradually develop and strengthen over time (van der Kolk, 2014, p. 206-209). As mentioned previously, consistent self-awareness along with a repetitive application of going through the values progression of Philippians 4:8 can—with prayer and time—actually impact the brain. [↑](#footnote-ref-11)
12. Some have referred to this loss as the loss of an “assumptive world.” (See Rogers et al, 2008). In the aftermath of trauma, it’s a reality that even casual, mundane, and normal routines can no longer be unconsciously assumed going forward. Diminished predictability can also expand to include a loss of meaning and purpose in life where the future no longer makes sense or simply lacks significance in light of what has been lost (Frankl, 1959). In the aftermath of traumatic events and losses, eventually making meaning from the trauma is the transition from trauma victim (no choice/no control) to post-trauma agent (new choice/new control). (See Bolton & Mitchell; 1983). Biblically, 2 Corinthians 12:7-10 seems to confirm that, while a whole range of bad things can happen to people in their human condition that reduce or eliminate their power, control, and choices in life, there will always be a choice available within one’s relationship to the love and grace of God. It should be noted, however, that some in the Christian community are actually less protected by their faith due, in fact, to their belief system. For example, those who see God as holy, punitive, and wrathful (somewhat like Job’s accusers) tend to self-condemn, and those who assumed that God’s sovereignty meant God’s protection and intervention tend to blame God for deceiving them and failing to keep His promises. Regardless, though, people who have been traumatized exist in co-realities: a present reality that is relatively secure, predictable, and manageable that co-exists side-by-side with a damaged but always-present past. [↑](#footnote-ref-12)
13. This loss also relates to the chronic increase of anxiety and fear, but is largely external in focus, characterized by a tendency to cast assumptive doubt on ordinarily benign systems, places, activities, processes, and routines. [↑](#footnote-ref-13)
14. Infant development includes a normal phase termed the *teleological stance*. It is the capacity to interpret one’s actions being sufficient to achieve goals within the limits of physical reality. Eventually the teleological stance progresses to a point whereby the child subconsciously experiences a mental state that includes desires, goals, and beliefs about the constraints of reality. In due course this subconscious experience transitions into a *reflective function* ability that allows the child to accurately understand his/her own subjective reality as well as the behavior, feelings, thoughts, motives, etc. of others. Traumatic experiences can radically impair the reflective function ability in post-trauma relationships (Allen, 2001, p. 80-82). [↑](#footnote-ref-14)
15. Shame, guilt, and a gnawing inadequacy can become strong components of the sense of a person’s real, inner self in contrast and in opposition to an individual’s idealized self. By default, one’s identity mirrors the perceived failure to stop, avoid, or be unscathed by the traumatic event or events experienced. That is, in some manner, one’s inner mantra becomes, “There’s something wrong with me” for even experiencing the traumatic event itself. But, as Susan Lawrence (2006) explains, “…the effects of trauma are *normal human reactions to overwhelming stress, and not a disease or sign of weakness* (p. 62).” [↑](#footnote-ref-15)
16. The trauma literature is replete with nuanced insight into the intrapsychic experiences of trauma victims. But trauma impacts posttraumatic relationships as well. (See Allen, 2001.) Trauma interrupts what is called “intersubjectivity”: the naturally shared meaning between people (Iacoboni, 2008, p. 262). For many, (for example, the Holocaust survivor mentioned previously) trying to find adequate words to describe and explain one’s traumatic experience is hard enough; but to explain to another who has no familiar reference point for one’s personal experience can seem hopeless or impossible. [↑](#footnote-ref-16)
17. “When people lose confidence in their core beliefs, they become literally “dis-illusioned” because they lack a functional blueprint of reality (Solomon, Greenberg, & Pyszczynski; 2015; p. 48).” [↑](#footnote-ref-17)
18. Connection with and a sense of secure attachment to others and God often becomes impaired, damaged, or even destroyed. Relationships tend to be based on fear instead of love. If attachment was insecure prior to a traumatic experience, posttraumatic secure attachments can be even more difficult to acquire (Baars & Terruwe, 1976). Fear, shame, and anxiety, based essentially in the limbic system (notably the amygdala), tend to distort reality, introduce lies, and impair the love of God in the brains (primarily via the anterior cingulate cortex) and minds of people. It seems that when Adam told God he hid from God because he was “afraid” (Genesis 3:8-11), a literally cataclysmic pattern was introduced into humanity from that time forward. Jesus, however, is not only the antidote for our sin through His death on the cross, but He also (through Mary, His human mother) had to battle the DNA-infected anxiety, fear, and anger tendencies passed on to Him through his human mom without even once giving in. So, it is no small issue that Jesus was made like us (Hebrews 2:14-18), was tempted like us, but was “without sin” (Hebrews 4:14-16). Amazing! That being said, however, trauma can significantly impact the fear-structures of anyone’s brain, introduce lie-based thinking, and impair a person’s view of the love and goodness of God (Jennings, 2013, p. 63-65). Keep in mind, also, that even Jesus battled his limbic driven fear reactions to dying on the cross before surrendering to the will of His *Abba* (Mark 14:32-42). [↑](#footnote-ref-18)
19. *Etic* and *emic* were terms coined by Kenneth Pike, an anthropological and missionary linguist, in 1954. *Etic* refers to phenomena observed universally across cultures; *emic* is an individual’s norms, values, motives and customs within the culture and context they live in. [↑](#footnote-ref-19)
20. At the same time, while acute stress reactions and PTSD symptoms may be essentially universal within the medical model of diagnosis and disease, how an individual experiences their own symptoms within (for example) their family, their local community, their religious framework, and their ethnic social group will be absolutely unique to that person. Somewhat similar in principle to Pike’s use of etic and emic, Kleinman (1988, p. 7) describes the difference in this manner: “…disease refers to the way practitioners recast illness in terms of their theoretical models of pathology…” while “…illness refers to the patient’s perception, experience, expression, and pattern of coping with symptoms…” Differentiating between disease and illness can be critical for understanding how people from distinct cultural paradigms experience similar traumatic events. [↑](#footnote-ref-20)
21. However, even when traumatic events do not result in PTSD, “Trauma results in a fundamental reorganization of the way mind and brain manage perceptions (van der Kolk, 2014, 21).” [↑](#footnote-ref-21)
22. Friedrich Nietzsche, the 19th century, atheist German philosopher, once said, “To live is to suffer; to survive is to find some meaning in the suffering.” Ironically, it seems that Jesus epitomized Nietzsche’s concept of finding meaning in suffering (Hebrews 5:7-10; Hebrews 12:2-3). Frankl (1959), also referencing Nietzsche, said, ”A man who becomes conscious of the responsibility he bears toward a human being who affectionately waits for him, or to an unfinished work, will never be able to throw away his life. He knows the “why” for his existence, and will be able to bear almost any “how” (p.127). Jesus is again the example *par excellence* of Frankl’s observation about human nature. John 4:34 reads, “My food,” said Jesus, “is to do the will of him who sent me and to ***finish*** his work.” Finding or reconstructing meaning in the wake of trauma may take a lifetime, will be unique to each person, and will usually require an “it takes a village” mindset regarding relationships and community. But ‘making meaning’ can be found.  [↑](#footnote-ref-22)
23. The American Psychological Association chose to reject Developmental Trauma Disorder (DTD) as a proposed diagnostic category for the DSM-5. Multiple research endeavors underpinned the proposed DTD diagnosis as it related to children and adolescents. Those based on data from Adverse Childhood Experiences (ACE) studies were especially powerful in their implications. Vincent Feletti (Kaiser Permanente) and Robert Anda (Centers for Disease Control and Prevention) were notable figures in the initial ACE studies. [The initial ACE research article—now just one of many—is listed in the bibliography.] For twenty years ACE studies have accumulated enough correlation data to easily move to cause and effect conclusions. The National Child Traumatic Stress Network, established by congress in 2001, focused exclusively on research and treatment studies of traumatized children. Their findings, in conjunction with ACE study outcomes and several major longitudinal studies, substantively supported the DTD diagnosis proposal and met the requirements for formally submitting a new diagnostic category. Inexplicably, however, the APA leadership rejected the proposal in 2009, four years before the DSM-5 was published (van der Kolk, 2014, p. 156-168). [By the way, the ACE Scale is a simple 10 question assessment of undesirable and/or painful experiences and relationship dynamics occurring between birth and age 18 that can be answered ‘yes’ or ‘no.’ The number of ‘yes’ answers is one’s ACE score. The higher the score the more likely a person will suffer from a number of significant, chronic medical (mental and physical) conditions. The ACE questionnaire can be accessed from multiple web sources. For example, see: <https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf>] [↑](#footnote-ref-23)
24. This is an assessment tool related to the experience of a traumatic event. The instrument is based on constructivist self-development theory (CSDT). Numerous articles can be accessed online that relate to CSDT and to Dr. Pearlman’s work in particular. [↑](#footnote-ref-24)
25. Foa and others have developed a treatment protocol for PTSD called Prolonged Exposure Therapy (PET). It is based on emotional processing theory. [↑](#footnote-ref-25)
26. EMDR is a method for addressing PTSD that Shapiro introduced into the mental health mainstream almost 30 years ago. It is essentially an exposure protocol that (theoretically) utilizes bilateral stimulation of the brain while simultaneously attempting to verbally and emotionally engage targeted traumatic memories. [Both EMDR and PET help an individual integrate traumatic experiences in meaningful ways based on reality and truth. Both can help mitigate intrusive memories, avoidance behaviors, negative and distorted cognitions, and impaired hyperarousal or emotional numbing. However, what happened cannot be undone. So, mitigating the footprints of a trauma experienced will never erase or extinguish the memories and emotions of that experience.] [↑](#footnote-ref-26)