

TRAUMA: HOW DO WE GET IT AND HOW CAN WE OVERCOME IT

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Abstract

The paper describes the major kinds of responses to traumatic experiences, and presents a three-stage model of progression from the event, to trauma and finally to posttraumatic response. Major treatments of traumatic responses are described, and are characterized in terms of their focus on elaborating the event or in contrast reducing contact with it. Two studies were briefly described, referring to responses to retrospective or prospective trauma. The results provided information about the factors responsible for high levels and low levels of disturbance in response to traumatic experiences, based mainly on dwelling in detail on the event and elaborating its personal connotations versus focusing on factual reports devoid of personal involvement.

Keywords: *Trauma, posttraumatic disorder, treatment, three-stage model, CBT.*

1. Introduction: The nature of trauma

Trauma is one of the most frequent and most difficult psycho-physical phenomena. According to the DSM-5 trauma occurs due exposure to real or threatened death, serious injury, or sexual violence, which involve intense fear, helplessness, or horror. It is assumed that it forms the basis for trauma-related diagnoses like Post-Traumatic Stress Disorder (PTSD). Criterion A of PTSD requires merely exposure to the event, which may be direct or indirect, i.e., hearing about it or seeing it happening to others); a trauma diagnosis also requires specific reactions to the event, including fear, helplessness, or horror; while PTSD requires subsequent symptoms like re-experiencing, avoidance, negative thinking, and hyperarousal.

The description of the event, trauma, and PTSD implies that we are dealing with a process that may have several stages. The first stage consists of exposure to the event that is identified as unusual, scaring and dangerous. Nothing much happens in addition or subsequently. The second stage consists in experiencing the event as a trauma. Trauma involves emotional reactions which consist mainly of fear, horror, shock, confusion, anxiety, denial, but the person is still able to function and take care of one's basic needs and obligations.

The third stage is identified as PTSD which involves physical symptoms (sleep disorders, nightmares, shortness of breath, sweating, trembling, digestive problems), cognitive symptoms (negative thinking and attitudes about oneself, others, the world, detachment, withdrawal from feeling positive, flashbacks), behavioral symptoms (avoidance, difficulties at work, difficulties in the family and with friends), and emotional symptoms (hyperarousal, irritability, intense startle reactions).

1.1. The inter-stage progression

Examining the described three stages implies the possibility that there may be a progression from stage 1 to stage 3. The progression consists in various respects and may be described in terms of four dimensions. The first one is in terms of the temporal interval between the occurrence of the event and the appearance of symptoms. Stage 1 occurs in direct proximity with the event, while stage 3 may occur weeks or months after the event. It may be assumed that stage 2 occurs in between direct exposure to the event in stage 1 and the occurrence of PTSD in stage 3.

The second dimension of progression is in terms of the durability of reactions or symptoms. In stage 1 the reactions disappear within minutes (up to 60 minutes) after exposure to the event; in stage 2 they may last for hours; in stage 3 they may last for weeks and months or even more.

The third dimension of progression is in terms of the range of symptoms. In stage 1 the reactions do not correspond to symptoms. In stage 2 there are symptoms and they are mainly emotional and cognitive, which means that they are relatively limited in their effect. In stage 3 the range of symptoms extends beyond the immediate emotional and cognitive boundaries to the behavioral domain which encompasses work, studies, friendships and family relations.

The fourth dimension of progression is in terms of the degree of pathology. In stage 1 there is merely experiencing but no pathology of any kind. In stage 2 there may be emotional reactions that may seem pathological, such as temporary confusion, but they do not always appear and mostly there are no further indications of pathology. In stage 3 there are definite signs of pathology insofar as the reactions overstep even the boundaries of the original by affecting wide domains of life and functioning.

The major conclusions supported by the description of the four dimensions of progression from stage 1 to stage 3 are that the stages appear sequentially in a fixed order progressing from stage 1 to stage 3; and that the progression is unidirectional and proceeds only from stage 1 to stage 3.

2. The hypotheses

The description of the inter-stage progression suggests that the progression from stage 1 to stage 3 is not absolutely necessary and can stop at any stage – stage 1 or stage 2 or stage 3, without proceeding further. This implication raises the following major questions: What are the factors which determine the progression from stage 1 to stage 2, and those that determine the progression from stage 2 to stage 3? Accordingly, the first hypothesis is that there may be one or more intervening factors that impact the inter-stage progression from stage 1 to stage 2. The second hypothesis is that there may be one or more intervening factors that impact the inter-stage progression from stage 2 to stage 3.

A further implication of the hypotheses is that when the intervening factors inhibit the progression from stage 1 to stage 2 or from stage 2 to stage 3, they may contribute to breaking or stopping the progression and may therefore be considered as protective factors.

2.1. The nature of the intervening factors

The nature of the intervening factors hypothesized for the present studies was determined on the basis of an analysis of several major studies concerning treatment of PTSD. The major type of treatment is called talking therapies, which include mainly or even exclusively CBT and its variations. This kind of therapy is based on different psychological techniques designed to help the patient to come to terms with what happened, recalling the details of the event, reducing avoidance, understanding what happened, and coping with the situation (Kar, 2011). A similar treatment is dynamic treatment based on psychoanalytic principles dwelling on the personal meanings of the trauma and hope (Levi, 2019; Paintain & Cassidy, 2018). Other kinds of treatment are based on mindfulness (Boyd, Lanius, & McKinnon, 2018; Lang, 2017), meditation (Talkowsky & Lang, 2017), social support (Jaffe, Walton, Walker, & Kaysen, 2023), physical training (Björkman & Ekblom, 1922; Li, Xia, Yu, Hu, & Zhu, 2025), the cognitive orientation approach that is based on beliefs about the self, goals and reality (Kreitler, 2014; Shiri, Wexler, Meiner, & Kreitler, 2010) or the psychological methodology of attention bias modification which consists in training shifting away from the threatening event (Alon, Azriel, Pine, & Bar-Haim, 2023).

The success of each type of treatment is assessed in terms of symptoms mostly based on self-report and the ensuing behavioral changes. All treatments lead to some degree of improvement. The best treatment seems to be CBT, possibly not only due to the major approach but also because of the wide array of skills that are being treated as adjuncts, such as identifying the patient's resources, enhancing self efficacy, applying shared decision-making, learning about trauma and ensuring the patient's safety (Wampolda et al., 2010). CBT is even better than dynamic treatment (Paintain & Cassidy, 2018). All other treatments have lower levels of success. It is however difficult to compare them due to methodological issues.

In sum, the following factors were used in the different types of studies: identifying verbally the event; discussing one's reactions of all kinds to the event, including mainly emotions; clarifying emotional complications and difficulties; making memories less distressing and vivid; learning different coping behaviors and thinking styles, - all these mainly in CBT and dynamic treatment and to some extent also in social support; doing things that help oneself to avoid the event and not think about it (mainly in meditation, mindfulness, physical training, attention modification). Another factor is cognitions and beliefs, mainly about the self, goals and reality (Shiri, Wexler, & Kreitler, 2010). However, CBT does not provide a clarification why PTSD developed or what specifically contributes to its reduction. The other treatments are more focused and their effect seems to rely mainly on distancing oneself from the event by avoiding thinking about it and thus also minimizing emotional reactions to it.

2.2. The factors and the three-stage model

Applying the identified factors to the inter-stage model shows that there are differences in regard to the three stages. In regard to stage 1, the focus is on attention to the event. According to CBT and dynamic therapy, there is a lot of attention to the event, while according to all other treatments and approaches there is less attention to the event.

In regard to stage 2, the focus is on emotions and cognitions concerning the situation. According to CBT and dynamic therapy, a great number of different kinds of emotions and cognitions are evoked and discussed concerning the traumatic situation as a whole. According to other approaches beliefs about oneself, one's goals and reality are considered. Other treatments and approaches, dwell little on specific emotions and cognitions.

In regard to stage 3, the focus is on evoking a lot of all psychological aspects – different kinds of factors are evoked, often spreading beyond the boundaries of the traumatic situation. According to CBT and dynamic therapy a great number of emotions, cognitions, and behaviors become involved, including personal experiences, goal beliefs, memories, habits, work and interpersonal relations, affecting many domains of one's life.

The expectations in regard to the two studies described in the present context were based on the following considerations: (a) the above reported findings of previous studies, (b) long-term observations of victims of traumas in survivors of the holocaust and many war veterans in Israel, and (c) focusing on the goal which was to identify the factors contributing most to preventing or weakening reactions and symptoms that may stop or reduce the progression from stage 1 to stage 2 and from stage 2 to stage 3, in contra to other approaches that apparently include also goals such as deepening understanding of the impact of the trauma and integrating the event into one's personality.

3. Study 1. Retrospective

Study 1 was designed to examine the hypotheses in terms of data collected retrospectively. The method consisted of interviewing individuals 25-38 years old who volunteered to participate in a study about their reactions to different traumatic events that have occurred in their life or to which they have been exposed, particularly during their service in the army. The interview referred to the following issues:

Table 1. The Interview in Study 1.

The examined issues	The suggested responses	The responses
(a) Identification of the event	Superficially, medium, in detail. Scores 1,2,3	The events were 39 military, 10 personal and family, 11 mixed. Mentioning briefly, short description, described a lot in great detail
(b) Preliminary reactions – their nature and amount	Emotions, cognitions. Some, medium, a lot. Scores 1, 2, 3	Anger, fear, surprise, sadness, curiosity, agitation, trembling. A little, endlessly
(c) With whom/to whom did you tell or talk about it?	Friends, colleagues; family; professional, Scores 1,2,3	Friends, colleagues, brothers, neighbors
(d) How often or how much did you talk about it?	Rarely, a little; medium; very often, a lot. Scores 1,2,3	Almost never, a lot
(e) What was the major contents of what you told the others?	Facts about the event; cognitions, thoughts and attitudes; emotions, sensations. Scores 1,2,3	Facts about how it happened, emotions, sensations
(f) If you had thoughts about the situation, what were they?	General, politics; about the enemy, the situation; about myself and how I was saved. Scores 1,2,3	Why it happened, how I survived
(g) If you had emotions about the situation, what were they?	General; about and of others; about myself. Scores 1,2,3	Emotions about others, emotions others had,
(h) How much were you bothered by the situation?	Not at all or barely; a little, medium; a lot. Scores 1,2,3	I was not bothered at all, I was scared but not all the time, I was crazy all the time
(i) For how long were you bothered by the situation after the event?	Hours, days; weeks, months; over a year. Scores 1,2,3	Just in the beginning; for some months, it never stopped
(j) Degree of disturbance by the situation. Please list or mention the disturbances	Emotions, cognitions, behaviors, disturbance at work, disturbance in studies, disturbance in relations with friends, disturbance in relations with family, physiological symptoms, disturbed sleep, nightmares, need for help. Each kind of disturbance (n=11) got a score 1-3, according to intensity	Listing of symptoms, emotions, frightening thoughts, difficulties of concentration, shaking, sweating, becoming angry and even shouting without real cause, withdrawing from social contacts, joining group therapy, sleep disorders, impatience

Method. Items (a) – (g) were scored 1 to 3. They served for identifying the causes for traumatic responses. Items (h) – (j) served for diagnosing the traumatic state of the individual, i.e., stage 2 or 3. Items (h) and (i) were scored 1-3, item (j) included 11 disturbances each of which was scored 1-3, so that the total was 1-33. Summing up the indicators of traumatic state, i.e., the scores for items (h) - (j) ranged from 13 (2-11) to 39 (6+33). The total range 13-39 was divided into three parts, each comprising 8.6. Thus, stage 1 was defined by the range of 13-21.6; stage 2 was defined by the range of 21.6-30.2; and stage 3 was defined by the range of 30.2-38.8.

Results. In terms of their scores (in items h-j), 53% (n=32) of the subjects were in stage 1, 21%(n=13) were in stage 2, and 25% (N=15) were in stage 3. The next issue that was analyzed was to identify the variables out of those in the list of (a) – (g) which were correlated with the degree of disturbance. For this purpose, a comparison was done between the means of the high and low scores in stage 1 in each of the items (a)- (g). The same procedure was repeated for the high and low scorers in stage 2, and again separately for the high and low scorers in stage 3. The results showed that the subjects who were in stage 1, scored high in short descriptions of the event (a), few and short preliminary responses (b), spoke about the event mainly to friends (c), and focused mainly on facts (d). The subjects who were in stage 2, score high in talking a lot about the event (a), in having varied and intense emotional preliminary reactions (b), in talking with many people including family, friends and colleagues (c), in talking very often (d), in telling others about the details of the situation in which the event happened (e), in thinking how bad the situation was and how many others have been hurt (f), about the emotions of others who were hurt or could have been hurt (g). The subjects who were in stage 3 spoke a lot and in great detail about the event and its context and similar events (a), , had many varied emotional reactions that recurred (b), spoke a lot with family, friends, colleagues, professional therapists, neighbors, strangers, spoke sometimes compulsively (c), spoke a lot sometimes endlessly but there were pauses (d), mainly emotions of others and those evoked by the situation (e), about what has happened and could happen to oneself due to what happened (f), about myself, how my life changed and will never again be the same as it was, emotions of oneself and one's life (g).

Conclusions. About a quarter of the sample had symptoms and reactions corresponding to PTSD. Comparing the responses of those in stage 3 with the responses of those in stages 1 and 2 indicated that a main difference seemed to be that those in stage 3 dwelt more on what has happened to them and could have happened to them, mainly physically, and on the self-related emotions. Also, their descriptions of the event were much more detailed.

4. Study 2. Prospective

The objective of study 2 was to examine the hypotheses in a prospective study. The study was performed in the course of the Israel-Iran 12 days war which occurred in 13-24 of June, 2025 (called Am-Kelavi). The subjects were recruited through the social media and by direct contact in a public shelter in Tel-Aviv. The participants were 30 individuals who experienced 3-5 missile attacks. The event consisted in experiencing the missile attacks by Iran while they stayed in a public shelter. The subjects were interviewed immediately after the war ended, on 24-28 of June. The questions used in the interview were the same as in study 1. The subjects consented to be contacted again after two-three months.

The results in the first phase of interviewing showed that 70% (n=21) of the subjects were highly disturbed, judging by the mean scores of their responses to items (h)–(j). Comparing their responses to those of the other subjects who scored low on disturbance show significant differences in their responses to items a,d,e,f,g. The responses to these items indicate that the highly disturbed subjects told in greater detail about each missile attack (a), spoke about their experiences a lot and very often (d), spoke mainly about physiological and psychological responses they and others had, emphasizing emotions and sensations (e), told about their thoughts, attitudes and expectations that the situation will become much worse in the future (f), and dwelt especially on emotions referring to themselves – comparing themselves to the soldiers in the front in terms of danger and afflicted harm (g).

In September 2025, the same subjects were contacted by phone, based on their prior agreement to be interviewed again. They were interviewed again with the same questions of items a-j. The sample included 22 highly disturbed subjects (73.3%), based on their scores in items (h) –(j), These 22 subjects included 16 who were highly disturbed also in the first phase of interviewing and 7 subjects who in the first phase of interviewing scored low on disturbance. Comparing the subjects who scored high on disturbance (n=22) with those who scored low (n=8) showed that the main differences concerned items a, b, e, f, g. The subjects with high disturbance described in great detail the event, emphasizing the minutest aspects (a), and their initial reactions, combining responses to items (a) and (b), spoke a lot (to whoever was ready to listen) about the frightening emotions and reactions of everyone around (e), welling mainly on physical sensations (e), negative thoughts (f), and emphasizing the personally relevant impact on themselves in all respects- their body, career, work, health, life plans and family relations. Five subjects planned to leave

their work and 3 more planned to emigrate to another country for an indefinite period of time. The low scorers were characterized by focusing on facts, political implications, analyses of present and future military developments and what has been learned from the war with Iran, and the impressions of the other people whom they have met in the public shelter.

5. Some general conclusions

In the two retrospective and prospective studies between 25% and 50% of the subjects had scores indicating high disturbance in the range close to PTSD. One indication of these results is that not all subjects exposed to a serious trauma develop a response that resembles PTSD and as our findings show even if they do start a development along these lines they may still retreat. The progression to the level of high disturbance depends on two major factors. The first is dwelling in detail on the event, elaborating it, widening its context in terms of time and place, comparing it to other similar events, reporting it to new listeners, adding new details, dwelling on it as often as possible. The second factor consists in emphasizing one's deep personal involvement in the event and its effects on one's health, emotions, thoughts, behavior, work and family. The subjects scoring high on disturbance due to the trauma consider themselves as having been harmed deeply, hopelessly and irrevocably by exposure to the trauma. They feel as if they were physically harmed and could deteriorate in the future. Hence, in order to save and guard themselves they consider even immigrating from the country so as to distance themselves from the location of the trauma.

The subjects who did not score high on disturbance talked briefly about the facts concerning the traumatic event, described briefly the reactions of others, did not report any personal effects but dwelt on political causes, results, implications and expected developments. Notably, both elaborating the event and withdrawing from it were used as major factors in the most common therapeutic treatments of traumatic responses. The therapeutic recommendations are to encourage the individuals to focus on brief reports of the event, based on impersonal facts rather than on emotions and thoughts reflecting personal effects.

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