Type III Trauma: Toward a More Effective Conceptualization of Psychological Trauma

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Abstract: Research on offenders and crime victims underscores the importance of identifying trauma-related events and treating their effects. The authors build on the work of psychiatrist Lenore Terr, who distinguished Types I and II psychological trauma, by proposing a third category: Type III trauma. Type III trauma occurs when an individual experiences multiple, pervasive, violent events beginning at an early age and continuing over a long period of time. Diagnostic criteria include alterations in memory and consciousness, frequently including dissociation; emotional numbing; major developmental deficits; poorly developed, often fragmented, sense of self; a core belief that he or she is fatally flawed and has no right to be alive; a sense of hopelessness and shame; trust issues that interfere with normal relationships; and no concept of a future. Treatment of individuals who have sustained Type III trauma is more complex and demanding relative to survivors of Types I or II trauma.

The young man confessed that he had killed his cousin. On the videotape of the police interview, Sammy came across as a cold, unfeeling sociopath. When the senior author first met with him to begin a forensic evaluation, she was surprised to find him rocking in a chair, staring ahead in an obviously dissociated state. After a careful evaluation involving both authors, the defendant was found to be mildly mentally retarded, a victim of extreme neglect and psychological abuse by both parents, and a victim of violent physical and sexual abuse by his father. Sammy was obeying his father's orders when he killed his cousin. He had little appreciation of what it meant to kill and was found incompetent to stand trial.

Sammy was a victim of severe trauma. Psychological trauma can be defined as the psychological effects of an event (or events) that cause intense fear, helplessness, or horror and that overwhelm the normal coping and defense mechanisms. Although the psychological effects of trauma are not always obvious, they are present both immediately and after many years (Briere, 1992; Herman, 1992; Sanford, 1990). Severe psychological trauma changes the child, perhaps even on a biochemical level (van der Kolk, McFarlane, & Weisaeth, 1996).

According to Terr (1991), four characteristics are seen in almost all survivors of childhood trauma, particularly during childhood. These include repeated
memories of the event, traumatic reenactment of the overwhelming experience in play or in other behavior, fears of specific objects related to the traumatic event, pessimistic attitudes about people and life, and a limited sense of any future.

Understanding the extent of trauma and its effects is essential in forensic assessments of victims and offenders and is important in treatment planning. Severe psychological trauma in childhood interferes with normal development and typically leads to symptoms of Post-Traumatic Stress Disorder (PTSD), anxiety, fear, depression, anger, lack of trust, and a negative view of the world. Some victims of trauma begin psychotherapy motivated by anxiety and depression that interfere with their social and occupational functioning. Others act out their despair and rage on other people and become forensic clients (Heide, 1992/1995, 1998). Both research and clinical experience indicate that males typically act their anger outward, whereas females often make themselves the target of their rage.

**TYPOLOGY OF TRAUMA**

Neither clinicians nor researchers have had an effective system for assessing the extent of traumatic experience. Alarcon (1997) proposed a typology of PTSD consisting of six clinical types: depressive, dissociative, somatomorphic, psychotomorphic, organomorphic, and “neurotic-like.” In addition, he suggests that substance abuse and personality disorders need to be considered. This classification appears to be problematic due to extensive overlap; many clients could easily fit into several categories.

Terr (1991) proposed that there are two basic types of trauma, which he called Type I and Type II. Type I trauma results from a single event, such as a rape or witnessing a murder. Survivors of Type I trauma who are 3 years old or older at the time of the event generally retain complete memory of their experience. These individuals struggle to make sense out of what happened. They may experience perceptual errors such as visual hallucinations or time distortions.

According to Terr (1991), Type II trauma results from “repeated exposure to extreme external events” (p. 15). Survivors of Type II trauma generally have at least some memory of their experience. Children who sustain Type II trauma use massive denial, repression, dissociation, identification with the perpetrator, and aggression against themselves as coping mechanisms. These children are often diagnosed as having Conduct Disorder, Attention Deficit Disorder, depression, or a dissociative disorder.

We propose a clinically-based typology of trauma survivors that reflects research findings and that builds on the work of Terr. This classification could be a useful guide for both researchers and clinicians in their assessment and treatment of victims and offenders.
TABLE 1
A TYPOLOGY OF TRAUMA

<table>
<thead>
<tr>
<th>Type I</th>
<th>Type II</th>
<th>Type III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single event</td>
<td>Multiple events</td>
<td>Multiple events/violent/early age</td>
</tr>
</tbody>
</table>

INTRODUCING TYPE III TRAUMA

We propose dividing Type II trauma into two categories: Type II and Type III, as reflected in Table 1. We suggest this distinction because, based on our clinical experience and that of our colleagues, individuals who survive Type III trauma suffer more severe psychological effects requiring different treatment strategies. Examples of Type II trauma include such experiences as repeated fondling by a neighbor or uncle, or growing up with parents who engage in moderate psychological or physical abuse.

Type III trauma is more extreme. It results from multiple and pervasive violent events beginning at an early age and continuing for years. Typically, the child was the victim of multiple perpetrators, and one or more are close relatives. The abusive events were likely frequent, yet unpredictable. Generally, force is used and the abuse has a sadistic quality. The child may have been threatened with torture or death, or death of a loved one. Both sexual and physical abuse may have been perpetrated. Examples would include enduring sadistic ritual abuse by an organized group or repeated violent physical and sexual abuse by caregivers.

DIAGNOSIS AND TREATMENT OF TYPE I AND TYPE II TRAUMA SURVIVORS

When clients who have suffered Type I trauma come into contact with mental health professionals, they typically report their experience and describe it in some detail. Brief therapy techniques such as behavioral strategies, Neurolinguistic Programming (NLP), or Eye Movement Desensitization and Reprocessing (EMDR), often can be used to quickly and effectively resolve the trauma (O’Hanlon & Weiner-Davis, 1989; Shapiro, 1995).

Clients who have sustained Type II trauma typically come into treatment with histories of moderate depression, dependency and trust issues, and relationship problems. Diagnostic characteristics frequently include poor self-esteem, feelings of shame, and difficulties trusting others. Often, anger is repressed or introjected and may be experienced only as depression. Many Type II clients have developed denial, repression, and dissociation as defense strategies.

Most psychotherapists have Type I and Type II trauma survivors among their clients. A skilled, well-trained therapist can effectively treat these individuals.
CLUES TO DIAGNOSIS OF TYPE III TRAUMA

A typical Type III trauma survivor presents for treatment feeling suicidal and hopeless and not knowing why. He or she may initially describe his or her childhood as “great,” and his or her parents as “wonderful.” These clients are frequently dismissed by mental health professionals as “borderlines,” or misdiagnosed as schizophrenic or bipolar (Ross, Anderson, & Clark, 1994). For example, two different psychiatrists quickly evaluated one of our Type III survivors who was dissociated and labeled her as repressed and psychotic. One warned that she might kill the new baby that she was expecting. The client was dissociative, not psychotic. She functioned as an effective parent, and held a job as a nurse. An astute clinician looks beneath the superficial symptomology to assess the client as a human being who has been profoundly affected by his or her traumatic experiences.

Assessment and diagnosis of trauma survivors is a challenging process. A thorough clinical evaluation includes a thorough social history. It is essential to gather detailed information about family relationships, school, work, friends, drug and alcohol involvement, activities, music and movie preferences, medical and mental health history, feelings and coping strategies, delinquent and criminal history, and history of neglect and abuse (Heide & Solomon, 1997).

The clinician may not be able to make an accurate diagnosis at the initial interview. Self-report and objective testing may not be dependable for two reasons: (a) the client may not trust the examiner sufficiently to be honest, and (b) the client may not remember his or her experience. For these reasons, the use of projective tests is indicated.

The first clue to a trauma history may be symptoms of PTSD. Burton et al. (1994) found that among delinquent adolescents with histories of multiple serious crimes, 24% evaluated met diagnostic criteria for PTSD. These investigators found that family dysfunction and exposure to violence were significantly associated with PTSD symptoms.

Behavioral observations of the client during the assessment can be helpful in identifying symptoms of PTSD. The client may noticeably flinch when a door slams or a telephone rings. She may scan the room in a hypervigilant mode, or exhibit signs of dissociation during the interview. A Type III survivor also typically reports nightmares or flashbacks.

Table 2 contrasts the long-term effects typically experienced by those who suffer from Type III trauma with those who suffer from Types I and II. Type III trauma survivors typically exhibit alterations in memory and consciousness, including dissociation. Lipschitz and colleagues (1996) reported that dissociative symptoms were significantly related to multiple episodes or combined types of abuse in childhood and adulthood. Type III survivors often do not remember the traumatic events they endured, and may in fact be amnesic for several years of their childhood (Heide & Solomon, 1991; Williams, 1994). Some Type III clients meet the diagnostic criteria for Dissociative Identity Disorder.
### TABLE 2
LONG-TERM EFFECTS OF TYPES OF TRAUMA

<table>
<thead>
<tr>
<th></th>
<th>Type I</th>
<th>Type II</th>
<th>Type III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full, detailed memory</td>
<td>X</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>PTSD symptoms</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Denial</td>
<td>V</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Repression</td>
<td>V</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Emotional numbing</td>
<td>V</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Poor self-esteem/self-concept</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Interpersonal distrust</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Superficial relationships</td>
<td></td>
<td>V</td>
<td>X</td>
</tr>
<tr>
<td>High anxiety</td>
<td>V</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Chronic depression</td>
<td>V</td>
<td>V</td>
<td>X</td>
</tr>
<tr>
<td>Suicidality</td>
<td>V</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Feelings of shame</td>
<td>V</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Foreshortened sense of future</td>
<td></td>
<td>V</td>
<td></td>
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<tr>
<td>Dependency</td>
<td>X</td>
<td></td>
<td>V</td>
</tr>
<tr>
<td>Rage</td>
<td>V</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Affective dysregulation</td>
<td>V</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Self-injury</td>
<td>V</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Eating disturbance</td>
<td>V</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>V</td>
<td></td>
<td>V</td>
</tr>
<tr>
<td>Narcissism</td>
<td>V</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>V</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Identity confusion</td>
<td>V</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Dissociative symptoms</td>
<td>V</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**NOTE:** X = typically, V = varies.

Clients with Type III trauma histories often have a history of disappointing and abusive adult relationships. They may be terrified of emotional intimacy and have major trust issues that interfere with normal relationships. One way that survivors reenact the trauma is by becoming involved with a series of chemically dependent or violent partners.

Asking the client how he or she would like his or her life to be different 5 years from now can be an effective diagnostic tool. A Type III survivor typically either looks at the therapist like he or she is crazy or with a sense of bewilderment. The client may say that he or she cannot even think about tomorrow or next week. The concept of having a future in 5 years is almost incomprehensible.

Other symptoms diagnostic of Type III trauma include somatization, high tolerance for pain, a history of injuries, and a history of severe headaches with unknown etiology. The client may report a history of chemical dependency and other self-defeating and compulsive behaviors.
TREATMENT IMPLICATIONS OF TYPE III TRAUMA

Treatment of individuals who have sustained Type III trauma is more complex and demanding relative to survivors of Type I or Type II trauma. Typically, a trusting therapeutic relationship must be developed before the client can let himself or herself or the therapist know about his or her traumatic experience. For someone who may never have had a safe relationship, developing this type of therapeutic alliance may take months, or even years.

Assessment and diagnosis of trauma survivors is an ongoing process. We have proposed a solution-focused model for the assessment and treatment of victims of trauma (Heide & Solomon, 1994). As the client’s personal history unfolds, both the client and therapist become increasingly aware of the extent of developmental losses. The relationship between major developmental deficits and the client’s psychological symptoms becomes more apparent.

In a child’s attempt to make sense out of his or her environment and to preserve some semblance of security, he or she tends to normalize what the adults do and to conclude that something is wrong with him or her. Thus, a survivor might have decided that they deserved the frequent beatings they received. There is also a tendency to minimize the abuse. A client who reported that he and his brother were beaten by his father at least once a week until they bled was amazed that the therapist described his experience as abusive (“Dad was just disciplining us”). Another client who had been frequently violently raped by her father stated, “That’s just how it was. No big deal.”

Careful and gentle clinical work may reveal a poorly developed, often fragmented sense of self and extremely low self-esteem. The client may talk about a deep sense of shame. Often, there is a core belief that he or she is fatally flawed and has no right to be alive. Occasionally, especially with male clients, there may be a profound narcissistic overlay. Emotional numbing with underlying rage is often typical, especially in women, with anger acted out on the self in the form of self-hate and self-mutilation. Victimization also appears to contribute to the development and maintenance of eating disorders such as Bulimia Nervosa (Danksy, Brewerton, Kilpatrick, & O’Neil, 1997).

As treatment progresses, the limiting effects of the trauma on the client’s present life become apparent. He or she may react with anxiety, fear, or dissociation to objects, sounds, and smells in the environment that are associated (generally on an unconscious level) with the traumatic events. These triggers tend to limit the client’s life because in order to avoid them, the client may avoid a wide variety of activities such as watching television or going to parties where he or she might smell alcohol.

Working with Type III survivors requires a therapist who is willing to develop a deep therapeutic relationship with the client, accepting of the client’s temporary dependence on him or her, comfortable with strong emotion, and skilled in emotional release work. In addition, the therapist needs to have an understanding of
such concepts as traumatic reenactment, the BASK model (Braun, 1988), and identification with the perpetrator.

**TYPE III TRAUMA AND REPRESSED MEMORIES**

Because many Type III clients do not at first remember their traumatic experiences, a knowledge of the literature regarding repressed memories and the legal ramifications of treating survivors is important. Much controversy has surrounded issues of repressed memories and claims of a false memory syndrome. These issues pose potential legal problems for mental health professionals treating Type III trauma survivors.

In their review of 25 studies of amnesia for childhood sexual abuse, Schefflin and Brown (1996) concluded that “amnesia for CSA (childhood sexual abuse) is a robust finding across studies using very different samples and methods of assessment. . . . recovered abuse memories are no more or no less accurate than continuous memories for abuse.”

**MINIMIZING THE PSYCHOLOGICAL EFFECTS OF TRAUMA**

How a child copes with traumatic events depends on his or her ego strength and coping strategies, as well as on the support of caring adults. A psychologically healthy child growing up in a supportive family is more likely to sustain a single traumatic event without major negative consequences. In fact, when a child is given the opportunity, he or she will make decisions during the traumatic period that best protect the child.

We recently observed these dynamics with two young children aged 3 and 5 years whose grandmother had just died. The grandmother had been like a second mother to the two little girls and both of them were devastated by her death. They associated the experience with a prior event in which their dog Jasmine had died: “Nan went to heaven to live with God like Jasmine.” The children had been very much a part of the grandmother’s illness. Their parents discussed the death with them and gave them the choice of attending the funeral. The 5-year-old cried with the adults and was unwavering in her decision to attend the funeral. The 3-year-old struggled with her decision. She asked such questions as, “Will it be very sad?” and wanted to know whether her sister was going. The morning of the funeral the child announced, “I have to go to school today.” And she did. These young children had been supported and consoled throughout the experience and their feelings of loss had been validated. When given the opportunity to make their own decision regarding attending the funeral, each was able to decide how she could best take care of herself during this traumatic time. As a result, these young Type I trauma survivors will suffer minimal long-term psychological effects.
CONCLUDING REMARKS

We have proposed a typology of trauma that has implications for accurate diagnosis and effective treatment of victims and offenders. We build on Terr’s work, dividing Terr’s Type II trauma into two categories: Type II and Type III. Survivors of Type III trauma have sustained multiple, pervasive, violent events beginning at an early age and continuing over a long period of time. As a result, they sustain more serious psychological effects and require specialized assessment and treatment.

Developing the therapist-client relationship with those who have suffered Type III trauma will typically require a longer period given that their ability to trust has been shattered by the extensiveness of the trauma. Thorough evaluation must include identification of the adaptive and maladaptive strategies employed by trauma survivors. Treatment can then focus on four therapeutic strategies integrated in therapy, which include (a) empowering the client throughout the assessment and treatment process by enhancing self-esteem, teaching containment strategies for strong, often painful and distressing feelings, and helping the client to set realistic goals; (b) helping the client to identify, experience, and express feelings appropriately; (c) metabolizing and integrating the various aspects of the traumatic experience and integrating fragmented parts of the self; and (d) facilitating cognitive restructuring aimed at success in the present and sorting out and letting go of past trauma.

NOTE


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