Chapter 3

Understanding the Core of Psychological Trauma:
Trauma in Contemporary French Theory

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ABSTRACT

This chapter examines the usefulness of the conceptualization of trauma in contemporary French theory for a better understanding of the core of organizational trauma. Starting with a short historical background, it investigates the contribution from contemporary French authors to current knowledge on psychotraumatology. The current position of the most influential contemporary French authors is that stress and trauma do not necessarily fit into the same concept. The French clinical description of psychological trauma is based on the concept of frozen fright in the face of death (effroi de la mort) and the repetition syndrome (syndrome de répétition). This may have implications for the analysis of what constitutes an organizational trauma since these clinically relevant but largely unknown theories shed another light on the currently used concepts in mainstream literature. The aim of this chapter is also to bridge conceptual gaps, understanding critical differences in clinical practice and offering a more integrative view of psychological trauma.

INTRODUCTION

Scientific research in recent decades has provided a clear, evidence-based description of the serious consequences of trauma-related experiences (Breslau & Davis, 1992; Carlson, Furby, Armstrong, & Shlaes, 1997; Foa & Rothbaum, 1998; Horowitz, 1986). Various concepts have been developed to explicate the consequences of these experiences (Gersons & Carlier, 1992; Kinzie & Goetz, 1996; Wilson, 1989, 1994). Post-Traumatic Stress Disorder (PTSD) and other mental disorders (including anxiety, depression, substance abuse, dissociative disorders and psychosomatic disorders) can result from psychological...
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trauma (Brewin, 2000). Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD) are described in DSM-IV-TR (APA, 2000) as mental disorders which may occur after traumatic experiences such as severe accidents, rape, torture, violence and war. The risk for PTSD increases with the degree of exposure to trauma and both the frequency and the severity of the traumatic events (e.g., Bramsen, 1995).

Over the years, a scientific consensus has appeared in the Anglo-American scientific literature about the symptoms of both acute and posttraumatic stress – i.e. intrusive recollections of the traumatic event, a profound sense of numbness, avoidance, increased arousal and hyperactivity and/or exaggerated startle response and dissociative reactions (Foa, Riggs & Gershuny, 1995). If these reactions – intrusive re-experience, avoidance and hyperarousal – persist (at least for one month) causing significant distress or loss of function, PTSD can be diagnosed according to the DSM-IV-TR (APA, 2000).

In DSM-5 (APA, 2013), PTSD was included in a new section on trauma- and stress-or-related disorders. This move from DSM-IV-TR, which addressed PTSD as an anxiety disorder, is among several changes approved for this condition that is increasingly at the center of public as well as professional attention (APA, 2013). In PTSD, the trigger is exposure to an actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual: directly experiences the traumatic event, witnesses the traumatic event in person, learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures or movies unless work-related). The disturbance, regardless of its trigger, is supposed to cause clinically significant distress or impairment in the individual’s social interactions, capacity to work or other important areas of functioning and was not the result of another medical condition, medication, drugs or alcohol.

In DSM-IV (APA, 2000), the controversy as to the definition of PTSD’s traumatic stressor criterion, since PTSD first appeared in the DSM-III (APA, 1980), may have implications for pointing at trauma in organizational context. This criterion (A1, in DSM-IV) represented an attempt to provide an objective definition of the traumatic event – such as a terror attack on an airport - that was necessary for the validity of the PTSD diagnosis. Despite a long controversy, there was little empirical research exploring whether events meeting DSM-IV-TR’s Criterion A1 were better associated with the diagnosis or severity of PTSD than non-Criterion A1 stressful events. In fact, the trauma literature of recent years is not well linked to the research that has been conducted on the psychological and physiological impact of “mere” stressful life events over the past century (e.g., Holmes & Rahe, 1967; Vinokur & Selzer, 1975).

In each subsequent version of the DSM, the potential range of events that would satisfy Criterion A1 has grown such that currently, in DSM-5, the traumatic stress criterion can be satisfied based on an indirectly experienced trauma (e.g., by witnessing or learning about a trauma occurring to someone else). This broadening of the stressor definition may result in concerns that is has become too lenient (Elhai, Kashdan, & Frueh, 2005; Frueh, Elhai, & Kaloupek, 2004; McNally, 2003; Mikkelsen & Einarsen, 2002). However, other researchers argued that Criterion A1 had to be expanded to include less severe, but still serious life events such as chronic illness, childbirth complications, sexual harassment, or bullying (Matthiesen & Einarsen, 2004; Olde, van der Hart, Kleber, & Van Son, 2006; Palmieri & Fitzgerald, 2005; Smith, Redda, Peyserb, & Vool, 1999).

For organizations such as armed forces, police, fire and rescue or NGOs, regularly confronted with trauma, a clear definition of psychological trauma, is essential with respect to the consequences coupled to the appearance of potentially traumatizing events in the context of daily routine. Compared to DSM-IV, the diagnostic criteria for DSM-5 draw a clearer line when detailing what constitutes a traumatic event.