Editorial

The Journey beyond PTSD and Trauma

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Posttraumatic stress disorder (PTSD) was introduced into the standard diagnostic classification over 40 years ago. PTSD, unlike most categories in the DSM system, is linked to a specific aetiology. Exposure to traumatic stress is, by definition, a necessary condition for PTSD. But the manual fails to emphasize that exposure is not sufficient. Research repeatedly shows that only a subgroup of individuals exposed to the same adverse events will develop posttraumatic symptoms [1].

Post-traumatic stress disorder (PTSD) is a disorder that may develop following exposure to an extremely threatening or horrific event or series of events. It is characterized by all the following: 1) re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares. These are typically accompanied by strong or over- whelming emotions, particularly fear or horror, and strong physical sensations; 2) avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events; and 3) persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Central to this definition is the principle that a core component of PTSD is a re-experiencing of the memories of the traumatic event in the present.

Diagnoses on the Border of PTSD

Acute Stress Disorder

Reactions occurring immediately after trauma exposure that last for less than a month. This diagnosis was introduced in DSM-IV to describe distressed people who could not be diagnosed in the initial phases but who might still be at risk for full PTSD. However, subsequent longitudinal studies indicated that the diagnosis is only a modest predictor of that out- come; in one sample, at least half of those who eventually developed PTSD had never initially met the criteria for acute stress disorder [2]. Also, people who develop PTSD do not necessarily display the same features in the acute phase as they do later. In DSM-5, the diagnosis of acute stress disorder does not require any specific symptom or symptom clusters to be present but states that nine of 14 features should be present.

Complex PTSD

ICD-11 [3] has introduced a new diagnostic construct: complex PTSD. To receive this diagnosis, one needs to present core PTSD symptoms, and in addition, disturbances in self-identity (a negative self-concept), emotional dysregulation (emotional reactivity, violent outbursts), and persistent difficulties in relationships. This syndrome overlaps greatly with persons with borderline personality disorder who also have an abuse history. Using the word "complex" is an attempt to acknowledge that repeated trauma is more important that single incidents. But the danger is that trauma will be considered the only cause of what we have up to now been calling a personality disorder.

Traumatic and Non-Traumatic Risks for PTSD

The drama of traumatic life events has distracted clinicians from considering the broader context in which PTSD develops. The discrepancy between exposure to stressors and the development of the disorder requires attention to other, nontraumatic risk factors. Severity of trauma is an important parameter affecting relationships between exposure and outcome. This has been shown in community populations of civilians experiencing traumatic events [4] and in veterans with a history of combat exposure [5], as well as in populations who have experienced rape [6]. Severity is related to earlier definitions of Criterion A, which are events that are violent and/or life-threatening. Again, we need to keep in mind that traumatic experiences are ubiquitous.

Another line of evidence pointing to a lack of specificity between trauma and PTSD is that traumatic events are a risk factor for many diagnoses, including depression, anxiety, and personality disorders [7]. Moreover, PTSD has a high comorbidity with de- pression, anxiety, and substance use and shares genetic risks with these disorders [8]. This finding points to a lack of specificity between stressors and pathological outcomes. It suggests that the disorder that develops after trauma depends as much on individual predisposition as on stressors alone.

PTSD overlaps with other mental disorders and does not necessarily present as a single diagnosis. It does not necessarily follow a linear course but can fluctuate over time.

Individual Differences in Response to Trauma

Very few diseases in medicine affect every person exposed to the same risks in the same way. In 2020–2022, a pandemic raged around the world, but not everyone who was infected developed symptoms, and among those who did, illness severity varied greatly. If the course of infectious diseases depends on variations in the immune system that reflect genetic differences and past exposures, the same could well be true for mental disorders. Individual differences lead to a wide range of responses to environmental challenges. At one end of the spectrum, some people will be affected by almost any kind of adversity, and they are easily overstimulated or upended by life events. At the other end of the spectrum can compartmentalize or ignore such events, and who have a much higher threshold for emotional response.

Genetic Susceptibility to PTSD

A large body of research shows that genetic vulnerability plays a role in PTSD [9]. But we should not think of genetic re- search as involving the identification of a single gene for a trait or a pathological outcome. Most outcomes in psychology are polygenic, and single genes rarely account for the heritability of any mental disorder. Instead, interactions between hundreds (or thousands) of genes are associated with major psychopathology [10].

A good deal of neuroscience research has examined the biological effects of trauma. Another possible mechanism involves epigenetics. These are the switches that can change the activity of genes in response to environmental conditions [11]. Another area of interest in neuroscience concerns differences in the size of brain structures, and whether specific regions are constructed differently in those who develop a disorder than in those who do not. One point of controversy is whether traumatic experiences can have permanent effects on the brain.

The Ubiquity of Resilience

Risk refers to the statistical probability that an individual will develop a mental disorder—even if most people at risk never develop one. Resilience refers, literally, to the ability to *"bounce back"* from the impact of adverse life events without developing psychological symptoms. We might think of resilience as a defence system against psychological trauma. Being able to move past trauma is not just a matter of luck; it depends on capacities intrinsic to the individual that can be termed a psychological immune system [12]. Just as immunological mechanisms protect us against the physical attack of microorganisms, resilience protects us against the emotional effects of adverse life events. Traumatic events in prehistory were much more common than they are today. Since humans are characterized by an unusually long childhood that allows them to learn the complex tasks required of an adult, they need to be born with an ability to learn. The acquisition of new skills plays an important role in helping us to rise above adversity. Resilience, like any other mental capacity or trait, varies between individuals. The effects of trauma depend on how the mind assimilates and processes adverse life events.

Childhood Trauma as a risk for psychopathology

Early childhood trauma is an established risk factor for psychopathology [13]. The evidence from multiple studies is clear and convincing, and the relationship has been confirmed by several meta-analyses [14-18]. However, this does not mean that every person exposed to childhood trauma will necessarily develop a mental disorder. Rather, it describes a statistical risk that affects some people, but not others. Although childhood trauma is a risk factor for a wide range of mental disorders, posttraumatic stress disorder (PTSD) is not the most common of these outcomes. The most common pathological outcomes were major depression and conduct disorder.

First, the overall role of early trauma as a risk factor does not mean that it has a specific relationship with posttraumatic symptoms. Instead, trauma is linked to many types of adult mental disorders, of which PTSD is only one. Even when PTSD features do develop, one sees significant overlap and comorbidity with other types of symptoms and disorders. A second issue is that most children exposed to trauma do not develop adult psychopathology [19-20]. This highly variable response depends on both the nature of the exposure and individual levels of resilience.

A third issue is that much of the research on childhood adversity in the community has depended on self-report, assessed years after the original event. For example, some researchers did not find that self-reports and informant-report of traumatic experiences differed in their association with later psychopathology but seemed to describe two non-overlapping populations [21].

A fourth issue is that traumatic events vary greatly in severity. We need to examine the parameters of adversities and measure the context in which they occur. As will be discussed below, this is a key issue in assessing childhood sexual abuse (CSA).

A fifth (and crucial) issue concerns what is and is not "traumatic." As we have seen, some epidemiological surveys of PTSD [22] have been willing to see such normative events as grief or divorce as qualifying as stressors for PTSD in adults. Doing so conflates adversities that are common in life but have little else in common. Similarly, we need to focus on the most important traumas in childhood, including CSA, physical abuse, and emotional abuse, and not conflate them with the effects of dysfunctional families in the absence of clear-cut traumatic events.

A sixth issue is that adversity in adolescence needs to be considered separately from early childhood trauma. Traumatic events at that stage of development do not necessarily arise directly from parental mistreatment. While they can be seen as reflecting previous vulnerabilities and adverse experiences, many traumatic incidents in the adolescent years are perpetrated by peer groups outside the family [23].

Finally, we need to consider whether traumatic events in childhood cause pathology in and of themselves or whether they must be understood in a wider context of family dysfunction. We also need to consider the impact of emotional neglect, a risk factor that often accompanies child abuse but does not really belong in a list of "traumas."

Emotional neglect is much more prevalent than events generally considered traumatic [24]. Since child maltreatment co-occurs with parental neglect and other forms of family dysfunction, long-term risks are not always due to any specific set of experiences. Instead, psychopathology is associated with multiple adversities and with problematic child rearing [25].

Post Traumatic Stress Disorder in the Context of Personality

Personality describes features of thought, emotion, and behaviour that vary between individuals. Understanding inborn temperamental variations, and the personality trait profiles that they shape, requires an evolutionary perspective [26-27]. Personality shows individual variation because trait profiles are a kind of evolutionary hedge, in that traits can be adaptive or maladaptive in different environments. Thus, Neuroticism will be adaptive in an environment that is unpredictably dangerous, but it can be maladaptive when the brain's alarm system cannot be turned off. At that point, traits begin to interfere with functioning, and symptoms of anxiety, depression, or PTSD can be framed within a broader diagnosis that is, personality disorder.

Childhood Trauma, PTSD and Borderline Personality

There is a very large body of research on borderline personality disorder [28]. Patients who suffer from this condition suffer from marked mood instability, unstable intimate relationships, and a wide range of impulsive behaviours (particularly self-harm and suicide attempts). Linehan hypothesized that emotional dysregulation (a construct closely linked to Neuroticism) is the key feature of BPD. This hypothesis was revised to include traits of impulsivity as an additional risk factor [29]. It is the combination of dysregulated emotion and impulsive actions, with effects in turn on interpersonal relationships, that defines this disorder.

Another, and rather popular, view of BPD sees its causes as deriving primarily from the long-term impact of childhood trauma. In summary, the attribution of causality to the relation between BPD and trauma, particularly CSA, is flawed and overly invested [30].

What has been found can be summarized as follows:

- A significant minority of BPD patients will have experienced CSA that involved physical contact.
- CSA and other forms of childhood maltreatment (physical abuse, emotional abuse) make symptoms worse but do not predict BPD on their own.
- Traumatic risk factors have a high co-occurrence with overall family dysfunction.
- Children who experience CSA are also more likely to be emotionally neglected and invalidated.
- CSA has a stronger effect on those who are temperamentally vulnerable.

These conclusions parallel a more general view that trauma does not consistently predict PTSD. Trauma also does not predict the development of a personality disorder.

In BPD, the theory that emotion dysregulation is the key to understanding the disorder has now gained wide empirical support [28]. Personality disorders arise from gene–environment interactions between heritable traits and environmental risks. Moreover, Linehan's [29] focus on decreasing emotion

dysregulation is often the focus of therapy in BPD patients and has the most research support of any therapy for the disorder.

Does PTSD require Trauma Specific Therapy

Posttraumatic stress disorder (PTSD), with prominent symptoms related to traumatic experiences, has been a particular magnet for therapies that claim specificity. These methods aim to help patients process traumatic memories, overcome problematic thoughts and behaviours, and develop effective coping and interpersonal skills. Most of these treatments are either part of a package of cognitive-behavioural therapy (CBT) or derived from CBT.

The principle behind some of the best-studied interventions for PTSD is that by avoiding triggers, patients fail to extinguish conditioned responses to fear [31]. In this view, patients require reexposure to a traumatic memory to process it. That could be accomplished by reliving the experience in one's imagination under the supervision of a therapist who teaches the patient how to reduce the toxicity of these memories. These concepts are the basis of exposure therapy [32] or a variant called prolonged exposure. ET was the first method of treatment for PTSD to gain support from clinical trials and still has the strongest evidence base. Its procedure involves retelling the traumatic event, followed by in vivo exposure to triggers, and then unpairing the memory from states of anxiety.

A significant minority of patients do not benefit from exposure therapy. While proponents [32], have dubbed exposure therapy a "gold standard," it does not necessarily yield better results than older methods. It may be that efficacy depends largely on processing and contextualizing a trauma in one's mind, so that processing an experience need not require exposure alone. In this view, efficacious methods focus less on re-experiencing the trauma than on reframing it, as in standard CBT.

A currently popular method based on the recall and reprocessing of traumatic experiences: eye movement desensitization and reprocessing (EMDR) [33]. EMDR is widely used, has gained support from clinical trials, and has been recommended by National Institute for Clinical Excellence (2018) guidelines, as well as by a Cochrane report [34]. This form of treatment for PTSD has also gained substantial publicity. But like most therapies, while EMDR is superior to placebo or waiting list comparisons, it does not yield better results than other well-structured treatments [35]. When comparative trials are carried out for psychotherapies of all kinds for mental disorders, that is the most common verdict. EMDR differs from exposure therapy primarily by its use of eye movements to guide patients in re-experiencing the traumatic event, again with the goal of taking the sting out of these memories. But while reprocessing memories is an element in most therapies for PTSD, there is no evidence that the use of a wand by a therapist to guide eye movements is necessary. This procedure could probably be called a gimmick. For that reason, EMDR may be no more specific to trauma than similar methods used by Franz Mesmer in the 18th century to guide people to undergo hypnosis.

Trauma-focused cognitive-behavioural therapy (TF-CBT) also has evidential support from research. TF-CBT was originally designed for PTSD in maltreated children and adolescents and involved parents in family therapy. Its evidence base in clinical trials on this population is good, and it has been recommended both by the National Institute of Clinical Excellence and with some reservations, by a Cochrane report [36]. TF-CBT is now being used in adult populations, and it differs from standard CBT by adding a larger component of trauma pro- cessing. However, meta-analyses show either few differences [37] or no clinically significant differences from standard methods.

Conclusion

Understanding PTSD requires a narrower definition of trauma. There is little doubt that rape and physical assault qualify as traumatic. However, some researchers and many clinicians have scored all kinds of adverse experiences in life, from family break- down to job loss, as qualifying as a traumatic stressor. This leads to overdiagnosis and to defining a clinical population that is too heterogeneous to be prescribed treatments that are specific for their problems. Traumatic events have always been a part of human life, and most people are significantly resilient to adversity.

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