Psychological trauma refers to the experience of overwhelming, uncontrollable events that are perceived to threaten a person’s sense of integrity or survival (van der Kolk, 1987). This represents a relatively new concept in the history of psychological sciences. During the 19th century, the word “trauma” generally referred to an open wound or a violent rupture to the surface of the skin; it carried no psychological connotations. The term psychic trauma was first introduced in scientific literature in the late 19th century, by the German neurologist Albert Eulenburg, to describe the psychological impact of stressful life events on the functioning of the central nervous system (van der Hart & Brown, 1990). The term entered the psychological lexicon due in large part to Jean-Martin Charcot (who introduced new diagnostic entities such as névrose traumatique and hysterie traumatique), Pierre Janet (who proposed dissociation as the crucial psychological process with which the organism reacts to overwhelming experiences, and showed that traumatic memories may be expressed as sensory perceptions, affect states, and behavioral reenactments), and Joseph Breuer and Sigmund Freud (who together distinguished traumatic neurosis from other forms of neurosis on the basis of its symptoms, giving rise to the psychoanalytic investigation into the dynamics of psychological mechanisms).

However, excluding some research on the “traumatic neurosis of war” during and after World War II (Kardiner, 1959), and a few studies on concentration camp survivors, for more than half a century, little work was done to explore the psychological effects of traumatic life events. Interest in psychological trauma dramatically resurfaced in the late 1970s, with the work of Horowitz et al. (1980), and the studies on the impact of the Vietnam war. Hundreds of thousands of Vietnam veterans in the USA presented with serious psychiatric problems and a new diagnosis, posttraumatic stress disorder (PTSD), was created. Il termine trauma psicologico sta ad indicare l’esperienza di un evento soverchiante ed incontrollabile, percepito come una minaccia al proprio senso di integrità personale o alla propria sopravvivenza (van der Kolk, 1987). Tale termine rappresenta un concetto relativamente nuovo nella storia delle scienze psicologiche. Per tutto il corso del XIX secolo, infatti, la parola “trauma” veniva generalmente utilizzata per indicare una ferita aperta o una rotura violenta alla superficie cutanea, senza alcuna connotazione psicologica. Il termine trauma psichico fu introdotto per la prima volta nella letteratura scientifica verso la fine del XIX secolo, dal neurologo tedesco Albert Eulenburg per riferirsi all’impatto psicologico degli eventi stressanti sul funzionamento del sistema nervoso centrale (van der Hart & Brown, 1990). Il termine fece definitivamente il suo ingresso nel lessico psicologico grazie a Jean-Martin Charcot (che introdusse nuove entità diagnostiche, quali la névrose traumatique e la hysterie traumatique), Pierre Janet (il quale ipotizzò che la dissociazione fosse il processo psicologico fondamentale attraverso cui l’organismo reagisce alle esperienze sconvolgenti e dimostrò che i ricordi traumatici possono manifestarsi sottoforma di percezioni sensoriali, stati affettivi, rappresentazioni comportamentali ripetitive), e Joseph Breuer e Sigmund Freud (i quali differenziarono le nevrosi traumatiche dagli altri tipi di nevrosi sulla base della sintomatologia, permettendo così le basi per la successiva esplorazione delle dinamiche dei meccanismi psicologici). Tuttavia, ad eccezione di alcune ricerche sulle “nevrosi traumatiche da guerra” durante e dopo la Seconda Guerra Mondiale (Kardiner, 1959) e qualche studio sui sopravvissuti ai campi di concentramento, l’effetto psicologico degli eventi traumatici ha ricevuto per oltre mezzo secolo scarsa considerazione da parte del mondo scientifico. Il tema riguardante il trauma psicologico ha conosciuto una improvvisa ondata di interesse verso la fine del 1970 con il lavoro di Horowitz et al. (1980) e con
ated in an attempt to capture their psychopathology for inclusion in the DSM-III (American Psychiatric Association, 1980). The creation of a formal diagnosis offered legitimacy to the idea that traumatic experiences could result in serious psychological repercussions, and were not merely the result of intrapsychic processes (van der Kolk & Courtois, 2005). However, international acceptance of PTSD was not rapid or without controversy. It was slow to catch on in Europe where the disorder was initially considered specific to the USA, and Vietnam veterans (Jones & Wessely, 2007). Nonetheless, since 1980, vast research literature has confirmed the relevance of PTSD for a large variety of traumatized populations beyond combat participants, examples being refugees, victims of accidents and natural disasters, and survivors of rape, child abuse, and other forms of domestic violence. Results of these studies have led to the development of a new field of study, traumatic stress studies (van der Kolk et al., 1996a).

Researchers have, until recently, focused predominantly on the relationship of trauma to a series of non-psychotic disorders, such as dissociative disorders, traumatic grief, somatization, acute stress disorder, borderline personality disorder, depressive disorders, and substance disorders (Moreau & Zisook, 2002), as well as on a wide range of trauma-related psychological problems that are not captured in the DSM-IV framework of posttraumatic stress disorder (PTSD) (van der Kolk et al., 1996b). However, the possibility of a relationship between early traumatic events and psychosis has been minimized, denied, or ignored. The possible reasons for this selective attention include rigid adherence to a rather simplistic biological paradigm, inappropriate fear of being accused of “family blaming”, avoidance of vicarious traumatization on the part of clinicians and researchers, and re-diagnosing from psychosis to PTSD and dissociative disorders, once abuse is discovered (Read et al., 2005). Over recent years, there has been growing awareness of a possible relationship between trauma and psychosis (Larkin & Morrison, 2006). Studies have demonstrated that, in the histories of people with psychosis, there is a high incidence of trauma, in general, and a high incidence of traumatic experiences during childhood, in particular (Read et al., 2005). Childhood adversity may take many forms. It may include actual abuse, whether physical, sexual or emotional. Such abuse seems to be common in the general population, but its prevalence has been found particularly high in people with psychosis (Janssen et al., 2004; Bebbington et al., 2004; Shevlin et al., 2007). Childhood trauma is important antecedent in psychosis, both theoretically and clinically. At the theoretical level, it potentially illuminates mechanisms by which psychotic symptoms are generated; at the clinical level it opens possibilities for gli studi sulle conseguenze emotive della guerra del Vietnam. Quando negli USA centinaia di migliaia di reduci del Vietnam cominciarono a manifestare gravi disturbi di natura psichiatrica, fu creata una nuova categoria diagnostica per il DSM-III (1980), il Disturbo Post-Traumatico da Stress (PTSD), all’interno della quale collocare la specifica sintomatologia presentata da tali soggetti. La formalizzazione di un’apposita categoria diagnostica sembrò legittimare l’idea che le esperienze traumatiche potessero determinare gravi ripercussioni psicologiche e che queste non fossero semplicemente il portato di processi di natura intrapsichica (van der Kolk & Courtois, 2005). L’accettazione del PTSD da parte della comunità scientifica internazionale, comunque, non fu né rapida né priva di controversie. Tale diagnosi prese piede molto lentamente in Europa, dove il disturbo venne visto inizialmente come uno specifico problema degli USA, legato esclusivamente ai reduci del Vietnam (Jones & Wessely, 2007). Tuttavia, a partire dal 1980 i risultati di numerose ricerche confermarono la rilevanza del PTSD in una ampia gamma di soggetti traumatizzati che andava ben al di là di coloro che avevano partecipato a conflitti bellici e che comprendevano le vittime di stupri, i profughi, le vittime di incidenti stradali, di disastri naturali, di abusi infantili e di altre forme di violenza domestica. I risultati di questi studi hanno condotto allo sviluppo di un nuovo ambito di indagine scientifica, quello degli studi sullo stress traumatico (van der Kolk et al., 1996a).

Fino a poco tempo fa i ricercatori si sono prevalentemente occupati del rapporto tra gli eventi traumatici ed una serie di disturbi dello spettro non psichico, quali i disturbi dissociativi, il lutto traumatico, i disturbi da somatizzazione, il disturbo acuto da stress, il disturbo borderline di personalità, i disturbi depressivi, i disturbi da sostanze (Moreau & Zisook, 2002) e di tutta quella gamma di problematiche psicologiche secondarie ad eventi traumatici che non hanno trovato spazio adeguato all’interno della categoria PTSD del DSM-IV (van der Kolk et al., 1996b). La possibilità di un rapporto tra eventi traumatici e disturbi psicotici è stata invece a lungo minimizzata, negata o ignorata. Sono potenzialmente numerose le ragioni alla base di tale “attenzione selettiva”, tra cui la rigida adesione a paradigmi semplicistici di tipo biologico, l’inappropriato timore di far ricadere sulle famiglie la responsabilità dell’insorgenza del disturbo, l’evitamento di possibili fenomeni di “traumatizzazione vicaria” da parte di clinici e ricercatori e la tendenza a modificare la diagnosi da...
improving cognitive-behavioural and other, trauma-focused, psychological approaches to treatment.

The purpose of the three Editorials published in this issue of EPS is to discuss the theoretical perspectives, and the possible clinical implications, of the relationship between childhood trauma and psychosis, in the light of existing evidence. Notably, three of the world’s best known experts in the field consented to give their valuable contribution.

Paul Bebbington (2009) provides a comprehensive overview of the literature linking childhood trauma, specifically child sexual abuse, to psychosis, and considers potential mechanisms for this association. As Bebbington emphasizes, the association between child sexual abuse and psychosis is strongly supported by the literature. Results clearly demonstrate that existence of multiple traumatic experiences is associated with an increased likelihood of psychosis, with a dose-response relationship. The mechanisms are certainly complex, and there is evidence of interacting contributions at genetic, neurophysiological, behavioural, cognitive, and emotional levels.

The relationships between PTSD and psychosis, as Bebbington points out, seem particularly interesting. Literature reports that rates of PTSD are generally high in people with psychosis (ranging from 13% to over 50%, according to the different assessment methods adopted), and that the severity of trauma is associated with the severity of both PTSD and of psychotic symptoms. Based on these findings, it has been hypothesized that PTSD is a co-morbid disorder that mediates the relationships between trauma, increased symptom severity, and higher use of acute care services in patients with psychosis (Mueser et al., 2002). PTSD is given a central role in this model because the symptoms which define it, as well as its common clinical correlates, can be theoretically linked to a worse prognosis of psychosis. It has been suggested that PTSD can both directly and indirectly affects psychosis. PTSD symptoms can directly affect psychosis through:

a) the avoidance of trauma-related stimuli (since most traumatic experiences are interpersonal in nature, avoidance often extends to close relationships, leading to reduced social contacts and to social isolation);
b) distress related to re-experiencing the trauma (patients who re-experience trauma in the form of intrusive memories, nightmares, or flashbacks, may be at increased vulnerability to relapses due to the stressful nature of these symptoms; moreover, extreme re-experiencing may take on delusional intensity in persons prone to psychotic symptoms);
c) overarousal (PTSD may worsen the course of psychosis by further increasing arousal in persons who are already physiologically compromised and who often evince high levels of activation). Common correlates of PTSD

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can also indirectly influence psychosis, including substance abuse, re-traumatisation, and a poor working alliance with clinicians, leading to receipt of fewer appropriate specialized treatments. It may also be possible that some psychotic patients may develop PTSD in response to their psychosis, since the subjective experience of psychosis may be viewed as a traumatic event itself. Negative experiences of hospitalisation in the midst of a psychotic episode, which may include forced medication and seclusion, can be considered both outside of normal experience and to involve threat to the physical integrity of the self, thus meeting DSM-IV criterion A for PTSD. However, while the negative experience of hospitalisation contributes to PTSD in people with psychosis, it is the positive symptoms that have been found to be the most traumatic part of the experience of psychosis (Morrison et al., 2003).

There are several clinical implications of the possible relationships between trauma and psychosis, and for many of these, there is currently sufficient evidence to support their implementation. Antony Morrison (2009), after having discussed the most recent cognitive behavioural models of psychosis that incorporate childhood trauma experiences in the development of psychotic symptoms, proposes a comprehensive overview of the therapeutic approaches that have been proved to be useful and effective in treating psychotic patients who have experienced childhood trauma. The author first underlines the need to assess patients with psychotic disorders for co-morbid PTSD, in order to ensure that it is detected and treated. He also suggests that, given the number of abuse survivors with diagnoses of psychotic disorders, routine inquiry regarding sexual abuse should be introduced in services for such patients. The Editorial provides evidence that specific treatment of PTSD symptoms can improve psychiatric and health outcomes in patients with psychosis. Therefore, the provision of high quality, comprehensive treatment of people with psychosis must include evidence-based trauma therapy for the trauma associated with psychosis. This could include alternatives to hospital admission, provision of normalizing information regarding the prevalence and incidence of positive symptoms in the general population, and education regarding common symptoms of trauma and the prevalence of PTSD in response to psychosis.

Morrison (2009) points out that psychological interventions for psychotic symptoms may be informed by equivalent treatments for PTSD, and that cognitive-behavioural approaches to PTSD, such as imaginal exposure, and re-appraising the meaning of the traumatic event, may be also applicable to trauma-induced psychosis. Moreover, helping a patient to clarify whether a psychotic symptom is a memory or not and, if so, assisting them in moving from traumatic, gravity of the symptoms, and increasing utilization of the services psychiatri for acute patients affected by psychosis (Mueser et al., 2002). At PTSD is stated conferred a ruolo centrale all’interno di questo modello, perché i sintomi che lo definiscono, così come i suoi più frequenti correlati clinici, possono teoricamente contribuire al peggioramento prognostico di una psicosi. La presenza del PTSD può condizionare il livello di gravità di un disturbo psicotico sia in maniera diretta che indiretta. I sintomi del PTSD possono agire direttamente sulla psicosi:

a) determinando condotte di evitamento nei confronti degli stimoli correlati al trauma (visto che la maggior parte delle esperienze traumatiche sono di natura interpersonale, l’evitamento spesso si estende ai rapporti sociali più prossimi e porta alla riduzione della rete sociale e all’isolamento sociale);

b) aumentando il disagio emotivo legato alla ri-esperienza del trauma (i pazienti che manifestano sintomi di ri-esperienza del trauma sottoforma di ricordi intrusivi, incubi o flashback possono manifestare un’aumentata vulnerabilità alle ricadute a causa della natura stressante di tali fenomeni; inoltre, fenomeni estremi di ri-esperienza possono assumere intensità delirante in persone vulnerabili alla psicosi);

c) incrementando i sintomi da iperattivazione (il PTSD può peggiorare il decorso di una psicosi attraverso l’ulteriore incremento dell’attivazione autonoma in persone che sono già compromesse da un punto di vista fisiologico e che spesso manifestano elevati livelli di attivazione). D’altro canto, i più comuni correlati del PTSD possono influenzare indirettamente il quadro clinico di una psicosi, attraverso l’abuso di sostanze, la tendenza alla ri-traumatizzazione e, soprattutto, determinando una scarsa alleanza terapeutica con i curanti, che può portare il paziente a non ricevere adeguati livelli di assistenza specialistica. Può essere anche possibile che alcuni pazienti sviluppi un PTSD in maniera reattiva al proprio disturbo psicotico, in quanto le esperienze soggettive vissute nel corso di uno scompenso possono essere di per sé considerate traumatizzanti. Esperienze negative di ospedalizzazione in corso di episodio psicotico acuto, che comprendono ad esempio provvedimenti di trattamento coatto e segregazione, possono essere considerate eventi che si collocano al di fuori della normale esperienza di vita e che comportano una minaccia alla propria integrità fisica, finendo per soddisfare il criterio A del DSM-IV per il PTSD. Tuttavia, al di là delle esperienze negative legate al ricovero, sono in realtà i sintomi positivi che rappresentano la componente più traumatizzante dell’episodio psicotico e a contribuire allo sviluppo del PTSD nei pazienti psicotici (Morrison et al., 2003).
externalizing to internalizing that memory, can be useful. Thus, retribution of psychotic experiences to an internal source may reduce distress and impairment. Strategies based on this approach can all be helpful in reducing distress, increasing perceived control, and improving quality of life (Larkin & Morrison, 2006). There is already a strong evidence base for many of these interventions, as they are often included within cognitive behaviour therapy for psychosis (Fowler et al., 1995; Kingdom & Turkington, 2005). However, there is little treatment research focusing specifically on those with a clear involvement of childhood trauma in the development of their psychosis.

From a theoretical point of view, Read et al. (2009) propose that the relationship between childhood trauma and psychosis may help to conceptualize a new model in considering the schizophrenia and psychotic disorders. These authors challenge the dominant “bio-bio-bio” model of schizophrenia, by giving special emphasis to a new “bio-psycho-social” model, in which social stressors should be considered as “causal agents” in the aetiology of psychosis, rather than as mere triggers, or exacerbators, of a supposed genetically inherited predisposition. Already in 2004, John Read along with other contributors from six countries (Read et al., 2004), and a range of disciplines (including service users), published (with Richard Bentall and Loren Mosher) an interesting book, Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia, in which they claimed that the supposed integration of perspectives implied by the term “bio-psycho-social” was more illusion than reality. Since the 1970s, an integral part of this model has been the “vulnerability-stress” idea that acknowledges a role for social stressors, but only in those who already have a supposed genetic predisposition. In this context, life events have been relegated to the role of “triggers”. The assumption that the diathesis is a genetic predisposition seems to have impeded adequate consideration of the relevance of stress traumatic events (physical or emotional), neglect, and loss by positioning, all psychosocial factors exclusively in the stress component of the diathesis-stress equation. According to Read et al. (2009), this bio-psycho-social formulation, with its assumption that the diathesis is predominantly, or exclusively, a genetic predisposition, has thus far not produced a balanced integration. The Traumagenic Neurodevelopmental (TN) model is an example of a more genuine integration of the reciprocal, complex interactions between social, psychological and biological factors. The TN model suggests that early traumatic life events produce activation of the hypothalamic-pituitary-adrenal (HPA) axis, which can subsequently impair the regulation of the HPA axis if exposure to traumatic experiences is prolonged. Read et al. (2009) provide convincing evidence, all drawn from biological...
psychiatry research, that traumatic experiences may directly affect and shape forebrain regulation systems, where crucial roles are played by the hippocampus and the medial prefrontal cortex (Bellani & Brambilla, 2008). The molecular mechanisms involved are epigenetic processes, which become shaped by the psychosocial experience, and in turn modify gene expression (thus brain development), to fit the “forecast” provided by the postnatal environment (Champagne & Curley, 2009). These trauma-induced neurobiological abnormalities may contribute to our understanding of various aspects of schizophrenia, including oversensitivity to stress, cognitive impairments, pathways to negative and positive symptoms, and the relationship between psychotic and dissociative symptoms. Within the proposed model, childhood traumatic events may be well considered as “causal agents”, rather than merely triggers.

In conclusion, we are glad to present these three Editorials to our EPS readers, particularly to the Italian-speaking audience, since in our country the debate on this issue, and the research in the field, though they deserve to be, are not yet as well-developed as they are in other national contexts. The evidence linking trauma, in particular in childhood, and psychosis, is not only scientifically sound, but also provides a means of tracing the psychological mechanisms of the phenomena of psychosis. The topic of childhood trauma in patients with psychosis, for the multifaceted perspective which it opens (theoretically, clinically, and therapeutically), represents a paradigm shift in our discipline, and promises major implications for researchers, clinicians and patients. Further research, however, is needed. We expect that future studies, by adopting more fine-tuned methodology, will be able to better clarify the nature and the strength of this association, since some recent reviews seem to be more cautious in the interpretation of the evidence (Morgan & Fisher, 2007; Bendall et al., 2008). We do hope to provide a useful contribution in order to promote and sustain the research in this field.

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The experience traumatic can influence directly and modify the systems of regulation of the structures of psychoneurotic, where the “niche” and the fronto-temporal medial play a role of primary stress. (Bellani & Brambilla, 2008). The mechanisms molecularly involved are represented by processes epigenetic,2 that are modulated by the experiences psychosocial and that at a low modifi- cation the expression genica and then the develop cerebral in mode that quest’ultimo si adatti alle specifiche condizioni del-l’ambiente post-natale che l’organismo incontrerà (Champagne & Curley, 2009). Tali modificazioni neuro-biologiche indotte dal trauma possono contribuire ad aumentare la nostra comprensione su vari aspetti della schizofrenia, tra cui l’ipersensibilità allo stress, i deficit cognitivi, i meccanismi generatori dei sintomi negativi e positivi e la relazione tra i sintomi psicotici ed i sintomi dissociativi. All’interno di un modello come questo, gli eventi traumatici infantili possono a buon diritto essere considerati “agenti causali”, piuttosto che semplici slaten-tizzatori della psicosi.

In conclusion, we aim to present these three Editorial to our readers of EPS, in particular to those Italian, at the moment that in our Paese the debate and the research on this specific theme non sono ancora sviluppati così come già avviene in altri contesti nazionali e come l’argomento merita. Le prove favore di un legame tra eventi traumatici, segnatamente quelli infantili, e psicosis non sono soltanto solide dal punto di vista scientifico, ma rappresentano anche un mezzo prezioso per identifica-re i meccanismi psicologici alla base dei fenomeni psicosis. Il tema degli eventi traumatici infantili nei pazienti con psicosi, grazie alle sfaccettate prospettive che è in grado di aprire (sul piano teorico, clinico e terapeutico), rappresen-ta un cambio di paradigma per la nostra disciplina con pro-mettenti implicazioni per ricercatori, clinici e pazienti. Sono comunque ancora necessarie ulteriori ricerche. Ci aspettiamo che studi futuri, attraverso l’adozione di più sofisticate tecniche di indagine, siano in grado di chiarire meglio la natura e la forza di questa associazione, in quanto alcune recenti revisioni sembrano suggerire maggiore cautela nell’interpretazione dei risultati (Morgan & Fisher, 2007; Bendall et al., 2008). Ci auguriamo davvero che sarà fornito un utile contributo alla promozione e al proseguimento della ricerca in questo settore.

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2Epigenetica - attività di regolazione dell’espressione genica mediante processi clinici che non comportino cambiamenti nel codice del DNA.