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 cre-
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, somatisation, 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

...
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 disturbo psicotico a PTSD o disturbo dissociativo allorquando veniva individuato nella storia clinica recente di un paziente un preciso evento traumatico (Read et al., 2005). Nel corso degli ultimi anni è comunque aumentata la consapevolezza che eventi traumatici e psicosi possono essere tra loro correlati (Larkin & Morrison, 2006). Alcuni studi hanno, infatti, dimostrato che nei pazienti affetti da psicosi esiste un’elevata incidenza di esperienze traumatiche, in particolare di tipo infantile (Read et al., 2005). Gli eventi traumatici infantili possono assumere diverse forme, tra cui le esperienze di abuso (fisico, sessuale o emotivo). Le storie di abuso infantile sono piuttosto frequenti nella popolazione generale, ma nelle persone che soffrono di psicosi la presenza di tali eventi è particolarmente elevata (Janssen et al., 2004; Bebbington et al., 2004; Shevlin et al., 2007). Il modello che concepisce i traumi infantili quali antecedenti delle psicosi rappresenta un campo di applicazione potenzialmente molto fecondo, sia da un punto di vista teorico che clinico. A livello teorico, può aiutare a comprendere alcuni dei meccanismi attraverso i quali si producono i sintomi psicotici; a livello clinico può consentire la sviluppo di nuove strategie di intervento cognitivo-comportamentale.

Obiettivo dei tre Editoriali pubblicati in questo numero di EPS è quello di discutere, alla luce delle più recenti evidenze scientifiche, le prospettive teoriche e le possibili implicazioni cliniche del rapporto tra traumi infantili e psicosi. Tre noti esperti mondiali dell’argomento hanno accettato di fornire il loro prezioso contributo.

Paul Bebbington (2009) fornisce un’esauriente rassegna bibliografica della letteratura che si è occupata del rapporto tra traumi infantili – abusi sessuali, in particolare – e psicosi, prendendo in considerazione le ipotesi sui possibili meccanismi alla base di tale associazione. Come sottolineato da Bebbington, il rapporto tra abusi sessuali infantili e psicosi è sostenuto in maniera convincente da numerosi studi. I risultati di queste ricerche dimostrano chiaramente che le esperienze traumatiche multiple si associano ad un aumento della probabilità di sviluppare una psicosi e che tale rapporto segue un gradiente di tipo dose-risposta. I meccanismi alla base di questa associazione sono indubbiamente molto complessi e coinvolgono diversi piani di interazione, a livello genetico, neuropsicologico, comportamentale, cognitivo ed emotivo.

Particolarmente interessante, appare il rapporto indicato da Bebbington tra PTSD e psicosi. La letteratura riporta che i tassi di PTSD sono generalmente molto elevati nei pazienti psicotici (dal 13% ad oltre il 50% a seconda delle metodologie utilizzate) e che la gravità degli eventi traumatici è associata all’intensità dei sintomi del PTSD e alla gravità della sintomatologia psicotica. Sulla base di tali evidenze, è stato ipotizzato che il PTSD rappresenti un disturbo in morbilità con la psicosi che funge da mediatore tra eventi...
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 reappraising 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 traumatici, gravity dei sintomi e aumentata utilizzazione dei servizi psichiatrici per acuti da parte dei pazienti affetti da psicosi (Mueser et al., 2002). Al PTSD è stato conferito un 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 comprendano 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 a rappresentare 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, reattribution 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

Le implicazioni cliniche che discendono dal possibile rapporto tra eventi traumatici e psicosi sono numerose e per molte di queste esistono sufficienti evidenze a sostegno di una loro implementazione nella pratica quotidiana. Antony Morrison (2009), dopo aver preso in esame i più recenti modelli cognitivi delle psicosi che contemplano al loro interno il ruolo delle esperienze traumatiche infantili, fornisce una esaustiva rassegna degli approcci terapeutici che si sono dimostrati efficaci nel trattamento dei pazienti psicotici che hanno subìto traumi infantili. L’autore sottolinea innanzitutto la necessità di esplorare l’eventuale co-presenza di un PTSD nei pazienti psicotici, allo scopo di garantirne l’identificazione ed un eventuale trattamento. Visto l’elevato numero di soggetti psicotici che presentano una storia di abuso, Morrison propone per questa tipologia di pazienti l’introduzione della valutazione sistematica di routine degli abusi sessuali. L’autore fornisce prove a sostegno del fatto che trattamenti indirizzati specificamente al PTSD possono determinare un esito migliore nei pazienti con psicosi sia dal punto di vista dei sintomi psicotici, che rispetto al benessere psicologico complessivo. Pertanto, qualunque strategia di intervento per i pazienti psicotici che voglia essere completa e di alta qualità non può prescindere dalla possibilità di fornire trattamenti di provata efficacia mirati ai sintomi-post traumatici e che abbiano come obiettivo terapeutico specifico gli eventi traumatici associati alla psicosi. Questi interventi possono comprendere misure alternative al ricovero ospedaliero, interventi di normalizzazione riguardo ai sintomi psicotici (mediante informazioni sulla prevalenza e l’incidenza di tali sintomi nella popolazione generale), interventi educativi sui più frequenti sintomi legati al trauma e sulla prevalenza del PTSD secondaria alla psicosi.

Morrison (2009) sottolinea che gli interventi psicologici indirizzati ai sintomi psicotici ricalcano sostanzialmente gli interventi specifici per il PTSD e che gli approcci cognitivo-comportamentali per il PTSD, come ad esempio l’esposizione immaginativa e la ristrutturazione cognitiva, possono essere applicati anche alle psicosi secondarie ad eventi traumatici. Inoltre, può essere utile aiutare il paziente a chiarire se un determinato sintomo psicotico sia un ricordo intrusivo o meno e, nel caso, aiutarlo a compiere il passaggio dalla esternalizzazione alla internalizzazione di tale ricordo. Analogamente, la riattribuzione di determinate esperienze psicotiche ad una causa interna può aiutare il paziente a ridurre il disagio emotivo e la relativa compromissione del funzionamento. Metodiche di intervento basate su tali approcci possono essere utili a ridurre lo stress, aumentare la percezione di controllo sugli eventi e migliorare la qualità della vita dei pazienti (Larkin & Morrison, 2006). Esiste già da tempo una forte base di evidenze scientifiche a sostegno di molti di questi interventi, d’altro canto già ampiamente utilizzati all’interno delle strategie psicoterapeutiche cogni-

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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 to the multifaceted perspective which it opens (theoretically, clinically, and therapeutically), represents a paradigm shift to the multifaceted perspective which it opens (theoretically, clinically, and therapeutically), represents a paradigm shift to the multifaceted perspective which it opens (theoretically, clinically, and therapeutically), represents a paradigm shift to the multifaceted perspective which it opens (theoretically, clinically, and therapeutically), represents a paradigm shift.

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Childhood trauma and psychotic disorders: evidence, theoretical perspectives, and implication for interventions


che le esperienze traumatiche possono influenzare direttamente e modificare i sistemi di regolazione delle strutture proencefaliche, dove l’ippocampo e la corteccia prefrontale mediale giocano un ruolo di primo piano (Bellani & Brambilla, 2008). I meccanismi molecolari coinvolti sono rappresentati da processi epigenetici, che vengono modulati dalle esperienze psicosociali e che a loro volta modificano l’espressione genica e quindi lo sviluppo cerebrale in modo che quest’ultimo si adatti alle specifiche condizioni dell’ambiente post-natale che l’organismo incontrerà (Champagne & Curley, 2009). Tali modificazioni neurobiologiche 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 slatentizzatori della psicosi.

In conclusione, siamo lieti di presentare questi tre Editoriali ai nostri lettori di EPS, in particolare a quelli italiani, dal momento che nel nostro Paese il dibattito e la ricerca su questo specifico tema 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 psicosi non sono soltanto solide dal punto di vista scientifico, ma rappresentano anche un mezzo prezioso per identificare i meccanismi psicologici alla base dei fenomeni psicotici. 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), rappresenta un cambio di paradigma per la nostra disciplina con protrattenti 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 di aver fornito un utile contributo alla promozione e al proseguimento della ricerca in questo settore.

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