Introduction

When the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) radically changed diagnoses in US psychiatry, one of its main goals was to directly remove Freudian or psychoanalytic causes from diagnostic definitions. The term "neurosis" was removed in general for that reason. In contrast, psychoanalytic ideas were reintroduced in psychiatric diagnoses more descriptively, with new diagnostic terms that had never existed before, such as borderline personality disorder and posttraumatic stress disorder (PTSD).

The original definition of PTSD included the important description that the traumatic experience must be something that was outside the bounds of usual human experience. This was done for two reasons. First, military trauma, such as occurred in during the Vietnam War, was an important influence on the drafters of DSM-III's definition of PTSD. And second, military trauma is by definition not a routine experience that happens to the general population, but rather a unique experience that happens to some soldiers during periods of war. Another factor contributing to this definition was the (mistaken) belief that childhood sexual trauma was uncommon.

In the years that followed DSM-III, the concept of PTSD evolved during a period of relative peace, with no active wars from the end of Vietnam in 1975 until the start of Middle Eastern wars after 2001. Instead of being used in its military application, PTSD was applied mostly to domestic trauma, usually sexual in nature and typically related to childhood. At the same time, PTSD work had become central to feminist-inspired theories in psychiatry. Research from these sources led to the observation that childhood sexual trauma (and indeed adult sexual trauma) was much more common than previously appreciated, reportedly occurring in 20% or more of the general population—and probably more, if one takes into account biases in memory or reporting of such events.[1]

As a result, by the time the DSM-IV was published in 1994, a strong movement existed to remove the descriptor limiting trauma to unusual human experiences. This apparently small change had huge effects.

The Life Event/Trauma Divide

The matter has not changed with DSM-5. Now "trauma" is defined as any terrible event that causes PTSD symptoms. This tautological definition has led to a common conflation of life events with trauma. The concept of trauma, as originally derived from the experience with hysteria and shell shock, didn't apply to any human experience. It applied to very troubling human experiences, such as rape and murder.

But trauma as defined by DSM-IV and DSM-5 opened the door to a much broader interpretation by adding the phrase "serious injury," so that the definition reads, "...exposure to threatened death, serious injury, or sexual violence...." Studies on PTSD using current definitions report that the most common traumata are car accidents. Clinicians have been using a very wide definition, applying the PTSD concept to even common adverse events, such as losing or getting a job, going through a divorce or getting married, or the death of a pet or birth of a child.

Another way of seeing the matter is that what has been termed "life events"—a more neutral descriptor for the experiences described above—are now seen as traumata. It has been shown in extensive research that clinical depressive episodes are preceded by life events in the prior 6-12 months in the vast majority of cases.[5] As noted, such life events are not unusual experiences, but rather the typical stresses of life. Those who prefer to take a social or psychological orientation to psychiatry consider those life events as "causes" of the depression that follows. A similar perspective is seen with proponents of PTSD, in which the traumata are "causes" of PTSD.

The problem with this is that everyone experiences these life events, yet 90% of the population never develops clinical depression. Similarly, about 80%-90% of persons exposed to severe trauma do not develop PTSD.[6] This means that the underlying biological susceptibility of the individual to depressive episodes or to PTSD is the deciding factor, not the occurrence of life events or trauma.

The concept of trauma has therefore been expanded in clinical practice to include many life events. By so doing, the importance of the "trauma" recedes, and one is faced instead with the question why most people who experience "trauma" never develop PTSD.
Kinks in the Rationalizing Machine

There is another aspect to this story, which is the natural human instinct to come up with "reasons" for things. We interpret life events as "causes" for our moods and our anxiety, when in fact they often aren't. The best evidence for this false instinct of rationalization is the split-brain studies of refractory epilepsy, where corpus callosotomy was used as surgical treatment; in this surgery, the fibers connecting the right and left hemisphere (the corpus callosum) are cut. In patients who have had corpus callosotomy, the two halves of the brain no longer communicate with each other, and it is as if they have two brains, not one. There are few noticeable changes in terms of personality or behavior, but these patients provide interesting experimental observations about how our brains function as rationalizing machines.

The right hemisphere of the brain controls the left visual field, whereas the left hemisphere controls the right visual field. In all right-handed persons, language is fully controlled by the left hemisphere (in left-handed persons, language is partly controlled by both hemispheres). Thus, in right-handed patients who undergo corpus callosotomy, the split between language and vision can be tested.

If an image is shown to the right hemisphere (in the left visual field)—for example, of a woman talking on a phone—the experimenter who asks the patient, "What do you see?" will get a wrong answer, but an answer nonetheless. The subject might say, "I see a friend." What is the friend doing? "Cooking dinner." Then with a phone nearby, the experimenter can ask the subject, "Show me what you saw." The subject will pick up the phone, with her left hand. The split-brain epilepsy patient "knows" what is seen by the right hemisphere, but she cannot speak it. What is most interesting is that she does not say something like, "I don't know" or "I am unsure." Sometimes the researcher says, "Now remember, you have had split-brain surgery for your seizures; keep that in mind when you answer my questions." Still, patients rarely say that they don't know what they saw, or why they feel as they do about what they saw. They rarely admit ignorance and instead usually make something up.

That is the way our brains operate, as rationalizing machines. We are designed, by God or evolution, to come up with plausible explanations for what we experience. We don't say we don't know.

Similarly, it seems to us that when we are depressed and something happened just beforehand, it must have caused us to become depressed. First x happens, then y; therefore, x must cause y. Long ago, the philosopher David Hume noted that we tend to attribute causation to the constant conjunction of events: First x, then y; first x, then y. But this by itself doesn't mean that the first event causes the second. Call it "Hume's fallacy"—the notion that an association of events is enough to infer causation.

These are facile assumptions: Something bad happens, therefore I'm depressed or anxious or I have PTSD, and that bad thing was a "trauma." Where does that therefore come from? It comes from our split brains—our common-sense reliance on Hume's fallacy, and it's often wrong.

References

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