

cal discourse. Gone et al<sup>8</sup> described formidable limitations in the current measures of IHT that have been developed and deployed within the health sciences, concluding that, as a result, “this literature has yet to cohere into a body of knowledge with clear implications for health policy or professional practice”.

Interestingly, few investigators have shown interest in establishing distinctive profiles of ancestral trauma for particular Native respondents (e.g., number of great-grandparents to survive a historical military massacre) or in designing studies that aspire to disentangle evidence for intergenerational causal impacts. All of this suggests that the real contributions of the concept of IHT are more critical and discursive rather than empirical and scientific<sup>1</sup>.

Indeed, several non-scientific, discursive functions may be served by IHT<sup>1</sup>: explain Indigenous health inequities, re-socialize Native community health problems, destigmatize these conditions with reference to shared suffering, legitimize Native healing traditions, harness trauma discourse for claims-making, tap into more plentifully resourced health care services, and represent an Indigenous scholarly contribution to health research.

Beyond these, IHT also anchors an “alter-Native psyche”<sup>5</sup>, an Indigenous mental health framework that contests and recasts conventional psychiatric knowledge across several domains: with respect to *distress*, IHT is preferred over mental disorders; with respect to *well-being*, Indigenous forms of relational selfhood are preferred over neoliberal individualism; with respect to *intervention*, Native healing traditions are preferred over empirically supported mental health treatments; and with respect to *evaluation*,

Indigenous “ways of knowing” are preferred over scientific outcome studies.

Perhaps most importantly, Native promotion of the concept of historical trauma expresses *survivance* in the health domain<sup>9</sup>. A portmanteau of “survival” and “resistance” introduced by Anishinaabe intellectual G. Vizenor, survivance attests to the improbable persistence of Indigenous peoples beyond the long colonial encounter. It rejects “victimry” and insists that Native self-determination is the way forward from trauma, PTSD, and colonial subjugation. It refuses narratives that reductively restrict attention away from Indigenous agency, kinship, love, struggle, tradition, humor and homeland. It insists that *we shall remain*.

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## The PTSD Gestalt switch

Approaching the 45th anniversary of the introduction of post-traumatic stress disorder (PTSD) in the psychiatric nomenclature, Brewin et al<sup>1</sup> have written a masterful review of the history and current status of research on this condition. This allows us to reflect on the level of our knowledge and think about the opportunities and challenges that lie ahead.

The field of traumatic stress research is in an odd place. The two main psychiatric diagnostic manuals, the DSM-5-TR<sup>2</sup> and the ICD-11<sup>3</sup>, provide distinct descriptions of trauma-related psychopathology. What people believe about the nature of this psychopathology probably depends in large part on which system they more closely adhere to. This is not a completely healthy situation<sup>4</sup>.

Reading Brewin et al’s paper was a peculiar experience. Through the various sections of the review, I was continually stuck by how much knowledge has been acquired, but yet how unable we are to provide answers to so many basic questions, such as: what is a traumatic event; how many post-traumatic stress disorders are there; what are the defining features of PTSD; what is the optimal way to assess PTSD; what proportion of the population has PTSD; whether PTSD is the same across cultures; what causes PTSD; who in the population is most likely to develop PTSD; what is the best way to treat PTSD; how effective are treatments for PTSD; why do treat-

ments work, when they work; and who benefits most from treatment.

Reading this review was like a Gestalt switch optical illusion. Look at the literature one way, and we seem to have a deep and profound understanding of so many fundamental issues. Look at it another way, and we seem to understand almost nothing about these same issues.

Consider just a few of these issues. We basically know what constitutes a traumatic event. Any event that provokes feelings of extreme threat or horror, whether occurring suddenly or gradually, at the moment it occurs or sometime later when meaning is assigned, can be traumatic. Furthermore, we know what the core post-traumatic stress response is, and what distinguishes it from other forms of psychopathology: it is the occurrence of intrusive experiences, usually images but also thoughts, sounds, smells or bodily sensations, in which the person feels like he/she is reliving the traumatic event again in the present moment. Additionally, we basically understand why this occurs: the cause lies fundamentally in the operation of memory. Extreme fear or horror inhibits hippocampal binding while promoting amygdala binding, resulting in the memory of the traumatic event containing little contextual information about time and place, and lots of sensory informa-

tion about emotions and somatic experiences. The disjunction between contextual and sensory information in memory means that, when it is cued, the individual feels like he/she is reliving the traumatic event in the present moment. Moreover, we basically know how to treat this problem, i.e. by reprocessing the traumatic memory in a way that it becomes integrated within autobiographical memory, so that, when it is cued, the person knows that the event belongs to the past and that he/she is not in current danger. And we know that, when this is achieved in a clinical setting, post-traumatic distress substantially decreases.

Given the extensive level of knowledge that exists, why then is there so little consensus in our field, such that after nearly 50 years we appear to be ignorant about so many fundamental issues? I do not claim to have a good answer, but I think it is a question we must all grapple with.

I think that a major source of the problem lies in the discrepancy between the ICD and DSM conceptualizations of post-traumatic stress. I recently had the pleasure of collaborating with a molecular biologist from Ukraine who works in a clinic for wounded Ukrainian soldiers. He had no previous experience with PTSD but, being faced with so many people who had been traumatized, was interested in whether it might be possible to identify biological markers for PTSD, in order to more efficiently identify soldiers with, or at risk of, this condition, and then possibly develop novel treatments. He asked me what he thought was a simple question: "What's the best way to assess PTSD?". I found myself in the unfortunate position of having to explain that it depends on which version of PTSD he wanted to assess. After he picked his jaw up off the floor, I then had to explain to him the thorny issues related to assessment and how reviewers for leading psychiatric journals might respond to different assessment methods. The molecular biologist's confusion and irritation by this exchange was matched only by my embarrassment.

As a paid-up, card-carrying scientist<sup>5</sup>, I fully recognize the dangers of ideological homogeneity and attempts to establish scientific consensus via authoritative declarations<sup>6</sup>, and I appreciate the value of researchers independently pursuing truth using different models and methods. Nevertheless, I think that, for our field to progress, we have to settle on an agreed-upon diagnostic model for trauma-related psychopathology.

## The paradox of the biopsychological and sociocultural levels in post-traumatic stress disorder

It is fascinating to see how the field of post-traumatic stress disorder (PTSD) has evolved over the past 50 years. The team of authors led by C. Brewin<sup>1</sup> – comprising psychologists, epidemiologists, psychiatrists, and intervention researchers – provides a comprehensive analysis of the significant developments in this field and the underlying empirical evidence.

I would like to enumerate a few points on which I am in complete agreement with the authors. First, there is now an accepted

I am reminded here of G. Box's famous aphorism that "all models are wrong, but some are useful"<sup>7</sup>. Nowhere is this truer than for psychiatric diagnoses. Surely nobody believes that DSM-5 PTSD, for example, represents something real. At best, our diagnostic models approximate real phenomena in a way that can be useful. They provide a common language for clinicians and researchers; they guide basic and applied research in a systematic way; they provide a framework for determining who needs care; and they help evaluate the efficacy of treatment.

Since our diagnostic models are not true, what is their point if they are not useful? My view is that the current situation of having two different diagnostic models of trauma-related psychopathology is severely undermining the usefulness of this approach, and is leading to a situation where we are unable to answer basic questions such as "What is a trauma?" and "How many trauma-related disorders are there?"

J. Swift<sup>8</sup>, and later S. Freud<sup>9</sup>, warned of the narcissism of minor differences. While many of us in the field might place great importance on whether the DSM or ICD provides a more accurate account of trauma-related psychopathology, consider it from the perspective of my molecular biologist friend in Ukraine. It is the narcissism of infinitesimally minor differences. It is time for us to get past it and come to a shared description of reality that is useful, and in doing so we may be able to break our illusion.

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set of different phenotypes of PTSD, which includes the "classic" PTSD known for several decades, complex PTSD, a severe dissociative condition, and other phenotypes that have been linked to childhood trauma. Second, the diagnosis should rely on the pattern of symptoms and resulting disabilities rather than on definitions of a trauma criterion, as is still often the case when diagnosing PTSD to this day. Third, delayed PTSD is essentially based on an altered stress sensitivity, and the patients display isolated