

Trauma and Psychological Trauma in Contemporary Psychology: A Theoretical and Analytical Study

Abstract

Psychological trauma is one of the most complex and consequential phenomena affecting human life. Its effects extend well beyond the traumatic event itself, encompassing an individual's emotional, cognitive, behavioral, and biological functioning. In recent decades, trauma has attracted growing scholarly attention owing to the rising prevalence of traumatic experiences associated with armed conflict, natural disasters, domestic violence, physical assault, and sexual abuse, as well as an increasing societal awareness of the importance of mental health.

Contemporary research demonstrates that the consequences of trauma are not confined to Post-Traumatic Stress Disorder (PTSD); they extend to anxiety disorders, major depression, personality disorders, and difficulties in social adjustment. This paper examines the concept of trauma across multiple dimensions: its principal forms, its psychological and neurobiological mechanisms, its diverse clinical presentations including PTSD and Complex PTSD (C-PTSD) and its broader implications for mental health. It concludes with a discussion of evidence-based therapeutic approaches used to support trauma-affected individuals.

Keywords: Trauma, Psychological Trauma, Post-Traumatic Stress Disorder, Complex PTSD, Mental Health, Clinical Psychology, Psychotherapy, Neurobiology of Trauma

Introduction

Traumatic experiences have accompanied human beings throughout recorded history, yet their psychological impact varies considerably depending on personal, social, and biological factors. Individuals may encounter events that threaten their physical or psychological integrity severe traffic accidents, natural disasters, or physical assault, to name a few. While some recover within a relatively short period, others develop lasting psychological difficulties in response to the same event.

The concept of psychological trauma underwent significant development during the twentieth century,

Review Article

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particularly following observations of the enduring effects of the World Wars on combatants. Symptoms such as recurrent nightmares, hypervigilance, and intrusive memories gained increasing recognition and clinical documentation. Over time, the concept broadened to encompass trauma arising from domestic violence, child abuse, chronic neglect, and other severe adverse life experiences [1].

Recent studies indicate that exposure to trauma does not inevitably result in mental illness. A substantial proportion of individuals demonstrate remarkable resilience and adaptive capacity following traumatic experiences. Consequently, researchers have increasingly focused on identifying protective factors and the mechanisms that facilitate recovery after trauma. This dual focus on pathology and on resilience reflects the more nuanced understanding of trauma that characterizes contemporary clinical psychology [2].

The present paper offers a critical and comprehensive review of the scholarly literature on psychological trauma, integrating theoretical and clinical perspectives, highlighting advances in neuroscience, and underscoring the importance of evidence-based therapeutic approaches.

The Concept of Trauma and Psychological Trauma

The term trauma derives from the ancient Greek word meaning wound or injury. In psychology, it refers to an emotional wound resulting from exposure to events that exceed an individual's ordinary capacity to cope with stress and adversity.

Psychologists define psychological trauma as an emotional, cognitive, and behavioral response that arises following exposure to an event involving severe danger or a direct threat to one's life, physical safety, or psychological well-being. This definition encompasses both single-incident and repeated events, and it recognizes that the subjective experience of threat not merely its objective severity is central to the traumatic process [3].

A critical distinction must be drawn between the traumatic event itself and the individual's response to that event. Not everyone exposed to the same experience is affected in the same way or to the same degree. Two individuals may survive an identical road accident: one may recover fully within a few weeks, while the other develops persistent symptoms of fear, anxiety, and avoidance of driving. These differences are shaped by several interacting factors [4], including:

- Age at the time of exposure
- Prior life experiences and trauma history
- Availability and quality of social support
- Biological and genetic predispositions
- Personality characteristics and emotional regulation skills

Beyond these individual variables, timing plays a particularly significant role. Traumatic experiences occurring during early childhood often produce deeper and more enduring effects on personality development and future stress responses, given the heightened neuroplasticity and developmental sensitivity of that period.

Types of Trauma

Acute Trauma

Acute trauma results from exposure to a single, sudden, and highly distressing event. Common examples include serious road accidents, earthquakes and floods, physical

assault, and witnessing an unexpected or violent death. In such situations, the nervous system enters a state of intense activation: large quantities of stress hormones notably adrenaline and cortisol are released in preparation for a fight-or-flight response [4].

Temporary symptoms may include insomnia, intense fear, difficulty concentrating, and recurrent mental images of the event. For the majority of individuals, these symptoms diminish gradually over a period of weeks to months, and full recovery is achievable.

Chronic Trauma

Chronic trauma occurs when an individual is subjected repeatedly to distressing or harmful experiences over an extended period. Unlike acute trauma, it does not involve a single defining incident; rather, the individual endures a sustained state of threat and psychological stress. Examples include ongoing domestic violence, persistent bullying, prolonged exposure to armed conflict, and living in chronically unsafe environments [1].

The cumulative burden of chronic trauma can be profound. A child who experiences daily humiliation or physical abuse at home may gradually develop low self-esteem, difficulty forming healthy social relationships, and a pervasive sense of insecurity effects that can persist well into adulthood if left unaddressed.

Complex Trauma

Complex trauma is widely regarded as the most damaging form of traumatic exposure with respect to psychological development. It typically arises from repeated abuse or neglect during childhood a period of critical neurological and personality development and may include repeated sexual abuse, chronic emotional neglect, sustained domestic violence, and ongoing psychological exploitation [1].

The severity of complex trauma stems from its occurrence during formative developmental stages, where it can disrupt identity formation, undermine self-confidence, impair emotional regulation, and compromise the capacity to establish stable interpersonal relationships. A child who grows up in an environment defined by fear and instability may develop a deeply ingrained belief that the world is inherently dangerous and that other people cannot be trusted a worldview that subsequently shapes all future relationships and coping strategies [5].

Psychological Explanations of Trauma

Multiple schools of psychology have sought to explain how traumatic events affect human behavior and mental functioning. Each perspective illuminates a distinct aspect of the traumatic process, and contemporary clinical practice draws on all of them.

The Behavioral Perspective

Behavioral psychologists argue that trauma-related fear is acquired through conditioning processes. An individual who survives a severe road accident, for instance, may develop a learned association between automobiles and danger, subsequently experiencing anxiety whenever entering a vehicle even in the complete absence of any objective threat. This mechanism accounts for the patterns of behavioral avoidance commonly observed in trauma survivors, and it forms the theoretical basis for exposure-based therapeutic interventions [6].

The Cognitive Perspective

The cognitive approach focuses on the beliefs and interpretations that emerge in the wake of traumatic experiences. Individuals may develop maladaptive thoughts such as: "The world is an inherently dangerous place," "I am incapable of protecting myself," or "Other people cannot be trusted." These dysfunctional beliefs tend to perpetuate psychological symptoms over time and are a primary target of evidence-based treatments such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) [6]. Cognitive restructuring challenging and reframing these distorted interpretations is central to many effective therapeutic protocols.

The Psychodynamic Perspective

The psychodynamic approach proposes that trauma leaves profound residues within the unconscious mind, and that certain psychological symptoms represent unconscious attempts to manage or communicate unbearable experiences. Proponents of this perspective argue that effective trauma treatment requires exploring the personal meanings attached to the traumatic experience, rather than focusing exclusively on observable symptoms. This insight has shaped approaches that prioritize the therapeutic relationship and the processing of narrative meaning [5].

The Integrative Perspective

Contemporary clinical psychology tends to favor integrative frameworks that account for biological, psychological, and social factors simultaneously. The diathesis-stress model, for example, proposes that individuals carrying certain biological vulnerabilities or prior psychological histories are at heightened risk of developing chronic disorders when exposed to trauma [4]. Such frameworks have given rise to biopsychosocial treatment models that address the individual as a whole, rather than targeting isolated symptom clusters.

Protective Factors and Psychological Resilience

Identifying the factors that promote resilience in the aftermath of trauma is a research priority of considerable clinical importance, as it informs the design of effective preventive interventions. The empirical literature consistently highlights the following protective factors:

- **Robust social support:** Research repeatedly shows that supportive social networks function as a significant psychological buffer against the effects of trauma.
- **Cognitive reappraisal:** The ability to reframe traumatic events in fewer threatening terms is associated with reduced symptom severity.
- **Self-efficacy:** Individuals who believe in their capacity to manage adversity demonstrate better recovery outcomes.
- **Emotional regulation skills:** Proficiency in managing emotional responses reduces the risk of developing chronic psychological disorders.
- **Meaning-making:** The capacity to find meaning or purpose in the experience of trauma is strongly associated with the process of recovery.

This growing focus on resilience has given rise to therapeutic interventions that actively strengthen protective factors alongside addressing trauma symptoms. Posttraumatic growth the positive psychological changes reported by some survivors in the aftermath of struggle represents an emerging research area that further challenges deterministic views of trauma as inevitably pathological [2].

Neurobiological Mechanisms of Trauma

Contemporary neuroscience has substantially advanced the understanding of how psychological trauma affects brain structure and function. Trauma is now conceptualized not merely as a psychological experience but as a neurobiological process, involving dysregulation across key brain systems responsible for stress response, memory consolidation, and emotional regulation [5].

The Amygdala

The amygdala occupies a central role in processing fear and detecting threat. Neuroimaging studies have consistently demonstrated heightened amygdala activation in individuals diagnosed with PTSD, even in response to neutral or non-threatening stimuli [7]. This hyperreactivity manifests clinically as intense fear responses triggered by stimuli that objectively pose no danger for example, a trauma survivor who experiences acute panic upon hearing a sudden loud noise in a safe environment. The finding reflects a hypersensitive threat-detection system that continues to respond as though the original danger remains present.

The Hippocampus

The hippocampus is essential for memory consolidation and contextual processing specifically, for situating memories within their correct temporal and spatial contexts. Trauma exposure has been associated with reduced hippocampal volume in some individuals, which may contribute to the fragmented and intrusive quality of traumatic memories [8]. This structural alteration helps explain why individuals with PTSD frequently experience flashbacks that feel immediate and present, rather than as recollections of past events. The hippocampal deficit appears to impair the brain's ability to encode the memory with appropriate contextual tags that would mark it as belonging to the past.

The Prefrontal Cortex

The prefrontal cortex governs executive functions including emotional regulation, decision-making, and impulse control. Trauma-related dysregulation in this region can reduce its inhibitory influence over the amygdala, resulting in heightened emotional reactivity and diminished capacity to modulate fear responses [8]. A clinical consequence of this dysregulation is that a trauma-affected individual may rationally recognize that a situation is objectively safe, yet continue to experience

overwhelming physiological fear responses that feel entirely beyond voluntary control.

The Hypothalamic-Pituitary-Adrenal (HPA) Axis

The HPA axis is the body's primary neuroendocrine stress response system. Chronic trauma exposure can produce lasting dysregulation of cortisol secretion, resulting in either a chronically hyperactivated or a blunted stress response [4]. Such dysregulation has been empirically linked to sleep disturbances, chronic anxiety, persistent fatigue, and impaired immune functioning findings that underscore the deep biological connection between psychological trauma and physical health.

Developmental Effects on the Brain

Longitudinal research indicates that trauma occurring during childhood can alter the trajectory of brain development, including the myelination of neural pathways involved in emotional regulation. These developmental disruptions provide a neurobiological explanation for the depth and persistence of the psychological consequences associated with early-life trauma [5], and they reinforce the clinical urgency of early intervention.

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder is a clinical condition that may develop following exposure to traumatic events involving actual or threatened death, serious injury, or sexual violence. According to contemporary diagnostic frameworks including the DSM-5-TR [3] and the ICD-11 [9]. PTSD is organized around four core symptom clusters.

Intrusion Symptoms

Intrusion symptoms represent the involuntary re-experiencing of the traumatic event. They encompass intrusive memories, recurrent distressing nightmares, dissociative flashback episodes, and marked psychological or physiological distress when exposed to internal or external cues that resemble an aspect of the traumatic event. A survivor of a natural disaster, for example, may be recurrently overtaken by vivid mental images of the event, producing intense distress that is difficult to interrupt or control.

Avoidance Symptoms

Avoidance involves persistent efforts to evade trauma-

related thoughts, feelings, conversations, activities, places, or people that arouse recollections of the traumatic experience. While this avoidance temporarily reduces distress, it perpetuates and intensifies symptom severity over the long term [4] by preventing the natural psychological processing and integration of the traumatic memory.

Negative Alterations in Cognition and Mood

This symptom cluster includes persistent negative beliefs about oneself or the world (e.g., “I am permanently damaged” or “No one can be trusted”), emotional numbing, pervasive feelings of guilt or shame, and loss of interest in previously meaningful activities. Individuals may also experience a persistent inability to feel positive emotions, a state sometimes described as emotional anhedonia [3]. These cognitive distortions frequently become self-reinforcing and are a primary target in cognitive-focused therapeutic protocols.

Alterations in Arousal and Reactivity

Hyperarousal symptoms include irritability and anger outbursts, chronic sleep disturbances, hypervigilance, and an exaggerated startle response [3]. An affected individual may persistently scan their environment for potential threats even in objectively safe settings, reflecting a nervous system that remains locked in a state of high alert as though the traumatic danger has never fully receded.

Complex Post-Traumatic Stress Disorder (C-PTSD)

Complex PTSD, formally recognized in the ICD-11 [9], extends beyond the classical PTSD symptom profile and typically arises from prolonged or repeated trauma especially trauma experienced during childhood or in circumstances where escape was not possible [1]. In addition to the four PTSD symptom clusters described above, C-PTSD is characterized by disturbances across three additional domains.

Disturbances in Emotional Regulation

Individuals with C-PTSD frequently experience extreme emotional volatility, persistent difficulty returning to a calm baseline following stress, and a chronic sense of emotional overwhelm. These difficulties reflect a

fundamental disruption of the self-regulatory systems that govern affective responses a disruption produced by repeated exposure to uncontrollable stress during developmentally sensitive periods [5].

Negative Self-Concept

C-PTSD is associated with pervasive and deeply internalized beliefs such as “I am fundamentally flawed,” “I am worthless,” or “I do not deserve care or respect.” These beliefs are typically highly resistant to change, even in the face of contradictory evidence, because they were formed during formative developmental experiences and became integrated into the individual’s core sense of identity [1].

Disturbances in Relationships

Individuals with C-PTSD frequently experience profound difficulties in interpersonal functioning, including a persistent inability to trust others, intense fear of abandonment, and patterns of either unstable emotional dependency or complete relational withdrawal. A person with a complex trauma history may oscillate between intense attachment and abrupt emotional disengagement [9], a pattern consistent with disrupted attachment development in early childhood.

It is important to emphasize that the formal recognition of C-PTSD as a distinct diagnosis acknowledges the scale of harm that repeated trauma can inflict on psychological and social functioning and underscores the need for tailored therapeutic approaches that differ in important respects from standard PTSD treatment protocols.

Psychological and Clinical Implications

The clinical implications of trauma extend well beyond PTSD and C-PTSD. A substantial body of research documents strong associations between trauma exposure and major depressive disorder, generalized anxiety disorder, substance use disorders, and personality disorders [5]. Moreover, trauma is independently associated with adverse physical health outcomes, including cardiovascular disease, immune dysregulation, and chronic pain reflecting the systemic biological toll of prolonged psychological stress [4].

Early intervention is critical in reducing long-term psychological consequences. The following evidence-based treatments have demonstrated strong efficacy in

reducing trauma-related symptoms [6]:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): Targets dysfunctional beliefs and avoidance behaviors through structured cognitive and behavioral techniques.
- Eye Movement Desensitization and Reprocessing (EMDR): Facilitates the processing of traumatic memories through bilateral sensory stimulation, enabling their integration into coherent autobiographical narrative [10].
- Prolonged Exposure Therapy: Involves the gradual, systematic confrontation of trauma-related memories and cues, reducing their capacity to trigger distress.
- Somatic and Body-Oriented Therapies: Address the physiological dimensions of trauma, focusing on bodily sensations and autonomic nervous system regulation [5].
- Dialectical Behavior Therapy (DBT): Particularly effective in C-PTSD presentations characterized by severe emotional dysregulation and self-harm behaviors.

At the public health level, trauma-informed approaches to education, healthcare, and social services can play a vital role in breaking intergenerational cycles of trauma. Community-based resilience programs, early childhood support initiatives, and caregiver training have all demonstrated measurable benefits in reducing the population-level burden of trauma-related disorders.

Future Research Directions

Rapid advances in neuroscience and behavioral genetics are opening new avenues for understanding individual differences in trauma response. The following areas are among the most promising directions for future inquiry:

- Epigenetics and intergenerational trauma: Accumulating evidence suggests that trauma may induce heritable epigenetic modifications, potentially transmitting vulnerability or resilience across generations. This line of research carries significant implications for prevention.
- Technology-assisted treatment: Virtual reality exposure therapy and digital mental health applications show considerable promise in expanding access to trauma

care, particularly in under-resourced settings.

- Precision psychiatry: Tailoring therapeutic interventions to individual biological, psychological, and social profiles is likely to improve treatment outcomes and reduce the trial-and-error currently inherent in clinical practice.
- Cultural competence in trauma research: A pressing need exists for studies that examine how cultural context shapes the experience, expression, and healing of trauma, given that most foundational research has been conducted in Western populations.
- Early intervention in humanitarian crises: As armed conflict and forced displacement continue to affect millions globally, developing scalable, culturally adapted, and evidence-based early interventions represents a critical research and policy priority.

Conclusion

Psychological trauma is a multidimensional phenomenon involving complex interactions between neurobiological systems, cognitive processes, and environmental circumstances. Advances in neuroscience have demonstrated convincingly that trauma can alter brain functioning, particularly in regions responsible for fear processing, memory integration, and emotional regulation changes that are measurable, significant, and, under the right conditions, amenable to therapeutic intervention [8]. At the clinical level, trauma-related disorders such as PTSD and C-PTSD represent serious public health concerns due to their chronic nature, functional impact, and frequent co-occurrence with other psychiatric and physical conditions. Nevertheless, research also highlights the remarkable human capacity for resilience and recovery, affirming the central importance of social support, early intervention, and evidence-based psychotherapy in facilitating healing.

Looking ahead, continued collaboration between neuroscience, clinical research, and frontline practice is essential for developing more effective, personalized, and globally accessible interventions. Understanding trauma more fully in all its biological, psychological, cultural, and social dimensions remains one of the most urgent tasks in contemporary mental health science.

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