Trauma and Emergency Care

Commentary ISSN: 2398-3345

PTSD as a future-oriented survival strategy

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Abstract

Posttraumatic stress disorder (PTSD) is generally conceptualized as a disorder of the past, with symptoms intruding into the present. By definition, the disorder occurs after a traumatic event, hence the term post-traumatic. PTSD and its symptoms, including flashbacks and hyper-arousal, can also be conceptualized as a future-oriented survival strategy, however. Looking at PTSD as a disorder of the future leads to an additional set of treatment strategies and techniques. These are illustrated with a case vignette.

Introduction

As described in DSM-5 [1], posttraumatic stress disorder (PTSD), involves symptoms "beginning after the traumatic event(s) occurred" (p. 271). PTSD is by definition a disorder in which traumatic events in the past are causing persistent symptoms in the present, hence it is called *posttraumatic stress disorder*. However, PTSD could also be called *pretraumatic stress disorder*, because its symptoms can be conceptualized as part of a future-oriented survival strategy. Discussion of the future in the PTSD literature, including in the deliberations of the Trauma/Stress-Related and Dissociative Disorders Sub-Work Group of DSM-5, does not include such a conceptualization [2,3]. The purpose of the present paper is to present a hypothesis: two core symptoms of PTSD, flashbacks and hyper-vigilance, can be conceptualized as future-oriented survival strategies.

In DSM-IV [4], one of the criteria for PTSD was the individual experiencing a sense of a foreshortened future; in DSM-5, according to Weathers *et al.* [3], this was replaced by Criterion D2: "Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined") [1, p. 27]). Negative thoughts and beliefs about the future are part of a general negative cognitive set in DSM-5, and represent a form of psychological injury without any future-oriented survival function. Likewise, in DSM-IV, a foreshortened future was conceptualized as a form of injury, involving a lack of trust, meaning, and optimism about what the future would hold. Similarly, future templates in Eye Movement Desensitization and Reprocessing Therapy are conceptualized as persistent negative cognitions and the goal is to install corrective positive cognitions to counter them, without the PTSD symptoms being thought of as survival strategies [5]. Torem [6] described a therapy technique he called 'back from the future" that involved hypnotically age-progressing an individual into the future to treat symptoms persisting in the present but he did not propose that symptoms of PTSD can have a future-oriented survival function.

When PTSD is conceptualized as a future-oriented survival strategy, however, its core symptoms of flashbacks and hyper-arousal can be understood as part of an ecological and evolutionary survival strategy. Therapeutic attempts to remove or extinguish these symptoms might fail in treatment-resistant cases, in part because that would involve eliminating a future survival strategy, without recognizing the functions of the symptoms, and without developing an alternative future-oriented survival strategy. In this paper, the author will describe the clinical rationale for this alternative conceptualization and treatment strategies that follow from it. PTSD as a disorder of the past persisting into the present, and PTSD as a future-oriented survival strategy, are not mutually exclusive perspectives; the author assumes that both commonly operate at the same time. Part of the foundation for the future-oriented perspective on PTSD is *the locus of control shift*, which will be explained below.

There are many possible perspectives on risk for and response to trauma in general and sexual victimization in particular, including social psychology as exemplified by the work of Frazier [7,8]. Although these authors discuss both self-blame for trauma and future risk assessment by trauma survivors, they do not describe the symptoms of PTSD as having a future-oriented survival strategy. Similarly, Nurius and Norris [9] discuss a cognitive-ecological model for responses to sexual assault, and Gidycz, McNamara, and Edwards [10] and Walsh, DiLillo, and Messman-Moore [11] discuss women's perceptions of sexual assault, but none of these authors describe the perspective outlined in the present paper.

To clarify, the idea that symptoms of PTSD can have a function as a future-oriented survival strategy does not in any way exclude or reduce the relevance of other theories or perspectives, nor does it imply the slightest amount of victim blaming. It does not diminish the relevance of gender, sexual orientation, race, culture, economics or any other factors in understanding human responses to trauma. Within this perspective PTSD is a disorder and requires treatment because the future-oriented survival strategies are maladaptive. Although based on mammalian threat responses that were adaptive tens of thousands of

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Key words: *posttraumatic stress disorder, future-oriented survival strategy, psychotherapy*

Received: October 09, 2020; **Accepted:** December 10, 2020; **Published:** December 14, 2020

years ago, as outlined below, they do not confer survival advantage in most cases. The purpose of the present paper is modest and limited, simply to introduce an idea or hypothesis that may be useful in clinical work and research. It is not the purpose of the paper to provide empirical support for the idea that symptoms of PTSD could be, in part, a future-oriented survival strategy. To the author's knowledge, there is no empirical evidence for or against this idea, since it appears not to be mentioned in the existing literature.

Thinking of PTSD as *pre-traumatic stress disorder* does not mean that the disorder arose before the trauma: the symptoms began with trauma in the past, persist in the present, and may persist in the future: nor does it mean that the future-oriented survival purpose of the symptoms is adaptive; if it was, the symptoms would not be part of a disorder.

The locus of control shift

The locus of control shift is a core concept in Trauma Model Therapy [12-15] and is a foundational concept for thinking about PTSD as a future-oriented survival strategy. The locus of control shift is based on normal childhood cognition: *I am at the center of the world; everything in my world revolves around me*; *I cause everything that happens in my world*; and *I have a magical power to make things happen*. When there is childhood trauma, the child automatically shifts the control point – the locus of control – from inside the parents, where it really is, to inside the self. Now the child knows that he or she is causing the abuse, it is her fault, and she deserves it. The locus of control shift gets reinforced over and over by parental abuse and neglect, by negative self-talk, by self-destructive behavior, and by dysfunctional or abusive relationships in adulthood.

When there has not been any severe, chronic childhood trauma and a traumatic event occurs in adulthood, a more muted and less entrenched form of locus of control shift takes place, in the form of "I could have" and "I should have" self-statements. The adult rape victim, for instance, blames herself for going to the bar, going on the date, giving the rapist her phone number, or other normal behaviors, even though there were no discernible red flags and the trauma was unpredictable and unavoidable.

The locus of control shift can be held onto tenaciously because it confers an illusion of power, control and mastery: *it is my fault the traumatic event happened*; *I could have known*; *I should have known*; *I could have done this*; *I shouldn't have done that*. The illusion of power, control and mastery conferred by the locus of control shift protects the person from underlying feelings of powerless and helplessness, but it carries the price tag of the badness of the self. In order for it to be true that the person was not powerless and helpless, it must be true that she could have done something, which means the rape happened because of her own negligence and lack of hyper-vigilance, which means she deserved it, within her magical child thinking.

The locus of control shift occurs in both *pretraumatic stress disorder* and *posttraumatic stress disorder*. It has survival functions in both the past and the future-oriented perspectives. These functions may be illusory, but they are nevertheless part of a psychological survival strategy. They protect the person from an internal sense of powerlessness and helplessness.

The idea that symptoms of PTSD can have a future-oriented survival strategy draws on the locus of control shift, but is not directly predicted by it or by any literature on self-blame for trauma, therefore, in the author's opinion, it is not necessary to review that literature here.

PTSD conceptualized as a future-oriented survival strategy

The conceptualization of PTSD as a disorder of the future is based in part on magical child thinking and the locus of control shift, as described by Ross [12-14] and Ross and Halpern [15]. Developmentally, according to the Trauma Model [12], magical child thinking is either integrated into the emerging adult self, or dissociated as a separate fragment of the psyche – the degree of integration occurs on a continuum from fully processed and integrated to fully un-processed and dissociated, not as two discrete categories. Whatever the degree of integration of an adult person's psyche, however, the mind of the magical child is still present and can still be the basis for emotions, perceptions, thoughts, beliefs, physiological reactivity and decision-making.

Flashbacks are described in the DSM-5 criteria for PTSD as "dissociative reactions," [1, p. 271]. They involve a sudden intrusion into the executive self of a previously dissociated traumatic event; the intruding material can include all five senses. Often, the person experiencing a flashback loses his orientation to the present and is "back in the past." According to the conceptualization of PTSD as a disorder of the future, however, flashbacks are not simply symptoms of unresolved past trauma; rather, they have a future-oriented survival function.

Based on *should have*, *could have* thinking (the locus of control shift), the person believes that he could have anticipated and avoided the traumatic event in the past. He missed the red flags of the impending trauma. In order to identify these red flags, it is necessary to review the tapes of the trauma. Flashbacks, then, are the mind's attempt to catalog the red flags that were missed last time, so that they can be spotted in the future; the person vows not to make that mistake again. In order to spot the red flags, which Lenore Terr [16] called *omens*, in the future one must be hyper-aroused, hyper-vigilant, easily startled and scanning for danger.

The flashbacks, nightmares and hyper-arousal symptoms of PTSD, from this perspective, are all strategies to anticipate and avoid trauma in the future. Next time, one will spot the *omens* and take evasive action, rather than being powerless, helpless, or trapped. The locus of control shift confers an illusion of power, control and mastery in both the past and the present; the traumatized person was not powerless and helpless in the past, he just failed to be observant, missed the omens, and did not take preventive action. That mistake was made in the past, but will not be made again in the future. The problem is, as Terr [16] described in detail, that the *omens* are based on magical child thinking, not objective threat assessment. Spotting the omens in the future will not increase one's safety because the omens in fact have no objective predictive value.

Flashbacks, hyper-arousal and other PTSD symptoms, according to this perspective, were selected for during evolution. The early human or other mammal was attacked, stalked or wounded by a predator, or a member of the mammal's group was attacked and killed. In order to increase the chances of survival in the future, the mammal must review the tapes of the prior trauma in order to have an inventory of red flags – a scent, a sound, an intuition, a sense of danger – and must review this inventory on a regular basis in order to spot the predator in advance, in the future, and take evasive action. Hyper-arousal and hyper-vigilance are required to stay on guard and be ready for fight or flight at any time. Thus, the mammal with PTSD had an increased chance of survival compared to the mammal without PTSD and those traits would have been selected for over millennia. In humans the cognitive components of PTSD as a future-oriented survival strategy evolved along with language and the cerebral cortex.

The following case example illustrates PTSD as a future-oriented survival strategy, and strategies for treating it in psychotherapy.

A case example of PTSD symptoms as a future-oriented survival strategy

The following composite case vignette illustrates both the logic of flashbacks and hyper-arousal as future-oriented survival strategies, and treatment techniques and strategies for addressing them. The content of the trauma varies from case to case, but the logic, structure, tasks and strategies of the psychotherapy are the same, irrespective of content. This is analogous to behavioral treatment of simple phobias: in one case, the topic of conversation may be spiders, in another snakes, and in another small furry animals. The content of the desensitization treatment varies, but the vocabulary, theory, logic, structure and steps are the same. Thus, the same strategies could be used for a combat survivor with PTSD, or a survivor of a civilian accident, childhood sexual abuse, or a natural disaster.

A rape victim with PTSD

A woman who was raped recently, and who has been having a lot of flashbacks, nightmares and hyper-arousal symptoms, is talking with her therapist:

Therapist: So you're saying that the rape was your fault, because you shouldn't have gone to the bar?

Client: Right. I should have known.

Therapist: I see. What were the red flags that you missed?

Client: I should have known not to take that drink.

Therapist: The drink he ordered for you?

Client: Right. I shouldn't have gone to the restroom.

Therapist: As far as you can tell, that's when he slipped the drug into your drink?

Client: That was the only time I wasn't holding it after the bartender gave it to me.

Therapist: OK, so that seems clear. But what were the red flags you missed?

Client: I should have known.

Therapist: Let's look at this from two perspectives: from the present, with the information you have now, and from before you went to the bar, with the information you had at that time.

Client: OK.

Therapist: Hindsight is perfect. It's a fact that if you hadn't gone to the bar that night, the rape wouldn't have happened. Correct?

Client: Correct.

Therapist: If you had known for a fact that the rape was going to happen before you left for the bar, what would you have done?

Client: I wouldn't have gone.

Therapist: Right. Exactly. If you had known. But you didn't know.

Client: I should have known.

Therapist: How? The problem isn't that you should have known, it's that the rape was completely unpredictable.

Client: What do you mean?

Therapist: If you had known in advance, you wouldn't have gone. The fact that you did go is the proof that you didn't know.

Client: Yeah, but I should have known.

Therapist: Remember when we talked about the locus of control shift? I think that's what's going on here. I think that blaming yourself creates the illusion that you weren't powerless and helpless to predict or prevent the rape. You had the power and control, you just messed up and didn't spot the red flags. But actually there were no red flags. That's the real problem.

Client: Oh. I kind of get it.

Therapist: How many hundreds of thousands of women go to bars in America every year without getting raped? It's perfectly normal behavior, and over 99.9% of the time everything works out fine. How many times have you been to bars since starting college?

Client: Lots.

Therapist: And how were you supposed to predict that this night was the one night you were going to get drugged and raped?

Client: I guess I couldn't, if you put it like that.

Therapist: You guess?

Client: OK, I couldn't.

Therapist: I think that part of what is keeping your PTSD going is you are trying to figure out what red flags you missed that night – to figure that out, you have to review the tapes of everything that happened that evening, equals have flashbacks. Then when you have the list of red flags, you can watch out for them in the future, and prevent trauma from happening again in the future. But to spot those red flags in the future, you have to be hyper-aroused, scanning for danger, easily startled and hyper-vigilant.

Client: I'm that way a lot.

Therapist: I think the PTSD might start to settle down if you could admit to yourself that there was no way you could predict or prevent the rape – in the past or in the future.

Client: I don't want that to be true.

Therapist: Of course you don't. No one in her right mind would want to feel those feelings of powerlessness and helplessness. So you avoid them by blaming yourself and telling yourself that you shoulda/coulda.

Client: That makes sense. I can see that.

Therapist: The real problem is the underlying feelings that fit the facts: it was unpredictable and you couldn't prevent it.

Client: That sucks.

Therapist: Definitely. But if you can learn to feel and tolerate those feelings, then you will be able to let go of the self-blame. Then you won't have to have flashbacks over and over to figure out what you missed, and you won't have to be so hyper-vigilant.

Client: It's not that easy.

Therapist: I agree. It's easy to understand as a theory. Actually doing the work is painful and difficult, but it can be done.

Client: OK. I believe you.

Therapist: I'd like to talk a little bit about your future threat assessment.

Client: What do you mean?

Therapist: Emotionally, and in your thinking, you are acting as if the risk of a future rape is very high. So you review the tapes, have flashbacks, and are scanning for danger all the time. Or, you shut down, withdraw and don't go out.

Client: That's what I do.

Therapist: But you've learned something. You'll never leave your drink unattended again. That reduces the risk of a future rape a lot. So you are better protected now than you were before you went to the bar.

Client: That's true, but I could still get raped again.

Therapist: You could, or you could get hit by a drunk driver, or even get stuck by lighting. But what are the odds? You've been operating as if the odds are very high, but actually they are very low. It was a bad event that is not likely to happen again.

Client: But it could.

Therapist: True, it could, but what are the odds? You're paying an awfully big price for your threat assessment, which I don't think is objectively accurate: self-blame; PTSD symptoms; no social life. All these future-oriented survival strategies aren't worth it if the threat in the future is actually quite low.

Client: I see what you mean. That makes sense.

Therapist: Good. This is going to take some work. It will involve some desensitization as well, with you taking small steps to get back out in the world, one step at a time.

Client: I can do it.

Therapist: I agree. Also, sometimes PTSD symptoms can be a form of self-punishment, if you believe the rape was your fault. But it wasn't. You've already suffered enough. You don't deserve anymore.

Client: I guess that could be true.

Therapist: And one more thing. How about if you get angry at the guy who drugged you then raped you in the parking lot? How about if you don't let him control your life, your feelings and your behavior anymore? Dump it all back on him, so you win, not him.

Client: That sounds good.

Therapist: Remember when we talked about fight, flight and freeze.

Client: I remember.

Therapist: How about turning your normal mammalian fight response outward onto him, instead of inward in the form of self-blame and self-punishment?

Client: How do I do that?

Therapist: We'll work on it. But the first step is figuring out what's going on inside, which we've been doing. It's hard to solve a problem if you don't know what the problem is.

Client: That's true.

Therapist: OK, good. I'd like you to think about all of this, write a summary of the session, and start going out just a little bit to push yourself out of your comfort zone. Not too much, just a little bit. Then I'll see you next session.

Client: OK.

This session, and ones preceding it, involved a wide range of different techniques and strategies including: education about the treatment model; education about mammalian threat response systems; normalization; reframing; analysis of defenses; validation; homework assignments; and cognitive restructuring.

Discussion

PTSD can be conceptualized as a disorder of the future, and as part of a future-oriented survival strategy. Looked at this way, the flashbacks, nightmares and hyper-arousal symptoms of PTSD serve a purpose, which is to defend against underlying feelings of powerlessness and helplessness. It follows from this perspective that treatment of PTSD – in some but not necessarily all cases – may require work on re-evaluating the future risk of recurring trauma, and developing coping strategies based on adult, analytical thinking, rather than on magical child thinking. This may be the case particularly in complex and treatment–resistant cases that have not responded to prior treatment efforts, and especially for individuals who have experienced not just a rape in adulthood, but chronic childhood sexual abuse; for such individuals the self-blame for sexual trauma is much more entrenched and has been reinforced much more extensively. The idea that symptoms of PTSD may be part of a future-oriented survival strategy does not in any way diminish or exclude the role of numerous other perspectives and factors that are relevant to a full understanding of human responses to trauma. The hypothesis presented in this paper is not meant to account for or apply to all symptoms of PTSD: it is focused on flashbacks and hyper-arousal. However, the hypothesis could be relevant for other PTSD symptoms such as numbing, for example, if one function of the numbing is to lessen the impact of future trauma.

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