

Microtrauma, microtraumatic relational patterns in our lives. Does constant dripping wears away the stone?

Mikrotrauma, mikrotraumatyczne wzorce relacyjne w naszym życiu. Czy kropla wody drąży skałę?

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Abstract

The purpose of this article is to present the phenomenon of psychological microtrauma, a trauma that is cumulative in nature and results from prolonged exposure to many stressful situations in one area of suffering that are usually not so severe as those causing post-traumatic stress disorder and are included in criterion A in the Diagnostic and Statistical Manual of Mental Disorders. The introduction to the International Classification of Diseases 11th Revision of a new disorder named complex post-traumatic stress disorder, despite allowing a better understanding of people who experience chronically repeating traumas, does not explain the consequences of microtrauma which can be approached from psycho-dynamic, clinical and social perspectives. Taking into account the difficulties associated with identifying microtrauma, knowledge of this phenomenon could be useful for clinicians and their patients. The theory of microtrauma is a promising area of research and may finally bring the answer why there is a high prevalence of diagnosing post-traumatic disorder among people who experience not severe but chronic stressful events in one area in terms of content in their daily lives, e.g. discrimination. It shows how much is still ahead of us in understanding trauma and how rich and complex this phenomenon is.

Keywords: trauma, microtrauma, post-traumatic stress disorder, complex post-traumatic stress disorder, insidious trauma

Streszczenie

Celem artykułu jest przedstawienie psychologicznego fenomenu mikrotraumy, traumy o naturze kumulatywnej, która wynika z doświadczania wielu sytuacji urazowych w jednym treściowo obszarze cierpienia, przeważnie jednak o znacznie mniejszym nasileniu niż te, które wywołują zespół stresu pourazowego i są zawarte w kryterium A w *Podręczniku diagnostyczno-statystycznym zaburzeń psychicznych*. Wprowadzenie do Międzynarodowej Klasyfikacji Chorób (wersja 11.) nowego zaburzenia, noszącego nazwę złożonego zespołu stresu pourazowego, pozwala nam lepiej zrozumieć osoby, które doświadczyły powtarzających się chronicznie poważnych urazów psychicznych, ale nie wyjaśnia konsekwencji mikrotraumy, która jest przedstawiona z perspektywy psychodynamicznej, klinicznej i społecznej. Biorąc pod uwagę trudności w identyfikacji mikrotraumy, wydaje się, że wiedza na temat tego zjawiska może być wartościowa dla klinicystów pracujących z pacjentami. Teoria mikrotraumy jest wysoce obiecującym obszarem badań i może w końcu przynieść odpowiedź, dlaczego zaburzenia zespołu stresu pourazowego są częściej rozpoznawane u osób, które w codziennym życiu doświadczają niezbyt nasilonych w swoim rozmiarze, ale przewlekłych stresujących wydarzeń w jednym treściowo obszarze, np. dyskryminacji. Pokazuje nam, jak wiele jeszcze przed nami w poznaniu traumy i jak bogate oraz złożone jest to zjawisko.

Słowa kluczowe: trauma, mikrotrauma, zespół stresu pourazowego, złożony zespół stresu pourazowego, trauma skryta

PTSD, C-PTSD AND MICROTRAUMA

There is an opportunity to recognise a traumatic disorder that is not a result of an individual traumatic experience, but rather develops as a response to very serious psychological injuries experienced chronically for an undefined period of time. The new version of the International Classification of Diseases – ICD-11 (World Health Organization, 2018) gives the possibility of diagnosing complex post-traumatic stress disorder (C-PTSD). Unlike the classically recognised trauma and its consequences in the form of post-traumatic stress disorder (PTSD), C-PTSD is a result of an undefined number of extremely threatening experiences which, if taken separately, would not have exactly the same effect as their sum. This does not mean that some of those experiences could not have resulted in the development of PTSD, but their total effect is contained in, but also beyond, the PTSD criteria. An earlier recommendation to extend the American Diagnostic and Statistical Manual of Mental Disorders – DSM-5 classification (American Psychiatric Association, 2013) by adding the phenomenon of developmental trauma disorder (DTD) was not successful. C-PTSD is a similar phenomenon in terms of the accumulation of distressing traumatic experiences, but it differs from DTD which develops only during childhood. C-PTSD does not assume any age limits. There are indications that both of these disorders are, in fact, similar to each other, and both differ qualitatively from PTSD (van Der Kolk et al., 2019; Spinazzola et al., 2018). In this paper, we want to address the phenomenon of microtrauma. Its most important differentiating feature from other traumatic phenomena is the potential for “building up” over time from usually less traumatic experiences than those included in criterion A in the diagnosis of PTSD in DSM-5.

EARLY PSYCHODYNAMIC CONCEPTS OF MICROTRAUMA

It was Freud (1893 – 1955) himself, who believed that “traumatic neurosis” is caused by a single, seriously threatening event, while hysteria is induced by a greater number of “partial” traumas that refer to one area of suffering. In his later works, he also pointed out that trauma is the result of strong stimuli both from the outside and the inside, which people’s protective shield is not able to filter and adequately weaken, meaning that the occurrence of a traumatic event depends on the relative strength of the stimuli, but also on the person’s constitution and development (Freud, 1920 – 1955). The ability of stimuli to break through the protective shield can be significant, but it can also contain less intense sensations stacked together (Laplanche and Pontalis, 1973). The idea of trauma in this latter case inspired later generations of psychoanalysts, and finally, in the tradition of this method, Khan (1964, 1963) coined the term of “cumulative trauma”. He described the phenomenon as one resulting

from the violation of the mother’s role as a protective shield for the child in the period from birth to adolescence, when the child still needs support from the mother as an auxiliary ego, to protect the immature and unstable functions of its own ego (Freud, 1920 – 1955). Khan was inspired by Kris (1956), who distinguished between shock trauma (caused by a single frightening experience) and strain trauma (resulting from prolonged stressful situations causing traumatic effects as the culmination of frustrating tensions experienced by the child). Kris believed the process of forming strain trauma to be subtle and imperceptible. These tensions are gradually embedded in the features of a given characterological structure (Greenacre, 1956). As a rule, parental violations in their role of protective shielding are not traumatic individually (Khan, 1963). The mother’s failure to ensure the child’s safety against this type of impingements may have a negative impact on the child’s functioning (Winnicott, 1960). These stressors do not necessarily have to be recognised as traumatic in the context of where they occur, but may emerge over time as a result of their accumulation (Khan, 1963). Cumulative trauma arises in the relationship between the child and the mother and later, during adulthood, can be activated when the person experiences relational sensations in these pre-formed areas of personality. When this happens, this sensitive area is reactivated and symptoms of a disorder may appear. The content of these sensitive areas is of great importance here. The consequences of such childhood experiences may manifest later in life (Freud, 1958).

In 1977, Peseschkian, the inventor of transcultural positive psychotherapy (TPP), coined the term “microtrauma”. He wrote about vulnerable points in people’s personality that are related to the values and norms that are deemed most important. The example of a patient from Peseschkian’s practice captures this phenomenon well: “When I hadn’t straightened up my room, it was ‘I don’t love you anymore!’ That filled me with panic-stricken anxiety. Now I’m more than picky, and for that reason often come into conflict with my husband and the children” (pp. 79, 1987). Here, we are dealing with a situation where cleanliness is so important for the patient that any frustration related to that aspect will be felt much more intensely than in the case of any person for whom cleanliness is not so important. The foundation underlying the development of such an individual sensitivity in specific areas consists of the efforts of our parents and society to induce in us a range of behaviours and traits that are desired from their perspective. The process of upbringing involves experiencing microtraumas in childhood in the areas of particular importance for parents and other caregivers, which results in the creation of “sensitive points” of an individual. The activation of these sensitive points is associated with their disproportionate, though subjectively perceived as adequate, reaction. Crastnopol (2017) calls these sensitive points our “Achilles’ heel”, it’s the source of which she identifies differently than Peseschkian. The situations that activate people’s sensitiveness can be completely trivial, yet their accumulation can cause

symptoms of the disorder (Peseschkian, 1987). These areas are a constant source of excessive sensitivity, a kind of triggers which may even be consciously activated and attacked by others, and consequently cause suffering to the microtrauma victim. The accumulation of such experiences, which often occurs over many years, can eventually have a dramatic result and produce effects similar to any single severe health and/or life threatening experience. This means that a person may experience similar symptoms as in PTSD, DTD or C-PTSD, without the precondition of experiencing one or more situations recognised as the cause of these disorders (American Psychiatric Association, 2013).

CONTEMPORARY UNDERSTANDING OF MICROTRAUMA

Most present-day researchers and theorists of the phenomenon of microtrauma note that it may occur outside the mother–child dyad. For example, for Crastnopol (2015), any actual relationship may also be microtraumatic. According to her, this type of trauma is characterised by the lack of drama, invisibility, and cumulative nature, partly because it occurs mostly in the context of relationships that seem “good enough” at first glance. In such relationships, positive experiences are intertwined with negative ones, and thus the person affected by microtrauma typically remains in such a relationship. It is worth mentioning that Crastnopol (2015) refers to the phenomenon discussed as “micro-trauma”, but I will continue to use the earlier Peseschkian’s version, i.e. “microtrauma” (Peseschkian, 1987). Both versions are accepted in medical sciences, and there is probably no reason to name them differently in other sciences. However, a more appropriate term would be in fact “cumulative trauma”, as it stresses the other necessary quality of this phenomenon which seems to be more important. In medical sciences it is also common to use the term “repetitive microtrauma”. The latter option seems to capture its nature even better.

The trouble with microtraumas is that they do not seem to matter that much and can therefore be overlooked and not considered as a source of serious psychological problems. Both the person who is the perpetrator of the hurt and the recipient of the hurt are often unaware of where the suffering comes from (Cavelzani et al., 2018).

According to Crastnopol (2012), the phenomenon of microtrauma usually occurs in the context of important relationships. She proposed seven different microtraumatic situations (Crastnopol, 2015). “Uneasy intimacy: a siren’s call” for example, is a situation where a close person strongly emotionally binds the other person in order to gain some benefit, e.g. a parent uses his or her emotional contact with the child in order to distance him or her from the other parent (Crastnopol, 2007). “Unkind cutting back” is when a partner withdraws from contact unexpectedly, leaving the other party frustrated, confused, and suffering (Crastnopol, 2013). Such situations may occur in relationships involving people with borderline,

with an avoidant attachment style or with postpartum depression (Cavelzani et al., 2018). People have unique relationship patterns that are not always hurtful, but they can be, provided that some specific conditions occur. Another example of microtrauma explored by Crastnopol (2018) is “subservient caretaking”. Similarly to “uneasy intimacy”, it involves a very close relationship that is both attractive and uncomfortable for one or both of the parties. The situation of caring, providing protection and subjection is particularly problematic here. The care provider initially assumes the role as an expression of sincere love, with a sense of commitment to such behaviour as a person who is “emotionally stronger and healthier” (narcissistic motives). It seems that the only way to support the “weaker” partner is to sacrifice one’s needs and wishes for him or her, but this will eventually lead to a conflict between the partners. There will be growing frustration and a desire to break free from such a burdening role. These feelings can be further strengthened by the fear of unmasking the real not-so-positive motives behind such behaviour, which at first glance may be unnoticeable.

Crastnopol (2015) points out that there are many favourable conditions for the development of microtraumatic relationships, and it may be a common phenomenon. She gives an example. A child with a melancholic temperament and shyness in his or her personality traits, born to a parent who is naturally more cheerful and sociable, may experience some level of frustration of his or her “happier” parent, resulting in parental rejection that will not be direct and firm, but rather subtle and hidden, often completely unaware to either side (Thomas and Chess, 1977).

In the psychoanalytic tradition, Bromberg (2006) introduced the term “developmental trauma”, which he uses interchangeably with “relational trauma”, by which he means a situation of experiencing a parent’s long-term non-recognition in some area of the child’s self. Such failure to recognise some aspects of the child’s self generates the child’s dissociative structure of self. It creates a situation in which a person has mutually combating states of self within their personality, which may manifest themselves in a different way of establishing relationships, result in relational dysfunctions, and cause suffering.

Another phenomenon with the characteristics of microtrauma is gaslighting (Tormoen, 2019), which refers to a situation where one person arouses in another doubts about his or her judgment and mental health. This behaviour aims to control the victim by the perpetrator (Miano et al., 2021). Gaslighting is a conscious or unaware form of psychological violence that occurs when the perpetrator distorts information to confuse the victim, causing them to doubt their memory and sanity (Kivak, 2017). The term has gained great popularity in the social sciences.

CLINICAL INSPIRATIONS

Most of the above considerations in the psychoanalytical tradition are theoretical in nature. Often, they are supported

only by observations and clinical case studies. However, this does not mean that there are no studies showing that exposure to stressful events that may not individually have the potential to be the cause of PTSD, in sum total may greatly elevate the risk of such consequences. This is the case of the studies in the paradigm of the phenomenon of peer violence, school and workplace mobbing (Idsoe et al., 2012). The form of victimisation seems to be irrelevant, as both cyber-mobbing and traditional forms of harassment are associated with an increased risk of experiencing PTSD symptoms (Holfeld and Mishna, 2021). Recently, new data have emerged indicating that alternative diagnoses to PTSD are more useful in the context of bullying. The complexity of symptoms of this type of violence better fits the diagnostic criteria of DTD and C-PTSD, however, not all the criteria proposed for DTD are linked to bullying (Idsoe et al., 2021). According to Shapiro (1995), traumas can be distinguished by “big-T” and “small-t”. The former refer to the events that are included in the A criterion for PTSD in DSM-5 (American Psychiatric Association, 2013), but also those of cumulative nature that would be recognised as a possible source of DTD and C-PTSD and are easily identifiable. In contrast, “t-traumas” are relatively less severe events in everyday life, which are much more difficult to be identified as the cause of difficulties in functioning. These can include stalking (Purcell et al., 2005), poverty (Kiser, 2007), or experiencing discrimination due to belonging to a group based on race, gender, religion, sexual orientation, etc. (Marsella, 2010). Straussner and Calnan (2014) also use the term “microtraumas” to refer to such stressors and believe they may cause considerable psychic pain and lifelong damage.

SOCIAL APPROACH

Another theory addressing the effects of lower-severity traumatic events that are experienced regularly is that proposed by Sue et al. (2007). It assumes that even short-term exposure to everyday verbal, behavioural and environmental comments, whether intentionally or not, directed in a hostile way and relating to someone’s race, gender, sexual orientation, religion, etc., can have detrimental effects on people’s health. Sue and associated call such events microaggressions and identify three types of them: microassaults – conscious, deliberate expressions of prejudices designed to hurt another person; micro-insults, often unconscious, subtle devaluations of a person through the characteristics of the group to which they belong, and micro-invalidations, which consist in negating the feelings, mental states, and experiences of people from discriminated groups. Microaggressions are interactive phenomena in which both sides face losses. People who are oppressive towards others must, on some level, become cold and emotionless. People who experience such microaggressions are exposed to a number of different effects. The authors of the concept believe that, fortunately, strategies can be developed to deal with these situations (Sue et al., 2019).

In 1992, Root recognised that people who were discriminated against could suffer significantly if they were affected by a great number of such experiences of discrimination. She coined a term that captures very well the cumulative nature of such chronic traumas as discriminatory behaviour – insidious trauma. People from discriminated groups may more commonly suffer from various types of trauma-related disorders. This could explain the observations that PTSD is more prevalent among people from these groups. Women, for example, suffer from this disorder more often than men, even though they encounter fewer traumatic events (Tolin and Foa, 2006). Insidious trauma should be understood as the outcome of discrimination, even at a low level, suffered throughout a person’s life. More frequent experiences of transgender discrimination and a greater number of attributed causes of this discrimination are associated with PTSD symptoms, even after taking into account previous experiences of trauma (Reisner et al., 2016). In a survey of bisexual people, experiencing discrimination was found to be related to symptoms of trauma (Arnett et al., 2019). The term “racial trauma” has also been used recently in the psychology of prejudice. The phenomenon is defined as a form of race-related stress. It refers to the reaction of People of Colour and Indigenous (POCI) to the threat of real or imagined experiences of racial discrimination. While it is believed the racial trauma may be similar to trauma that causes PTSD, it is unique in that it involves constant, recurring individual and collective harm due to exposure to race-related stress (Comas-Díaz et al., 2019). It has been argued that hidden, cumulative trauma understood in this way should be included in criterion A of the PTSD diagnosis in the next edition of the DSM classification (Holmes et al., 2016). However, there is also the alternative proposal of a new diagnosis of race-based trauma (Carter, 2007). There could be a qualitative difference between the impact of microtrauma and shock trauma. Crastnopol (2015) believes that microtrauma will mainly have an impact on the level of anxiety and self-esteem of those affected by it. This is partially supported by research in the insidious and racial trauma paradigms. Watson et al. (2016) for example, found self-esteem moderately mediating the relationship between multiple forms of discrimination and symptoms of trauma among Women of Colour. In another qualitative study, the authors found that People of Colour who experienced racism, reported symptoms of PTSD, such as extreme emotional distress, hyperarousal, avoidance, intrusion, and distrust (Lowe et al., 2012). Comas-Díaz et al. (2019) state that racial trauma carries psychological and physiological effects that include hypervigilance to threat, flashbacks, nightmares, avoidance, suspiciousness, and somatic manifestations such as headaches and heart palpitations. However, De Maynard (2010) found that People of Colour who experienced derogatory race-related comments and low self-esteem had scored significantly higher on a measure of dissociative experiences, which is another common symptom of traumatisation. More recently,

Williams with her associates (2018) claimed that the phenomenology of racial trauma might differ from PTSD in the DSM-5, as it may include a wider range of symptoms, such as paranoia, avoidance of dominant group members, somatic complaints, and excessive worries about loved ones. What is also important in this discussion is the inclusion of vicarious trauma in criterion A in the recent version of DSM-5 (American Psychiatric Association, 2013). There have been suggestions that it may be appropriate for ethnic minorities who have experienced, witnessed, or only been told of generational and communal discrimination (Williams et al., 2018). This could mean that individuals from minorities may not need to experience discrimination themselves at all for it to have an effect. The vicarious trauma concept is also interesting for us because of its cumulative nature. It is similar to microtrauma because exposure to one independent event that is defined as a possible source of vicarious trauma, is very unlikely to cause secondary PTSD, and there must be a higher number of such experiences to result in such an effect. It could be useful to add a word from the author of the insidious trauma theory. Root (1992) stresses that trauma is a very personal experience and what is deemed traumatic should be determined by the traumatised person rather than the observer. Research seems to support this hypothesis. Perceived threat may be a much more likely causal factor in the development of PTSD than a pre-defined list of “traumatic” events (e.g. Pinto et al., 2015). It could be that social psychologists may teach us something again and about a very “clinical” subject as trauma and give new answers to what American Psychiatric Association also acknowledges: women are twice as likely as men to have PTSD; U.S. Latinos, African Americans, and American Indians – are disproportionately affected and have higher rates of PTSD than non-Latino whites (American Psychiatric Association, 2013).

Criterion A is one of the most discussed in the debate about PTSD among clinicians and researchers. Introduction of vicarious trauma in 2013 can be viewed as weakening it, but DSM-5 actually narrowed and clarified the types of events that qualify as “traumatic”. There is a strong need to save the uniqueness of PTSD from other related disorders, as a result of serious, life-threatening experiences, however, more and more studies suggest that the presence of PTSD symptoms is possible without any exposure to criterion’s A events (e.g. Franklin et al., 2019). Events that do not present an immediate threat to life or physical injury are not considered trauma and formally cannot be the recognised as the cause of PTSD. Only in the latest revision of the classification, sexual violence was explicitly added. ICD-11 states similarly, that PTSD requires exposure to a trauma defined as an extremely threatening or horrific event or series of events. Adopting this approach, Kilpatrick et al. (2013) demonstrated that 60% of PTSD cases met DSM-4 but not newer DSM-5 PTSD criteria. Studies suggest a weaker, similar effect in case of ICD-10 and ICD-11, but for a different reason than criterion A,

which is similar in both versions (Barbano et al., 2019). Recently, Kira et al. (2021) showed what could happen if criterion A was enriched by adopting a development-based trauma paradigm which focuses on cumulative trauma. It should increase its predictive validity, advance our understanding of PTSD aetiology and improve on current prevention and intervention strategies. There has also been a discussion about PTSD in the context of COVID-19 pandemic and it is related to the criterion A problem. Some researchers say one can consider pandemic as a potential and direct source of PTSD, while others reject this claim (see Shevlin et al., 2020). There is a very new concept of social trauma that involves humiliation or rejection, and a study examining this phenomenon shows how a person with a certain personal susceptibility may develop PTSD symptoms as a result of such an experience (Bjornsson et al., 2020). The debate about what causes PTSD is not likely to be resolved soon, and it is intriguing and very important, also from the perspective of microtrauma theory which sees racial trauma as a good example of its own. Nevertheless, it is not possible to present it fully in this article. There are no studies confirming the existence of the phenomenon of microtrauma and, therefore, it is not possible to propose it as a conceivable source of PTSD. We can only hope it will change, and researchers will put this theory to the test. Interestingly, there is a similar situation with the physical microtrauma which is not recognised as an official disorder yet, the difference being that there is a substantial and constantly growing, body of research about it and very few doubt that it exists (van Tulder et al., 2007).

It is worth noting that according to the ICD-11 classification, a situation in which a stressor of lesser intensity than proposed in criterion A, that otherwise meets the symptom requirements for PTSD, should be recognised as an adjustment disorder (AjD). If so, is it where microtrauma should belong? Apparently, this solution does not satisfy everyone, in particular researchers focused on racial trauma. It should also be noted that the concept of AjD has its own theoretical and practical issues, even if it is one of the most often used diagnoses in the clinical practice (e.g. Morgan et al., 2022; Zelviene and Kazlauskas, 2018). One of the difficulties with such diagnosis regarding microtrauma is that the presence of symptoms in response to (an) identifiable stressor(s) should occur within 3 months (DSM-5) or even 1 month (ICD-11) of the onset of the stressor(s). As we know, it may take years for microtrauma to manifest fully. Another problem is that in patients diagnosed with AjD it is expected that symptoms should resolve within 6 months and if they fail to do so, the diagnosis should be changed to another relevant mental disorder. What should be done, then, if the most relevant disorder is still PTSD? ICD-11 also postulates that the distinction between AjD and PTSD should be made based on whether the full diagnostic requirements for either disorder are met, not solely based on the type of stressor. It complicates the situation even more. We can only hope that recent changes regarding AjD, introduced to

DSM-5 and ICD-11, will be inspiring for researchers and bring more clarity in the area of all stress-related disorders, including microtrauma.

CONCLUSIONS

The presented review of research and considerations on cumulative trauma may help to better understand the phenomenon. DTD and C-PTSD are similar to PTSD, but more complex in form and caused by prolonged exposure to threatening situations that could independently lead to the development of PTSD (Hyland et al., 2017; Karatzias et al., 2017). In particular, they also relate to interpersonal experiences (Karatzias and Levendosky, 2019). Certainly, these diagnoses indicate significantly greater difficulties in functioning than PTSD, which are not included in the latter (van Der Kolk et al., 2019; Karatzias and Levendosky, 2019). However, we still do not know how to explain the consequences of a prolonged exposure to stressful events in one area of suffering which independently do not result in the development of PTSD, but when experienced jointly over time, may lead to such an outcome. There is no shortage of studies indicating that exposure to such experiences may be associated with a higher risk of developing PTSD (Arnett et al., 2019; Holfeld and Mishna, 2021; Idsoe et al., 2021; Reisner et al., 2016). Crastnopol's proposal (2018, 2015) is far more reaching. The author points out that certain situations which, at first glance, do not cause PTSD, may have a very significant negative impact on the well-being and functioning of people experiencing them. What is more, it is very likely that virtually none of us can feel completely safe and assume that finding ourselves in a microtraumatic situation is impossible. The hidden nature of such experiences makes it difficult to identify them, and hence to counteract them. It is also possible that all people have their own areas of sensitivity that only require specific conditions to become active and trigger symptoms of a severe mental disorder (Peseschkian, 1987). In fact, probably everyone has his or her "Achilles' heel" (Crastnopol, 2017) and is not free from the risk of irritation or even serious injury in the situations where it is least expected – in relationships with loved ones.

Microtrauma is an extremely subtle mechanism, and identifying it often requires the competence of a trained clinician. There is still a very long way to go before it can be proposed as another source of PTSD, like vicarious trauma, or source of another stress-related disorder, or a new diagnostic category. Nevertheless, there are many indications that we are dealing with such a phenomenon, and it poses significant threats to the people experiencing it. There is a need to familiarise clinicians with this phenomenon, as their help can be invaluable in identifying the microtraumatic patterns in important relationships of their patients and addressing them. One can easily imagine various situations involving an increased risk of getting a microtraumatic pattern in a relationship. For example, people with non-safe attachment

styles in certain relational constellations (e.g. a person with an anxious relating style to a person with an avoidant style) may generate innumerable chronic, stressful interpersonal experiences (Mikulincer and Shaver, 2019). It is also fairly easy to imagine the possible effects of permanent emotional invalidity received in a relationship. Research findings confirm that the chronic experience of emotional inhibition presented by parents has far-reaching negative consequences for the child later in life (Adrian et al., 2018; Krause et al., 2003; Shenk and Fruzzetti, 2011).

In a very early "predisposition-excitation framework" (PEF) for the aetiology of insanity, which inspired the diathesis-stress model, it was believed that while individual dramatic events often excited a psychiatric disorder, the daily repetition of lesser shocks could also bring on insanity (Kendler, 2020). According to this theory, individuals with "special susceptibilities" are at greater risk of developing symptoms while exposed to exciting causes. This claim sounds very familiar in this context. Hence, it could be also useful to explore the theory of microtrauma in the frameworks of the diathesis-stress and differential susceptibility models. This may put the concept of microtrauma in a new light, bring new insights, and provide a better understanding of the phenomena. Crastnopol's "Achilles' heel" theory seems to be a good example of diatheses that, if exposed to stress, may result in the development of the disorder. It seems that there are still more questions than answers in this area. Identifying microtraumatic patterns in relationships can be a method of therapeutic work itself. The theory of cumulative trauma shows that trauma is an extremely rich and complex phenomenon, and narrowing it down to situations that threaten health and/or life may prevent it from being fully understood.

Conflict of interest

The author does not report any financial or personal affiliations to persons or organisations that could adversely affect the content of or claim to have rights to this publication.

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