

Trauma-Informed Care in General Adult Psychiatry: Beyond the Diagnosis. Discuss the need for trauma-focused approaches in everyday psychiatric practice.

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Summary

For decades psychiatry has recognised the importance of traumatic events in an individual's life, with several cognitive models hypothesised. The application of such models has led to the development of revolutionary approaches, such as trauma-focussed cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing therapy (EMDR) for post-traumatic stress disorder (PTSD).

Recent evidence strongly demonstrates their clinical relevance in the management of PTSD, however, everyday psychiatry is much broader than this one mental illness. This essay aims to discuss the necessity and implementation of trauma-based approaches in a wide range of mental illnesses, including depression and eating disorders, as well as the potential impacts of such approaches on society and clinicians. It will not only discuss the necessity of trauma-based approaches, but also the extent to which they should be implemented in particular individuals and specific mental illnesses.

Lastly, another major discussion point explores the significance of individuality and holism in psychiatry, and how this may interact with trauma-informed care to offer the most appropriate, patient-centred management. In recognition of the complexity of mental illnesses and their causative factors, a biopsychosocial approach often underpins the management of many mental illnesses. This essay will discuss the role of trauma-informed

approaches within this framework, as well as suggesting the implementation of a screening tool to aid identification of an individual's suitability for trauma-based management.

Introduction

From as early as the 19th century, trauma has underpinned several psychiatric models in an attempt to explain mental illness. In the 1880s, Hermann Openheim introduced the idea of traumatic neuroses, in which psychiatric symptoms result from traumatic accidents [1].

Freud further recognised the importance of trauma when he suggested a traumatic memory “acts like a foreign body which long after its entry must be regarded as an agent that is still at work” [2]. Two centuries later, it is apparent these early ideas still shape psychiatry today, with recent evidence suggesting severe childhood maltreatment significantly increases the risk of alcoholism, depression, drug abuse and suicide attempts [3].

The mechanism of the trauma response

Reactions after a traumatic event vary significantly between individuals, with acute reactions affected by their own experiences, coping and life skills, and support from family [4]. Immediate reactions typically include exhaustion, confusion, anxiety, dissociation and blunted affect, all of which are considered normal responses to an acutely traumatic event. For the majority of individuals, with adequate resilience and coping strategies, these symptoms typically resolve without long-term consequences [4].

However, exposure to trauma can lead to a chain of biological changes that can contribute to the development of conditions such as PTSD. These changes include, but are not limited to:

- The death of neurons and glial cells in the cerebral cortex [5]
- A decrease in intracranial volume and total corpus callosum measurements [6]
- Damage to executive regions of functioning in the brain [7]
- An increase in amygdala activity [8]
- Variability in cortisol levels due to hypothalamic-pituitary-adrenal axis activity changes [4]

As well as the above biological changes, several cognitive models have been proposed to explain the development of mental illnesses as a consequence of traumatic events. Ehlers and Clark's cognitive model of PTSD suggests the illness is maintained via three processes [9]:

- Meanings
 - Meanings that arise from how the individual themselves has perceived the traumatic event, which often leads to an ongoing sense of threat.
- The nature of traumatic memories
 - Impaired memory processing of the event consequently results in poorly detailed and disjointed memories which are easily triggered and recalled.
- Cognitive and behavioural coping strategies
 - Development of such strategies to reduce their sense of external or internal threat.
 - For example - avoidance, social withdrawal and substance use.

Such models have paved the way for the development of trauma-focussed approaches in everyday psychiatry, with examples including trauma-focussed cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing therapy (EMDR), which are now recommended as first line approaches for post-traumatic stress disorder (PTSD) as per NICE guidelines [10].

This essay aims to explore the importance of such therapies in psychiatry today. Discussions include the evidence for trauma-based approaches in treating mental illnesses, as well as a discussion of the theoretical cognitive models, and whether trauma focussed approaches target the cause of mental illnesses. I will also discuss the impact on clinicians, as well as the individual and societal implications of such approaches.

What the research says

With evidence confidently emphasising the role of trauma in the development of mental illness, many therapies now target the traumatic event as an avenue for treatment. The development of PTSD in response to a traumatic event clearly highlights the importance of trauma-focussed approaches. Evidence has concluded that interventions, such as EMDR, reduced PTSD and other trauma-related symptoms [11]. Furthermore, Lewis et al's recent meta-analysis confidently recommends CBT-T and EMDR as first line treatments for PTSD, strongly suggesting that trauma-focussed approaches play a significant role in everyday psychiatric interventions.

However, research into the treatment of complex PTSD is less supportive of its efficacy. For example, one study compared the efficacy of CT-PTSD between individuals who had experienced a single incident of trauma and those with multiple traumas. It was concluded that individuals with multiple traumas experienced less symptom reduction as opposed to the single incident trauma group, and that more time may be required in therapy [12]. However, it is important to recognise that CT-PTSD still remained effective, despite a decrease in symptom reduction, and that such treatment can still be transformative for those with complex PTSD. In further support of this, evidence has emerged that a range of trauma-focused treatments are effective following childhood sexual abuse and complex PTSD, demonstrating trauma-informed care is of important benefit, even in complex PTSD [13].

However, everyday psychiatry is much broader than PTSD and trauma induced symptoms. Whilst EMDR and TF-CBT are first line recommendations for PTSD, for many other conditions treatment is not primarily trauma focussed, and evidence is less confident in the role of trauma based approaches for other mental illnesses - however, some positive evidence is emerging. For example, one study concluded that EMDR can be more effective in treating depression than non-trauma focussed CBT, with effects of EMDR being sustained even after the treatment had ended [14]. This once again supports the importance of a trauma-focussed approach in psychiatry. However, limitations of this research include a small sample size, decreasing both its internal and external validity, leading one to question the generalisability of the findings to all patients with depressive symptoms. The lack of confidence in current research evidence to support such approaches in depression

management is evident in the NICE guidelines, where guided self help and group or individual CBT remain first line recommendations for mild-moderate depression.

Furthermore, many individuals with depression are unable to identify any negative or triggering events to their illness. Many report having a safe and happy childhood, and feel unsure as to why they have depression. Therefore, cognitive models emphasising the role of trauma are unlikely to be applicable to such individuals, where individual traumatic events cannot be identified. This presents a clear barrier in the use of trauma-centred approaches in other mental illnesses, arguing that psychiatry cannot solely rely on these approaches.

Cause and effect

The above argument also reveals doubts on the causative nature of trauma on mental illness. It is common knowledge, supported by research evidence, that environmental, genetic and social factors interact to influence whether someone develops a mental illness [15], therefore one must argue trauma-based approaches in psychiatry only target specific causative domains of a condition, leaving many contributing factors untouched. The biopsychosocial approach has been widely accepted and implemented in psychiatry, and so a solely trauma-focussed approach appears too restrictive to effectively target mental illness.

However, this does not exclude such approaches from psychiatry altogether. For individuals with identifiable trauma, they can be a valuable tool to help reprocess the traumatic events. The above discussion simply argues such approaches should be implemented alongside

other therapies and treatments in order to target the widest scope of influencing factors, thereby decreasing the risk of relapse and leading to greater patient outcomes.

The effect of traumatic events on the brain raises an interesting point of discussion as to whether focussing on the event truly targets the subsequent mental illness. Even if we oversimplify mental illness into a direct result of trauma, targetting the traumatic memories may not alter the outcomes of the illness. As stated in the introduction, traumatic events have several effects on the biological functioning of the brain as well as thought patterns. In this case, the traumatic event acts as the initiating damage factor, in which subsequent biological changes lead to the development of the mental illness. One could argue then in order to treat the resultant mental illness, we must target the biological changes and alterations in thought processing instead of directly relating back to the traumatic event.

To demonstrate this point further, one can compare this to the development of cancer as a consequence of gene mutations. If one cell develops a mutation resulting in hyperproliferation, a cascade of genetic changes may result, ultimately leading to the development of a tumour. However, treatment does not target that first cell and its mistakes in DNA replication. By this point, the damage has already been done, the gene mutation has occurred, and treatment relies on extracting the tumour. To apply this principle to psychiatry, the gene mutation can be compared to a traumatic event, both of which act as the initiating damage factors, and the tumour represents the resulting symptoms caused by the trauma, such as social withdrawal, substance abuse and depression. Therefore, treatment in psychiatry should focus on the subsequent biological and cognitive consequences of the damage, rather than focussing its attention on the

traumatic event itself. Using this principle, one would suggest that non-trauma focussed approaches such as CBT, family intervention and medication are more effective at 'extracting the tumour', thereby decreasing the effects of the traumatic event without addressing the event directly, and that trauma-focussed approaches are not a necessity in everyday psychiatry.

Beyond the diagnosis

It is well recognised that diagnostic frameworks, such as the ICD-11 and DSM-5, are necessary in standardising specific disorders, which is crucial in the field of psychiatric research to allow for the testing new treatments, medications and interventions. However, such frameworks and the use of diagnostic labelling could result in a lack of clinical understanding of patients as individuals [16]. This becomes a problem when considering trauma-focussed approaches in the treatment of mental illnesses. Labelling an individual with 'PTSD' could result in clinicians overlooking the social and cultural factors influencing their presentation, resulting in the implementation of a one-size-fits-all treatment approach, consequently proving ineffective for some individuals. Moving away from PTSD, such oversight can also be seen in cases of depression where specific traumatic events have been identified in their background [17]. The presence of these events may cause clinicians to overlook the importance of other influencing factors, and rather than considering the patient holistically, overemphasising the effects of the trauma on the individual. This does not argue against the need for trauma-focussed approaches in psychiatry, but simply highlights the importance of a biopsychosocial approach towards each individual, regardless of the diagnosis in question.

For some, a trauma-based approach may be the most suitable way forward, but for others with the same diagnosis, such approaches may prove less effective if other factors contribute more significantly towards the presentation. The development of eating disorders such as anorexia nervosa offer a clear example, whereby the individuality of the patients' circumstances can guide treatment. For example, evidence suggests a strong link between eating disorders and trauma, such as abuse, neglect or assault [18]. For such individuals, trauma-informed care can improve longer-term health outcomes and treatment adherence. However, many individuals with eating disorders do not recall noticeable 'trauma' in their lives, and the disorder arises from a manifestation of many factors, including societal and cultural beliefs about oneself [19]. For these individuals, a trauma-based approach would prove inappropriate and not address the key factors influencing their presentation.

This begins to highlight the limitations of national guidelines, whereby specific treatments are recommended based on the diagnostic label, rather than the individual patient experiences.

In response to this, one could propose the importance of a screening tool, used to highlight the factors most heavily contributing towards an individual's presentation. For example, questions could be categorised into: biological influences (including family history), childhood and traumatic events and social and cultural influences and pressures. Scores for each category could be calculated and compared, providing an objective measurement that also guides the pathway for rehabilitation. Clinicians may gain insight into which treatments

could prove more effective for an individual, rather than based on their diagnostic label. For example, high scores for childhood and traumatic events may benefit from trauma-informed care as a first line approach, whereas those with higher scores in social/cultural factors or biological factors may benefit from individual CBT or medication as a first line. The use of an objective scoring system would still allow for the application of standardised national guidelines, but with a more individualised approach for each patient. Subsequently, this could decrease the burden on NHS services by identifying the most effective treatment first, rather than working through the recommended treatments until an effective one is found. With such an approach, trauma-focused approaches would play an important role in everyday psychiatry, but other factors would not be overlooked when guiding treatment.

The clinician's role

The delivery of psychiatric therapies cannot be compared to the administration of a drug. Each clinician is different, and subject to their own biases. Therefore, when evaluating the use of trauma-focussed approaches, we must look at the attitudes of clinicians and their perspectives, as they contribute to treatment as much as the therapeutical model itself.

Recent evidence has found confidence in trauma-focused treatments is generally high amongst clinicians [20], leading to an increased likelihood of delivering such approaches. However, a recent review suggested one of the most common barriers to delivering trauma focused interventions for PTSD is fear of “retraumatising” patients [21], despite evidence suggesting low rates of reported retraumatisation [17].

The concern of development of secondary trauma symptoms in clinicians may also act as a barrier to the delivery of such approaches [22], despite evidence concluding clinicians endorsed low levels of secondary trauma symptoms, and distress levels were below cut-offs to be clinically significant [23]. The incongruency amongst clinicians' opinions demonstrates the need for more research into the impact of such approaches on the therapeutic providers. One must not over-emphasise the importance and necessity of trauma-informed care before the impacts on clinicians have been confidently established. Such mistakes could lead to a higher burden on the NHS as clinicians develop their own mental health difficulties, as well as understaffing due to changes in career paths.

Conclusion

When considering the effectiveness of trauma-based approaches, it is evident they contribute significantly in treating certain mental illnesses. Evidence is extremely strong for the use of such approaches in the treatment of PTSD, a disorder primarily underpinned by the cognitive model of traumatic memories [9]. With such evidence in mind, approaches such as EMDR have been revolutionary for patients suffering from this condition, and the use of such trauma-focussed approaches must be deemed a necessity in everyday psychiatry.

The lack of convincing evidence for other mental illnesses highlights the importance of a holistic approach when addressing such disorders. Once again, there is evidence to support trauma-focussed approaches in their efficacy in treating disorders such as depression and eating disorders, but the variability and lack of confidence in such data introduces the need

to assess to what extent trauma-focussed approaches can be used for each individual patient. In consideration alongside this, a lack of clinician confidence could not only lead to improper delivery, but also contribute to a greater burden on the NHS if such approaches are not implemented in the correct way. In response to this, more research is required, primarily with larger sample sizes, to establish the efficacy of trauma-informed care in conditions other than PTSD. One could suggest that whilst doubts persist, we should refrain from over exaggerating the importance and necessity of such approaches, particularly when other treatments, such as individual CBT and medications, have proved effective.

In response to varying clinical attitudes and the fear of retraumatisation, clinicians have advocated an increase in resources for the prevention and treatment of secondary trauma symptoms. The variation in confidence of trauma-focused therapies also indicates that clinician training to increase confidence in such approaches could be warranted in order to achieve the best patient health outcomes [24].

The variation in evidence, clinician approach, and discussion over cause and effect all demonstrate the importance of a holistic, biopsychosocial approach in psychiatry. The use of diagnostic manuals are valuable, but have their limits, and diagnoses must not mask the underlying individual beneath them. The proposal of a biopsychosocial screening tool may be useful in guiding first line treatments, rather than guidelines based on the diagnostic labels. There is no doubt that trauma-informed care can play a huge role in the treatment of many patients, and therefore they are necessary in psychiatry, but the question is how we utilize them for their maximum potential benefits. With more clinician training required and

therefore a higher cost burden than non-trauma focussed approaches, their use should be directed at individuals identified to be most likely to benefit from them.

Adopting a holistic approach to treatment, rather than basing treatment options off the diagnostic label, could shift patient and societal perspectives away from 'what is wrong with you?', towards 'what happened to you?', and ultimately improve health outcomes and patient satisfaction.

In order to look beyond the diagnosis, we must look before the diagnosis, and outline the factors influencing a patient's mental state in order to 'extract the tumour', and fully understand their condition.

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