

2nd Place Winner of 2022 PIF Australian Essay Competition

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Essay topic - What is the role of psychiatry in recovery from severe trauma?

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Introduction

'Trauma', a word once limited to psychological jargon, has entered mainstream discourse in recent years and has spurred increasing interest in associated notions of early life adversity and developmental trauma. Whilst 'trauma' has been used in the medical field since the writings of Freud and re-entered medical vernacular with the presentation of war neuroses in military veterans, contemporary research in childhood trauma, in particular, has propelled increasing awareness of the relationship between traumatic experiences and psychopathology. This essay will begin by examining the role of trauma in mental illness and the lasting effects of adverse experiences, setting the foundation for a discussion of the process of recovery and the psychiatrist's role as a facilitator and advocate on the patient's path to healing.

Past, present and future

Trauma does not end with the initial experience itself, its lingering effects on one's self-perception, interpersonal relations and overall wellbeing are often harbingers of future psychopathology. The introduction of post-traumatic stress disorder (PTSD) in the DSM-III catalysed major advances in our understanding of the association between traumatic experience and mental illness. More recently, interest in trauma has resurged as traumatic experiences, especially childhood adversity, are recognised as a common foundation for many psychiatric illnesses. Investigations into trauma and its effects have revealed links between early life adversity – including physical abuse, neglect and witnessed domestic violence – and an increased risk of depression (Spatz Widom, DuMont, & Czaja, 2007), anxiety disorders (Agnew-Blais & Danese, 2016), psychosis (Varese et al., 2012) and suicidality (Afifi et al., 2008). This vulnerability may be attributed to a combination of environmental factors, neurobiological remodelling and disrupted integration of traumatic memories. A history of trauma also has implications for severity of illness and response to treatment. In a prospective study by Elizabeth P. Hayden and Daniel N. Klein (2001), the presence of poor parental relationships and childhood sexual abuse were predictive of higher levels of depression and poorer recovery from depressive symptoms at a five-year follow-up in individuals with chronic dysthymic disorder. Treatment resistance was also found in a separate study of patients presenting with depression who reported a history of childhood emotional abuse (Kaplan & Klinetob, 2000).

Developmental trauma has been referred to as the "hidden epidemic" (van der Kolk, 2014) and "psychiatry's greatest public health challenge" (Sara & Lappin, 2017). Prevention of further mental ill-health is an imperative consideration in the treatment of the patient with trauma, beginning with appropriate assessment. Given the far-reaching and deeply embedded effects of childhood trauma, a sensitive inquiry into the patient's developmental experiences and any traumatic events should form an essential component of any psychiatric assessment. Numerous clinicians and researchers have called for a universal paradigm shift in mental healthcare towards an uptake of trauma-informed care.

Trauma-informed care represents a change in thinking from "what is wrong with you?" to "what happened to you?" (Sweeney, Filson, Kennedy, Collinson, & Gillard, 2018). In so doing, it steers away from a reductionist view of self-induced afflictions and encourages recognition of the deeper developmental, interpersonal and societal influences on their mental state, thus providing a holistic and complete image of one's mental health. As outlined previously, a history of trauma is a common risk factor for several mental disorders and should be addressed in the treatment process to allow proper healing. Trauma-informed care also allows the psychiatrist to identify specific risk factors for future psychopathology – including time and level of exposure, presence of social disruption and pre-existing

psychopathology – such that appropriate preventative interventions may be initiated early in the recovery process and vigilant monitoring may be exercised for emergent psychiatric symptoms (Pine & Cohen, 2002). Once the traumatic experiences have been recognised, the psychiatrist may then act as a facilitator to guide the individual in the process of healing from the wounds of trauma.

Healing as treatment

Whilst the raw experience of the traumatic event cannot be undone and, as such, the trauma itself cannot truly be cured, treatment focussed on guiding the individual to make sense of their memories, restore a sense of self and re-instate a feeling of security and fulfilment in their relationships can propel them on a path to recovery.

The treatment of trauma is complex, with regards to both the means and manner by which it is done. First, there is the option of pharmacotherapy. Some drugs targeting neurobiological changes implicated in exposure to trauma, namely SSRIs, have proven effective in reducing the symptoms of PTSD (Alexander, 2012) and the improvements these medications afford on the quality of life in individuals with PTSD should certainly not be understated. However, the origins of psychiatric illness arising from adversities such as chronic emotional abuse and witnessed violence extend far beyond the effects of biological substrates. Recovery from severe trauma necessitates a strengths-based treatment model that incorporates symptom relief and an exploration of the psychological imprints from the past. Thus, the psychiatrist takes on the role of a guide and an advocate, providing a safe space for the patient to unveil their trauma, learn to understand its influence in the present and develop the resilience to carry on in despite of it.

The foremost priority when engaging a trauma patient is to build a therapeutic alliance between the patient and psychiatrist founded on trust and security. This is particularly important in individuals who have experienced childhood trauma, for whom feelings of safety in childhood relationships were betrayed and secure bonds may have never been a reality. Once the therapeutic alliance is formed, then begins the process of integrating and making sense of the person's experiences. Many patients who with histories of trauma relive their experiences in a dissociated and fragmented form. Carefully extracting shards of the traumatic memory and bringing them into conscious awareness is necessary to weave the pieces into a coherent narrative that can be fully acknowledged by the individual (van der Kolk & Fisler, 1995). This will instil in the person a sense of control, reframing their present emotions and experiences as remnants of trauma rather than terrifying and incoherent intrusions from the past. When the trauma and its effects are recognised, the patient may then be guided in process of understanding and adapting to the lasting effects of trauma through psychotherapy. Cognitive behavioural therapy (CBT) and eye-movement desensitisation and reprocessing (EMDR) are two examples of psychotherapy modalities that have been empirically verified as effective for the treatment of trauma (Pine & Cohen, 2002; Solomon & Heide, 2005).

Throughout this entire process, the psychiatrist must be sensitive to the potential for re-traumatisation. Psychiatry is ethically complex in all aspects of its practice. Patient autonomy is often regarded as the foremost pillar of medical ethics. Yet, this is challenged each time the psychiatric patient is restrained against their will or forced to undergo treatment under the Mental Health Act. While these measures are carried out with a heavy heart in any situation, caution must especially be taken when exercising such means of restriction or isolation in the traumatised patient for risk of re-traumatisation. Exposure to the initial traumatising event is a key component of psychotherapy for trauma and is essential in learning to adapt and overcome its lasting effects, however unnecessary exposure to potential triggers for re-sensitisation should absolutely be avoided. Thorough initial assessment may help elicit some of these triggers that should be considered in the therapeutic process.

Beyond the psychiatrist's clinic, for the person whose livelihood has been disrupted by past terrors, restoring one's engagement in all aspects of life, participation in society and ability to form fulfilling relationships are all crucial aspects of recovery from trauma. This process of restoration is a gruelling one and will require resilience on the part of the patient and unfailing patience and empowerment from the psychiatrist.

While this essay has focussed primarily on developmental trauma, it is important to recognise other groups of individuals who are particularly vulnerable to psychiatric illness as a result of trauma stemming from transgenerational adversity, societal oppression and severe social and economic deprivation. These include Indigenous Australians, refugees and asylum seekers and LGBTQIA persons. For such groups, treatment models must be individualised in a way that is sensitive to their experiences of trauma and considers their psychological, sociocultural and spiritual needs.

Conclusion

The recovery from severe trauma is lifelong. Van der Kolk (2014) in his book 'The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma', describes this process of restoration as "the road to life". The role of psychiatrist in this journey is to guide the patient through acceptance, adaptation and growth. Ultimately, trauma is not something that is cured, but rather overcome, such that it becomes an element in the story one's life and not the dominating force.

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