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# Trauma informed care: a radical shift or basic good practice?

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**Sophie Isobel** Sydney Local Health District Mental Health Service, Administration, Concord Centre for Mental Health, Concord, NSW, Australia

**Abstract**

**Objective:** There is significant multidisciplinary work contributing to the implementation of trauma informed care (TIC) into mental health policy and practice in Australia. Within psychiatry, there may be potential confusion about how to navigate the integration of TIC into a speciality built upon treating psychological distress; creating dismissive reactions of a patronising approach and paradoxical radicalism. This paper aims to discuss the need for psychiatry to view TIC as a significant and urgent paradigm shift required to integrate existing knowledge about the prevalence and effects of trauma into a progressive articulation of the relational and interpersonal underpinnings of modern psychiatric practice; and to lead and support its widespread implementation.

**Conclusion:** Active consideration of the intent of TIC may aid in reducing misunderstanding and misaligned resistance while allowing services and individuals an important opportunity to reflect on how to deliver mental health treatment that is universally sensitive to the dynamics of trauma in the care environment.

**Keywords:** trauma informed care, trauma

Trauma informed care (TIC) is a term being incorporated into public mental health documents and discourse in Australia, yet it risks becoming rhetoric without careful consideration of its intent and implications. To maximise clinical leadership, there is a need for psychiatrists to formulate a shared understanding of the term and its place within a specialty built upon treating psychological distress.

TIC is frequently misused to describe the treatment of adult survivors of child sexual abuse who may come into contact with services. While inclusive of this, true TIC is a much broader and universally applicable approach to care that requires a wide understanding of complex forms of trauma; recognition of the prevalence of trauma; understanding of how trauma impacts upon the life and experiences of individuals; and a reassessment and modification of all processes of service to reduce iatrogenic harm.[1,2] TIC emerged from recognition that mental health services often provide care for survivors of trauma without addressing trauma, and often without even being aware that trauma has occurred.[3] TIC is based on significant research demonstrating the wide reaching effects of trauma on individuals, including their mental health and their responses to services and treatment. TIC is not about trauma-treatment but is a way of delivering care around a central organising principle that trauma is a possibility in the lives of all consumers; irrespective of the service provided and whether a trauma history is known.[4] The use of the word 'trauma' may itself be a source of misaligned resistance, creating a reactive defensiveness of clinical territory amongst professions. While psychiatry may work often with the sequelae of trauma, diagnose trauma and treat trauma; not all psychiatric practice is innately delivered in a manner sensitive to the effects of trauma and dominant biomedical models of psychiatry are one of the identified obstacles to implementing widespread TIC in mental health services.[5] Currently trauma survivors often present to multiple services and receive fragmented ineffective care at high personal and social cost.[4]

Trauma in this context refers broadly to the psychological and neurobiological effects of circumstances or events, primarily interpersonal and often sustained or cumulative; incorporating physical, sexual and psychological abuse of all kinds as well as dynamics of power and vulnerability.[1,4] The trauma is the effect rather than the event(s) and in contrast to the diagnosis of post-traumatic stress disorder, where symptoms relate to a triggering event; the effects of sustained interpersonal trauma alter neurobiological structures and subsequently affect

Corresponding author:
Sophie, Isobel, Concord Centre for Mental Health, Hospital Road, Concord, NSW 2139, Australia.
Email: sophie.isobel@sswahs.nsw.gov.au

all functioning in more intrinsic ways.[6,7] Trauma as an overarching concept differs from current trauma based diagnostics yet international psychiatric bodies have demonstrated profound resistance to the widening of trauma diagnostic constructs, despite significant evidence.[7–9]

Up to 90% of public mental health service users have been found to have experiences of psychological trauma.[10–13] While acknowledging heterogeneity within prevalence studies, there is consensus that the majority of mental health service users have trauma histories,[1] and that this shapes their responses to services.[4] These figures may not match local data as gathering accurate trauma histories can be compounded by the differing diagnostic constructs as well as the demonstrated effects of trauma upon the construction of a clear narrative of self and time,[14–16] and the attribution of language to experience.[17] Trauma may not be able to be articulated; it does not exist distinctly in the past of individuals,[6,18,19] but can be experienced in the present as a non-verbal part of self.[7,20,21]

Neurobiological research has identified a large number of brain changes potentially related to trauma. These include: dysregulation of stress response systems via the hypothalamic–pituitary–adrenal axis;[22] lowered cortisol levels and hippocampal volume impairing the deactivation of the survival response;[7,18,23] a reduced corpus callosum impairing integration between hemispheres with significant implications for mood and personality;[24] and disrupted regulation, reception, expression and communication of emotion.[16,17] Trauma that occurs during the developmental stages interrupts the relationally developed neural pathways of predominantly the right side of the brain,[4] with significant lifelong implications including affect dysregulation and alteration of the development of 'self'.[7,19,20] Increasingly large numbers of changes in the brain are being correlated to trauma,[22] and although the pathways between trauma and mental health are complex,[25] there is increasing evidence that trauma plays a significant role in the aetiology of many psychiatric disorders.[15,17]

The 2012 'Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care Service Delivery' provide clear evidence,[4] strategies and recommendations for recognising, and being sensitive to, complex trauma across settings. Amongst the guidelines and wider TIC literature, is acknowledgment that mental health treatment can itself be traumatic.[1,26] This is in part due to the often necessary nature of the care but is also related to the understanding that due to neurobiological changes and their psychological correlates, people who have experienced trauma routinely don't feel safe in relationships or systems, even those designed to be therapeutic or protective; and that establishment and reestablishment of psychological safety in all interactions is essential to counter hyper-aroused neurological stress response systems, prior to being able to be effectively treated.

The nature of psychiatric practice provides pertinent opportunities to utilise interpersonal interactions to enact relational safety. There is, however, a concurrent necessity to acknowledge the bidirectional risks and effects of vicarious trauma occurring within these interactions. Vicarious trauma causes alterations in cognitions, beliefs and schemas,[27] as a result of observing or experiencing the trauma of others. With dissociation well documented as a response to trauma and now widely acknowledged as taking many forms;[19] psychiatry risks widespread displays of professional dissociation as a traumatic defence, potentially affecting acceptance and use of TIC.

While specific services or therapists will continue to treat trauma, TIC suggests that universal trauma precautions are employed with all service users.[2,5] What constitutes a trauma precaution in psychiatry is determined by the application of knowledge about the effects of trauma on individuals and interactions into practice, consumer collaborations and systematic reviews of practice. It also requires an overt acknowledgment that TIC may be more of a radical shift in the thinking of clinicians and services than in interventions or practice. Psychiatry has an imperative to consider how increasing knowledge about trauma prevalence and effects may affect practice and to provide clinical leadership in realigning mental health care accordingly. Ignoring TIC as basic good practice or isolating it as a form of antipsychiatry radicalism ensures that psychiatry is self-positioned outside of important paradigm shifts in care; subsequently risking both forgoing its role as offering leadership in the mental health profession and providing suboptimal patient care. Understanding the impact of trauma on individuals does not discount their current or future diagnosis, nor alter the course of their care, but rather contextualises them, their diagnosis, their behaviours and their experiences, while informing practice in a way that aids effective treatment and recovery.

## Conclusion

Clarification of the intent and purpose of TIC is the first step towards understanding its relevance to psychiatric practice. The sophistry of discussions about TIC can detract from acknowledging that psychiatry has been working with trauma throughout its existence and there are elements of psychiatric practice that are inherently trauma informed. Yet assuming innate TIC or seeing TIC as a threat to professional domain, may pose greater risks than its consideration.

TIC requires clinicians and services to consider that all individuals may have experiences of trauma, that having mental illness or treatment can be traumatic and that psychological harm can occur in the context of care. TIC requires the prioritisation of psychological safety to deliver care in a way that is informed by the evidence about trauma and its effects. TIC therefore ensures the provision of care that is neither merely good practice nor a radical shift but rather evidence-based, humanised and considered.

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## References

1. Jennings A. *Models for developing trauma-informed behavioral health systems and trauma-specific services*. Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning, 2004
2. Raja S, Hasnain M, Hoersch M, et al. Trauma informed care in medicine: Current knowledge and future research directions. *Family Community Health* 2015, 38: 216–226.
3. Fallot RD and Harris M. A trauma-informed approach to screening and assessment. *New Directions Mental Health Serv* 2001; 89: 23–31.
4. Kezelman C and Stavropoulos P. *Practice guidelines for the treatment of complex trauma and trauma informed care service delivery*. Adults Surviving Child Abuse, 2012.
5. Bateman J, Henderson C and Kezelman C. Trauma-informed care and practice: towards a cultural shift in policy reform across mental health and human services in Australia, a national strategic direction. *Position paper, Mental Health Coordinating Council*, 2013.
6. Van der Kolk B. *The body keeps the score: brain, mind, and body in the healing of trauma*. Penguin, 2014.
7. Van der Kolk BA. The neurobiology of childhood trauma and abuse. *Child Adolesc Psychiatr Clin North Am* 2003; 12: 293–317.
8. Herman J. L. Complex PTSD: a syndrome in survivors of prolonged and repeated trauma *J Traumatic Stress* 1992; 5: 377–391.
9. Van der Kolk BA and d'Andrea W. Towards a developmental trauma disorder diagnosis for childhood interpersonal trauma. In: Lanius RA, Vermetten E and Pain C (eds) *The impact of early life trauma on health and disease: the hidden epidemic*. Cambridge: Cambridge University Press, 2010, pp.57–68.
10. Mueser K, Goodman L, Trumbetta S, et al. Trauma and posttraumatic stress disorder in severe mental illness. *J Consult Clin Psychol* 1998; 66: 493–499
11. Mueser KT, Salyers MP, Rosenberg SD, et al. Interpersonal trauma and posttraumatic stress disorder in patients with severe mental illness: demographic, clinical, and health correlates. *Schizophrenia Bull* 2004; 30: 45.
12. Cusack K, Frueh B, Hiers T, et al. Trauma within the psychiatric setting: a preliminary empirical report. *Admin Policy Mental Health* 2003; 30: 453–460.
13. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. *Am J Prev Med* 1998; 14: 245–258.
14. Perry R and Sullivan RM. Neurobiology of attachment to an abusive caregiver: short-term benefits and long-term costs. *Dev Psychobiol* 2014; 56: 1626–1634.
15. Gaskill RL and Perry BD. Child sexual abuse, traumatic experiences, and their impact on the developing brain. In: Goodyear-Brown P (ed) *Handbook of child sexual abuse: identification, assessment, and treatment*. John Wiley & Sons, 2011, pp.29–47.
16. Schore AN. Dysregulation of the right brain: a fundamental mechanism of traumatic attachment and the psychopathogenesis of posttraumatic stress disorder. *Aust N Z J Psychiatry* 2002; 36: 9–30.
17. Perez L. Intergenerational dynamics of trauma. *J Infant Child Adolesc Psychother* 2009; 8: 156–168.
18. McCrory EJ, De Brito SA, Sebastian CL, et al. Heightened neural reactivity to threat in child victims of family violence. *Curr Biol* 2011; 21: R947–R948.
19. Siegel DJ. Toward an interpersonal neurobiology of the developing mind: attachment relationships, "mindsight," and neural integration. *Infant Mental Health J* 2001; 22: 67–94.
20. Meares R, Schore A and Melkonian D. Is borderline personality a particularly right hemispheric disorder? A study of P3a using single trial analysis. *Aust N Z J Psychiatry* 2011; 45: 131–139.
21. Hull AM. Neuroimaging findings in post-traumatic stress disorder. Systematic review. *Br J Psychiatry* 2002; 181: 102–110.
22. Ford J. Treatment implications of altered affect regulation and information processing following child maltreatment. *Psychiatr Ann* 2005; 35: 410–419
23. Cozolino L. *The neuroscience of psychotherapy: building and rebuilding the human brain*. WW Norton & Company, 2002.
24. Wilson K, Hansen D and Li M. The traumatic stress response in child maltreatment and resultant neuropsychological effects. *Aggression Violent Behav* 2011; 16: 87–97.
25. Mueser KT, Rosenberg SD, Goodman LA, et al. Trauma, PTSD, and the course of severe mental illness: an interactive model. *Schizophrenia Res* 2002; 53: 123–143
26. Muskett C. Trauma-informed care in inpatient mental health settings: a review of the literature. *Int J Mental Health Nurs* 2014; 23: 51–59.
27. Dunkley J and Whelan TA. Vicarious traumatisation: current status and future directions. *Br J Guidance Counselling* 2006; 34: 107–116.