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Trauma-Informed Care in Psychiatric Practice

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Abstract

In recent years, the public has become aware of the issue of child abuse, which is closely associated with the need for psychiatric care. Many psychiatric patients have reported a history of abuse during their childhood. In psychiatric care, it has been warned that the symptoms of post-traumatic stress disorder (PTSD) resulting from child abuse is likely to be overlooked. Developed in the USA, trauma-informed care is a basic framework of care that can be applied to all clinical scenarios, including psychiatric practices. Trauma-informed care emphasizes the prevention of re-victimization amongst traumatized individuals. There is an urgent need for psychiatric practice in Japan to introduce and implement trauma-informed care.

Keywords：adverse childhood experiences, trauma-informed care, PTSD

Introduction.

In recent years, child abuse has become a major challenge in many areas, including medical health, welfare, education, and the administration of justice. It has become clear that adverse

childhood experiences (ACEs) have a major impact on mental and physical well-being and social adjustment. In other words, ACEs are a long-lasting issue not only during childhood but also into adulthood.[8)]

Meanwhile, child abuse can also be understood in terms of psychological trauma. Currently, the Child Abuse Prevention Law includes physical abuse (violence that inflicts or threatens to inflict injury on the child's body), sexual abuse (committing indecent acts to a child or making a child perform such acts), neglect (significant reduction in food or prolonged neglect so as to prevent normal physical and mental development of the child, neglect of abuse by a person living with the child other than their guardian, or other excessive neglect of custody obligations as a guardian), psychological abuse (gross abusive language toward the child, gross rejection of the child, or acts that causes gross psychological trauma to the child, for example by having them witness violence or corresponding acts against a spouse or someone else living in the same household as the child).[18)] These abusive behaviors often correspond to item A of the DSM–5 diagnostic criteria for posttraumatic stress disorder (PTSD), which refers to directly experiencing or witnessing events such as actual or threatened death, serious injury, or sexual violence.[2)]

Here, I will summarize the links between child abuse and psychiatric care, as well as consider the potential of trauma–informed care (TIC) in psychiatric practice.

I. Child Abuse and Psychiatric Care

Psychiatric clinics occasionally get visits from caregivers who "abuse their children" and by patients who "were abused when they were children, and who are still suffering." At the same time, among patients presenting with various chief complaints, including depressive and/or anxiety disorders, it has been reported that many were abused as children. In clinical groups with a psychiatric diagnosis, 13-70% of women and 0-26% of men reported having been sexually abused during childhood, and 31-74% of women and 29-78% of men reported having been physically abused during childhood.[4,7)] There are also reports that 51% of female

psychiatric inpatients were sexually abused during childhood, although most providers were not aware of this.[6)]

It is generally said that patients in mental health and substance abuse treatment systems seldom complain of current or past history of abuse or seek trauma treatment when seeking services.[9)] They may be ashamed of being a victim, may not be confident, or may be afraid of being blamed for having caused it. Also, there may be no opportunity to talk or seek help for men because they are isolated and withdrawn, which is a pattern more common in men. Moreover, and this is the biggest dilemma, there are many patients who visit a psychiatric clinic on their own but think that they "do not want to be treated as a psychiatric patient" or "do not have a mental illness." They may come knocking on the clinic's door because they need to find a way to deal with their depression, insomnia, nightmares, and other PTSD symptoms, but at the same time, they feel that "I'm not the one at fault" and "I'm a victim," so when they are prescribed drugs at the clinic without any explanation, they feel that they are branded with "It really was you who were at fault." Such patients often drop out of treatment quietly.

II. Child Abuse and PTSD

Associations between child abuse and PTSD have also been reported. People who suffered physical abuse, neglect, and rape in their childhood have been found to have a high lifetime prevalence of PTSD of approximately 20-65%.[15)] In addition, the prevalence of PTSD in children in social care ranged from about 15.7% to 24.9% and was reported to be comparable to that of American returning soldiers.[17,19)] That is, it can be said that childhood abuse is an experience as harsh that of combat.

PTSD is one of the diseases that can be easily missed in psychiatric care. It has been reported that 66% of inpatients at state-hospital psychiatric clinics in the United States who had ever been sexually abused during childhood met the diagnostic criteria for PTSD, but none of them had been diagnosed with PTSD.[6)] In general, trauma exposure rates in people with mental illness have been reported to be between 68.5% and 97%, which is found to be higher than the lifetime trauma experience rates in the general population.[16)]

In general, PTSD itself is a

pathological condition with many comorbidities.[15] PTSD comorbidity for schizophrenia is 12.4%,[1] and PTSD comorbidity for those being treated for substance use disorders is reported to be 12-34% (30-59% for women).[20] In other words, many patients who have been abused and those with PTSD are already in the psychiatric care system.

In some cases, PTSD manifestations are directly related to child abuse. For example, an intrusion symptom, flashback or replay, may result in perpetration of abuse. For example, let us assume that a mother who has experienced physical abuse during childhood and developed PTSD is now raising a child. It is common for the child to cry and grumble. The child's behavior may be reminders, causing flashbacks in the mother. In this case, the mother's consciousness has switched to a childhood setting in which she is abused (flashback), where she is herself abused and crying. Then her child's crying and her own crying overlap, causing her to fall into a remarkable state of confusion, somehow trying to escape the scene, and acting violently (reenactment). This action results in physical abuse of the child. As a result, she cannot stop by her own efforts and the physical abuse persists until the beating hand feels like it will break or she is so exhausted she has to sit down. Advice to such mothers, such as "Don't beat your child" and "If you are a mother, you should take care of your child," is not only invalid, but it serves to inflict new trauma on the mother (re-traumatization).

III. Development of Trauma Informed Care

As it became clear that trauma and ACEs have diverse and profound adverse effects on later life, the idea that trauma-based treatment and support are essential became the consensus.[13,22] This is the fundamental concept behind trauma-informed care (TIC).

TIC is a framework is based on developing understanding of the impact of trauma and strength to handle it. TIC is a new framework of care that can also be offered by clinicians without expertise in trauma treatment which have demonstrated therapeutic efficacy in Japan, such as prolonged exposure therapy. TIC emphasizes the

safety of physical, psychological, and emotional aspects of both the therapist and the patient, thus providing patients with the opportunity to regain and empower a sense of control.[11] In all aspects of treatment and support, the safety, choice, and control of the patient is a top priority.[22] This is particularly important at the beginning of treatment and support for these patients who have been forced to go through the irrational experiences of child abuse.

The TIC concept was developed primarily in the United States. Based on enormous knowledge gained from studies like the Great Smoky Mountains Study[5] and the ACE study,[8] the "Trauma–Informed Care for Children and Families Act of 2017" and "A resolution recognizing the importance and effective-ness of trauma–informed care" passed US Congress in 2017 and 2018, respectively. The former is intended to promote the dissemination and implementation of TIC by setting up an expert panel of US agencies to develop the best form of TIC. In order to investigate the impact of trauma in the future, the US Department of Health and Human Services will collect data on ACEs through the behavioral risk factor surveillance system of the Centers for Disease Control and Prevention as well as further demonstrate new intervention methods in demonstration projects in several states, thereby contributing to improving service delivery in the future. The latter is to acknowledge the importance and effectiveness of TIC and to encourage TIC practice in federal agencies. In any case, the United States is in the process of implementing TIC through nationwide efforts.

By contrast, in Japan, TIC was introduced mainly in the field of psychiatric nursing around 2014,[12,14] and then the practice in the field of schooling and child welfare has been reported. The Japanese Association for Emergency Psychiatry was the first academic organization to incorporate the concept of TIC. The incorporation of the TIC concept into Sugiyama's study to minimize movement restrictions[23] and the association's guidelines in 2015,[21] noting that many disquiet patients have a traumatic history, is advanced. Child guidance centers, which are on the frontline for

supporting abused children, have also reported that repeated trauma staff training resulted in changes in child psychologists' support attitudes and advances in TIC efforts.[3)]

IV. Re-traumatization in Psychiatry

TIC can be said to be a form of care that "visualizes" invisible trauma. TIC is also a concept that has been developed to prevent re-victimization of the patient. Various practices that have been used as "normal practices" in various service organizations in the health, welfare, education, and justice domains may not only interfere with the recovery of persons with traumatic histories and ACEs but the alarm has been sounding that they might actually re-victimize these persons.[13,22)] These include seclusion and forceful responses in psychiatric care, invasive procedures in health care, swift separation of children from abused families in the child welfare system, implementation of strict discipline in education and social care, and threatening action in criminal justice. These practices have been considered "normal practices" for too long, so the persons providing support may be insensitive to the potential harm of these practices.

In daily clinical practice, when communicating with people with PTSD who do not appear to have a psychiatric disorder and who do not themselves complain about symptoms, what happens when you tell them "Everything is fine with you. We don't need to examine further" without doing any proper examination? Would this not make this person who finally worked up the courage to come feel "rejected"? What happens when a mother says that she wants her children to be taken in by social services because she ends up physically abusing them and are then told that "mothers should raise their own children by themselves"? Is this not stigmatizing her for being unqualified as a mother d when she is unable to raise the children by herself? What happens when you meet a patient who talks about their experiences of childhood abuse and tell them to "quickly forget about things so far back in the past"? Does this not force the patient to the edge of despair as they are at the mercy of their traumatic memories and do not know what to do?

In TIC, it is essential for clinical

practitioners to be aware of this re-traumatization (Table 1).

V. The Practice of Trauma Informed Care

TIC is said to begin with practicing the four Rs (Table 2).[22] That is, you should know a wide range of effects of trauma and recovery processes (Realize), notice the traumatic signs and symptoms observed in the individual (Recognize), and respond with appropriate methods (Respond). Finally, on the basis of these three Rs, you should prevent re-victimization (Resist re-traumatization).

In TIC, it is considered to be crucial to know the traumatic history.[9] To do so, therapists and supporters can visualize the trauma triangle (Figure 1) and fill out the top of the triangle for each patient. In everyday clinical practice, all items may not be filled in at first, but it is the first step in TIC if the therapist or supporter first notices this triangle and then informs the patient of this triangular mechanism so that the patient and the therapist will be able to talk about trauma using common terms. In other words, it is important for the patient to understand that it is because of the trauma that they have not been feeling well, rather than because of something they did wrong (Figure 2). In my own experience, the expression "mental injury" seems to be a term that does not trigger patient stigma so much.

Finally, for those who assume that their life is over or that they cannot change their past because of their PTSD symptoms, it is desirable to help them understand that they can change the future through their own efforts and that they can control the symptoms of their traumas, and then proceed with pharmacotherapy and other psychotherapeutic efforts on that foundation (Figure 3). Thus, for the first time, individuals can be actively involved in their treatment by practicing adequate TIC prior to the introduction of regular psychiatric treatment.

Conclusion.

J. L. Herman[10] states that traumatic events disrupt individuals' sense of being linked to society. In other words, trauma

disrupts interpersonal relations and social relations that people are supposed to have. In the psychiatric clinic, I think it might be possible to utilize conventional psychiatric treatments by making slight modifications to heal this rupture. That is exactly what TIC is.

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Table 1. What to avoid to prevent re-victimization

- Forceful responses
- Overwhelming attitudes (arming, provocative attitudes)
- Loud voice, ordering tone, and verbal abuse
- Unfriendly and indifferent attitudes
- Inadequate explanation of support content and goals
- Sudden change in support policy, breaking promises
- Saying things that mislead the other person
- Words posted by support organizations (violence/prohibition)

Table 2. The four "R" needed in TIC

1.Realize
2.Recognize
3.Respond
4.Resist re–traumatization

(Adapted from Literature 22)

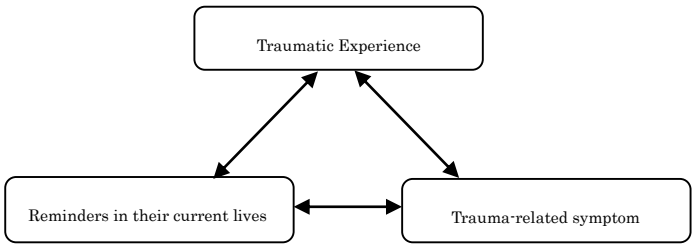

Figure 1. Trauma triangle

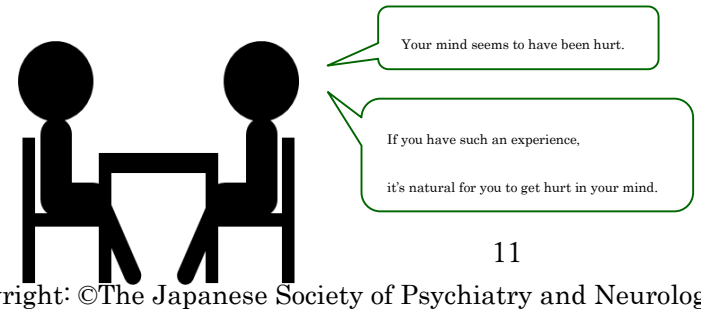

Figure 2. Shared review and assurance of validity

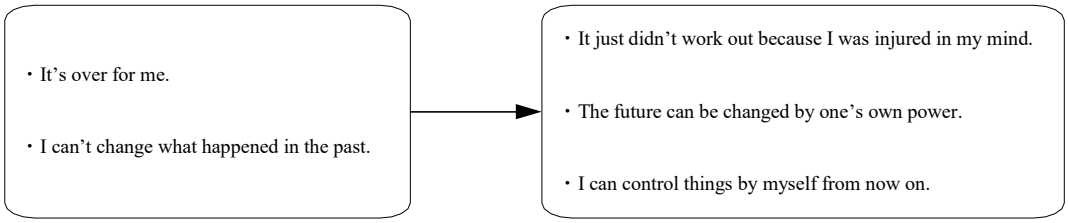

Figure 3. Paradigm shift