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Opinion piece; Society and Culture Spotlight

Summary

Adverse childhood experiences (ACEs) and trauma are linked to significant short and long term negative physical and mental health outcomes for both children and adults. Extensive research emphasises the need to prevent and address trauma across various services and societal levels. However, trauma approaches are often rooted in the medical model of pathologisation which can results in additional complexity and potential harm.

Trauma extends beyond psychiatric implications into political and social dimensions. Trauma describes human experiences and influences self-perception, with terms like “trauma survivor” reflecting this shift. Despite this broader understanding, the diagnosis and treatment of mental disorders remain medicalised, isolating trauma pathology within individuals. This approach overlooks trauma’s relational nature and broader social contexts, prioritising symptom reduction over a holistic understanding of individuals’ experiences. This can perpetuate stigma and shame associated with complex trauma and may cause iatrogenic harm.

In young people’s mental health services, increased demand and long waiting times exacerbate the crisis, leading to higher emergency referrals and hospital admissions. Inpatient care can be essential, however, safe avoidance of hospitalisation is preferable due to the potential harm from restrictive practices and reliance on psychotropic medication. Inpatient settings can involve complex power imbalances, acute distress and separation from family/social networks.

A case vignette illustrates these points. Alex, a 15-year-old residing in foster care, was admitted to a mental health unit due to severe mental health concerns. The structured environment of the ward provided stability, but Alex’s self-harming behaviours intensified with positive reinforcement. Home leave, initially a motivator, also increased incidents of self-harm due to the tension between connection and instability. The ward’s predictability and consistent care offered Alex a sense of security, but restrictive practices used to manage distress could evoke memories of previous trauma.

Advocates for trauma informed care call for a shift from traditional biomedical models to strengths-based perspectives, recognising the adaptive strategies survivors develop. However, focussing on trauma without addressing its social and structural roots risk a reductionist view. Trauma discourse must incorporate a social perspective, acknowledging economic and gender-based causes of suffering. Effective responses require a structural critique of economic and political systems, moving away from pathologizing trauma toward empowering survivors and addressing broader social factors.

Adverse childhood experiences (ACEs) and trauma are linked to negative physical and mental health outcomes, both in the short and long term for children and adults. Extensive research underscores the significant impact of ACEs, emphasising the need to prevent and address trauma across various services and society (Felitti et al., 1998; Hughes et al., 2017; Hiller & St.Clair, 2018). However, the way that trauma is conceptualised, and the support offered in contemporary society often pathologises it, creating additional layers of complexity and potential harm.

Trauma's implications extend beyond the psychiatric realm into political and social dimensions. Originally a psychiatric category, trauma has evolved within public discourse to describe human experiences and influence self-perception. Terms like "trauma survivor" have entered common usage, reflecting how individuals understand and narrate their experiences.

Despite this broader understanding of trauma, the diagnosis and treatment of its associated suffering is medicalised. This medical model, which seeks to identify treatments for symptoms based on categorised diagnoses, tends to isolate the pathology of trauma within the individual. By doing so, it overlooks the relational nature of trauma and the broader social and societal contexts in which it occurs (Peckham, 2023). This approach can be pathologizing as it prioritises symptom reduction over a holistic understanding of the individual's experiences and needs.

The medical model's focus on symptom management often leads to misidentification of trauma-related suffering as pathology, which in turn prompts responses that rely heavily on diagnosis and medication (Gomez et al., 2016). Such responses can perpetuate stigma and the shame associated with complex trauma and may cause iatrogenic harm. By failing to consider the relational and contextual factors of trauma, this approach risks neglecting the deeper healing process necessary for true recovery.

I have included below a case vignette that illustrates how previous trauma can shape the experiences of those admitted to inpatient psychiatric units. This is based on my clinical practice as a mental health nurse and is shaped by my opinions on how Tier 4 services often do not best meet the needs of those who have experienced trauma and focus on pathologisation of symptoms. The current demands on community mental health services mean that, whilst hospitalisation rates for most paediatric conditions decrease, the number of admissions to child and adolescent inpatient mental health units are increasing (Torio et al., 2015). Mental health inpatient admissions can provide vital, intensive care for CYP, however, it is widely recognised that safe avoidance of hospital admission is favourable (Edwards et al., 2015; Alderwick & Dixon, 2019). Inpatient care involves complex power imbalances, risk management, acute distress, separation from family/carers and restrictive practices (Clark and MacLennan, 2023)

<u>Case vignette</u>

Alex, a 15-year-old, was admitted to a Tier 4 child and adolescent mental health unit from foster care due to severe mental health concerns. Upon admission their foster placement broke down, exacerbating their already unstable home life. Alex has a history of disordered eating and referred to this as a mechanism to exert control over their unpredictable home environment.

Upon arrival to the unit, Alex demonstrated an ability to manage an adequate diet, and the structured environment of the ward provided a stark contrast to their prior living conditions, offering a semblance of stability. Nonetheless, during their admission, Alex's self-harming behaviours intensified, especially when praises or acknowledgement were made to their improvements in managing their diet. This appeared to trigger a counterproductive response, highlighting the complex relationship Alex had with receiving positive reinforcement. Home leave is often used a motivating factor for young people in hospital. For Alex whilst initially home leave served as a motivator and was used for goal setting, it also led to an increase in self-harming behaviours. This dichotomy highlighted the tension between Alex's desire for connection and their fear of returning to instability and potential loss of the relationships built at the hospital.

The predictability of the ward environment and the consistent care from nursing staff provided Alex with a sense of security, they developed relationships with staff members who maintained secure boundaries and effectively managed the stresses inherent in a hospital setting. These relationships were characterised by reliability and dependability, offering Alex a new model of stable care. Throughout their admission, Alex exhibited behaviours aimed at testing the stability of their relationships with staff. This manifested in differing patterns of risk and diet intake depending on the staff working that day.

When Alex was unable to manage their difficult thoughts around self-harming and diet restriction, restrictive practices were used as is often the practice within inpatient psychiatric services. These experiences may have been re-traumatising for Alex, and often resulted in disagreements among staff about whether this was the best care approach.

Alex's case illustrates the impact of an unpredictable home life on a young person's mental health. Their disordered eating and self-harm can be understood as ways of surviving chronic instability and neglect. The structure environment of the ward, combined with consistent care provided, a crucial therapeutic space for Alex, however, this made working towards discharge challenging and Alex was witness to and involved in restrictive practice that may have evoked memories of previous trauma. This journey highlights the ongoing challenge of navigating support in mental health units, home leave as a motivator and the complex interplay of attachment and relational support.

**This case vignette is based on my clinical experiences with multiple patients, and all identifiable information has been removed and a pseudonym has been used.*

Many of those with lived experience of trauma are advocating for an approach that de-emphasises diagnosis and the narrative of pathology inherent in the medical model of psychiatry. Instead, they advocate for an approach that recognises the adaptive strategies survivors of complex trauma have developed to navigate and survive traumatising environments (Sweeney & Taggart, 2018).

Proponents of trauma-informed care suggest a shift from traditional biomedical models to a strengths-based perspective. However, it is important to caution that the current focus on trauma does not necessarily signify a radical departure from the biomedical model. There is a risk of creating another reductionist understanding of human experience and its responses (Smith & Monteux, 2023). The failure of trauma discourse to adopt a more social perspective on human distress has led to critiques around medicalisation of suffering. Trauma discourse often neglects the structural causes of suffering, whether economic or gender based and it has been argued that many roots of social suffering can be traced back to austerity and social inequalities.

Any social welfare response needs to offer a well-developed structural critique of the current economic and political systems. Without this, trauma-based approaches will serve as temporary solutions to deeper social issues (Smith & Monteux, 2023). As far back as 1978 Lasch recognised that psychologising the social origins of suffering prevents more effective and lasting solutions to social problems.

Pathologising trauma makes symptoms reduction the primary goal of treatment, viewing psychological distress and abnormal and thus requiring interventions to change the person's behaviours or coping strategies (Peckham, 2023). In contrast, a non-pathologising model of trauma posits that the abnormality lies in the situation, not in the individual (Gomez et al., 2016). This approach emphasises the need for care systems to move away from institutionalising, iatrogenic harm and further traumatisation, focusing instead on empowering survivors and addressing the broader social and structure factors contributing to their suffering.

The way that society and culture are understood and experienced in the contemporary world is intertwined with our approach to adverse childhood experiences and trauma. Early social experiences and caregiving systems contribute to our development as members of society and our

ability to be integrated members of social groups, collaborate with others and provide meaning to our lives. Many behavioural patterns that are associated with mental illness are rooted in social conditions, without recognition of this, trauma discourse risks becoming another reductionist understanding of human experience. Prioritising child protection, adopting a non-pathologising model of care and addressing the roots of social suffering often linked to austerity and social inequalities could facilitate lasting solutions to social adversity, that I believe could lead to a shift in cultural understanding and a healthier society.

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