THE RELATIONSHIP BETWEEN TRAUMA AND MENTAL HEALTH

1. Introduction

The field of mental health as well as the general population holds the belief that a causal relationship exists between trauma and mental health problems (Sewell, 2009). In order to explore the relationship between trauma and mental health one have to get a clear working definition of both the concepts involved in the relationship. The term trauma refers to an event the individual experiences, witnesses or learns about in which unexpected, actual or threatened death, serious injury or other threat to the physical integrity of the self or another individual is present (Joubert, 2015). The term mental health refers to the process of effectively and happily adapting or becoming used to individuals as well as the environment in which we find ourselves in (Basavanthappa, 2007). Thus based on these two definitions and the fact that a causal relationship exists between trauma and mental health one can come to the conclusion that trauma will influence the individual's degree of adjustment towards other individuals as well as the environment in which he or she functions.

2. Factors Supporting the Direct and Causal Relationship between Trauma and Mental Health Problems

The first factor in support of the relationship between trauma and mental health problems is the postulation that individuals do not have the inclination or natural tendency to experience mental health problems but that such problems emerge naturally and are seen as normal due to the atypicality of the traumatic event. (Sewell, 2009) (O'Brien, 1998) Biological explanations are also employed when they look at the relationship between trauma and mental health even though they understand that mental health problems are natural following a traumatic event.

Evidence exists which supports biological causes to the mental health problems experienced due to trauma (which is also known as post-traumatic illness or PTI (O'Brien, 1998)), it must however also be noted that these research findings have been carefully studied and reviewed and has been found to have many weaknesses such as the notion that the social and political environment in which mental health care workers operate favours the biological model; this is the second supporting factor. (Sewell, 2009) There is also evidence which supports a link between trauma and the onset of physical illnesses such as thyrotoxicosis (O'Brien, 1998).

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A third supporting factor is the large number of female victims of physical and/or sexual abuse whom are diagnosed with post-traumatic illnesses. Direct links are harder to make due to reluctance to disclose as they might feel embarrassed or ashamed which results in a time delay or non-reporting which in turn may lead to diffuseness of the trauma which may open the door to other influences of post-traumatic illnesses such as dopaminergic abnormalities. (Sewell, 2009)

a. Factors Influencing the onset of Post-Traumatic Illnesses after Experiencing Trauma

Due to the fact that not everyone who has a mental disorder has been exposed to a traumatic event and not everyone exposed to a traumatic event goes on to develop a mental disorder (Pollet, 2009) research searched for factors influencing the onset of post-traumatic illnesses after an individual has been exposed to a traumatic event (American-Psychiatric-Association, 2013). One study suggests that the differences in intensities and duration of stressors may account for the differing levels of post-traumatic illnesses presenting in victims of a traumatic event. (O'Brien, 1998) Another factor influencing the onset of post-traumatic illnesses is the perception the person has of the traumatic event due to the fact that an event that is traumatic to one individual may be exciting to another, this is seen in instances where two individuals witness the same traumatic event and only one of the individuals present a post-traumatic illness, an exception is universally negative agents such as the murder of a loved one. (O'Brien, 1998). Thus it is clear that the onset of a post-traumatic illness is influenced by the nature, severity and the meaning of the traumatic event as well as the individua'ls personality, poverty, substance abuse, experiences and the level of support available to the individual. (Pollet, 2009)

b. The most Common Post-Traumatic Illnesses

The most common post-traumatic illnesses include post-traumatic stress disorder, acute stress disorder, anxiety disorders, affective disorders, adjustment reactions as well as substance abuse disorders as well as other axis 1 disorders. (O'Brien, 1998) The DSM-V now has an entire category devoted to disorders which is brought on by trauma and stressors; this category is referred to as Trauma- and Stressor-Related Disorders (American-Psychiatric-Association, 2013). Research discovered that it is almost a given fact that after exposure to a traumatic event that an individual will present with three or more axis-1 disorders (according to the DSM-IV-TR), this is referred to as comorbidity. Research has furthermore established that 80% of those diagnosed with post-traumatic stress disorder also exhibit symptoms which fulfil the diagnostic criteria for at least another disorder. (O'Brien, 1998)

i. Reactive Attachment Disorder

Reactive attachment disorder is diagnosed when a child rarely seek or responds to comfort when he or she is distressed and shows a persistent social and emotional disturbance. These symptoms are brought on by patterns of extreme insufficient care in children such as social neglect and repeated changes of primary caregivers. Such events have been found to be very traumatic to children. The patterns of insufficient care are present from as soon as the first months of the child's life and the symptoms typically present between the ages of 9 months and 5 years. (American-Psychiatric-Association, 2013)

ii. Disinhibited Social Engagement Disorder

This disorder is a common response to patterns of extreme insufficient care in children such as social neglect and repeated changes of primary caregivers. These events are traumatic to children and need to take place prior to the child's 2nd birthday. This disorder is characterised by the child being open to interacting in various means with unfamiliar adults and even being willing to go off with unfamiliar adults. (American-Psychiatric-Association, 2013)

iii. Adjustment Disorders

Adjustment disorder is described as emotional or behavioural symptoms which presents as a response to a distinct stressor within three months of the first contact with the stressor, the duration of the symptoms is no longer than 6 months after the stressor and its effects have vanished. It must also be noted that the severity of the event determines the incubation period for symptoms to present, the more severe the trauma the sooner the onset of the symptoms. An individual diagnosed with adjustment disorder exhibits marked distress which is distinctly out of proportion in relation to the magnitude of the stressor as well as the cultural and social norms which govern the reactions to a specific stressor. These symptoms bring about clinically significant levels of distress or impairment in all areas of functioning. (American-Psychiatric-Association, 2013)

iv. Acute Stress Disorder

The diagnostic criteria A for acute stress disorder requires that the individual needed to directly experience, witness in person, learn that a close friend or family member experienced or that the individual needed to have repeated or extreme exposure to actual or threatened death, serious injury or sexual violation prior to the onset of the other symptoms. The symptoms that characterise acute stress disorder include intrusion symptoms, negative mood, dissociative symptoms, avoidance symptoms and arousal symptoms. These symptoms bring about clinically significant levels of distress or impairment in all areas of functioning.

A diagnosis of acute stress disorder cannot be made until three days after a traumatic event. Acute stress disorder may either go into remission or progress to posttraumatic stress disorder depending on whether the symptoms subsided or worsened due to ongoing life stressors or further traumatic events. (American-Psychiatric-Association, 2013)

v. Posttraumatic Stress Disorder

The diagnostic criteria A for posttraumatic stress disorder requires that the individual needed to directly experience, witness in person, learn that a close friend or family member experienced or that the individual needed to have repeated or extreme exposure to actual or threatened death, serious injury or sexual violation prior to the onset of the other symptoms. The symptoms that characterise posttraumatic stress disorder include intrusion and avoidance symptoms as well as negative alterations in cognitions, mood, arousal and reactivity; these symptoms usually present within the first three months after the traumatic event. It is also not uncommon for a delay of symptom presentation for months or even years due to the fact that some of the symptoms do present during the first three months after exposure but meeting full criteria may be delayed. Posttraumatic stress disorder's diagnostic criteria is in about 50% of the time no longer met after three months, however in some individuals it may be present for as long as 50 years. Continuous exposure to stressors, reminders of the original trauma, newly experience traumatic events as well as declining age and worsening cognitive functions and social isolation may lead to symptom recurrence and intensification. (American-Psychiatric-Association, 2013) Research conducted by the Stanford University School of Medicine and Lucile Packard Children's hospital found that a diagnosis of PTSD instead of attention deficit/hyperactivity disorder should be considered in children from low-income and abusive neighbourhoods due to the similarities in symptoms. (Digitale, 2011)

vi. Dissociative Disorders

An individual whom is diagnosed with a dissociative disorder is depicted as feeling detached from the self and the surrounding as if he or she is dreaming. Dissociative disorders can be brought on by various events, the event that leads to the onset thereof determines the level of distress experienced by the individual. If the disorder is brought on by a lack of sleep it will not be as distressing as when it is brought on by a trauma such as an accident. Even though research findings indicate that between 31% and 66% of those whom experienced a traumatic event will display dissociative symptoms there is still great controversy as it is difficult to measure dissociation and therefore to discover the connection between trauma and dissociation. (Barlow & Durand, 2009)

1. Depersonalization Disorder

An individual whom is diagnosed with depersonalization disorder is described as being in a dream or watching the self due to the fact that your sense of your own reality is temporarily lost due to an altered perception. During a study conducted at Stanford University it was discovered that this is a common reaction to a traumatic event. This disorder leads to clinically significant distress or impairment in the social, occupational and other areas of functioning. (Barlow & Durand, 2009)

2. Dissociative Amnesia

Dissociative amnesia is characterised by the inability to recall vital information that is too extensive to be attributed to ordinary forgetfulness. The inability to recall the information generally pertains to a traumatic or stressful event or memory. It is also not uncommon for the individual to have amnesia to the emotional reactions to the traumatic or stressful event. These symptoms bring about clinically significant levels of distress or impairment in all areas of functioning. (Barlow & Durand, 2009)

3. Dissociative Fugue

During dissociative fugue the individual escapes an intolerable situation, such as an abusive household, and often assumes a new identity or becomes confused about the old identity. The individual escaping from the intolerable situation generally find themselves in a new place without having any recollection of how or why they got there. It is important to note that the memory loss experienced is linked to a specific incident. These symptoms bring about clinically significant levels of distress or impairment in all areas of functioning. (Barlow & Durand, 2009)

4. Dissociative Trance Disorder

Dissociative trance disorder just like the other dissociative disorders are more common among females and is often brought on by a current traumatic or stressful event. (Barlow & Durand, 2009)

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5. Dissociative Identity Disorder

Individuals suffering from dissociative identity disorder can take on as many as a 100 new identities with the average number of new identities being about 15. These alters may emerge in response to traumatic or stressful events which the individuals original personality is unable to deal with. It has been found that the leading cause for dissociative identity disorder is unspeakable abuse during their childhood as the child is unable to get help otherwise, these alters allow grant the individual to escape and experience relieve from the physical and emotional pain for a short period of time. Thus it is said that dissociative identity disorder is encapsulated in the natural tendency to dissociate oneself with severe trauma and stress. (Barlow & Durand, 2009)

c. Other responses to trauma

Even though these responses are not directly linked to the onset of posttraumatic illness they may negatively affect one's mental health due to the fact that trauma may negatively affect the believes one hold with regards to the self, the purpose of life as well as your religious convictions.

i. Spiritual responses to trauma

The spiritual impact of trauma can either be positive or negative as it is said that a person affected by trauma may either lose faith or find it. The individual who lost his faith baffles with questions about God's nature, about forgiveness and comes to accept the Satan as evil. (Joubert, 2015)

ii. The subjective response

Traumatic events have the potential to make one question the meaning and purpose of life due to the fact that trauma directly impacts our basic beliefs. As humans we hold the belief that life is safe and secure and thus the experiencing of a traumatic event will make one doubt this belief of invulnerability. Humans in general hold the believe that they have a reason and purpose to carry on, something which is easily shattered by the loss of a significant other as an example. The last belief that is challenged by traumatic events is the belief that the individual is a fairly good and decent human being, this belief is challenged as people tend to think that bad things do not happen to good people. (Joubert, 2015)

iii. Psychological responses to trauma

After an individual has bared witness to or experienced a traumatic event various psychological responses takes place within the psyche of the individual. It is common for such an individual to lose his sense of self as well as lose faith in the predictability of the world. Such an individual is tormented with feelings of helplessness and powerlessness. Childhood trauma negatively affects the development of the self and the child's ability to trust others and to verbally express emotions. (Joubert, 2015)

d. Positive responses to trauma

Even though evidence suggests and supports that trauma negatively affects mental health it must also be said and noted that the vast majority of those dealing with trauma have the capacity to cope adaptively and to not get tangled up in the process. Through the continuous recollections and attempts of avoiding said recollections of the traumatic event the victim somehow manages to find meaning in what has happened and manages to restore the equilibrium in his functioning. This process has laid the foundation for two positive responses to trauma namely resistance, resilience and posttraumatic growth. (Pat-Horenezyk & Brom, 2007)

i. Resistance

Some individuals are not affected by trauma as they appear to be emotionally unscathed by the traumatic events that have taken place. Such an individual is said to be resistant to trauma and thus there is no emotional, spiritual or physical reaction in response to the traumatic event nor does any growth take place within such an individual. No lessons are leant and no positives are extracted from the events. (Joseph, 2011)

ii. Resilience

A resilient individual is described as an individual whom is affected by the traumatic event but once the event has passed the individual returns to his normal state of functioning. It is said that such an individual recovers from the traumatic event and therefore bounces back to equilibrium. (Joseph, 2011) It is also said that in actual fact a resilient individual bounces forward in the face of trauma bringing about a positive development after trauma. This notion has laid the foundation for the emergence of the concept of posttraumatic growth. (Pat-Horenezyk & Brom, 2007) An important finding to keep in mind is that the current generation of individuals have been found to be less sturdy and robust than the previous generations therefore individuals today are less capable of coping with stressful life events and traumas (O'Brien, 1998).

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iii. Posttraumatic growth

The concept of posttraumatic growth is relatively new in field of responses to trauma and along with this various issues exist with regards to clarity as to what it entails (Pat-Horenezyk & Brom, 2007). One way of describing what posttraumatic growth entails is to define as a transformation an individual has undergone which has changed his sense of who he is and his capabilities are. Thus an individual whom has undergone posttraumatic growth is said to still be emotionally affected by the trauma he endured but his sense of self, his view of life, priorities as well as future goals and behaviours have been positively reconstructed. Research has shown that at least 30 – 70% of those who survive trauma benefit in some way from the ordeal they endured. (Joseph, 2011)

Posttraumatic growth entails reconfiguration in mainly three areas of ones being. The first area is personal changes in which the individual may find new inner strength, achieve greater wisdom and become more compassionate; this observed in individuals whom assist others who are going through the same battles they have gone through such as the suicide of a child. The second area is philosophical changes as the individual has a renewed sense of what is important in life. (Joseph, 2011)

The third is changes in ones relationships as the individual become aware that having contact with other individuals is one of the most important aspects of life, such individuals also grow a deeper love and appreciation for their family and friends. Posttraumatic growth is not an instantaneous event but rather develops over time, thus more growth is observed as time goes by since the event took place. Studies have shown that small to moderate degrees of posttraumatic growth is typical in trauma survivors. (Joseph, 2011)

What is interesting to note is that in contradiction with its theoretical possibility of alleviating the effects of posttraumatic illness the majority of research findings show that posttraumatic growth leads to higher levels of and more sever incidences of posttraumatic stress disorder. Other findings yet again support the notion that posttraumatic growth is a protective factor against the onset of posttraumatic stress disorder. Researchers have attributed the difference in research findings firstly to the degree to which one's believes are turned into action as the higher the degree of action the greater the protective effect and secondly it is postulated that the worse the survived event the greater level of growth is desired by the survivor. (Pat-Horenezyk & Brom, 2007)

Research has furthermore discovered that greater levels of posttraumatic growth is recorded when the individual is exposed to more traumatic events as well as experiencing more symptoms of posttraumatic illness. Thus it is clear that more research is needed to further explore the relationship between posttraumatic growth and mental health. (Pat-Horenezyk & Brom, 2007)

3. Conclusion

Based on the above and on research findings one can conclude that the relationship between trauma and mental health is bidirectional as trauma may either lead to the onset of a posttraumatic illness or it may lead to growth. (Joseph, 2011) A danger exists in the notion that posttraumatic illness is both a normal and acceptable response to trauma and that it is different to other psychopathology, this may lead to individuals using trauma as an excuse for gaining compensation (O'Brien, 1998). Research shows that the general population is in actual fact resilient and thus able to either resist the stressor or to quickly recover and maintain a good level of functioning after the traumatic event. (Joseph, 2011)

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