

Trauma-Oriented Medical Care: Bridging Medicine and Psychotherapy

NADIA KRUSZYŃSKA, PH.D. PSYCH.¹, ZOFIA KAMINSKA, M.A.²

¹ Center for Psychological Support and Psychotraumatology, Poznan University of Medical Sciences
ORCID: 0000-0002-8860-1139

² Center for Psychological Support and Psychotraumatology, Poznan University of Medical Sciences
ORCID: 0009-0006-6494-5216

Abstract

In the past decade, the issue of trauma has gained significant attention in psychological and medical research. Advances in psychophysiology, neuropsychology, and psychotherapy have greatly improved our understanding of the progression and consequences of psychological trauma. Treatment methods for trauma now boast a high success rate.

Trauma and psychotraumatology are especially critical in emergency and medical services. Recognizing the nature of trauma and applying principles of early intervention can considerably reduce its long-term negative effects (Goldstein et al., 2024). Additionally, understanding how past trauma – sometimes from long ago – affects current psychological and physical health can clarify behaviors often seen as maladaptive, such as excessive anxiety, heightened sensitivity to pain, uncontrollable anger, substance addiction, or self-harm. This insight can enhance the diagnostic and treatment process.

Trauma-informed care in medicine acts as a bridge between medical treatment and psychotherapy. Since trauma affects both the mind and the body, treatment should be grounded in a holistic view of the individual (Mikhail et al., 2018). Understanding trauma mechanisms is also crucial for preventive mental health care professionals (McKann & Pearlman, 1990).

Keywords: trauma-oriented medical care, PTSD, CPTSD, psychological trauma

Introduction

The scientifically accepted definition of psychological trauma originates from Janet's psychodynamic approach, described as an event or series of events that, due to their nature, impact the psyche and risk fragmenting its coherence. According to the American Psychiatric Association, trauma is "any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning. Traumatic events include those caused by human behavior (e.g., rape, war, industrial accidents) as well as by nature (e.g., earthquakes) and often challenge an individual's view of the world as a just, safe, and predictable place" (APA, 2018). Individual trauma results from an event, series of events, or set of circumstances that are perceived as physically or emotionally harmful or life-threatening, leading to a lasting negative impact on mental, physical, social, emotional, or spiritual functioning (SAMHSA, 2014).

This article provides an overview of aspects of trauma-informed care that are relevant to the practice of healthcare professionals. A broader understanding of the impact of psychological trauma on psychophysical functioning significantly boosts the effectiveness of patient treatment and improves the comfort of healthcare providers. Knowledge of the reactions resulting from chronic stress and trauma, as well as specific patterns of patient behavior, helps reduce the potential risk of treatment failures.

Trauma-Oriented Medical Care

People encounter various psychological traumas throughout their lives, but only some experience lasting effects from these traumas. While severe trauma is part of many people's life experiences, not everyone will face its consequences. Epidemiological studies reveal that over 70% of the general population is exposed to stressors that could potentially lead to post-traumatic stress disorder (PTSD; Frans et al., 2005; Kessler, 2017). Trauma can affect any social group, but factors such as social exclusion, migration, and poverty increase the risk. Loneliness and a lack of social support also heighten this risk.

Most people will recover from trauma without long-term effects. However, about 20% may experience significant negative outcomes later in life, such as psychiatric disorders or physical illness. PTSD is notably more common in clinical populations, with symptoms affecting 75% of patients (Breslau & Kessler, 2001; Koenen et al., 2017). It is important to differentiate between one-time trauma and relational trauma experienced in early childhood. The latter, often occurring in the pre-verbal stage, relates to early developmental experiences.

Diagnosing Trauma

According to the latest ICD-11 classification, diagnosing PTSD involves three key elements (Bowin 2021):

1) re-experiencing the traumatic event, as evidenced by intrusive memories, flashbacks, and/or nightmares; 2) avoidance of traumatic reminders, as evidenced by the avoidance of internal and/or external stimuli; and 3) a persistent sense of threat, evidenced by hypervigilance and being prone to startle. One symptom from each category is required, and the symptoms must have persisted for several weeks and cause significant impairment in functioning.

The ICD-11 has also introduced the concept of Complex PTSD (CPTSD). To be diagnosed with CPTSD, a person must meet the criteria for PTSD and also show three additional features related to “disturbances in self-organization” (DSO): 1) affective dysregulation (e.g., trouble calming down or numbing); 2) negative self-concept (e.g., worthlessness); and 3) disturbed relationships (e.g., difficulty feeling close to others). “According to Herman’s (1992) original conceptualization of CPTSD the etiology included exposure to prolonged or repetitive events from which escape is difficult or impossible. Although ICD-11 CPTSD does not require the event be prolonged or repetitive, it notes that it often stems from such. Moreover, the developers note that regardless of the nature of the stressor, the diagnosis of PTSD versus CPTSD is determined by the symptom profile” (Cloitre et al., 2013).

These symptoms can often be observed in patients receiving medical care. Understanding them properly can help in interpreting the patient’s often subtle reactions. For patients, recognizing and normalizing these symptoms can be an important step toward recovery.

DSO 1: affective dysregulation (e.g., trouble calming down or numbing)

Due to the hyperactivity of the amygdala, patients with PTSD often remain in a constant state of anxiety and can interpret potentially safe situations as threatening. Additionally, because of the dysregulation between the amygdala and the orbitofrontal cortex, triggering the fight/flight response, the body’s stress response system (H-P-A axis) might not deactivate properly even after the initial threat has passed. This means the patient continues to feel anxious and is unable to relax. Soothing verbal reassurances or rational explanations that there is no real danger may not bring the intended effect (Zhang, 2018).

PTSD is characterized by persistent, chronic hyperarousal of the autonomic nervous system (AUN). Individuals with PTSD experience continuous stress. When daily life stresses are added on top of an already overloaded AUN, it fails to function properly. Consequently, patients feel – and this perception is valid – that they are unable to manage their stress. Therefore, simple directives from a doctor such as “please calm down” or “try to avoid stress” are counterproductive for these patients, as they are simply unable

to relax. Paradoxically, moments of tranquility and rest, when nothing extraordinary is happening, can actually increase tension because they are interpreted as “the calm before the storm,” creating a sense of impending disaster.

Patients may respond with heightened anxiety and express numerous concerns about their diagnosis and treatment process. They often complain of various troubling psychosomatic symptoms, which can be traced back to functional dysregulation of the autonomic nervous system.

This emotional numbness can manifest both mentally and physically and may be mistaken for apparent indifference or a disregard for clinically significant symptoms. Individuals who have experienced trauma frequently report a diminished ability to feel physical sensations. For example, one patient who frequently suffered injuries during manual labor without adequate protection mentioned that he chose not to wear protective gear because it allowed him to “feel something.” Another patient recounted sitting on her porch in thin pajamas during a winter snowfall until she no longer felt the cold. She justified this behavior similarly. Some patients describe feeling like zombies – going through the motions, functioning, but devoid of any real emotional or sensory experience.

DSO 2: negative self-concept (e.g., worthlessness)

Although some symptoms may resemble elements of a depressive episode, for traumatized individuals, they are part of a broader picture (Post, 2011). Feelings of worthlessness, inadequacy, and loss of meaning and hope manifest as apathy and negative self-perception. Patients may express that they see no point in seeking treatment and may show limited motivation for it. When PTSD or CPTSD symptoms are severe, there is an increased risk of self-destructive behavior, either actively (e.g., self-harm) or passively (e.g., not taking treatment, abandoning medication). Patients may feel an overwhelming sense of guilt and excessive responsibility for failures, and sometimes prefer to endure their condition rather than seek help (Asarnov, 2020).

DSO 3: disturbed relationships (e.g., difficulty feeling close to others)

This pattern can affect both the patient’s personal life (turbulent relationships, divorce, multiple breakups, or living alone) and the doctor–patient relationship. To seek treatment, patients must trust their doctors and medical staff. Trauma, especially in relationships with people, often destroys this trust (Campbell, 2018). A patient may logically accept a doctor’s arguments, understand rational explanations, and feel assured about the safety of selected treatments. However, when faced with their own dependence, helplessness, physical proximity (during examinations or treatments), surrender of control, and need to trust another person, they experience inundating anxiety. Deep-seated traumatic experiences cause internal conflict and distrust. From a doctor’s perspective, this can lead to frustration due to the patient’s inconsistent responses.

One reason for this inconsistency is that logical arguments rely on declarative memory, which is conscious and language-based (semantic), formed after the age of three. In contrast, emotions, trust, or threats related to proximity and pain from trauma are recorded in procedural memory, which is stored from birth in an unconscious, non-verbal way. The lack of synchronization between these two long-term memory systems is typical of psychiatric disorders like PTSD. Therefore, building trust in the patient–doctor relationship is critical (Goldstein, 2024).

One factor that influences the depth and persistence of trauma, as well as the potential for psycho-physical recovery, is the attachment style developed in early childhood (Bryant, 2023). If a child grows up in a safe, predictable environment with reassuring relationships, allowing them to explore the world and develop an inner life safely, they develop a secure attachment style. In adulthood, people with this style can recognize stressful or traumatic situations, seek help when needed, and regulate their emotions effectively. Even if they face a serious crisis or trauma, they can recover. In times of danger or discomfort, they seek support from others. Physical proximity, like touch or a hug, helps their nervous systems to synchronize, reducing anxiety and tension, and returning their physiological responses to normal. Just as a baby calms down in its mother’s arms, adults find emotional comfort in the presence of loved ones (Weismann, 2021).

However, if a child experiences prolonged stress due to inconsistent parental care, neglect, rejection, or violence, their developing brain and nervous system are flooded with stress hormones. This causes their forming implicit memory systems to center around fear. According to the principle of “use it or lose it,” the most frequently activated synaptic connections become fixed and form pathways for rapid neuronal response. These circuits are easily activated later in life when a person anticipates a threat, which is common in individuals who have experienced trauma (Le Doux, 2017).

Guilt, Chronic Shame, and Trauma

People with trauma often experience chronic shame and a heavy sense of guilt. Sometimes, this feeling is so intense that it influences major life decisions, such as choosing a career path or completely sacrificing oneself for others as a form of atonement for one’s guilt. For example, one patient sought therapy for repeated anxiety attacks. During a session, he recounted a traumatic childhood experience: at age seven, he witnessed his younger sister being sexually abused by a neighbor. The boy entered the room and hid under the table, unable to call for help or defend his sister. He wanted to intervene but was paralyzed, feeling glued to the floor.

When the therapist explained the freeze response in extreme danger, the patient felt immensely relieved and moved. He realized his reaction was not within his control; his nervous system reacted in the only way it could to protect him. The neighbor was

a formidable man, weighing over 100 kilograms. Understanding this, the patient could better cope with his gnawing sense of guilt. Similar reactions are seen in survivors of accidents where loved ones died. It is vital to explain that their inability to move and help was not a sign of weakness or cowardice, but an automatic nervous system response aimed at self-preservation (Bub et al., 2017).

This understanding is also therapeutic for victims of violence, especially sexual violence. Immobility and lack of defense are often misinterpreted as acquiescence, while, in reality, freezing is a protective response when fleeing or fighting is not possible. If death or serious injury is imminent, numbing can make potential death painless. Awareness of this mechanism is particularly important in countries where the legal system presumes the culpability of rape victims. There is still a societal belief that a woman who does not scream or defend herself must have consented to intercourse, which retraumatizes victims of sexual violence (Lopez-Castro et al., 2019).

Summary: The Role of Health Care Providers in the Prevention and Treatment of Trauma

This discussion is only an introduction to a very complex problem. Although it focuses on a few selected aspects and provides a general overview, it shows that understanding trauma and integrating this knowledge into medical care is crucial for preventing and treating its effects. Educating patients about the meaning and mechanisms of their symptoms can be therapeutic, restore a sense of control, and help them understand their reactions. Furthermore, normalizing symptoms helps reduce anxiety and feelings of helplessness in the face of difficult experiences. Addressing shame and educating patients about neurophysiological mechanisms can help destigmatize their symptoms. Additionally, awareness of trauma pathomechanisms provides a foundation for healthcare workers to take care of their own mental health.

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