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Mental Health, Trauma and Trauma Related Disorders

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1. Introduction

Mental health is a complex phenomena including life satisfaction and subjective well-being. Satisfaction with life reflects the degree to which external living-conditions 'fit' with inner life-abilities. Subjective well-being refers to how people evaluate their lives, and include variables such as life satisfaction, marital satisfaction, positive moods and emotions, lack of depression, lack of anxiety (Diener, 2004). The investigations on people suffering from mood and anxiety disorders abound in psychology and psychiatry literatures (Seligman & Diener, 2002). The interaction between individuals and their environment generates both happiness and psychopathology. Traumas may easily influence negatively the interaction. In other words, psychological traumas as one of the crucial dimension of mental health may cause some impairment in the intra and interpersonal adaptive process of human functioning (Guney, et. al., 2010).

2. What is “mental health”?

It is good to mention about what mental disorder is to answer the question? There is no any single reason causing mental disorders. That's why mental health may be seen as a continuum where an individual's mental health may have many different possible aspects. In this continuum, mental health can be defined as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community”. While a healthy individual can remain focused, flexible and creative in bad times as well as good the individual suffering from a mental disorder can not. The people suffering from mental disorder have problems in everyday functioning in their life with some degrees. Research has shown that a combination of existing factors and triggers may cause mental health problems and disorders (Ozer and Weiss, 2004; Linden, 2003; Linley, 2003). These existing factors are traumatic life events, family history, social and individual environment, hormonal changes, drugs, and alcohol etc. Some mental disorders have some aspects of conditions. Most common of these are anxiety disorders including post-traumatic stress disorder, eating disorders, clinical depression, bipolar disorder and schizophrenia. These disorders are a different form of “an overdose” of “normal” fears and concerns. The disorders are particularly amenable to modification through existing evidence-based mental health treatment procedures and preventive interventions.

3. Psychosocial trauma

A psychosocial trauma is a type of damage to the psyche that occurs as a result of a traumatic event experienced by individuals in their psychosocial environment. Psychological trauma can be caused by natural disasters including earthquakes, flooding, bush fires, and man-made events including war, rape, abuse, violence, mechanized accidents such as car, train or plane crashes etc. or medical emergencies. The trauma responses potentially are normal responses to an unusual, an extreme traumatic event. They also involve the creation of emotional memories about the distressful event that are stored in structures deep within the brain. Moreover a traumatic event involves a single experience, or an enduring or repeating event or events that completely overwhelm the individual's ability to cope the emotions involved with that experience. There are several behavioral responses common towards stressors including the proactive, reactive and passive responses. Proactive responses include attempts to correct a stressor before it has a noticeable effect on lifestyle. The individuals who are able to be proactive can often overcome stressors. They are more likely to be able to cope well with unexpected situations. Reactive responses occur after the stress and possible trauma has occurred and is aimed more at minimizing the damage of a stressful event. The individuals who are more reactive will often experience more noticeable effects from an unexpected stressor. The individuals who are passive, victims of a traumatic event are more likely to suffer from long term traumatic effects. They often enact no intentional coping actions. However there is no available research outcome showing that these reactions are always true for the trauma victims. By the way, the clinical study outcomes suggest that a passive response is often characterized by an emotional numbness or ignorance of a stressor (Ozer and Weiss, 2004; Street et.al., 2005). The only evidence based outcome we have on the effect of the psychological traumas indicated that they may lead to serious, long-term negative mental health consequences. This ambiguity comes from the differences in the perception of the trauma at individual level.

Different individuals react differently to similar events. One may experience an event as traumatic while another person would not suffer trauma as a result of the same event. This unique characteristic of the perception of traumatic events makes the explore of the traumatic experience of the individual much more complex. Post traumatic reactions such as flashback memories, heightened anxiety, feeling depressed, feeling overwhelmed, strained family reactions, social withdrawal required to work with the biological, cognitive, emotional and behavioural areas of the individual suffered as a back ground factors of the reactions precisely. For example, the maladaptive cognitions of the individual such as self-talks "I don't think I can manage seeing what's left of our home, because there won't be much. I'll probably get so upset I won't handle it well and he'll think I'm a wimp.", self-rules ("I must never show signs of weakness"), schemas ("I deserve to feel bad for letting my family down") are examined and treated precisely by the trauma professionals. Therefore working with psychosocial trauma is essentially difficult not only for the individual suffered but also the professional dealt with them. There is increasing theoretical, clinical and research evidence for the role of perceived trauma and personal characteristics in trauma related disorders. There are many studies examining intra and interpersonal process investigating the role of cognitive variables such as anxiety, depression, life satisfaction, negative attributional style, and dysfunctional attitudes of the traumatized individuals (Ozer and Weiss, 2004; Ehrling and Ehlers, 2010, Ehrling, et.al., 2008 and Guney,

et. al., 2010). The studies represent these process are the serving moderator variables of the trauma - psychopathology - post traumatic growth association and interaction (Tedeschi and Calhoun, 2004; Zoellner and Maercher, 2005; Seligman, 2002; Rashid and Anjum, 2007, Guney, 2009). The perception of the trauma experienced and the attributions to the trauma are another crucial factor in the road of understanding of the effect of the trauma. There has been little research done on the perceived attribution of traumatic events and the effect of this on posttraumatic growth. A literature review done by Linley and Joseph (2006) suggests that posttraumatic growth scores are affected by the subjective experience of a traumatic event and not just the event itself. This result shows a relationship between perceived attribution of the traumatic event experienced and posttraumatic growth but does not explain if these two concepts are negatively or positively related. There has been little research done about the perceived traumatic life events and their influences into individual's daily life. Guney (2011) in her study asked university students to review their traumatic experiences last two years. In the study the students sorted out their negative and traumatic memories and then they labeled their experiences as traumatic and non-traumatic in terms of their subjective perception. The main result of the study has showed that there is an association between the reported traumatic events, the strengthspotting characteristics and the scores from posttraumatic embitterment disorder in the well-functioning university students who had suffered a variety of negative and traumatic events. While the ruminated more about negative events, the students also have reported low overall affective intensity in her study. The traumatized students in her study reported a paucity of pleasant for a while, and then highly activated and loving interpersonal emotions in their social environment. Some of them did not even report more anxious mood on a daily basis.

4. The trauma related disorders

Trauma symptoms refer to cognitive, emotional and behavioral difficulties that are directly related to traumatic experiences. These typically correspond to symptoms of post-traumatic stress disorder and also encompass other depressive, anxiety or behavioral symptoms including self-injury, substance abuse, impaired interpersonal trust and affective instability. It is true that individuals with traumatic symptoms may experience a profound change in the way they see themselves, the world and other people. Additionally, there is growing evidence that many of these individuals also experience psychobiological changes that may contribute to the development and maintenance of these psychological and psychiatric symptoms. These symptoms may be divided into several general categories. These symptom categories are with affective, cognitive, behavioral, and psychobiological trauma symptoms, acute stress disorder, the complex PTSD, and the post traumatic embitterment disorder offered as a new traumatic disorder category for DSM-V by Michael Linden (Unal et.al., 2011), a German Psychiatrist. The disorders on mental health including PTSD are a complex psychiatric phenomenon resulting in considerable emotional distress and impaired social functioning and often constitutes a significant treatment challenge. The mental health professionals have pointed out the critical importance of the impact of the negative life events and traumas in people's life time in terms of the occurrence of mental health disorders. From this perspective there are several threats in the traumatic experience: threat to life, to physical integrity, to injury and loss of close and beloved people, threats to self-image and values. The traumatic event shatters survivors' basic assumptions about the world being a safe place, their known self-image and the values on which they based their

lives (Street, et.al., 2005; Herman, 1997), disrupting the normal life of the survivors and rupturing their connection with the surrounding normal environment. The consequence of these negative life events may cause some psychological problems because the fear of the unknown and helplessness arise. Even after the event there remains the worry that the physical or mental injury will decrease the quality of life of the injured including their ability to continue and maintain an independent and productive life. Guney, et. al. (2011) found that there are statistically significant relations between the aspect of the mental health such as anxiety and other psychiatric symptoms and the impact of negative and traumatic life events.

Therefore the preventive mental health professionals take into account the interrelations between traumatic life events and the people's psychological states. The DSM IV-R (APA, 1994) delineates two types of disorders which develop in response to traumatic events: acute stress disorder, which develops immediately and resolves within one month, and Post Traumatic Stress Disorder (PTSD), which is considered as a chronic condition. In both disorders the first criteria is exposure to a traumatic event. Both disorders are classified as anxiety disorders and require three central categories of symptoms: intrusive, avoidant and hyper-arousal. In order to merit a diagnosis the symptoms must cause clinically significant distress or impairment. Acute stress disorder also includes symptoms of dissociation. We usually believe in that 'it will never happen to us'. This denial is necessary for normal life. So when something terrible does happen, we are in a state of shock. The experience haunts the survivors, enters their dreams, impacts their lives and changes their perception of reality. Some lose their faith in mankind, distance themselves from people and from close connections, and shut themselves off psychologically, sometimes physically. This is especially true if the traumatic experience was caused by another person or a group of persons, such as in the case of sexual abuse, terror attacks or domestic violence. In such instances the survivors' normal denial of the possibility of human cruelty is fractured, because other human beings inflicted merciless harm upon them. In response, they develop distrust in relationships. They feel helpless and horrified long after the experience has ended, especially if the trauma was continuous and they had no control of its occurrence or recurrence. They develop learned helplessness that occurs whenever organisms learn that their actions have nothing to do with the consequences of their behavior. This helplessness also occurs in cases of natural disaster or other traumas.

The post traumatic responses of the traumatized individual may not lead to a psychiatric disorder such as post traumatic stress disorder, anxiety disorder, and some affective disorders. These responses differ in the level of functioning. Many individuals suffered from some acute stress symptoms diagnosed as acute stress disorder and then they return to their previous level of functioning. Some resists the traumatic event with no traumatic and/or stress responses. Others react to the traumatic event as delayed response. Some others suffered the traumatic event with the chronic states. Therefore it is known by all the mental health professionals working on trauma mental health problems can be manageable for a while, then return previous level of functioning and/or a psychiatric disorder. The overall percentage of the individuals suffering from the psychiatric disorders such as PTSD, anxiety and affective disorders after a traumatic event is very small (e.g. 10 - 15 %). The background factors of the traumatic experience may cause some psychiatric disorder. In this context, adversity, life threatening experiences and negative life events may trigger mental disorders and also cause the post traumatic growth. The triggering event may happen over a

short or prolonged period of time. As the event triggering, the high levels of personal trauma carry out the potential risk for making the damages of adaptive human functioning. It may be good to say personal trauma has a different meaning and refers to an experience being emotionally painful, distressful, shocking, which often results in lasting mental and physical effects. Dealing with the post traumatic growth, there is a recent approach called as positive psychology.

5. Positive psychology: the recent approach to psychosocial trauma

In general it is believed that the more direct the exposure to the traumatic event, the higher the risk for emotional harm. In some degrees this may be true but the recent research and approaches (Seligman, 2000, 2002, 2004; Fazio and Fazio, 2005; Rashid, 2008; Diener and Diener, 2005) on the area show that the traumatic experiences can be converted into successful life experiences in the condition of individuals realized their basic aspects of human functioning. Seligman (2011) in his last book named as flourishing states that “there are two kinds of reality. One kind is not influenced by what human beings think, desire, expect, or wish for. There is an independent reality out there when you are a pilot deciding whether to fly during a thunderstorm. There is an independent reality out there when you are deciding which graduate school to attend: how well you will get along with the professors, whether there is adequate laboratory space, whether you can afford the cost. There is the reality of her rejecting you when you propose marriage. In all of these your thinking and your wishes do not influence the reality, and I am all for keen realism in these circumstances. The other kind of reality called as “reflexive reality”, is influenced and sometimes even determined by expectations and perceptions. Reflexive reality is strongly influenced by perception and expectation. I believe “reality” is reflexive and the value of fundamentals is influenced.” The science of Positive Psychology (and his book) is entirely about such reflexive realities.

In the line of Seligman words (2000, 2002, 2006, 2011), a new direction within psychology for traumatic life events gains more and more popularity. Thus the effect of trauma can be considered as a “reflexive reality”. There are human strengths that act as buffers against mental illness: courage, future-mindedness, optimism, interpersonal skills, faith, work ethic, hope, honesty, perseverance, the capacity for flow and insight, to name several. Positive psychology considers the traumatic events suffered as its pioneering concept, that the trauma psychology should be as concerned with strength as with weakness, be as interested in building the best things in life as in repairing the worst, be as concerned with making the lives of normal people fulfilling as with healing pathology, develop interventions to increase well being, not just to decrease misery. Positive Psychology does not rely on wishful thinking, self-deception or hand-waving; instead it tries to adapt what is best in the scientific method to the unique problems that human behavior presents in all its complexity.

The approach from which Positive Psychotherapy evolves is the scientific study of positive emotions, positive individual traits and strengths (Seligman, et.al., 2006). The goal is to help individuals learn that they can grow as a result of their experiences even if the experience is traumatic. Character strengths serve individuals best not only when life is easy but also when life is difficult (Park, et.al., 2004). During challenging times, helping people to discover their strengths such as optimism, hope, humor, resilience, and meaning takes

added importance for mental health professionals. Thus it is found that individuals who use their strengths more have been shown to have higher levels of self-esteem, self-efficacy, vitality, well-being (Linley, et.al., 2010; Govindji, and Linley, 2007) and also to be more effective in their personal growth (Rashid, 2008) after a traumatic exposure in their daily lives. Focusing on strengths can provide the clinician a powerful perspective to understand individuals' intact repertoires which can be effectively deal with troubles stimulates a very different discussion. Trauma "get under individual's skin" as it's subsequent outcomes can not always recognized and lead to a psychiatric morbidity. In other words it may disrupt the adaptive processing of human functioning for a while but not for long-term psychological disorder. In a study, the traumatized students in this study reported a paucity of pleasant for a while, highly activated and loving interpersonal emotions. Some of them did not report more anxious mood or a daily basis (Guney, 2011). In the condition of the mechanisms linking traumatic life events and psychopathological symptoms and their influences to the adaptive human functioning process are explored, the personal traumatic experiences can be converted into successful life experiences which mean traumatic growth.

Over the last 10 years there has been significant progress in the understanding, diagnosing and the treatment of trauma related disorders. Even their chronic and debilitating states have been extensively documented. By the recent advances in psychotherapeutic research great professional awareness of effective treatment is offered through cognitive, behavioral and positive psychological approaches with post-traumatic growth. More recently applied positive psychological approach has pointed out the prevention strategies emphasizing the avoidance of risk factors, and has promoted aims to enhance the individual's ability to achieve a positive sense of self-esteem, mastery, well-being, and social inclusion.

Positive therapy emphasises the need to understand the positive side of human experience as well as understanding and ameliorating psychopathology and distress (Joseph and linley, 2006). Both of the terms refer to how people evaluate their traumatic experiences and also the terms include lack of anxiety, lack of depression, positive moods and emotions. Therefore it may be said that the application of positive psychology principals into the mental health settings is going to give an opportunity to the professionals in the area to train their patients and clients on how the patients/clients can help themselves and their lives with positive and optimistic thinking style. If so, we teach them the positive psychology principles. They can easily learn how to "not being into depressed/anxiety mood and states". A positive change following the experience of traumatic, negative events and adversity may occur or the return to a higher level of functioning than which existed before the trauma occur. This positive changes include the perception of better relations to others, new possibilities in life, enhanced personal strength and an increased appreciation of life (Tedeschi and Calhoun, 1995; 2004; Tedeshi, 1999; Guney, 2011). Bonanno, Wortman, et. al. (2002) provided strong evidence in support of the idea that many individuals exhibit little or no grief and that these individuals are not cold and unfeeling or lacking in attachment but, rather, are capable of genuine resilience in the face of loss, and adversity.

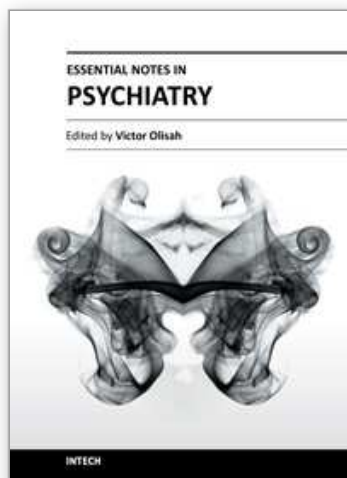
In this manner, by reminding the fact that the entire well-being can increase the quality of life, the psychologists and all mental health professionals are to meaningfully contribute to the public applications including universities with the positive psychology principals in the way of flourishing communities with happy people even with their traumatic experience (Seligman, 2006; 2011).

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Psychiatry is one of the major specialties of medicine, and is concerned with the study and treatment of mental disorders. In recent times the field is growing with the discovery of effective therapies and interventions that alleviate suffering in people with mental disorders. This book of psychiatry is concise and clearly written so that it is usable for doctors in training, students and clinicians dealing with psychiatric illness in everyday practice. The book is a primer for those beginning to learn about emotional disorders and psychosocial consequences of severe physical and psychological trauma; and violence. Emphasis is placed on effective therapies and interventions for selected conditions such as dementia and suicide among others and the consequences of stress in the workplace. The book also highlights important causes of mental disorders in children.

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