

Psychiatry's missing link – mental injury

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The study of medicine is largely based on categorisation of clusters of symptoms and deviation from a state of health is generally described according to the type of derangement such as disease, illness, inflammation etc. It seems ironic that an area of medicine that is as subjective as psychiatry should have the most rigid of all diagnostic criteria. The broad headings of diagnostic categories are: 'mental health', 'mental illness' and 'mental disorder'. I would like to propose the addition to the psychiatric paradigm of 'mental injury'.

My work as a general practitioner in a remote rural practice, where I am the only woman doctor within a 100 km radius has given me experience in an area of medicine which I have found enormously inspiring but harrowing, ie. working with survivors of childhood sexual abuse. These courageous individuals have taught me much about human nature but their horrific stories have done more to boost my wonder for the human mind than make me depressed. The quality of resilience fascinates me and I believe that its anatomy is one of the Holy Grails of mental health.

The field of mental health can be frustrating due to the apparent necessity for classification of every group of symptoms. People do not readily slot into categories and I believe that in the area of mental health such pigeon holing is often unhelpful or harmful. Survivors of abuse present difficulty with classification. The majority are not mentally ill, but neither are they

mentally healthy. Unfortunately, the box to which many are relegated is 'personality disorder', which has connotations of being innate and permanent, the prognosis therefore not optimistic. How differently would the use of the term 'mental injury' affect both the owner and clinician?

Psychological and emotional trauma can be viewed in the same way as a physical wound with an analogous pathophysiology and therefore similar range of treatment options. In broad terms a wound has: an acute phase, a recovery phase with scar formation, and a prolonged healing phase when scar tissue consolidates. At any stage, complications may arise. Lack of care in the early recovery phase can result in re-opening of the wound and/or increased disability. Conversely, good attention to after care and steps to protect the injured area can result in a less troublesome scar. How then, does mental trauma differ? The expression 'opening old wounds' is often used in everyday speech, when a person's emotions are deeply stirred, yet there is no recognition of this in the formal study of mental health.

A child who has been sexually abused has a mental wound that can heal given the right conditions, although the time frame may be very prolonged. Should the child receive excellent 'first aid' with validation, protection and counselling, the wound may leave a faint scar with later emotional pain causing a 'tingle' in that scar, just enough to remind its owner of its existence. Imagine now a child similarly

abused, without any support, experiencing ongoing abuse, who does not disclose until adulthood. There has been no 'first aid', with ample opportunity for secondary infection in the form of mental illness. Such an individual may employ substances such as analgesia for their emotional pain, leading to substance abuse and paradoxically, self injury. The wound remains a 'running sore'. Any emotional strain tugs at the open wound causing acute pain and such pain interferes with that individual's ability to function.

Post-traumatic stress disorder is the closest psychiatry comes to the concept of mental injury and it is a fine example of this proposal. The term 'disorder', although not incorrect, has a passive ring to it, which belies the active nature of the damage done to the psyche by trauma.

How then can the adoption of the term 'mental injury' become more than a question of semantics? In surgery, wound care has become almost an art form. There are specialists in the subject, who are struggling to change the practices of many older practitioners. I believe that the equivalent of modern dressings and therapeutic ultrasound should be sought to help heal the wounds of those with mental injury. The very use of the word injury has a very different connotation from 'illness' or 'disorder' and the implied prognosis is far more promising. Furthermore, it is a term that could do much to reduce the stigma of mental health problems, both in the general public and for the individual.

Inclusion of mental injury into the psychiatric lexicon allows for the differentiation of primary from secondary, or endogenous versus reactive mental illness. It also invites the development of a protocol for mental injury first aid and the psychiatric equivalent of physiotherapy to reduce re-injury. The opportunity presents to explore mental injury prevention by promoting resilience in children.

In discussing mental injury with patients and colleagues, I have been struck by the effect that it has and the enormous hope that it engenders, as their difficulties are suddenly viewed from a subtly different angle. I believe that incorporation of the term 'mental injury' into our clinical work would not only give our patients more hope but would also reduce our own feelings of frustration when dealing with the many individuals who defy categorisation according to the DSM.

I anticipate many stimulating and lively discussions on this idea and look forward to debating its merits and shortcomings. Few doctors are able to practise without encountering survivors of mental injury, so this is an issue that reaches far beyond the confines of psychiatry.

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