



The trouble with trauma and triggering

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Half of all mental illnesses in adulthood are already evident by the age of 14 years;¹ therefore, prevention early in development is crucial. Mental health research has provided advances in understanding the neurodevelopmental effects of early adverse life events, and this evidence is informing the development of appropriate policies, services, and preventive and therapeutic interventions. By childhood adverse events, we are referring to a wide range of experiences, including verbal, physical, and sexual abuse; emotional and physical neglect; parental mental illness, incarceration, drug and alcohol misuse, domestic violence, or separation; bullying; isolation; poverty; peer rejection; racism; death; multiple and traumatic losses; violence in the community; food scarcity; experience of care system; poor academic performance and educational exclusion; and living in an unsafe environment, among others. Adverse childhood experiences are associated with increased risks of mental illnesses in adulthood, substance and alcohol misuse, suicide and self-harm, and shortened life expectancy.^{2,3} Indeed, mental illnesses in adulthood might be better understood to be the consequence of cumulative life-course trauma, including early childhood and contemporary social disadvantages. Poverty, unemployment, discrimination, poor housing, fear of crime, and violence all affect mental health. Therefore, trauma-informed care should be improved in health and social services, and in public services in general, such as welfare, schools, and policing.³⁻⁵ Asking about intimate and horrible experiences, such as sexual, psychological, and emotional abuse, is often uncomfortable, although the difficulty appears to fade with training.⁶ Despite a growing awareness of the importance of trauma-informed care, ambivalence and avoidance of this topic remain within health-care settings and other public services, as well as society in general, and in policy formulation.⁶

The way adversities are experienced depends on several personal factors: emotional and cognitive flexibility, emotional processing, access to community and family supports, protective relationships, and other factors such as neurodiverse identities, poor educational performance, or poverty. Thus, clinicians, researchers, and others in the public sector (eg, teachers, welfare services, or police) are not in a good

position to understand or predict any one person's unique response without careful assessment of their circumstances and contexts. Furthermore, some experiences might be felt as traumatic only by some individuals or specific groups, such as people with autism. The frequency, intensity, and duration of adversities are also relevant to how they are experienced.

Failure to discuss or ask about adverse life experiences can lead to inappropriate care not commensurate with a person's needs or the complexity of their situation. For example, children might be excluded from school if perceived to show poor conduct. There is an emerging desire to be cautious and not directly ask about adversity for fear of inducing distress, assuming enquiry might harm a person, overwhelm them, or lead to more sustained emotional distress. There is a risk of collective avoidance, whether conscious or unconscious. Well-intentioned desires to avoid re-traumatisation might be a missed opportunity to understand more about a person's emotional life and biography. Furthermore, immediate safeguarding needs might be overlooked.

Structured questionnaires can help people to ask about adverse childhood experiences. A meta-analysis showed that individuals who were asked about distress did not regret being asked, even if they experienced mild to moderate distress.⁷ There were benefits, such as becoming aware that questions about adversity can be asked and can lead to support. This delicate process is familiar to psychotherapists and mental health professionals, and cognitive behavioural therapies rely on exposure to the feared memories and reminders of the adverse experiences. Asking about adversity in adolescents and adults, in a safe and supportive manner, does not inevitably lead to long-term or serious harms, and might have psychological, social, and legal benefits. When asked about adverse childhood experiences, people do respond most of the time; they seem satisfied and have a disclosure opportunity.⁷

The concerns about asking are often expressed in the form of fears of triggering. What could triggering involve (panel)? Triggering narratives, we contend, might be used by clinicians (and researchers, policy makers, and commissioners) as a reason not to hear experiential testimonies and not to develop ways of

Panel: Triggering responses

- No reaction at all: if adversity is common, it is not out of the ordinary
- Surprise and startle that are transient
- Dysphoria or experience of anxiety and depression that is transient or fluctuating; although recalling traumatic experiences is distressing, some people are unable to recall the experiences and autobiographical memory is disrupted, a common consequence of trauma
- More sustained experiences of dysphoria that warrant therapeutic input
- A response that amounts to an emotional crisis that requires support or a more specific intervention until the person feels able again to return to their life or usual situation, perhaps with awareness of therapeutic needs or recall of forgotten moments in their lives

asking questions in practice (eg, through play, creative modalities, or relevant open-ended interviews rather than closed questions). Hearing about the painful lives some people have experienced is difficult, but it is essential if trauma is to be understood in its historical and biographical contexts. Clinicians (and researchers, policy makers, and commissioners) must take care to develop the skills to manage their responses and potential vicarious trauma.

Trigger warnings are useful, if carefully placed and worded, but they should be designed not to overstate fears of re-traumatisation, for example, by being repeated too frequently or by assuming each person will correctly anticipate what is to come in the questions. “Content notes” might be a useful alternative phrase. Too much of a focus on trauma might also distract from better assessment of the personal situation or of underlying neurodivergence. Trigger warnings might be tailored to people with specific conditions, such as epilepsy, but otherwise they cannot predict individuals’ responses because there are so many other mediating and moderating influences. Some practitioners state that trigger warnings might encourage the avoidance of trauma-related cues in individuals with a post-traumatic stress disorder.⁷⁻⁹ Some studies even suggest trigger warnings might make no difference and should not be used.⁸ Repeated questioning can create considerable emotional demands and should be avoided. There

should also be a dynamic consent process to ensure people are always aware of how their data might be used, who is protecting their data, and with whom their data might be shared.

Asking and learning about adverse experiences and life events is crucial. Creativity provides opportunities to modulate emotions and to explore experiences in multiple sensory modalities that might soothe and activate reflection and emotional processing. In response to this need, we are developing guidance, using co-design, on empowering ways of working with service users, young people, and public service stakeholders. Additional tailored approaches are needed for those with sensory or communication impairments. In the meantime, we urge that those affected are provided as much agency and choice as possible to answer questions about adversity, either in research or in clinical service assessments.

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