

INTRODUCTION

Introduction to the Special Issue: Complementary Medicine and Integrative Health Approaches to Trauma Therapy and Recovery

Sandra Mattar¹ and Paul A. Frewen²

¹ Department of Psychiatry, Boston University School of Medicine

² Department of Psychiatry and Psychology, The University of Western Ontario

The popularity of complementary and integrative health (also complementary integrated health; CIH) approaches has significantly increased in recent years. According to the National Center for Complementary and Integrative Health (NCCIH), part of the National Institutes of Health, about 1 in 3 adults and 1 in 9 children used CIH approaches to healing. Some reports estimate that the use of CIH approaches will continue to increase (Clarke et al., 2015) as these therapies are cost effective and also due to the difficulties in finding trained mental health professionals (Simon et al., 2020). For the purpose of this special issue, we use the NCCIH's definition of CIH as "a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine" (Barnes et al., 2004, p. v).

However, the integration of these therapies into the health system has not followed the same pattern despite the fact that patients report the need to discuss CIH therapies with their doctors or are actually using them (de Jonge et al., 2018; Jou & Johnson, 2016; Stapleton et al., 2015). This inability to keep up with the demand or patients' preference is possibly due to providers' lack of understanding and/or knowledge of these therapies, as well as scientific skepticism (Ali & Katz, 2015; Fletcher et al., 2017). Using data from the 2012 National Health Interview Survey, Jou & Johnson (2016) identified patterns of CIH use in the United States and reasons for patients' nondisclosure of the use of these therapies. Patients' fear of disclosure due to perceived skepticism or disapproval from their provider was frequently attributed as a cause of patients' nondisclosures to providers about the use of these therapies (Eisenberg et al., 2001; Jou & Johnson, 2016; Thomson et al., 2012).

The arrival of patient-centered care models is beginning to shift the ways we understand the patient's role in treatment engagement.

Patient-centered approaches often emphasize the use of preventative and holistic wellness models that go beyond the use of evidence-based treatments. This approach also seeks to be culturally responsive, which is a key factor in addressing health disparities in the United States (American Psychological Association [APA], 2019). The Institute of Medicine, in its report on CIH therapies, highlighted the importance of engaging patients in their own care, including having a decision about therapeutic options (Bondurant et al., 2005). Likewise, the Race and Ethnicity Guidelines in Psychology (APA, 2019) recommend psychologists engage the patient's cultural beliefs, or what Kleinman called the "explanatory belief model" (Kleinman, 1978)—for example, by "aim[ing] to understand and encourage indigenous/ethnocultural sources of healing within professional practice" (APA, 2019, p. 24).

Mind-Body Approaches

Mind-body approaches to healing, including as a means of recovering from traumatic experiences, have been practiced for thousands of years across many cultures. However, these modalities have been largely ignored only until recently, arguably because of the difficulties in finding evidence for such interventions within the framework of Western science.

In the field of clinical psychology, there has been an influx of mind-body approaches informed by Buddhist psychology and energy medicine that have served as the foundation for widespread trauma treatments based on meditation and relaxation techniques such as mindfulness, acceptance and commitment therapy, eye-movement desensitization and reprocessing, emotion-focused therapy, dialectical-behavioral therapy, mindfulness-based stress reduction, progressive relaxation, biofeedback, neurofeedback, and guided imagery. Systematic reviews of randomized controlled trials (RCTs) have attested to the effectiveness of these treatments for treating symptoms related to trauma exposure (Banerjee & Argáez, 2017; Wahbeh et al., 2018). Likewise, yoga, reiki, tai chi, and acupuncture have become widespread complementary options for trauma treatment. In spite of progress and research advances, however, CIH approaches remain relatively marginalized as treatments for trauma and posttraumatic stress disorder (PTSD), with researchers raising conceptual and methodological challenges (Davidson & Kaszniak, 2015).

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Correspondence concerning this article should be addressed to Sandra Mattar, Department of Psychiatry, Boston University School of Medicine, 850 Harrison Avenue, Dowling 7, Boston, MA 02118, United States. Email: smattar@bu.edu

CIH Therapies and Trauma Psychology

Although many [CIH] approaches have been in practice for thousands of years, the application of rigorous methods to standardize and evaluate the efficacy of these treatments is a relatively new development in the field of interventional PTSD research. (Strauss et al., 2011, p. 40)

CIH therapies have been used for several years to treat PTSD symptoms, depression, and anxiety disorders. For example, nearly 40% of veterans receiving care in the Veterans Affairs report the use of CIH therapies (Fletcher et al., 2017; Libby et al., 2012). Another body of research provides evidence of efficacy for yoga and meditation and the ways they enhance overall physical and mental well-being (Gallegos, 2017; Jindani et al., 2015; Lang et al., 2012; Mitchell et al., 2014; Salmon et al., 2009).

Barnett and Shale (2012) noted that psychologists

are uniquely positioned to educate clients about [CIH], to monitor their use of [CIH], to communicate with primary-care physicians, and, if possessing the needed competence, to make crucial decisions about when [CIH] may be appropriate to include in a client's treatment. (p. 581)

Further, in an international study on the use of CIH therapies among psychologists, almost all (99.6%) admitted having used at least one CIH therapy in the past year, and 64.2% were trained to deliver at least one CIH therapy (Stapleton et al., 2015).

Special Issue Goals and Articles

The goal of this special issue is therefore to bring awareness into mainstream trauma psychology of the emerging body of work examining complementary and integrative therapies. We also hope to encourage the integration of CIH therapies as well as training in these modalities by psychologists and other health professionals. Although far from exhaustive, the articles presented in this special issue represent a good sample of the use of CIH therapies mainly in the modalities of mind-body interventions and energy therapies (Barnes et al., 2004). In the following, we provide a brief summary of each of the articles that are included in this special issue.

In the first article, Fortuna et al. (2020) discuss the development and evaluation of a manualized intervention that includes cognitive therapy and mindfulness practices to improve a variety of symptoms such as anxiety, depression, PTSD, and co-occurring substance use disorders in order to optimize the delivery of their interventions for Latinx immigrant populations. Their use of a mixed-methods approach helps identify key factors in therapy such as the therapeutic alliance and the integration of mindfulness approaches in cognitive therapy skills for illness management and recovery. Findings from this study will increase the knowledge base on not only mindfulness but also effective cognitive behavioral therapy transdiagnostic interventions with Latinx populations.

Nguyen-Feng et al. (2020) performed a secondary analysis of treatment moderators of an RCT of a trauma-sensitive yoga intervention for treatment-resistant PTSD. The authors' main goal was to target interventions for those adults with histories of interpersonal trauma. Their findings suggest that this type of trauma-sensitive yoga is better suited for those individuals with fewer rather than a greater number of adult interpersonal traumas. The authors hope that this protocolized trauma-informed approach will be more amendable to yoga research for trauma but also make all forms of hatha yoga practices more trauma informed.

Mistry et al. (2020) explored the possibility of applying virtual reality as an aid to meditation for young adults with varying symptoms of PTSD. However, participants with higher PTSD symptoms experienced elevated distress regardless of the modality used, consistent with prior research. This research therefore also continues to highlight the risk for distress when people with trauma histories and posttraumatic symptoms practice meditation. The authors recommend tailoring the meditation environment and content of guided meditations to the expressed needs of people with PTSD symptoms.

In their article, Gallegos et al. (2020) present a pilot RCT to examine symptoms of posttraumatic stress among women survivors of intimate partner violence. This study focuses particularly on emotional regulation, attentional focus, and physiological stress dysregulation in women with elevated posttraumatic stress symptoms. This study, though preliminary, offers insights on the effectiveness of the use of mindfulness-based stress reduction techniques with individuals with PTSD and their key role in improving the ability for emotional regulation and attention and psychophysiological stress regulation.

Stapleton et al. (2020) examined changes in cortisol levels among persons exposed to emotional-freedom techniques (EFT), specifically acupoint stimulation. The authors replicated a study by Church et al. (2012) that focused on changes in stress biochemistry and psychological distress symptoms and the positive resulting changes when applying EFT. The current replication trial found greater decrease in cortisol levels than the original study, but the authors did not find improved psychological symptoms. This study suggests that EFT may be an effective treatment to reduce biological stress markers in general.

In their article, Johnson et al. (2020) examine the use of trauma-informed wilderness therapy (TIWT), a complementary/integrative approach frequently used on trauma-exposed and vulnerable youth. TIWT showed moderate to large improvement in the youths' psychological functioning and family life and small to moderate changes in psychophysiological functioning. Caregivers also reported improvements in family and psychological functioning. This study's preliminary results add to the growing empirical evidence on TIWT as a complementary treatment for youth with trauma histories.

Chopin et al. (2020) present the results of a 4-year pilot study, examining the use of yoga for comorbid chronic pain and PTSD symptoms in veterans. Their study is the first research study to consider the effects of yoga on individuals presenting both chronic pain and PTSD simultaneously. Their findings suggest that yoga is a feasible and effective complementary treatment for PTSD symptoms and chronic pain in combat veterans. It also decreases fear of physical activities and improves family/social interactions.

Reeve et al. (2020) present a mixed-methods study using healing touch (HT), an energy-based therapy that focuses on the human energy field to treat PTSD in combat veterans. It is the first of its kind to use HT as the sole form of treatment for PTSD. HT is an adaptation of ancient healing techniques such as reiki. The HT approach runs on the premise that trauma impacts the energy field of the human body and crates "congestion," which in turn impacts recovery from trauma. This study showed positive effects on reducing physical and emotional symptoms of PTSD in combat veterans. While the results look promising, some subjects expressed the positive HT results were temporary. The authors suggest the use of HT as a low-cost and low-risk complementary treatment of PTSD alongside evidence-based treatments.

Davis et al. (2020) conducted what is to our knowledge the largest RCT of a holistic yoga program consisting of postures (asanas), breathing practices (pranayama), and relaxation techniques designed for PTSD when compared to an active control condition, that is, a wellness lifestyle program that also included some physical activity (walking). Promising results were seen for several secondary outcome measures, specifically self-reported sleep problems, interoceptive awareness, attention, perceived stigma, and various other indicators of emotional and self-regulation. However, group differences were found not to be sustained by 7-month follow-up, and approximately 3 in 5 patients retained their PTSD diagnosis by follow-up, regardless of what intervention they received.

Another pre-post trial of a trauma-sensitive yoga intervention was undertaken by Zaccari et al. (2020) among a smaller number of veterans with PTSD, which had a particular interest to determine outcomes not only for PTSD and other mental health symptoms but also for cognitive functioning and salivary cortisol. To our knowledge, this is the first published RCT of a yoga intervention to include salivary cortisol as an outcome. Referring to cognitive outcomes, participants were assessed using a number of executive function tests as well as for digit span (short-term memory). Results showed improvements specific to a measure of response inhibition (color-word interference, i.e., Stroop task) and mental health symptoms; however, null effects were detected for other objective measures of cognitive performance and cortisol.

Finally, Rogel et al. (2020) examined outcomes in an RCT of 24 sessions (twice weekly) of electroencephalogram neurofeedback training (NFT) versus treatment as usual among 37 children with PTSD and other problems associated with their developmental trauma history—for example, being victims of chronic neglect, impaired caregivers, separation from caregivers, physical abuse, and domestic violence. To our knowledge, this is the first RCT using NFT among children with PTSD. The study determined that 24 sessions of NFT were associated with decreased PTSD symptoms, caregiver-reported executive functioning, and other emotional and behavioral outcomes associated with developmental trauma, with effect sizes ranging from moderate to large at treatment end and for the most part retained by 1-month follow-up.

Conclusion

In summary, all the studies included in this special issue include evaluations of several different approaches to trauma treatment that fall under the broad umbrella of CIH interventions. Among the populations that researchers evaluated were veterans and survivors of intimate partner violence and childhood trauma. The majority of the research examined outcomes for meditation practices and yoga, which are among the mainstays of CIH-based interventions. Besides meditation and yoga, however, other approaches examined EFT, TIWT, HT, and NFT, broadening the scope of the CIH approach as an integrative interventional framework for trauma treatment. Beyond PTSD alone, these interventions were seen to produce positive outcomes for other comorbid psychological disorders (anxiety, depression, substance use disorders), emotional sequelae, executive functions and other neurocognitive outcomes, as well as cortisol as a marker of the function of neuroendocrine stress systems.

We would like to thank the researchers for their efforts to evaluate this diverse set of CIH interventions among traumatized persons. We

hope that this special issue will promote further research similar to the studies presented here. It is our hope that CIH interventions will continue to be helpful to those in recovery from psychological trauma and that these interventions will earn their due prominence alongside evidence-based interventions for PTSD.

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