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OPINION

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Beyond the Silos: The Case for a Constellation of Care in Mental Health and Psychotraumatology Practice

Charlotte O'Brien¹  | Divine Charura² 

¹John Wiley & Sons, Oxford, UK | ²York St John University, York, UK

Correspondence: Charlotte O'Brien (cobrien@wiley.com)

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ABSTRACT

Despite longstanding efforts to implement multidisciplinary approaches within mental health care systems, contemporary therapeutic practice remains largely fragmented across the fields of psychology, psychiatry, psychotherapy and neuroscience. These divisions reflect entrenched historical and professional boundaries which limit our ability to adequately address the holistic complexity of human experience. This opinion piece argues that such fragmentation is both theoretically outdated and clinically restrictive. Drawing on our work in embodied trauma, we propose that the now widely rejected concept of mind–body dualism necessitates a genuinely holistic and integrative framework for mental health care and psychotraumatology practice. This includes a holistic approach that spans the bio-psycho-social-sexual-spiritual-existential-cultural realms of human experience. We conceptualise this within a constellation of care model, emphasising the urgent need for relational, culturally responsive, trauma-informed and holistic therapeutic engagement. Bridging disciplinary divides, we suggest, is not simply advantageous, but essential for achieving meaningful and sustained therapeutic outcomes.

1 | Introduction: The Limits of Fragmented Care

Despite decades of progress in mental health care and psychotraumatology research, clinical practice remains structured around divisions that fail to adequately address the lived reality and the diverse needs of patients/clients. Individuals seeking support are often distributed across siloed systems, including, but not limited to, accessing generic mental health services, cognitive and behavioural assessment in psychology, pharmacological treatment in psychiatry, relational work in psychotherapy and mechanistic insights in neuroscience. These approaches, whilst individually valuable, are rarely integrated nor applied in a way that reflects the holistic complexity of human distress.

This fragmentation is not simply logistical within in health care systems, it is also conceptual. It reflects an enduring legacy of mind–body dualism (Descartes 1641), in which mental and physical processes are still often treated as distinct domains. Yet such a division is increasingly difficult to justify. Utilising our

work on embodied trauma (O'Brien and Charura 2023b; O'Brien and Charura 2024a; O'Brien and Charura 2024b), we make the case that psychological distress is not merely in the mind but is experienced and expressed holistically throughout the lived body (Merleau-Ponty 1962).

Through our research and published works, we have continuously asserted that psychological distress cannot be fully understood through isolated diagnostic or intervention frameworks because mental health, trauma, identity, embodiment, culture and relationships are deeply interconnected dimensions of human experience (Charura and Smith 2024; O'Brien and Charura 2024b; Smith and Charura 2024). Fragmented care risks reducing individuals to symptoms, categories or service pathways rather than recognising the whole person, and their idiosyncratic meaning-making processes through which their lived experiences or distress is communicated. In clinical practice, this can lead to disjointed treatment experiences in which patients/clients, couples or families repeatedly recount painful

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histories to different professionals who rarely work from a shared systemic perspective embedded within a joined up multidisciplinary mental health service.

Our relational psychotraumatology perspective emphasises that trauma is frequently formed and healed within relationships, requiring integrative, trauma-informed approaches that attend simultaneously to the bio-psycho-social-sexual-spiritual-existential-cultural dimensions of human experience or suffering (O'Brien and Charura 2023b; O'Brien and Charura 2024a; O'Brien and Charura 2024b). Similarly, elsewhere we have highlighted the importance of socially just (Winter and Charura 2023) and transculturally informed therapeutic practice, particularly when working with refugees, asylum seekers and marginalised communities whose experiences often do not fit neatly within conventional psychiatric formulations (O'Brien and Charura 2024a; O'Brien and Charura 2024b).

The limits of fragmented care therefore extend beyond inefficiency; they concern the ethical and clinical capacity of services to genuinely meet human needs. Holistic and integrative approaches, grounded in culturally responsive therapeutic relationships, collaboration and contextual understanding, provide a more coherent framework for addressing the complexity of psychological distress and fostering meaningful psychological growth (Paul and Charura 2015; O'Brien and Charura 2024; O'Brien and Charura 2024a; O'Brien and Charura 2024b).

The central argument of this piece is that contemporary mental health systems often remain fragmented, with professionals frequently moving across overstretched services and disciplines that operate in isolation from one another. Such conditions are far from optimal for supporting individuals who have experienced trauma and relational distress. We argue that meaningful integration across therapeutic and mental healthcare disciplines must be grounded in a non-dualistic understanding of human experience one that recognises the inseparability of mind, body, relationships and social context. Without this fundamental shift towards holistic and relational models of care, attempts at interdisciplinary collaboration risk becoming superficial, mechanistic, and at times, inadvertently re-traumatising the person. A constellation of care therefore requires not only structural integration between services, but also a shared philosophical commitment to understanding distress as embodied, relational, socially and structurally situated.

1.1 | From Dualism and Siloed Services to Embodiment and Holistic Care

The historic shadows of mind-body dualism (Descartes 1641) continue to shape mental healthcare services in subtle but pervasive ways. In settings such as the National Health Service [NHS] in the UK, psychiatry can often be seen to prioritise biological mechanisms and psychopharmaceutical interventions, psychology to prize and emphasise cognitive and behavioural approaches and psychotherapy to focus on relational and subjective experiences. Whilst each offers valuable siloed insights, the implicit separation of these domains reinforces a fragmented understanding of the person. For example, a person may attend a psychiatrist appointment and

receive an assessment and formulation of their distress, and if referred to psychology or psychotherapy services may have another, having to re-tell their history. Whilst it could be argued that assessment and multiple formulations from different services may be a way of triangulating different professional perspectives, in some cases, this disjointed and at times repetitive process may lead to retraumatisation, mistrust or disengagement with services.

The holistic approach to embodied trauma challenges this separation (O'Brien and Charura 2023b; O'Brien and Charura 2024a; O'Brien and Charura 2024b). We argue that trauma is not simply a cognitive or emotional phenomenon but is held within the body (Van Der Kolk 2014), shaping physiological responses, sensory experiences and patterns of relating (O'Brien and Charura 2023b; O'Brien and Charura 2024a; O'Brien and Charura 2024b). The body is not a passive container for psychological processes but an active participant in them (Merleau-Ponty 1962).

This perspective aligns with broader developments in neuroscience, which have highlighted the bidirectional relationship between brain, body and environment (Gray et al. 2020; Porges 2025, 2026; Van Der Kolk 2014). The concept of embodiment extends this argument further. We suggest that integration is not simply about combining perspectives but about reconceptualising the holistic nature of human experience itself. It also resonates with earlier calls for integration, such as those of Nobel Prize Laureate Eric Kandel (2014), who emphasised the need to bridge biological and psychological levels of psychoanalysis. In line with this, we postulate from a relational psychoanalytic perspective that where psychic fragmentation and internal splitting are met with siloed and fragmented services this can result in further distress (O'Brien and Charura 2023a). However, holistic therapeutic support and interventions can serve to facilitate internal integration and post-traumatic growth or equilibrium.

This embodied understanding of trauma highlights why fragmented and siloed models of mental health care are often insufficient. Trauma permeates interpersonal, social, cultural and physiological dimensions of experience, requiring responses that are equally relational, culturally responsive, trauma-informed and interconnected. Our work on relational and embodied trauma and psychotraumatology emphasises that psychological growth and transformation occur within safe, attuned and compassionate relationships rather than through isolated interventions alone (Charura 2024; Charura and Smith 2024; O'Brien and Charura 2023b; O'Brien and Charura 2024a; O'Brien and Charura 2024b). Individuals presenting to different mental health services often carry implicit embodied memories of disconnection, shame, threat or abandonment, which can be inadvertently reinforced when services operate in isolation from one another. A holistic constellation of care therefore invites collaborative, trauma-informed systems that integrate psychological, community, social, cultural and embodied approaches to wellbeing. Such an approach recognises that recovery is not merely symptom reduction but the restoration of relational safety, agency, meaning and belonging (O'Brien and Charura 2024a; O'Brien and Charura 2024b). Moving beyond silos allows practitioners to work more

holistically with the lived realities of disease or trauma, supporting psychological growth that is facilitated through collective, relational and socially just mental health care approaches (Charura and Smith 2024; Winter and Charura 2023).

1.2 | A Holistic Framework: Beyond the Biopsychosocial Model

The biopsychosocial model (Engel 1977) has long served as a framework for integrating multiple dimensions of health. Whilst valuable, it may no longer be sufficient to capture the full complexity of lived experience. We proposed in our recent work on embodied trauma an expanded framework across the biopsychosocial-sexual-spiritual-existential-cultural or holistic realms of human experience (O'Brien and Charura 2023b; O'Brien and Charura 2024a; O'Brien and Charura 2024b).

This formulation recognises that human experience is shaped not only by biology, cognition and social context, but also by:

- Sexuality and relational embodiment
- Spiritual and existential meaning-making
- Cultural and systemic influences

Taking this idea one step further, we now also include linguistic experiences, as language acts as the primary bridge between the brain, our subjective emotional experiences and society, which is therefore crucial to our holistic understanding and expression of mental health (Ma and Liu 2023).

Such a model resists reductionism by acknowledging that distress emerges within a web of interrelated factors. For example, trauma may involve not only neurobiological dysregulation and cognitive disruption, but also disruptions in identity, meaning and connection. Importantly, however, this framework is not additive in a simplistic sense. It does not merely expand a checklist of factors but emphasises their holistic interdependence. Biological processes influence psychological experience, which in turn is shaped by cultural narratives and existential concerns. These dimensions cannot therefore be meaningfully separated in practice.

2 | The Case for a Holistic Constellation of Care

If human experience is inherently multidimensional, then care must be organised accordingly. Our notion of a holistic constellation of care offers a useful conceptualisation (O'Brien and Charura 2024). Rather than positioning a single practitioner or discipline at the centre of treatment, this model envisions care as a dynamic network of relationships and interventions. Each component, including the psychiatric, psychological, psychotherapeutic and neuroscientific, contributes to a broader system oriented around the patient. This broader oriented system includes practical support such as housing or benefits, social prescribing for relational connection and physical activity, religious support within the patient's chosen spiritual community, sexual screening and physical health support.

A constellation of care (O'Brien and Charura 2024a), advances beyond traditional integrated or multidisciplinary team (MDT) models by moving from coordination of expertise to a fundamentally de-centered, relational and ontological reconfiguration

of care. Whilst MDT and integrated care approaches typically organise collaboration around a central clinical pathway or lead professional, often retaining implicit hierarchies and a primarily biomedical anchor, the constellation model rejects this centralisation altogether. Instead, it conceptualises care as a dynamic, anti-oppressive patient/client-oriented network in which multiple domains (psychological, biological, social, cultural, spiritual and embodied) are not simply coordinated but recognised as mutually constitutive and continuously interacting (O'Brien et al. 2025).

In the context of transculturally informed, humanistic practice with refugees and asylum seekers (O'Brien and Charura 2024a), we demonstrated that distress cannot be adequately understood or addressed through standardised, discipline-bound interventions alone, particularly where trauma is embodied, culturally mediated and relationally situated. The holistic constellation model is therefore superior not because it adds more disciplines, but because it reconfigures the logic of care itself, prioritising lived experience, cultural meaning, embodiment and relationality over procedural integration. In doing so, it addresses key limitations of MDT frameworks, which may still fragment experience across professional boundaries, and instead offers a fluid, context-sensitive and ethically attuned approach capable of responding to the full complexity of human distress.

2.1 | This Approach has Several Implications

2.1.1 | Decentering Professional Silos

No single discipline holds a privileged position. Instead, expertise is distributed, anti-oppressive and collaboration becomes essential.

2.1.2 | Emphasising Relationality

Care is not only delivered through techniques but through relationships between patient/client and practitioner, and among practitioners themselves.

2.1.3 | Adapting to Individual Needs

The configuration of the holistic constellation of care may shift depending on the patient's/client's context, needs and stage of recovery.

2.1.4 | Integrating Embodied Practice

Interventions may include not only talk-based therapies and medication, but also body-oriented approaches that address the holistic and integrated dimensions of trauma.

In this sense, integration is not merely structural but philosophical, grounded in an understanding of the person as an embodied, relational being.

2.1.5 | Trauma-Informed, Culturally Responsive Practice

A holistic constellation of care must also be grounded in trauma-informed and culturally responsive principles. This involves creating services and relationships that prioritise safety, trustworthiness, choice, collaboration and empowerment,

(Scottish Government & NHS Education for Scotland 2021), whilst remaining responsive to the cultural, relational, historical and social contexts in which distress is experienced.

We assert that a trauma-informed practice stance recognises the widespread impact of trauma and seeks to avoid re-traumatisation through compassionate, relational and ethically attuned care (Charura 2024; Charura and Smith 2024; O'Brien and Charura 2023b; O'Brien and Charura 2024; O'Brien and Charura 2024b). Importantly, culturally responsive practice extends these principles by acknowledging the influence of identity, migration, racism, oppression, faith, language and community on experiences of trauma and healing or recovery. Our postulation of going beyond the silos and making a case for a constellation of care in mental health model is not something delivered to individuals in isolation, but something co-created through respectful, inclusive and empowering relationships across systems and communities.

2.1.6 | Clinical Implications

Within a traditional framework, mental health difficulties may be treated through medication, psychological therapy or both. An embodied, integrative approach expands this understanding. It considers how psychological disease may be experienced somatically (e.g., fatigue, heaviness), relationally (e.g., withdrawal) and existentially (e.g., loss of meaning).

A constellation of care might include:

- Psychosocial support to stabilise wellbeing
- Pharmacological support to stabilise mood
- Psychotherapy to address cognitive and emotional patterns
- Body-based interventions to reconnect with physical experience
- Social prescribing or social green prescribing to reconnect with community and nature
- Exploration of meaning, identity and cultural context
- Linguistic collaboration to better understand the lived experience of the individual
- Integration of spiritual care, such as chaplaincy services or other faith services, recognising that spirituality, faith and existential meaning can play a significant role in coping, recovery, resilience and post-traumatic growth.

Such an approach moves beyond symptom reduction towards holistic recovery.

2.2 | A Case Example of a Holistic Constellation of Care Model in Trauma Informed Practice

Trauma provides perhaps the clearest example of the limitations of dualistic thinking. As we emphasised in our own research, trauma is fundamentally embodied (O'Brien and Charura 2023b; O'Brien and Charura 2024a; O'Brien and Charura 2024b). It is encoded not only in memory but in physiological responses and sensory experience.

An integrative approach recognises that:

- Neuroscience can illuminate mechanisms of fear and regulation

- Psychotherapy can facilitate narrative processing
- Psychiatry can support symptom management
- Embodied practices can address dysregulation at the level of the nervous system
- A constellation of care that includes engagement with spiritual frameworks to make sense of trauma, suffering, identity, hope and post-traumatic growth or healing.

Without such integration, treatment risks addressing only part of the challenges that an individual presenting with embodied trauma or PTSD may be experiencing.

3 | Barriers Reconsidered: Cost, Culture and Paradigm

Many of the barriers to integration include training structures, institutional and professional divisions and resource constraints which are often treated as practical challenges. However, they are also expressions of an underlying medicalised paradigm. As long as this paradigm remains implicit within mental health care services, integration will be partial at best. True collaboration requires not only structural change but a shift in how practitioners conceptualise their work.

Organisations such as the American Psychological Association have begun to emphasise interdisciplinary approaches (Nolan et al. 2024), yet progress remains uneven. Without a unifying conceptual framework, efforts at integration may remain fragmented.

Whilst the case for a holistic constellation of care is conceptually and clinically compelling, the practical realities of implementing such a model cannot be overlooked. Integration across disciplines carries both financial and systemic costs, alongside significant challenges in organisational change.

From an economic perspective, integrated care models often require substantial investment. These include restructuring services to enable interdisciplinary collaboration, funding additional roles, and developing shared infrastructures for communication and coordination. Evidence suggests that whilst implementation costs are real, they may be relatively modest at scale. For example, collaborative care models in mental health have been estimated at approximately \$40 per patient, with associated reductions in hospitalization costs and overall cost savings over time (Miller et al. 2020). Broader reviews similarly indicate that integrated care can improve efficiency and reduce duplication of services, though robust cost-effectiveness data remain variable and context-dependent (Thomson and Chatterjee 2024).

However, the persistence of fragmented systems itself generates inefficiencies, including repeated assessments, poor communication and conflicting treatment pathways, all of which increase long-term costs and reduce quality of care. Integrated approaches, by contrast, have been associated with improved outcomes, enhanced patient satisfaction and more efficient resource utilisation, particularly in collaborative and multidisciplinary models (Isayeva et al. 2025).

Beyond financial considerations, the difficulty of implementing change presents a more pervasive challenge. Barriers to

integration are deeply embedded within healthcare systems, including entrenched professional boundaries, institutional silos and divergent epistemologies across disciplines. Empirical research highlights structural, cultural and organisational barriers such as rigid service criteria, fragmented governance, and risk-averse institutional cultures that inhibit collaboration (Castelli et al. 2023). Workforce-related issues, including training gaps, role ambiguity and resistance to new models of practice further complicate implementation (Isayeva et al. 2025).

Additionally, integrated care initiatives frequently struggle to move beyond pilot phases, often due to inconsistent funding, political shifts and a lack of sustained organisational commitment (Health Management 2024; World Health Organization 2018). Even when supported at policy level, implementation may be constrained by workforce shortages, competing service demands and limited system capacity (Limb 2022).

These challenges reinforce the central argument of this paper: that the barriers to integration are not solely logistical but paradigmatic. Without a shift away from dualistic and reductionist models towards a shared holistic ontology of human experience, structural reforms risk remaining partial and unsustainable. Conversely, when integration is grounded in a coherent conceptual framework—as proposed by our constellation of care—economic and organisational challenges, whilst significant, become more navigable within a unified vision of practice.

4 | Towards an Integrated Future

Advancing this vision requires action on multiple fronts:

4.1 | Education and Training

Mental health practitioner training programmes must incorporate embodied and interdisciplinary, anti-oppressive perspectives, equipping practitioners to work across boundaries.

4.2 | Clinical Practice

Services should be organised to facilitate collaboration, with shared formulations and ongoing communication. Such collaboration may involve psychologists, counsellors, psychotherapists, psychiatrists, General Practitioners, occupational therapists, social workers, peer-support workers, chaplaincy and spiritual care teams, community organisations, educators, and where appropriate, family and carers.

4.3 | Research

Greater emphasis is needed on studies that bridge levels of analysis, linking neural, psychological and experiential processes. In addition, greater value should be given to practice-based evidence emerging from services that are already providing integrated and joined-up models of care, as these approaches increasingly demonstrate improved continuity of support, enhanced relational safety, reduced fragmentation and better therapeutic outcomes for service users experiencing complex distress and trauma.

4.4 | Conceptual Clarity

Perhaps most importantly, the field must move beyond dualistic thinking towards a genuinely holistic understanding of the person. This requires recognising that emotional, bodily, relational, cultural, social and spiritual dimensions of experience are deeply interconnected. Such conceptual clarity strengthens collaborative practice by enabling services to respond more meaningfully and ethically to the complexity of human distress and healing.

5 | Conclusion: Integration as Ontological Shift

The integration of psychology, psychiatry, psychotherapy and neuroscience is often framed as a matter of improving coordination. Whilst this is important, it does not go far enough. What is required is a more fundamental shift, one that recognises the inseparability of mind, body and context. Our work on embodied trauma underscores this point (O'Brien and Charura 2023b; O'Brien and Charura 2024a; O'Brien and Charura 2024b). By rejecting mind-body dualism and embracing a holistic, multi-dimensional framework, it provides a foundation for rethinking both theory, research and practice.

A constellation of care, grounded in this perspective, offers a way forward (O'Brien and Charura 2024a). It acknowledges complexity, prioritises relationships and aligns treatment with the realities of human experience. In this light, integration is not simply a clinical strategy. It is an ethical imperative.

Author Contributions

Charlotte O'Brien: conceptualization, writing – original draft, writing – review and editing, project administration, formal analysis, visualization.
Divine Charura: conceptualization, writing – original draft, visualization, writing – review and editing, formal analysis, supervision.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

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