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Mental Health Professionals Network

Webinar

Complex Trauma: working together, working better to support adult survivors of childhood abuse

An interdisciplinary panel discussion

Tuesday 20 September 2011

"Working together. Working better."

Supported by The Royal Australian College of General Practitioners, the Australian Psychological Society, the Australian College of Mental Health Nurses and The Royal Australian and New Zealand College of Psychiatrists

This webinar is presented by

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Mental Health Professionals Network

Panel

- Dr Cathy Kezelman
- Ursula Benstead
- Professor Warwick Middleton

Facilitator

- Dr Michael Murray

This webinar is hosted by

mhpn
Mental Health Professionals Network

- A Commonwealth funded project supporting the development of sustainable interdisciplinary collaboration in the local primary mental health sector across Australia
- Currently supporting approx. 450 local interdisciplinary mental health networks
- For more information or to join a local network visit www.mhpn.org.au

Learning Objectives

At the completion of the session participants will be better equipped to consider the possibility that their next patient may have experienced complex trauma. The webinar will:

- ***Raise awareness of prevalence and indicators of complex trauma***
- ***Identify the key principles for effective assessment and management of mental health issues for people with complex trauma***
- ***Assist recognition of the challenges and opportunities of interdisciplinary collaboration in the provision of mental health services for people with complex trauma***

To find out more about your disciplines' CPD recognition visit www.mhpn.org.au

Session outline

The webinar is comprised of two parts:

- Facilitated interdisciplinary panel discussion
- Question and answers

Session ground rules

- The facilitator will moderate the panel discussion and field questions from the audience
- Submit your question/s for the panel by typing them in the message box to right hand side of your screen
- Ensure sound is on and volume turned up on your computer
- For further technical support and/or if you have issues with audio call **1800 733 416**
- If your specific question/s is not addressed or if you want to continue the discussion join the post-webinar **Complex Trauma online forum on MHPN Online**

Complex Trauma

All trauma can invoke fear, helplessness and horror and overwhelm coping mechanisms

Complex trauma

- Compounded and cumulative
- Interpersonal
- Early life onset
- Often occurs within care-giving system
- Disrupts early attachment

Dr Cathy Kezelman

Adverse Childhood Experiences Study (1998)

- 11.0% emotional abuse, 30.1% physical abuse, 9.9% sexual abuse
- 23.5% exposed to family alcohol abuse
- 8.8% exposed to family mental illness
- 12.5% witnessed mothers being battered
- 4.9% reported family drug abuse

ACE's are far more common than recognised
Many individuals experience multiple ACE's

Dr Cathy Kezelman

ACE study – impacts:

Highly significant relationship identified between ACE's

- **depression, suicide attempts**
- **alcoholism, drug abuse**
- **sexual promiscuity, domestic violence**
- **cigarette smoking, obesity, physical inactivity, and sexually transmitted diseases**

The more adverse childhood experiences, the more likely to develop heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease

Dr Cathy Kezelman

Impacts of complex trauma

- Rapid development of brain especially first 3-5 years, but into twenties
- Trauma in childhood affects neuro-chemical processes, growth, structure and function of brain
- Potentially has pervasive long-term effects on the development of the mind and brain
- Interferes with capacity to integrate sensory, emotional and cognitive information

Combination of ongoing trauma exposure and developmental impact of such exposure typifies *complex trauma*

Dr Cathy Kezelman

Child abuse

Establishes lifetime patterns of fear and mistrust

Impacts

- **personal identity and self-worth**
- **relationships with other people and the world**
- **emotional regulation**
- **capacity to self soothe**
- **capacity to manage stress**

Adult survivors often additionally struggle with somatic symptoms and chronic feelings of hopelessness

Dr Cathy Kezelman

Extreme coping strategies

Extreme coping strategies adopted to manage overwhelming traumatic stress

- **suicidality**
- **substance abuse and addictions**
- **self-harming behaviours such as cutting and burning**
- **dissociation**
- **and re-enactments such as abusive relationships**

In the context of trauma these behaviours make perfect sense

Dr Cathy Kezelman

Sonya: case study

- Multiple compounded traumas in childhood
- Little consistency and predictability in primary relationships
- Disruption in early attachments
- Multiple attempts to manage traumatic stress
- Extreme coping strategies
- Repetition of abusive relationships

Dr Cathy Kezelman

Challenges

- Physical and psychological safety
- Trust
- Healthy relationships
- Self esteem / self respect
- Coping mechanisms – self-defeating
- Building strengths/empowerment
- Validation

Dr Cathy Kezelman

Treatment for complex trauma impacts:

Complex trauma leads to complex impacts which require complex (multimodal) interventions used across 3 broad stages of recovery

Ms Ursula Benstead

3 Stages of Recovery: *(Herman, 1992)*

1. Establishment of safety **(physical and emotional includes actual and perceived safety and development of emotional awareness, regulation, distress tolerance and therapeutic alliance)**

2. Traumatic experience processing **(involves revisiting and examining the traumatic events and the subjective usually negative self & relational cognitions associated with these events)**

3. Integration and reconnection **(involves establishment of new identity and self esteem and repair and enlargement of interpersonal and social connections)**

Ms Ursula Benstead

Examples of Therapeutic frameworks and interventions used in each stage:

1. Safety

- Therapeutic alliance
- Attachment
- Psycho-education
- Containment

Ms Ursula Benstead

Safety cont...

Skills training:

Examples of specific approaches

- **Dialectical Behavior Therapy (DBT)** (Linehan, 1993)
- **Skills Training in Affective and Interpersonal Regulation (STAIR)** (Cloitre, Cohen & Koenen, 2006)
- **Acceptance & Commitment Therapy (ACT)** (Walser & Westrup, 2007)
- **Sensorimotor Psychotherapy** (Fisher & Ogden in Courtois & Ford (Ed's), 2009)
- **Shark Cage work** (Benstead, 2011)

Ms Ursula Benstead

2. Traumatic experience processing

Principles

- **Safety must be mastered first and be continually revisited and reinforced for the duration of therapy**
- **Attain client agreement to gradually look at and process traumatic memories. Provide rationale. Have agreed procedure for if client is becoming too overwhelmed**
- **Aim to stay within the therapeutic window when exposing client to traumatic material** (Briere & Scott, 2006)

Ms Ursula Benstead

Traumatic experience integration cont..

Examples of Frameworks:

- **Narrative Story Telling (NST)** (Cloitre, Cohen & Koenen, 2006)
- **EMDR**
- **CBT exposure techniques**
- **Experiential**
- **Sensorimotor**

Ms Ursula Benstead

3. Integration and reconnection

Examples of Frameworks:

- CBT
- Attachment/self schema / personal construct frameworks
- Interpersonal skills training / Psycho-education
- Systems theory (couples / family therapy)
- Group work
- ACT

Ms Ursula Benstead

Proposed criteria for Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (1996)

A) Alterations in regulating affective arousal

1. chronic affect disregulation
2. difficulty modulating anger
3. self-destructive & suicidal behaviour
4. difficulty modulating sexual involvement
5. impulsive &risk-taking behaviors

B) Alterations in attention & consciousness

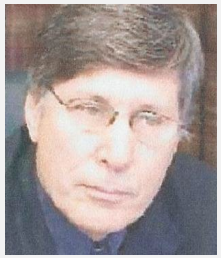
1. amnesia
2. dissociation

C) Somatization

D) Chronic characterological changes

1. alterations in self-perception, chronic guilt & shame: feelings of self-blame, of ineffectiveness, & of being permanently damaged
2. alterations in perception of perpetrator, adopting distorted beliefs & idealizing the perpetrator
3. alterations in relations with others:
   a. inability to trust or maintain relationships with others
   b. tendency to be revictimized
   c. tendency to victimize others

Bessel van der Kolk



Christine Courtois

E) Alterations in systems of meaning

1. despair & hopelessness
2. loss of previously sustaining beliefs

Professor Warwick Middleton

PATIENTS WITH DISSOCIATIVE IDENTITY DISORDER (M.P.D.) SYMPTOMATOLOGY & DIAGNOSTIC SPECTRUM

(Based on Dissociative Disorders Interview Schedule & Comprehensive Histories)

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Patient awareness of previous diagnoses: commonly reported entities (N = 62; f54/m8

Previous diagnosis of	depression	81%
	mania	20%
	schizophrenia	29%
	anxiety disorder	37%
	anorexia or bulimia nervosa	35%
	childhood enuresis	39%
	hyperactivity (A.D.D.)	5%

(Middleton & Butler, 1998)

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Patients with dissociative identity disorder (M.P.D.)
Childhood /adolescent physical and sexual abuse reported
(N = 62; f54/m8)

Sexual abuse involving father and/or stepfather	53%*
Sexual abuse involving mother and/or stepmother	11%
Childhood sexual abuse involving vaginal intercourse (Females) (N = 54)	67%*
Childhood sexual abuse involving anal intercourse (Males) (N = 8)	37%*
Sexual abuse by a health professional, religious minister or other therapist as adolescent or adult	35%**
Continuation of incestuous sexual/physical abuse beyond time of presentation (as an "adult")	13%***
Physical abuse involving father/stepfather	65%
Physical abuse involving mother/stepmother	47%*

Professor Warwick Middleton

* These percentages are likely to be underestimates
** Includes one case of attempted sexual abuse
*** In two instances involving police sexual offences branch

(Middleton & Butler, 1998)

Incidence of 23 dissociative symptoms in 220 persons who have dissociative identity disorder

•Memory problems	100%	•"Made"/intrusive impulses	85%
•Depersonalization	95%	•"Made"/intrusive actions	98%
•Derealization	93%	•Temp loss of knowledge	90%
•Posttraumatic flashbacks	93%	•Self-alteration	98%
•Somatoform symptoms	83%	•Self-puzzlement	98%
•Trance	88%	•Time loss	88%
•Child voices	95%	•"Coming to"	78%
•Internal struggle	100%	•Fugues	83%
•Persecutory voices	88%	•Being told of actions	85%
•Speech insertion	85%	•Finding objects	61%
•Thought insertion/withdrawal	93%	•Evidence of actions	71%
•"Made"/intrusive emotions	95%		

161 outpatients (US &Canada), 57 inpatients (California, Texas, Massachusetts, Canada & Brisbane, Australia)

(Paul F. Dell, PhD "A New Model of Dissociative Identity Disorder." Psychiatric Clinics of North America 29:1 1-26 March 2006)

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Table 16.1 Prevalence of child abuse among female psychiatric inpatients and among outpatients of whom at least half were diagnosed psychotic

		n	*Child sexual abuse*	*Incest*	*Child physical abuse*	*Sexual or physical abuse*	*Sexual and physical abuse*
Friedman and Harrison (1984)	SC	20	60				
Bryer *et al.* (1987)		66	44	23	38	59	23
Jacobson and Richardson (1987)		50	22		44	56	10
Sansonnet-Hayden *et al.* (1987)	AD	29	38		23		
Craine *et al.* (1988)		105	51	42	35	61	26
Goodwin *et al.* (1988)		40	50				
Hart *et al.* (1989)	AD	16	75		69	81	62
Chu and Dill (1990)		98	36		51	63	23
Jacobson and Herald (1990)		50	54				
Shearer *et al.* (1990)		40	40		25		
Goff *et al.* (1991a)	PS	21				48	
Lanktree *et al.* (1991)	CH	18	50	44			
Margo and McLees (1991)		38	58		66	76	47
Rose *et al.* (1991)	OP	39	50	41	38		
Carlin and Ward (1992)		149	51				
Lobel (1992)		50	60				
Ito *et al.* (1993)	CH	51				73	
Muenzenmaier *et al.* (1993)	OP	78	45	22	51	64	32
Mullen *et al.* (1993)	EX	27	85				
Greenfield *et al.* (1994)	PS	19	42		42	53	32
Ross *et al.* (1994)	SC	25	32		32	48	16
Swett and Halpert (1994)		88	61	40	57	76	50
Trojan (1994)	PS	48	25				
Darves-Bornoz *et al.* (1995)	PS	89	34	18			
Goodman *et al.* (1995)	OP	99	65		87	92	60
Cohen *et al.* (1996)	AD	73	51		52	68	34
Davies-Netzley *et al.* (1996)	OP	120	56	26	59	77	38
Miller and Finnerty (1996)	SC	44	36				
Wurr and Partridge (1996)		63	52	17			
Briere *et al.* (1997)	OP	93	53		42		
Mueser *et al.* (1998)	OP	153	52		33		
Goodman *et al.* (1999)	PS	29	78[a]				
Lipschitz *et al.* (1999a,b)	AD	38	77		47	90	34
Lipschitz *et al.* (2000)	AD	57	39		30	65	
Fehon *et al.* (2001)	AD	71	55		51		
Goodman *et al.* (2001)	OP	321	49		54	67	36
Friedman *et al.* (2002)	SC	9	78				
Holowka *et al.* (2003)	SC	7	57		17	57	17
Offen *et al.* (2003)	PS	7	71				
Resnick *et al.* (2003)	SC	30	47				
Weighted average			50%	29%	48%	69%	35%
			1199	193	831	944	437
			2396	666	1723	1370	1241

Abbreviations: SC = all diagnosed schizophrenic, PS = all diagnosed psychotic, OP = outpatients with at least 50% diagnosed psychotic, AD = adolescent inpatients, CH = child inpatients.

[a] Midpoint of two measures.

(Read, Goodman, Morrison, Ross & Aderhold, 2004)

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Table 16.2 Prevalence of child abuse among male psychiatric inpatients and among outpatients of whom at least half were diagnosed psychotic

		n	*Child sexual abuse*	*Incest*	*Child physical abuse*	*Sexual or physical abuse*	*Sexual and physical abuse*
Jacobson and Richardson (1987)		50	16		54	58	12
Sansonnet-Hayden *et al.* (1987)	AD	25	24		52		
Metcalfe *et al.* (1990)	OP	100	34[a]				
Jacobson and Herald (1990)		50	26				
Goff *et al.* (1991a)	PS	40				42	
Lanktree *et al* (1991)	CH	17	12				
Rose *et al.* (1991)	OP	50	22	9	38		
Ito *et al.* (1993)	AD	53				34	
Greenfield *et al.* (1994)	PS	19	16		47	53	11
Palmer *et al.* (1994)	OP	100		6			
Ross *et al.* (1994)	SC	56	30		23	43	11
Trojan (1994)	PS	48	27				
Cohen *et al.* (1996)	AD	32	34		47	62	19
Wurr and Partridge (1996)		57	39	7			
Mueser *et al.* (1998)	OP	122	36		38		
Goodman *et al.* (1999)	OP	21	45[a]				
Lipschitz *et al.* (1999a,b)	AD	33	33		45	66	12
Lipschitz *et al.* (2000)	AD	38	16		55	71	
Fehon *et al.* (2001)	AD	59	12		68		
Goodman *et al.* (2001)	OP	461	29		58	65	22
Lysaker *et al.* (2001a)	SC	52	35				
Friedman *et al.* (2002)	SC	13	0				
Holowka *et al.* (2003)	SC	19	47		21	53	16
Offen *et al.* (2003)	PS	19	26				
Resnick *et al.* (2003)	SC	17	18				
Weighted average			28%	7%	51%	60%	19%
			386	14	489	477	128
			1356	207	964	801	670

Abbreviations: SC = all diagnosed schizophrenic, PS = all diagnosed psychotic, OP = outpatients with at least 50% diagnosed psychotic, AD = adolescent inpatients, CH = child inpatients.

[a] Midpoint of two measures.

studies where people were actually asked about abuse are included. Studies of inpatient alcohol services (Windle *et al.* 1995) and military inpatient units with low proportions of psychotic patients (Brown and Anderson 1991) were excluded. A mixed gender (predominantly male) outpatient study could not be included because the child sexual abuse and child physical abuse rates were not analysed by gender. This study, which included abuse since childhood, found that 55% of the women and 24% of the men had been either sexually or physically abused at some point in their lives (with higher rates of adulthood abuse than childhood abuse) (Coverdale & Turbott 2000). Also excluded were two studies of inpatient units serving populations with

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Read, Goodman, Morrison, Ross & Aderhold, 2004

Professor Warwick Middleton

Art work courtesy Arts Project Paul Hodges Not titled (ship and coastline), 2010 ink on paper 35 x 50cm

Thank you for your participation

- To continue the interdisciplinary discussion please go to the Complex Trauma online forum on MHPN Online
- Complex Trauma recommended resources and the webinar PowerPoint slide show are on MHPN's website NOW
- You will all be sent a link to the recording (podcast) of this webinar within the next 48 hours
- Please complete the exit survey before you log out

For more information about MHPN networks and online activities visit www.mhpn.org.au

Thank you for your contribution and participation