MHPN WEBINAR

Transcript

Trauma-informed care: The impacts of trauma on the physical body

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Panellists:

- Felicity de Blic (Pelvic Physiotherapist, NSW)
- Lou Kerley (She/They) (Occupational Therapist, VIC)
- Andy Moloney (Accredited Exercise Physiologist, QLD)

Facilitator: Professor Stephen Trumble (General Practitioner, Vic)

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Steve Trumble (00:00:01):

Good evening everybody, and welcome to all the participants who have joined us for tonight's webinar and also the viewers who are watching this on the recording. Afterwards. MHPN would like to acknowledge the traditional custodians, the land season waterways across Australia, upon which our webinar presenters and participants are located. We do wish to pay our very sincere respects to elders, past, present, and future for the memories, the traditions, the cultures, and the ongoing hopes of Aboriginal and Torres Strait Islander Australia. Steve Trumble is my name. I'll be facilitating tonight's session. I'm a GP by background, most recently working in the unheard remote communities of the Northern Territory, but also professor of medical education at Melbourne Medical School. But if we look at tonight's panel, they're the people you to hear from tonight about the impact of trauma on the physical body to great panel. You've seen their biographies disseminated earlier, so we won't go through those in detail. But just to quickly acknowledge each person. Andy Moloney. Hello Andy. Welcome. You're physiologist and you've recently completed your master's of mental health. So tell us what were your intentions in doing that degree when you began it?

Andy Moloney (00:01:19):

It was at the beginning of Covid, and there was two parts to it. One was I was a new father and I wanted to take further steps in understanding my own emotional health and wellbeing so I could pass on some healthy traits to my daughter Freddy. But second, I kind of got to the point where I was just the statement of exercise is good for mental health, it wasn't enough for me anymore and I wanted to investigate it further. And I started my master's in mental health at S C U with Professor Richard Lakeman, and that was the lens of, for many of my essays and reports, was how does exercise influence mental health and mental illness? And part of what I've learned is what we're going to talk about tonight.

Steve Trumble (00:02:04):

Great. Well that's great to have you with that background. And I must say being a bit appear is one of the best reasons for the high studies I've ever heard. So good on you. Great to have you. Now we've also got Lou Kerley. So hello Lou. You are an occupational therapist based here in Victoria, as am I, and he's in Queensland. Now you've undertaken a PhD looking at sensory processing. Can you tell us what impact that's had on your practise as an OT? Yeah,

Lou Kerley (00:02:29):

Thanks Steve. So my PhD looked at sensory processing and how it shapes and gets shaped by our relationships and experiences in childhood. It was a pretty sort of theoretical PhD with sort of a focus on quantitative research, but we did develop a model towards the end of it that we called the Diotic model of sensory modulation, which we found was a really practical way of working with children and families to help them explore and unpack their own experiences within the parenting dyad with the child to understand how both the child and parents' sensory processing needs might impact their relationship and the quality of that relationship. So it was a way of exploring ideas of sort of co-regulation. And what I found when I started doing some work with families, particularly families of Young Neurodiverse children, was that it was a really gentle way in to doing relational work and work around attachment, which can be a really sensitive area. So talking about our senses was really powerful

Steve Trumble (00:03:33):

Now. Fabulous. Well, that really does set you up well for tonight. So looking forward to hearing from you and also Felicity de Blic who's a physiotherapist. Now, Felicity, you've studied at University of Sydney, University of Queensland, and also University of Melbourne where I'm from, where you did pelvic health. So you're a pelvic physiotherapist. What continues to draw you to that particular area of practise?

Felicity de Blic (00:03:57):

Yeah, hi Steven. Hi everyone. Yeah, it kind of took me a bit of my career to land in public health. I originally started in paediatrics and working in child and adolescent acute psychiatry as well as persistent pain at Sydney Children's Hospital and worked with many children and many families who had had really, really challenging experiences and that had either manifested in mental health concerns or physical health concerns such as persistent pain. And it was when I became a mom, to be honest, that I started to become more interested in pelvic health and kind of the stars collided and looking at the issues that are arising within our populations that are experiencing particularly pelvic dysfunction and pelvic pain through that lens of how I'd kind of grown up in mental health and psychiatric services was really fascinating and incredibly helpful. So right now my work really focuses on people experiencing persistent pelvic pain and I've got a special interest in endometriosis and sexual dysfunction, so

Steve Trumble (00:05:00):

Well great, and certainly that background is spot on for the case that we're looking at tonight that's been disseminated to the audience. So you'll obviously have a lot to say about the particular issues going on there. So as you can see, MHPN has put together the most brilliant panel of people to talk to us about this topic tonight. I'm intending to learn an enormous amount, so let's get into it. But before we do, we do have to just quickly run over the instructions for operating the webinar interface, the web

player. So please have a look at the screen in front of you, make sure you can see the three dots at the lower right corner of your screen, which is where you access information. Under the information tab, you'll find links to slides, resources, the feedback survey, and also you can get technical support there if you need it.

(00:05:43):

You can access the chat room at top, right? You can see some speech bubbles up there. We do keep an eye on the chat room, not those of us involved in the webinar, but the background staff, keep an eye on that and we'll let us know if there's anything really getting hot and heavy in the chat room that we can maybe address. So please have good conversations there and keep things ticking along. If you do want to ask a more formal question of the panel, then please do click the speech bubble icon at the lower right of your screen. You can submit a question there and I'll be trying to put together the questions as well as ones that have been submitted beforehand in the registration process so we can touch on things and answer questions that are really important for you. If you do need any technical support, please click live webcast support on the info tab.

(00:06:29):

And if the webinar does stop at any time or the webcast does stop, please just try refreshing your browser, come in again. But if you can't get back in or if something happens at home that you've got to attend to, don't worry, the recording is being done. You can catch up at a time it suits you. A couple of quick ground rules, those of you who've been before will know this. Please do be respectful of other participants and the panellists in the chat room because obviously what you are writing there is seen by all the participants. And try and give your comments on topics so that we don't distract people from what's going on in the webcast. Now we do have the case, but what's going to happen is that each panellist will give a short discipline specific presentation, and then we'll get into questions and answers and conversation between the panel, which I'm sure will be pretty vibrant.

(00:07:22):

The learning objectives are there, and you can see that the aim is about looking at latest innovations. This is the third in our series of trauma-informed practises, and we're particularly looking at how we can sustain these activities. These practises in the real world learning outcomes are about particularly looking at physical health and looking at the short and long-term impacts on the physical body are looking at the different types of impact that trauma can cause and how you as practitioners can respond. And finally for me, what's always the most important one, how to communicate effectively with other mental health practitioners to better support people through a team approach, those who are experiencing physical symptoms resulting from their trauma. So that's all the background and getting into it. If you do run into problems, please do contact the staff via the button down at the bottom there. And off we go. So we'll start with Andy. Andy, you are going to present to us from the exercise physiologist perspective. Rip in friend.

Andy Moloney (00:08:33):

Great, thanks, Steve. Yeah, so exercise physiologist perspective, I suppose that perspective, like I said before when it came to my research, was to look at how does movement influence the outcomes when it comes to mental health and mental illness? And so today the first couple of slides are going to be setting up the theoretical underpinning to what I'm going to talk about with the case study and Sarah,

and then a bit of an overview about how running is effective at regulating these systems. So if everyone's not aware, in 1998, there was a fantastic study that was the adverse Childhood experiences study in 1998 with felli etal, and they found that those who had that there was a large survey and they found that those who had experienced four or more childhood adversity experiences, and that could be physical abuse, sexual abuse, neglect, social determinants also have been expanded into this.

(00:09:31):

There were significantly higher rates of physical illness, mental illness within this first study suicidality especially as well. This study has then been built upon recently with the Australian child maltreatment study finding that one in four Australians have experienced three to five adverse childhood experiences also. And there has been study after study finding that there is a strong relationship between age-related disease and childhood adversity. And so when I first came across this as an exercise physiologist, seeing the list of physical and mental health conditions, these are the people in our community that we work with. We work in persisting pain and cardiovascular disease, but as movement professionals we're never really told that there was this potential underlying experiential reason that increases the likelihood to the development of these conditions. We've put it towards more lifestyle choices. And since then I've really changed my thinking towards that is because the behaviour such as being inactive, smoking, high sugar intake or fast food intake or drug use, in my mind now, they are safety behaviours.

(00:10:48):

They're the best tool that individual had at that time to regulate their sense of self, their emotions, and to keep them feeling in a place of calm. So from there I wanted to understand if it was such a range of metabolic conditions, cardiovascular conditions, mental illnesses, what was the common factor that was underlying all of this? Surely it wasn't all due to just behavioural elements and causing such a wide range of illness and disease. Surely there was something underneath that that was physiologically occurring that potentially increase the likelihood towards the development of these illnesses and diseases. And as we can see, Sarah experienced four adverse childhood experiences. And I must say I'll also preface this as I have an extreme amount of gratitude and empathy to work alongside and learn from those with lived experience. And the case tonight, even though I'm talking science and I'm talking about evidence, it's a made up case study, but it is still a case study and this is still a person. So please understand that while I might get sciencey at points, I have immense empathy and gratitude. So next slide please.

(00:12:09):

Okay, so that brings us to the allostatic model. So if anyone hasn't heard of this, there's a history to the current contemporary understanding of allo stasis and allostatic load beginning in the early 19 hundreds, Claude Bernard determining that we had this internal milieu that the cental system was able to regulate itself. So hormonally, neurotransmitters, they then found that led to Walter Buchanan. Then labelling homeostasis was that the internal system had this ability to, when it moved away from say blood pressure for example, moved away from a set point, there would be a negative feedback loop and it would regulate it back to this ideal set point. And then we move into the last 20 years, Joseph, Joseph Ire and Peter Sterling brought to us also Hans Shale as well with general adaptation syndrome.

(00:13:09):

Allostasis was bought into terminology by Peter Sterling, and what it allowed us to understand is that rather than the internal system being this homeostatic system which moved from a setpoint and regulate itself, the allostatic understanding is that it's actually adaptable to our experience. And our

internal system learns from our experiences to better protect us within future experiences by allocating energy to certain systems. So whether that's endocrine system, immune system, neurological system, it is a learning system and allows us to keep on learning and keep on adapting to our environment if that environment like we see in the case of Sarah has early adversity, that has significantly disrupted sense of safety, trust, autonomy, empowerment, all these things that sort of come into a trauma-informed model. We know that those systems become highly sensitised to safety and threat. I kind of deem it as a volume dial.

(00:14:10):

So in an allostatic state where these systems are starting to become dysregulated. So the neuroendocrine immune system is a highly integrative system, and that is our allostatic system. Dr. Lisa Felman Barrett also calls it the visceral motor system. There's a number of names for it. So what happens is that if someone is experiencing some form of stress within their life and they have had an experience of a lot of adversity through their childhood, their potential for their volume dial to ramp up and to dysregulate their immune system, endocrine systems like stress systems, neurological systems can really ramp up. And that's why we see over a cumulative period of time, Dr. Bruce McEwen then labelled that allostatic load. So the cumulative effects of stress on these allostatic systems has shown to be significantly high in those who had experienced ACEs, those who have with mental illness, severe mental illness.

(00:15:12):

And so we start to see that relationship between adverse childhood experiences and the diagnostic later conditions we see and the allostatic load that you see here as well, we see the same system, so cardiovascular system, metabolic system, neurological system and immune system. So we're starting to understand that it isn't just these behavioural adaptations that people go through to regulate themselves. There is actually underlying physiological adaptations that we have to understand better because the homeostatic theory doesn't apply to these variable allostatic systems. And the reason why we look at this is because if we continue to see these allostatic systems as systems that should be clamped and held back, that's what we see high rates of hydrogenesis, high rates of comorbidities, high rates of ongoing multi-morbidity because we're clamping down these adaptive systems and it's just causing a lot of dysregulation within these systems. So we need to learn how to better communicate to them and better treat them from an allostatic perspective. Next slide please.

(00:16:25):

So how's the trauma informed? How is alostatic model trauma informed? It means that we have to understand that per individual's narrative. We have to listen. We have to understand their language, their understanding of their experience, the perception of their experience, the perception of their healthcare experience, especially to ensure that we provide a sense of safety. Because sense of safety isn't just this global term. Dr. Johanna Lynch has a fantastic book about this, make sure you do read it, but it is an individual biocultural spiritual existential sociodemographic experience. So what is a sense of safety for one person is completely different for the next person. So the aesthetic model requires us to understand the individual and operate from a person centred, strengths focused narrative approach. Because if we understand that, then we understand the individual and what is safety and trust and empowerment to them. And so how we can interpret Sarah's story is that we have, how I interpret it, if you've read the case study is I see a brilliant young woman who's taken incredible agency over her life and over the choices in her life.

(00:17:34):

She has excelled in academia at certain points when her environment felt safe around her. She wants to express herself, she wants to move into the creative world of being a chef. She has a relationship which Felicity will talk about. So I see a really empowered young woman, and if I was to see Sarah, she was to come into me and I was to see that there is a history of chronic fatigue syndrome and having some persisting pain. All that does is for me, it just creates an awareness. Okay, okay. There is a system here. There is an aesthetic system that is starting to increase into an aesthetic state. So it's starting to communicate to her, it's an emotion system, but she's taken a choice. She wants to start running. She's been told that running would really help her. And my job as a health professional is to not add any more barriers to that, not add any fear-based education to what she should or shouldn't be able to do. If she asks me what she can be doing, then certainly I'll interpret that and work with her. But I, yeah, I see a really young woman and I would be great to work with someone like this. Next slide please.

(00:18:52):

So how I deem running or aerobic exercise, I give it under the label of inner resilience. So the systems that are involved in our allostatic systems, they are stress response or safety systems or survival systems, threat systems, neuroception polyvagal theory kind of labels it like that. So what we understand is that especially the H B A axis, which is cortisol response system, if there is a prolonged period of time where that is being used, what happens is that we start to see in some cases, like in Sarah's, it starts to become suppressed over a period of time. And we see that there is a relationship between chronically suppressed H B A axis or cortisol and the likelihood towards chronic fatigue syndrome and persisting pain. Like I said before, it has to do with a neuroendocrine immune system. It's a bigger conversation, but we'll move through things as quickly as we can.

(00:19:48):

So inner resilience, these systems function well if they're running efficiently, they require oxygen, they're all in your brain. So they require oxygen, they require glucose. So when it comes to what running does for the individual, it provides an efficiency to their stress response system. It's protective against stress, psychosocial stress. There's research and psychological stress reactivity, which is showing that we're finding there is a buffering that we find if for those who are more aerobically fit to those who are not. And we also find that there's this theory coming through, it's called cross stress or adaptation, is that if we can increase the level of aerobic fitness with an individual that has a layover towards psychosocial settings. So for Sarah's example, she wants to move into the kitchen. And if anyone's ever worked in a kitchen, it's a stressful environment, but it's a eustress. It's a positive stress for her.

(00:20:42):

But nonetheless, if we understand that Sarah's system can become hypersensitized to chronic exposures to stress, we don't need to tell Sarah this, but if she has an efficient cardiovascular system or efficient allostatic buffering system with resilience, then it will not have the same detrimental cumulative wear and tear effects that someone who may not be exercising at that time. So it's a protective way to look after their system. So what the allostatic model provides us with is a different interpretation of what exercise is when it comes to mental illness and mental health. It's not about weight loss, it's not about a six pack. It's about the efficiency of your stress response system and how protective that is towards the cumulative effects of your experience. And so for Sarah to know that she can be empowered to understand her body and at times checking in with her body, is today a run day or is today a day where I

go through some breath work or some inner flow work, some yoga, some technique, or just a walk with a friend? So the education would be giving her the tools to actually understand what's in her cup to be able to build up, increase her window of tolerance and all that. So inner resilience is sort of the label that I give to aerobic exercise now, next slide.

(00:22:11):

And so the last one, why work for an exercise physiologist? So there are a number of exercise physiologists who are very keen to move into the mental health setting where four or five year university educated exercise specialist we operate with, we can assess, we can prescribe in accordance with certain models of care. If you are looking to collaborate with an exercise physiologist, I would highly recommend it and I would probably ask them a couple of questions. Do they understand what trauma informed care is? There's a likelihood that they may not, because this is fairly new for our field as well, although I'm going to be developing a professional development platform regulate physical health, please check it out at the end. But I work with and have colleagues who are fantastic clinical professionals who just within themselves operate within trauma informed principles. And so asking them, who do you like to work with?

(00:23:01):

You'll either get an answer of, I like to work with people with ATLs and hamstrings and this, and they're a bit more of a clinical exercise physiologist. But then if you understand their treatment method and how it is that they communicate, and if they use fear-based education, you'd be able to will it down? Or is this someone that I would refer to if someone has a strong history of adversity or if they say, I like to work with an individual and their experience and I want to just work with the person, then you've got someone who's a bit more clued into working from a person-centered approach and find someone who's passionate about their modality. So it could be, I'm a gym-based exercise physiologist, so that's my approach, but it's not for everyone. So I'm not forcing people to move into those settings. But we want to provide a trauma-informed within my business, trauma-informed to say, look, come in the door, check it out. Let's see what we can work with and if you do want to stay, please do. If not, let's develop a fantastic home-based programme or whatever it may be. So yeah, I hope that's helpful and onto the next.

Steve Trumble (00:24:00):

Yeah, thanks so much indeed, Andy. In fact, I'm going to quickly jump in with a question that Kelly Wrights asked because it does tie into what you said. You mentioned about systems being clamped down. Do you mean by things that US gps do with beta blockers and that sort of stuff, we block the normal physiological response or is that what you were referring to?

Andy Moloney (00:24:17):

Yeah, yeah. So clamping down an adaptive system. Then the inner system, the brain, the inner milieu doesn't understand that that is being clamped down. So it drives other markers. So blood pressure, you've got, oh, now you're going to ruin my memory. There's three functions to blood pressure. You clamp down one, the other two get driven. So what happens is you then start to clamp down, clamp down, clamp down these adaptive systems, they then they decrease their capacity for adaptation. So there is the likelihood of exercise intolerance and stress intolerance because these adaptive systems which are trying to communicate to the person emotionally are no longer talking to them. So there's this

sort of disconnect from the inner self and from the experience, which is what Claude Bernard really thought of the inner system as this sort of homeostatic system that wasn't adaptive to our experience, but we're now seeing that those who have a lot of adversity within their childhood had significantly higher rates.

(00:25:18):

So it seems to be that social determinants of health, hierarchy of needs, all these sort of experiences and exposures does increase their likelihoods of illness and disease. However, I didn't really talk about it, but protective factors and coping strategies are significantly helpful. So someone like Sarah has had her mother, it seems she has a relationship, she has agency, so she personally has personality traits that are really empowering for her. So she's making agents, she's having incredible decisions through her life, and so she has a number of protective factors around her, which is why she's talking with us. So trauma isn't an illness progression, it is an experience that does create saliency or valence to our emotion systems. But if we learn how to communicate to it and our therapies provided and our relationships provided and our culture provides it from a trauma-informed approach, then we can see that these systems no longer need to feel threatened all the time. They can feel engaged and part of something, which is what we all want, is just to feel loved and part of something. So my ram,

Steve Trumble (00:26:24):

No thanks, Andy. You've challenged everything I do as a GP with my pills and potions. So good on you, Lou. Let's hear the OTs perspective on this case. Thanks very much.

Lou Kerley (00:26:42):

Thanks, Steve. So I'll give the OTs perspective, but in particular, looking specifically in terms of sensory processing. So to start with, sensory modulation refers to our ability to get the just right sensory input that we need throughout the day. It's what we can do to help ourselves feel calm and regulated, but it's also how we respond adaptively to environments when they feel like they're too much, it's overwhelming, it's too hot, too loud, or they're not enough. We need more stimulation, we need more input. And we could see for Sarah from a young age, she seemed to have quite a clear idea of what her sensory processing needs were and whether it was through dance, through play, she was meeting those needs. Sensory modulation not only shapes but also gets shaped by our relationships and experiences. And so we'll talk about how experiences of trauma as well as the broader experiences of adversity that Sarah experiences shape her sensory modulation.

(00:27:40):

So in doing so, what we can do is we can start to sort of untangle Sarah's relationship to her body over her life. And I think what's important here is to see sensory modulation, not just in terms of what's happened as a result of her traumatic experiences, but create a more coherent narrative throughout her life. With Sarah, we can also talk about sensory modulation in terms of windows. So sort of drawing on Dan Siegel's ideas of a window of tolerance. We can apply that to sensory modulation and we can have a look at how experiences of adversity and trauma narrow a person's window and what they can tolerate, but also experiences of co-regulation and safe experiences can widen that window. Next slide.

(00:28:28):

So we know that trauma can have both generalised and also sensory specific changes in the body. Something like sexual abuse, which we know she's experienced, can directly lead to localised experiences of hypersensitivity and pain, but they can also lead to hyposensitivity. So an absence of sensation, similarly verbal abuse, and we know that she was in a very volatile household can lead to altered sensory auditory detection. So we can become once again hyper or hyposensitive to sound, but also that broader adverse childhood environment that she was in can more broadly alter her generalised sensory reactivity, the strength and size of reactions that she has to the environment. And that might be that they're dampened down or they can be really elevated as well. So we can't really anticipate based on someone's trauma exactly how they're going to present and what they're going to experience. And instead we have to work with them and listen with our clients to get a picture of what their experience of this trauma is going to be.

(00:29:40):

Another of making sense of this is through exploring interoception, which is how we make sense of our body signals, the signals we get from our body, which tell us how we're feeling and what our body is doing. What Sarah has seems to experience is this profound sense of disconnect from her senses, and we can sort of see that manifesting as she's gotten a little bit older as well, where as she's older, she's experiencing that exhaustion, but she's not necessarily able to put a name on exactly what it is. She's also been told things throughout her life like when she was bullied to just ignore them and she was taught not to trust herself or what her body was telling her. Next slide.

(00:30:27):

So one of the ways I explore this with clients directly is in terms of their sensory modulation window. So that's the green band in the middle. And we can see the line varies depending on the amount of sensory input that a person is getting over time. So depending on the sensory input they're getting based on the environment they're in, they might move from within to outside of their sensory window. So they might become hyper aroused or overwhelmed when the environment's become overstimulating or under aroused if there's not enough input. And when we're able to regulate ourselves really well, we can conceptualise that as having quite a wide window where we can tolerate a really wide band of sensory inputs. But depending on our experiences in childhood as well as our natural sensory processing patterns that we're born with, we might have a particularly narrow window. We might have a really high window where we actually need lots of input, which it sounds like initially Sarah did, or we might have a really low window where we can only have a tolerate a small amount of input. Next slide.

(00:31:34):

So how has Sarah's sensory modulation window changed over time? We can sort of think of Sarah's window as having narrowed over her experiences of ongoing adversity, the lack of potentially positive experiences of co-regulation, as well as through distinct experiences of abuse and trauma. So she's able to tolerate a smaller range of stimuli, but she's also seems to be less aware of her signals and what her body is telling her. So she's spending a lot of time outside of her window, she's feeling hyper aroused or hyper or hypo aroused. And what this can do as we saw with Andy was there's that buildup of allostatic load spending that time in a state of fight or flight or freeze is going to lead to a buildup of allostatic load at all levels of the body. This can also contribute to a feeling of dysregulation, of disconnection from your body and it has impacts for our relationships and how we connect with others. It also has an impact on our identity where we are feeling out of control or that we're not connected to our body as well. Next slide.

(00:32:49):

So I think it's really important that we focus on using strengths-based supports when we're working with Sarah. While we're talking about primarily sensory-based approaches here, I think as an OT as well, it's important that we work with Sarah and think about what it is it that she really wants to do and what is it that her body needs. We can see that her body needs movement, it needs input, it needs stimulation. And so whether that's through running and engaging with someone like Andy in terms of exercise physiology, but also as an ot, we can start to explore what is meaningful activity for Sarah. We know when she was young, she really loved to dance, she loved to be outside, she loved to be artistic. So some of those strengths-based supports might be explicitly through those areas. What we can also do is we can start to untangle some of that chronology for her and with her so we can reclaim some of those childhood sensory patterns that she had and explore a positive relationship to her neurodiversity as well.

(00:33:52):

So we know that she loved all of those things and that she had a sensory identity before these experiences of trauma and adversity. We can also start to recontextualize some of those experiences and in terms of her body's reactions and responses to 'em that while they may be manifesting and challenges at the moment, they may have been what helped her stay safe at the time. All of this can give us quite an integrated understanding of her current sensory patterns, which might be helpful in helping her create this sort of coherent narrative. We can also do some work with her to start to safely reconnect with her body. So starting to explore interoception and that capacity to notice body signals and what they're telling us. Being able to notice when maybe I'm starting to feel overwhelmed rather than I've already gone into freeze or fight or flight and starting to reconnect and link our body back to those feelings and experiences.

(00:34:48):

At the same time, we know that she's had these acute experiences of sexual abuse. So it is really essential that we're focusing on that transdisciplinary approach and recognising that any work that we might be doing around interception, we're also engaging with our psychologists as well as our pelvic physios to make sure that we're doing that in a really safe and graded way. At the same time, given that we know that she's in a relationship and she's had this challenging upbringing as well, we can start to explore her sensory windows not only in terms of what hers looks like, but how they match and potentially mismatch with those around her so she can see and explore the fact that it's not just her. She's not the only one that has sensory modulation and maybe difficulties in some areas, but it's something that everyone holds and that can start to normalise it.

(00:35:42):

I'll just finish by saying that we've really, and we all are really zoning in on that idea of the body. I'm zoning in on the idea of sensory processing and we're really looking closely at Sarah as an individual, but it's really important that we continue to place her in a broader context, whether that's in her family and her relationships, as well as exploring her place within the community and potentially her interactions with services. She's had these traumatic experiences and this adversity, but she's also potentially experienced recurrent cases of being let down by the services that have been asked to support her when she was younger, given she's experienced abuse and trauma, but hasn't seemed to get the help that she needed when she was younger. So it's important to place that and recognised when she's

coming to us as practitioners as well, as well as the systemic and societal structures that create a capacity and a place where this sort of trauma and abuse can occur. Thank you.

Steve Trumble (00:36:45):

That was again spot on for what we need for this case. So very grateful to you and we'll certainly explore some of the questions that have been asked when we get to that part of the presentation or that part of the evening. But before then, let's hear from Felicity about the physio's perspective on this. Thanks, Felicity.

Felicity de Blic (00:37:04):

Thank you. So such a huge topic, so much to unpack and I'll do my best to talk through my piece and then look forward to questions later. And I thought I'd start with this beautiful quote from the phenomenal Bessel Van Der Kolk who I'm sure you are familiar with. If you're not, go and look him up. The single most important issue for traumatised people is to find a sense of safety in their own bodies. I'll let that sink in. Next slide, please. And I'd just like to start with a conversation around safety versus threat. So responding to real or perceived threats in our environment or within ourselves or in our relationships is an incredibly and profoundly physical task. And trauma does set the stage for an overactive threat detection system that then requires various outputs from our nervous system to try to promote safety and survival for ourselves.

(00:38:04):

We're probably all familiar with the concepts of fight, flight, freeze, and collapse mode, and these are incredibly adaptive and useful mechanisms from our nervous system to keep us safe. But when they are persistently activated, and this ties in beautifully with everything Andy was talking about in terms of that allostatic load, the system changes and our nervous system becomes wired differently. We can talk about HPA axis dysregulation and the chronic cortisol production that can then significantly impact all of our body processes. And there's very fascinating research on cortisol dysregulation in the early days, very much high cortisol levels, and then sometimes a bit of a cap put on that system that leads to the very low cortisol levels that we may have seen in Sarah with her experience of chronic fatigue, that physical tension, inflammation and immune dysfunction can really, really become apparent. Next slide.

(00:39:07):

So when we are thinking about safety versus threat, what are the different safety outputs from our brain that can occur, especially if we're perceiving threat all the time? And now this is going to be incredibly unique to the individual, and I think it's nice to step back and think about the variety of physical health complaints that we might see in the clinic as physios, as gps, as various health practitioners that we might see a certain tendency towards a hypervigilance and hyper sensitivity, whether that's to external stimuli or from sensations within ourselves. There might be patterns of bracing and closing down. And as physios, we commonly see this in those protective muscle groups. Think about how do we get into that very protected position We feel jaw, chest, hips, and pelvic floor. These muscle groups are really commonly rigid and tense and causing dysfunction in people who have had adversity and that persistent H P A access drive, we could also have an output of feeling on edge and revved again, that hypervigilance. But we can also feel pain more. We can feel tired more, we can feel numb or checked out, and these can be considered as symptoms, but they can also be considered as safety messages that are trying to get that person to a safe situation. Next slide.

(00:40:42):

And so I found the work of Dr. Steven Porges and Deb Dana, who's really taken his theories into a more practical realm, incredibly helpful to really create a bit of a framework around how we can understand our own nervous systems and how we can regulate ourselves and as clinicians support our patients to start beginning to understand how their nervous system is regulating or dysregulating and how to move between these different states. And one thing I really like about this ladder approach is that down the bottom here we are placed in, we see placed the more immobilised, parasympathetic, dorsal vagal system where we're shutting down and we're low energy and we're numbing out and we're kind of giving up our resources to be able to respond to the threat have been overwhelmed. And from here, the next level up in order to move out of that immobilised state is actually immobilised sympathetic drive more of a fight or flight.

(00:41:44):

It's an action state, it's an energetic state. There might be some irritability and panicky sensations and tension here. There might be a sense of needing to act and change something right now that in itself can be dysregulation. But interestingly, that's the state we need to move a little bit into, come out of an immobilised state. And then top of the ladder dream state where we'd all like to be where we can feel safe and centred and connected is that parasympathetic, ventral vagal system. So I'd like you to reflect on Sarah's history and where she's at and her history of adversity and have a little bit of a think about the different points in time where she might have been in more of a mobilised state to protect herself more of an immobilised state and how as she's growing and as she's learning and as she's reaching out to different health professionals and searching for different relationships, she's able to find more periods of safety and from whatever profession you're working in, how we might be able to use a ladder like this to help her understand where she's at and support her to move in the direction she needs to go in to create that sense of safety within herself.

(00:42:54):

Next slide. So as physios and thinking more broadly about trauma and the body, we really commonly work with people that I'm experiencing pain and tension and just to reflect on what are the populations that walk in the door and that we just feel, oh, this is going to be tricky. This is going to be tricky to treat, or that horrible term treatment resistant populations. And maybe you can think in your minds now what that particular cohort might look like. Maybe they're the ones with very widespread symptoms, maybe the pain isn't isolated, but it's kind of everywhere. Maybe there's lots of chronic overlapping conditions, maybe there's a lot of physical and mental health comorbidities. But if we zoom out and step back and look at these patients through a trauma-informed lens, sometimes things start to get a little bit more cohesive. Next slide.

(00:43:49):

So I thought I'd introduce the tropic of what we call central sensitivity syndromes, also called chronic overlapping pain conditions. And we can look through this and think, okay, we have chronic fatigue syndrome in here. We have some pelvic pain syndromes in here. We have some chronic tension syndromes in here referring in their diagram there to an interesting paper by Adams at O, which really talked about the bio-psychosocial drivers of these syndromes. And I think when we kind of then reflect on those kind of tricky patients, that tricky cohort we were talking about, oftentimes these different conditions are showing up. And if we want to zoom out and think, okay, if these conditions, these

overlapping pain conditions are all interconnected and it's common for people to present with a number of them, what's going on there? Next slide.

(00:44:42):

And so the common denominator is of course a concept of neuroplastic pain and central sensitization. And this is all about our nervous system becoming increasingly sensitive and having altered functioning of our ascending and descending pain pathways. It's effectively a maladaptive neuroplasticity, which means our brain has become really, really good at doing or feeling pain. And it can lead to the interpretation of normal sensations to be painful, which we call allodynia or somewhat uncomfortable sensations to be considered or sensed as very painful, which we call hyperalgesia. And that could be something like i b s where the sensation of just normal peristalsis can become quite painful, or that could be the touch of clothes on the skin or underwear on the body or something like intercourse can become incredibly painful. And interestingly, the research well and very makes sense to all of us working in the field. No c CPL pain patients have much higher rates of emotional trauma and mental health diagnoses. Next slide.

(00:45:55):

So getting to Sarah, we know that sexual abuse is a risk factor for pelvic pain. And in terms of the presentation, Sarah is experiencing vaginismus, or we could call that a chronic persistent pain syndrome. We could call it vaginismus, we could call it provoked vestibular denia. She's experiencing a kind of sensory motor dysregulation where she's quite disconnected to the muscles of her pelvis and pelvic floor, and she's not really aware of how to control these muscles. In addition to that, there's heightened sensitivity allodynia of these regions. So when she tries to be intimate with her partner, things are shut down, locked down, and she doesn't really know where to go with it. Next slide.

(00:46:40):

So one thing I think is really important to point out is if Sarah walks into our clinic for an initial appointment and she's a resilient and courageous young woman, she's reached out and self-referred and showed up, we don't know her background, so is she going to disclose in our initial client interview her history of trauma? And from a pelvic physio perspective, it is essential that we take the time to really get an understanding of what's going on for our clients and the reason why we're there. And it's happened to me and it's happened to many of my colleagues that even with the best intentions, trauma histories haven't been disclosed. And then physical assessment has been incredibly challenging. So a couple of points that I like to always note is a, of course, taking time with your history, asking a bit about a patient timeline of when they started to connect the dots on these symptoms and how things started to develop and any other patterns of chronic tensions in their time.

(00:47:40):

And also about asking the client, what do you think is going on here? Do you have any sense of what's driving this or informing this? And sometimes I find that's a really fantastic question to once you've built rapport and you have that nice warm therapeutic alliance that someone might actually say, well, you know what, this happened to me and I just feel like it's connected somehow. But then lastly, another essential question before a physical assessment. And I think this would be relevant to not just a pelvic assessment, but any assessment is, is there anything in your past that could make today's physical assessment difficult? That's also a really great question to ask to give another opportunity for someone to say, actually, yeah, there's something that's tricky in my past and I'm really freaked out about this

assessment. So anyway, leading into what we're trying to do with Sarah, we're trying to help her feel in control of the process of therapy.

(00:48:39):

And if we're talking pelvic floor physiotherapy, these are intimate exams and hands-on treatments, but they also don't have to be, and we can start much more broadly in a movement-based scenario with the goal of trying to create a sense of safety within herself, somatic safety, and also of course trying to create safety within our therapeutic relationship. We want her to start to understand symptoms of dysregulation in her nervous system and understand that lateral approach and start to build in some strategies. So she's able to move back into feeling settled and safe because of course, that's where we need her nervous system to be. If intercourse, which is her goal, is going to be able to occur, and then work with strategies to broaden out that window of tolerance for sensations previously perceived as threatening. So we would be doing lots of functional anatomy education to try to empower her and approach that sensory motor dysregulation and disconnect she has from her pelvis. We would be thinking about hands-off and then hands-on approaches and lots of mindful movement and exercise interventions to get her connecting to that part of her body. Next slide.

(00:49:47):

And a little bit more of the details here, which perhaps we can skimm through. I dunno, Steve, if we've got the time. Yeah. But we are thinking about, what was that? Yeah, beautiful. I think we're second last slide. Building that safety, building that connection, thinking, looking, self touch, therapist, touch perhaps the use of modalities such as dilators or thera ones or vibrators on her own. And when she feels safe on her own, then feeling into whether she's ready again within her control to integrating the treatment into the relationship with her partner with very clear boundaries and a ladder approach to what feels safe and when, so the partner knows his role and treatment timeline is going to be incredibly unique to the patient. It could be six months, it could be three years. I saw someone this week in the clinic that I've been working with for three years, and we've just done our first very successful manual therapy treatment where there was no dissociation, there was no disconnection, there was no distress, and it was a really fantastic outcome for her.

(00:50:51):

So timeline, again, very patient specific. Next slide. And in terms of looking at including a body oriented approach to working with clients like this and that collaborative multidisciplinary care, thinking about zooming out and taking a nervous system perspective on working with clients that seem to have lots of individual diagnoses that they're collecting and starting to feel very broken when we zoom out and find the common denominator and start working from a nervous system perspective, everything can really make sense and make friends, just make friends with your local physios, your OTs, your eps, your yoga therapists, your gym trainers, and people that have an interest in working and supporting people who have a trauma background to facilitate those cross-referrals and collaborative care. And that's me.

Steve Trumble (00:51:48):

Thanks. What a great way to finish up Felicity, draw your network around you and become friends with those who can support your treatment, which is just so fantastic. So thank you for that. Now the good thing is that the panellists have seen the questions that were asked before the webinar or during the registration process. So they've already answered a lot of the things that people were asking about in

that process. And now we'll move on to asking some of the questions that have come up during the conversation or during the presentations. I think possibly the first one is just a little bit more on interception, and there was a question that came in from Frank, Frank asking about where we are in terms of being able to assess interception and particularly validated tools for that. And I think, Lou, you might be the person to kick us off on that one. Yeah,

Lou Kerley (00:52:38):

Thanks Steve. It's a really good question. I mean, there are formalised assessments that have been developed for measuring and assessing interoception. In my experience, I take a real client-led approach to measuring and assessing interoception using their own words and figuring out where they're at. It is usually based on a really sensitive approach to their body as well, considering what other experiences they might be having, are they, I know in particular I think's important, recognising what other factors might shape whether interceptive work is appropriate for the client at this point in time. I know I worked with young autistic children and families, and sometimes we talk about feeding interventions in that space and sometimes interceptive work and that tuning into the body is not actually going to be a really safe way of doing that. Similarly, I think someone had flagged that in the case of chronic pain, that disconnection from the body has actually been something that has kept them safe to an extent. And so doing interceptive work where we're noticing what our body's feeling isn't necessarily always the safest thing to do at that point. So I'd follow a client led approach there in terms of exploring and assessing. But I mean, Felicity, did you have anything else on that as well?

Felicity de Blic (00:54:14):

Yeah, I was just racking my brain because I remember when, can you guys hear me there? I remember when I was working in adolescent mental health, I was really keen to put some outcome measures into place for a mindful movement group. I was developing, and there was an incredibly long, I think it was called the Interceptive Awareness Scale that I tried to get my 15, 16 year old clients to fill in. And it was quite arduous and just a little bit too detailed. So that one I kind of gave up on, but I think it's a really important topic, and even if we're not able to put a specific assessment tools around it, it can be really brilliant to kind of educate around and work with from a therapeutic perspective. One specific measure that I'm using at the moment in Pelvic health and in persistent pain management is the Fremantle questionnaires.

(00:55:11):

So you can do it with the back, you can do it with an ankle, you can do it with a shoulder, but there's also a peroneal Fremantle peroneal awareness questionnaire free pack that's currently being validated. And that is all about measuring sensory motor dysregulation or disconnection to the pelvic region. And so that's the questionnaire that you give to someone and they fill it out and go, this is weird. I don't understand these questions. It makes no sense to me. And you're like, great, no dysregulation there. Whereas the people that fill it out and go, I feel so seen, I have no idea what's going on in that part of my body. I can't even feel anything below my rib page. That questionnaire made me feel like someone else is experiencing what I'm experiencing. So those Fremantle questionnaires I found really helpful to help identify people who just aren't connecting and then set some specific treatment targets about how to get there.

Andy Moloney (00:56:04):

Well, you familiar the answer, a question that just popped up from Jen Cael who asked exactly a question about neuroplastic pain and what we can use to measure that. Andy, what are your thoughts about this? So interception, again from an allostatic understanding is that these systems are our emotion systems and our internal system is always trying to communicate to our conscious self. And if you're tapped into that, you can be aware to it or if you are not used to it and you can dissociate. So there's this gap between 'em. So I found that providing that I explained as your soul talking to you, you're a spirit talking to, and so providing it with language, so providing it with some emotional granularity, which is to, I did it with a client at the start of the week. We got the emotion wheel out and we just talked about what was their experience at the moment, because their physical body was really starting to become quite heightened, quite sensitive, quite protective affecting his sleep.

(00:57:02):

Behavioural behaviours were starting to become quite heightened. Everything was sort of becoming black or white, and we identified that within that emotion wheel that the body was trying to say that it was in a state of fear because we sort of directed a lot of the current situation towards fear elements. So I had it on my phone, what do we pick up? We saw we labelled scared, anxious, helplessness, frightened, overwhelmed, worried, nervous, and there's a number of she, she's going on and there's a strong trauma history for this client as well. So what does fear mean to her? Understanding her experiences and understanding what she went through. Fear has a lot of power in her body, and so the sensitivity that fear provides in her system, her interceptive system, it needed language, it needed to be heard. And us going through that strategy, I literally just used a laminated bit of on the emotional wheel, and I just used the whiteboard market to sort of highlight it out, and I gave it to her to take home to reflect on. Later that day, I talked with her trauma-informed yoga practitioner, and she had a really great experience with labelling the experience of the interceptive experience of what her body was communicating. So it gave us some breathing space between the emotions and the thoughts. It allowed her to notice the thoughts and the feelings and experience rather than being fearful. She was noticing that she was fearful, and then we had strategies from there. So it was a good tool to give that interceptive in a world a voice really, and it needs some words.

Steve Trumble (00:58:37):

Thank you for that. And I did actually skip off quite quickly from the question about neuroplastic pain. Felicity, are there any other tools that you can just quickly recommend to the audience that might be useful?

Felicity de Blic (00:58:48):

Yeah, look, I find in terms of patient reported outcome measures, the central sensitization index can be helpful. It's not a determinant that central sensitization is present, but it's an interesting screening tool. In addition to things like the tamper scale of kinesia phobia pain, self-efficacy questionnaire, we can also do assessment of light touch. So is there allodynia, hyperalgesia present? The cotton swab test is one we use just cotton swab or Q-tip on the skin, whether that's pelvic or other wear in the body, two point discrimination. Can someone sense where they're feeling sensation on the body and is that sensation heightened? There's some good outcome measures like questionnaires and clinical skills and clinical tools that I would often use.

Steve Trumble (00:59:40):

Excellent. Thanks for that. Now, I just wanted to touch on a question that's coming from Susan Platts about fibromyalgia and asking how you would particularly support a client who has pain associated all over their body with fibromyalgia and where they have trauma, but not quite sure if it's connected. Who wants to go first in how you might actually approach that person who's struggling with that situation?

Felicity de Blic (01:00:08):

I'm happy to go there if

Steve Trumble (01:00:09):

That. Oh, there's okay. Thank you. Good on you.

Felicity de Blic (01:00:12):

And have a lot to me. Yeah, so this is fantastic that they're kind of connecting the dots there. They're not sure it's connected, but they're realising that both these phenomena are present. Fibromyalgia, again, is considered one of the hallmark neuroplastic pain diagnoses, and so I would be counselling that. Yeah, this is definitely connected. This sort of heightened sensitivity in the nervous system that has developed because of adverse experiences as a protective response, as a safety output is now presenting itself through sensitivity to what is normal sensation. People with fibromyalgia will just say, everywhere aches, I can't wear this bra, I can't sit on that seat, I can't do this, do that. It can be very, very widespread. And so when we start to try to chase the knee and the ankle and the neck and the jaw, it can be very overwhelming for therapist as well as for the client.

(01:01:16):

So zooming out and looking at that regulation ladder and looking at creating a sense of safety in your body, what would that be like? What would that feel like? Is there any way you can connect to in your body right now that feels safe, that feels neutral? Maybe it's their little finger, maybe it's their ear lobe. And how can we start working with not necessarily mindfulness in terms of body scanning procedures, because that can be quite overwhelming for clients. We're going into the body and paying attention to sensation. It's actually really scary and unpleasant. But some tools from the iris yoga nidra tradition can be really helpful here in terms of toggling between sensations. So a mindful way of searching out for a sensation of coolness versus a sensation of warmth. Searching a sensation of tension versus a place where there is a sensation of ease and starting to create some safety in accessing their body while bringing in gentle movement, bringing in breath work, bringing in cognitive strategies either through yourself, if you've, I love acceptance and commitment therapy and I bring that in all the time. And engaging with your friendly social workers and psychologists, whoever else is working with that person to understand some different cognitive strategies you can be bringing into play to really be supporting that person to understand themselves as a whole. That their pain is not a elbow problem and a knee problem and a back problem and a pelvic problem, but their pain is a pain system problem. They have a pain problem, not a knee pelvis back problem. And under that framework, kind of moving gently from there.

Steve Trumble (01:03:01):

Well, Felicity that touches on something I was going to ask Andy and Lou about a question from Susan Gia about a client of hers with chronic fatigue syndrome using a heart rate monitoring watch to try and keep within a window of tolerance with their exercise. And the question coming up about whether this could maybe sustain a fear response or protective behaviour if it to deliberately keep somebody within that zone, do either of you two have a thought about that? Andy, looks like your first up

Andy Moloney (01:03:38):

My confused look. Sure or no, you've

Steve Trumble (01:03:42):

Come off your microphone. You mute? Can you hear me? Sorry. You did come off the mute. So that's

Andy Moloney (01:03:47):

Okay. I think when people are in a state where they feel like they're losing control of their sense of self and their ability to self-motivate, then providing tools that they give them a sense of control and ownership, such as whether it's heart rate, whether it's heart rate variability, and using that as a strategy to guide them can be helpful. So it's certainly something that I would recommend. My style of treatment is very, whatever we kind of determine at the time. It's very sort of flexible, adaptable, and I find from a trauma informed perspective, that's always served me in a way. So if someone wants to talk about that and wants to use a tool and wants to sort of bring this through, then I'll talk with them about it and we'll think if it's a good idea for them and it's coming from them, then it's obviously a great idea. And if it sticks and it works, then it's a fantastic idea. But yeah, a degree of external control can be helpful.

Lou Kerley (01:04:55):

Yeah, they can be useful, particularly where it's been led by the client, but just being conscious and cautious as well in terms of how and why we're integrating that technology into what we're doing and what purpose it's serving as well. It can be a really nice indicator and prompt for the client, but also a consciousness about the accuracy of biomarkers and what they are actually indicating. They aren't direct measures of these things. They are oftentimes when we're using something like a watch, they're an indicator of a biomarker. So just being conscious that it's not a replacement for some of all of that other work we're doing and that it's being led by the client as well.

Steve Trumble (01:05:39):

Thanks, Lou. Now I've got one final question that I've been leading up to all night and one of our colleagues watching from Jerusalem. Walter has asked this question, would like to ask the panel for what advice they can give on triaging the first approach to people in a war situation where obviously the lack of safety, the loss of safety, the existential crisis of being in that. I can only think of a parallel here and working as a GP in Marysville after the fires in 2009, but what are a few thoughts from the panel on how you would make the first approach to somebody whose whole world has just been torn apart in that way?

Andy Moloney (01:06:24):

I can start with that. There's a fantastic researcher here in Australia and exercise physiologist. His name is Dr. Simon Rosenbaum, and he has done a lot of work in refugee camps and has been working with the communities within that and very much directed towards sport, understanding the influence of culture and food and not labelling anything as a sort of an exercise or a gym. This open-ended approach to how is it that we can create some sense of community safety and enjoyment through such adverse experiences and times. And you see the footage of the kids just going straight into it and then the adults streaming in that sense of play. And if you can get into a sense of play going through such adversity, then that's a fantastic book. So he's doing some great work there in that space. Thanks

Steve Trumble (01:07:29):

Very much. Any other thoughts, Felicity?

Felicity de Blic (01:07:31):

Yeah, just first heart goes out to you and your community. We've all been touched so deeply by what's going on over there. I think everyone from a triage perspective, what someone goes through versus their physiological response and trauma response to it is different. So someone might have a level of resilience whereby they are doing better in their nervous system, even though they've seen something horrific compared to someone else who might not have seen as much but isn't coping. So for me, it would be looking at who's in freeze, who's numbed out, who's shut down on that latter scale that we were talking about? Who's mobilised, who's vigilant, who's upregulated? And then how do we provide strategies to each of those cohorts? So if we're upregulated, exercise, walk, pushups, move, pull, push, kicking actions, all of those moves that you want to do to get that energy out can help to down-regulate frozen, numb, checked out grounding movements, feeling the body on the floor, feeling the touch of their hands on their body, gentle breath, and then getting some rhythmic movement happening, potentially cross body movement happening to bring them back into their bodies would be the way to go there.

(01:08:46):

So in terms of triaging, yeah, I would be thinking how do we block people into who's upregulated, who's numbing out, and how do we support them to move down, if you like, into a more regulated place?

Steve Trumble (01:09:00):

Alright, well, let's hope that we're not confronted by anything at that scale in this country, although things have been bad enough. So thank you so much. Now it's time to hear final words from each of our panellists as we head towards the close of the webcast. So we'll probably, I think we should start with you, Lou, what are your final thoughts on this matter?

Lou Kerley (01:09:21):

Yeah, I guess we've spent a lot of time sort of zoning in on the body and for me, zoning in on sort of sensory processing and thinking about that case that we've just sort of explored as well in terms of Jerusalem, that we need to place these things in a context as well and we need to take an intersectional approach to any of this work that we're doing. And so having a body-based approach and a trauma-

based approach also means working with the whole of the person and the whole of their support network as well. Whether that means also tapping into things like faith. I know there's a bunch of really good work around sensory-based faith interventions in a bunch of contexts. So while we're talking about the body and while we're talking about sensory processing, we're also considering those within the whole person. And whether that's faith, whether that's interests, whether that's all of those things. So just because a person might need a particular type of sensory input or a particular type of body-based intervention, we can still focus that around what is meaningful to them, what motivates them, and in the case of Sarah, whether that's through things like dance and movement. Yeah, I'll finish with that.

Steve Trumble (01:10:39):

Thanks so much Lou. Andy, what are your final thoughts?

Felicity de Blic (01:10:43):

My final thoughts, I want to zoom out even further and the theories that I've sort of spoken about before. There is this sort of fundamental shift and a paradigm shift that I think we can see moving forward that brings in towards physical, a better contemporary understanding of physical and mental illness and the experience of trauma within the body and what the therapies that are associated with it. So the emerging theories of allostasis, predictive regulation, constructed theory of emotions, free

Andy Moloney (01:11:12):

Energy principles. There is this paradigm shift that is coming within healthcare because these sort of classical models of understanding, so homeostasis or classical view of emotions makes it difficult for us to explain what we've been talking about tonight with those theoretical underpinnings. So as these new theories come through and as we provide and as we research and we provide therapies, basing this new contemporary theory, I think we're all here tonight to talk about how it is we're searching for something new and it's a fantastic thing to be a part of movement. I don't want to use the term exercise, but movement is a fantastic strategy when it comes to regulating these systems. I kind of put it into three categories. So inner flow, inner resilience, inner strength rather than sort of exercise or whatever it may be. So inner flow, that sort of mindful meditation, trauma-based yoga, Felicity mentioned i r s yoga. There is some fantastic strategies that exist within that field that at a baseline to help people provide their sense of safety and orient them in space. Fantastic in a resilience we spoke about. And then in a strength is that the mastery of those interceptive sensations that can come through with getting the body a little bit stronger and protecting against the tightness or the feelings that go along with that. So yeah, there's a new paradigm coming and it's great to be part of.

Steve Trumble (01:12:42):

Fantastic. Thanks so much Felicity. The final word is yours.

Felicity de Blic (01:12:46):

Oh, no pressure. I think I'd really love to see that when we're working with this trauma-informed framework, when we're seeing the person in front of us with a background experience of trauma and we're seeing the pain or the physical dysfunction that they're presenting with that, we see that and we help the client see that as something that has been protective and adaptive for them and their nervous system at some point in their lives, yet that's not serving them anymore. And having creative

conversations with them and inviting them to have creative conversations with themselves and their symptoms around, I hear you and thank you, but we're okay now. And building again that connection to safety within their bodies and stepping forward in treatment with their physical health concerns with a sense of I can regulate my nervous system and I can create change in my pain system and I can create change in my body. Not just a list of diagnoses, but yeah, feeling more in charge.

Steve Trumble (01:13:57):

Thank you so much to everybody on the panel for what's been an excellent night's discussion to all the people who've attended and watched. Please do express your thanks to the panel through the chat box. We'll pass that on. I would also like to acknowledge Dr. Johanna Lynch, who's done a lot of work on the trauma-informed Care webinars series with the design and delivery of the webinars. And on behalf of M H P N, thank you so much, Johanna. Now the survey, please don't forget the survey. It's really important that you do that and provide feedback. Clicking the banner above all that QR code, you can see up there on the screen, the recording will be available and you'll be receiving an email telling you how to get onto that. Our next webinar is on treating panic disorder Wednesday the 15th of November. There's also a hypothetical case scenario, a special event coming up on the 21st of November.

(01:14:47):

So be there for that and a webinar on Monday the 11th of December, looking at strategies working with children who present with A D H D concerns. The latest podcast in the M H P N stable on a for monthly basis is in the first person peer worker expert by experience. So before I close, I'd like to acknowledge the lived experience of people and carers who have lived with mental illness in the past and those who continue to live with mental illness in the present. Thank you everybody for participating. Apologies to those. These are questions we didn't get to. We really appreciate your input, but I think we've had a wonderful conversation from our three panellists. Good evening to you all and thanks so much.