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Webinar

An interdisciplinary panel discussion

Recognising, Screening and Assessing Complex Trauma

Tuesday , 20th May 2014

"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 mhpn

Mental Health Professionals' Network

MHPN gratefully acknowledges the support of Adults Surviving Child Abuse (ASCA) in the production of this webinar.

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MHPN is funded by the Commonwealth Department of Social Services to deliver this professional development series of three webinars to practitioners who support individuals and communities affected by or engaging in the Royal Commission into Institutional Responses to Child Sexual Abuse.

This webinar is presented by mhpn

Mental Health Professionals' Network

Tonight's Panel

- Mr Dragan Wright (consumer advocate)
- Ms Michelle Everett (clinical psychologist)
- Dr Johanna Lynch (general practitioner)
- Adjunct Prof Warwick Middleton (psychiatrist)

Facilitator

- Dr Mary Emeleus (GP and psychotherapist)

Ground Rules

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To help ensure everyone has the opportunity to gain the most from the live webinar, we ask that all participants consider the following ground rules:

- Be respectful of other participants and panellists. Behave as if this were a face-to-face activity.
- Post comments and questions for panellists in the 'general chat' box. For help with technical issues, post in the 'technical help' chat box. Comments posted in the chat boxes can be seen by participants and panellists. Please keep all comments on topic.
- Your feedback is important. Please complete the short exit survey which will appear as a pop up when you exit the webinar.

Learning Objectives

Through an inter-disciplinary panel discussion about Tanya (case study), at the completion of the webinar participants will:

- Understand the prevalence, epidemiology, characteristics and impact of complex trauma
- Be better equipped to recognise, screen and assess the physical, mental and psychosocial presentations which might indicate unresolved trauma.
- Take home tips and strategies for interdisciplinary collaboration to screen, recognise and assess people who have been exposed to or experienced complex trauma

Consumer Advocate Perspective

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Here I am… what can you do for me…
what do you think of me?

Openness, no assumptions, non-judgement

Dragan Wright

Consumer Advocate Perspective

dominant paradigm

How am I supposed to be? You have the power, you can affect my life…how would someone like you understand someone like me?

Equalise the power differential as much as possible

Dragan Wright

Consumer Advocate Perspective

I'm not coming out to talk to you about anything real until I feel safe enough

It's all about creating a 'safe enough' relationship

Dragan Wright

Consumer Advocate Perspective

My responses can be erratic, I'm aware of this, it feels like I'm out of control of my own body… and it causes me more shame

Facilitating someone being able to stay present and regulate their arousal - 'window of tolerance'

Dragan Wright

Consumer Advocate Perspective

I came didn't I? I might not know what to do now I'm here, I might fight you, avoid you, resist you, expect you to fix me, think you'll just be like everyone else, over-attach to you, be disappointed by you… but I'm here

The organic desire to change, to get support to recover… to heal

Dragan Wright

Clinical Psychologist Perspective

Initial Meeting

- Recognise she made it in the room, the risk she is taking & what this would have taken for her to get here.
- The importance of a trauma-informed context – ensure the practice as a whole is set up to be receptive to, & soothing & validating of trauma survivors.
- Warm (enough) welcome & a cup of tea.

Michelle Everett

Clinical Psychologist Perspective

Initial Meeting

- Recognise the barriers to seeking help – services are responsible for some of them.
- Accept Tanya's apparent ambivalence,in fact, it makes good sense that she may be finding it difficult to trust people.
- Recognise & respect *all* adaptations to trauma – as having some survival utility – including *'who'd blame her?'*(mother) & *'like blokes do'* (mothers bf).
- Take extra care that nothing we do resembles 'doing to' Tanya.

Michelle Everett

Clinical Psychologist Perspective

- Focus more on process than content - i.e. opportunities for validation "*…how would you be, hey?*"
- Respect her stated (& unstated) boundaries & limits – "*don't want my head read*".
- Resist the temptation to get 'the story' - we know enough to accept that she is likely to be experiencing the multiple impacts of complex trauma and loss.
- Dissociation appears likely - roll with changes in state, & accept any need for repetition, re-orienting statements & support to self soothe.

Michelle Everett

Clinical Psychologist Perspective

Managing arousal - staying safe in the room

Increased sensation
Emotional reactivity
Hypervigilance
Intrusive imagery
Disorganised cognitive processing

Hyperarousal Zone

Window of Tolerance
Optimal Arousal Zone

Hypoarousal Zone

Relative absence of sensation
Numbing of emotions
Disabled cognitive processing
Reduced physical movement

The three zones of arousal: A simple model for understanding the regulation of autonomic arousal (Pat Ogden, Kekuni Minton & Claire Pain, *Trauma and the Body*, New York: Norton, 2006, p. 27)

Michelle Everett

Clinical Psychologist Perspective

- For Tanya, put aside the pen & paper - at least for now.

- **Assess her strengths** (this is more for the clinician to keep this lens at this point *not* about telling Tanya what her strengths are) & systematically consider her current **coping strategies,** her capacity to self soothe & her relationships.

- Diagnostic assessment ? - **hold lightly** & be honest about the benefits & limitations.

Michelle Everett

Clinical Psychologist Perspective

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Research that applies to Tanya's experience:

- **Three or more forms of gender based violence** – increases the risk of developing a serious mental health problem 11 times (Rees et al,2011 Lifetime Prevalence of Gender-Based Violence in Women and the Relationship With Mental Disorders and Psychosocial Function JAMA **)**

- ACE studies – ACE score of four or more, **46 times more likely to attempt suicid**e than people with and ACE score of zero (Dube, et a 2001 Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span *JAMA*)

- For CSA survivors, there are high lifetime odds of developing an **Anxiety Dis** (OR 3.09), **Depression** (2.66) **Eating Dis** (2.72) **Sleep Dis** (16.17) and suicidality (4.14) (Chen et al 2010 Sexual Abuse and Lifetime Diagnosis of Psychiatric Disorders: Systematic Review and Meta-analysis *MayoClinicProc*)

Michelle Everett

Clinical Psychologist Perspective

Slide continued…

- For girls abused by more than one perpetrator, **risk for psychosis** is greatly increased (**OR 15.8** Cutajar, M et al 2010 Schizophrenia and Other Psychotic Disorders in a Cohort of Sexually Abused Children *ArchGenPsych* 67(11)

- Meeting criteria for **multiple DSM diagnoses is likely** – cumulative trauma **associated with greater symptom complexity** (Cloitre, Stolbach, Herman, van der Kolk et al 2009 A Developmental Approach to Complex PTSD: Childhood and Adult Cumulative Trauma as Predictors of Symptom Complexity *JnlTraumaticStress*)

Michelle Everett

Clinical Psychologist Perspective

End of session issues

- Decisions to make: the request to ‘not tell’ the GP & whether to address the self harm.
- Make it clear that it’s her decision to come back - but I am offering a space where she will not be judged, will never be ‘in trouble’ & always be treated with courtesy and respect.
- Support for the GP - being a patient of the same clinic for 16 years tells us something about the practice & Tanya’s capacity for the development of trust over time.
- Consider - what developments are likely to be most helpful for her in the short term - in the context of a safe relationship.
  - Emotional regulation? Awareness of triggers?
  - Managing intrusive memory and dissociative experience?
  - Relationship with children and reframing her role as a mother to a young adult?

Michelle Everett

General Practitioner Perspective

- Aware of the **countertransference** of hopelessness, ambivalence & 'heart sink' dread - need to be actively managed.
- Aware of **affect regulation** as a key safety priority - need to titrate emotion especially as she reflects on memories or relational distress. No need to get all the story in this session. Main goal of the session is to start safe connection and not have too much arousal or attachment demands.
- **Coherence** (& mentalising) as an antidote to dissociative processes - actively holding my own self, Tanya aware of the system beyond us both.

Dr Johanna Lynch

General Practitioner Perspective

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"Emotional content associated with traumatization can be overwhelming... the therapist gives individual's safety and welfare precedence over the story."

Courtois (2004) p416

Dr Johanna Lynch

General Practitioner Perspective

Safety

- in **social** setting: finances, home, work
- in **relationships:** boundaries, moving away from abusive relationships and clarifying ambivalent ones
- in their **body:** sleep, appetite, exercise, chronic pain, somatic memories, DSH, mindfulness
- in their **mind:** content and quality of thoughts
- in their **emotions:** understanding and managing hypo and hyper arousal - including memorial experiences
- in their **sense of self:** esteem, value, purpose, control
- in their **spirit**: meaning making

Dr Johanna Lynch

General Practitioner Perspective

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Complex trauma alters:

(adapted from Treating Complex Traumatic Stress Disorders. (2009) Courtois, Ford

- **Affect regulation** (includes self soothing, addictions, self harming behaviours)
- **Attention and consciousness** (amnesias, dissociative episodes, depersonalisation)
- **Self perception** (chronic guilt, shame, not worthy)
- **Perception of the perpetrator** (may exacerbate ambivalent, avoidant or disorganised attachment)
- **Relationship with others** (difficulties with trust & intimacy)
- **Connection with their body** (inc somatisation, body memories, or dismissive & ignoring)
- **Systems of meaning** (hopelessness, despair, feeling punished, deep hope)

Dr Johanna Lynch

General Practitioner Perspective

- A division of consciousness or personality (onno van der hart)
- Involves a parallel owning & disowning of experience... An experience of 'not me'... It leaves one of more parts of the person "stuck" in unresolved experiences and another part forever trying to avoid these unintegrated experiences." (Boon et al., 2011. *Coping with Trauma Related Dissociation*. p8-9)
- Spectrum from 'highway hypnosis' to DID
- Very adaptive in situations where someone is trapped & cannot get away or in a relational double bind – but becomes a liability when they are dissociating in day to day adult life
- Means that some parts of the person are unaware of other parts –has implications for therapeutic rapport – explains shifts or changes that bewilder people around them.

Dr Johanna Lynch

General Practitioner Perspective

My hopes for Tanya

- Listened to with safe connection and context
- Grow in hope and power
- Taught to be less phobic of her emotions and to be confident to soothe her levels of arousal using sensorimotor awareness and creativity
- Understand the triggers she experiences
- Begin to see her relational patterns - real change in her parenting
- Notice all of herself - learn to be kind and caring (including intrapsychic unity).
- Engage other help - housing, exercise, health, parenting, grandparent support, family therapy
- Be helped by a team that collaborates - actively working against dissociation of the system.

Dr Johanna Lynch

Psychiatrist Perspective

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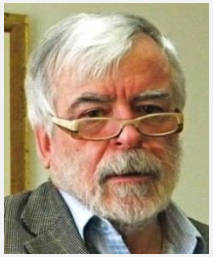
Example of the symptomatology of Complex Trauma - Dissociative Identity Disorder, N=62, Middleton & Butler 1998

- At least one mental health centre admission - 87%
- Previously worked in/are working in the health field - 34%
- Recurrent suicidal thoughts, wishes to be dead or attempted suicide - 100%
- Previous diagnosis of "schizophrenia" - 29%
- Previous diagnosis of "mania" - 20%
- Past iv drug use - 23%
- Previously prescribed lithium - 19%

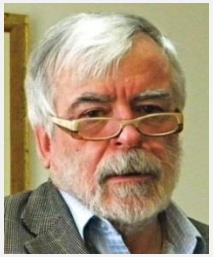


Adj Prof Warwick Middleton

Psychiatrist Perspective

Slide continued…

- Patients satisfying criteria for current/past major depression - 94%
- Patients satisfying criteria for current somatisation disorder - 71%
- Patients satisfying criteria for current borderline personality disorder - 73%
- Patients satisfying criteria for current/past PSTD - 90%
- Mean number of Schneiderian First Rank Symptoms - 6.5
- Mean Dissociative Experiences Scale score - 51%



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Psychiatrist Perspective

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PROPOSED CRITERIA FOR DESNOS (1996)

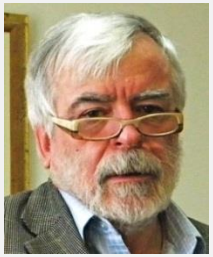
A) Alterations in regulating affective arousal

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

B) Alterations in attention and consciousness

1. amnesia
2. dissociation

C) Somatization



Adj Prof Warwick Middleton

Psychiatrist Perspective

Slide continued….

D) Chronic characterological changes

1. alterations in self-perception: chronic guilt and shame: feelings of self-blame, of ineffectiveness, and of being permanently damaged

2. alterations in perception of perpetrator: adopting distorted beliefs and idealizing the perpetrator

3. alterations in relations with others:

a. an inability to trust or maintain relationships with others

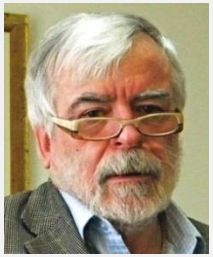
b. a tendency to be revictimized

c. a tendency to victimize others

E) Alterations in systems of meaning

1. despair and hopelessness

2. 2. loss of previously sustaining beliefs



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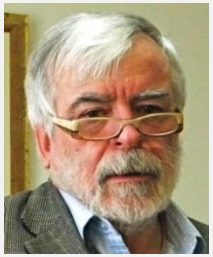
Psychiatrist Perspective

Emerging Awareness: Abuse, Neglect & Victimization

- 1897 - Freud renounces his “seduction theory”
- 1911 - Bleuler’s construct of “schizophrenia” effectively subsumes DID, “hysterical psychosis” etc.
- 1940 - Study of 295 female middle-class hospital patients, 23.7% sexually abused before puberty (12.5% by a family member) (C. Landis)
- 1948 - United Nations Universal Declaration of Human Rights
- 1962 - “Battered - Child Syndrome” (Kempe, Silverman, Steele, Droegemueller & Silver)
- 1972 - “Shaken - Baby Syndrome” (Caffey)



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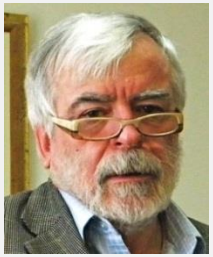
Slide continued…

- 1977 - Feminist analysis, “The Freudian Cover-up” published (F. Rush)
- 1978 - Introduction of the use of the diagnostic entity, Post Traumatic Stress Disorder (PTSD)
- 1983 - Founding of the International Society for the Study of Multiple Personality and Dissociation (in New York)
- 1984 - Publication of “The Assault on Truth” by Jeffrey Masson
- 1986 - Publication of “The Secret Trauma: Incest in the Lives of Girls & Women”(D. Russell)
- 1989 - United Nations Convention on the Rights of the Child



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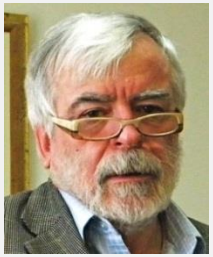
Slide continued…

- 1989 - First comprehensive texts on the diagnosis and treatment of multiple personality disorder (F. Putnam, C. Ross)
- 1992 - “Trauma and Recovery: The Aftermath of Violence: From Domestic Abuse to Political Terror” (Judith Herman)
- 2000 - Initiation of Royal Commission into sexual abuse of children by members of Irish Catholic clergy.
- 2002 - World-wide attention focussed on Boston Archdiocese and sexual abuse of children by >10% of its priests.
- 2008 - The case of Josef Fritzl who imprisoned his daughter Elisabeth in an underground cellar for 24 years while treating her as a sex-slave who bore him 7 children, attracts world-wide attention.



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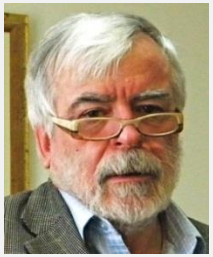
Psychiatrist Perspective

Slide continued…

- 2009 - Publication of “The Franklin Scandal” by Nick Bryant which documents the cover-up by law enforcement agencies, the judiciary, elements of the press, and of the Republican Party, of a high level US paedophile ring.
- 2013 - First scientific publications identifying the widespread and endemic nature of ongoing incestuous abuse during adulthood (W. Middleton).
- 2014 - United Nations demand that the Vatican ‘immediately remove” all clergy who are known or suspected child abusers and turn them over to authorities.



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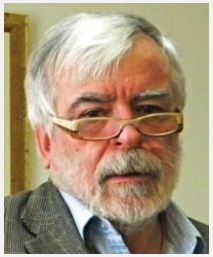
Psychiatrist Perspective

"Never try to teach a pig to sing, it wastes your time and it annoys the pig."

Robert A. Heinlein



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Q&A session

Thank you for your participation

- Please ensure you complete the *exit survey* before you log out (it will appear on your screen after the session closes). Certificates of attendance for this webinar will be issued in 4-5 weeks
- Each participant will be sent a link to online resources associated with this webinar within 1-2 days
- This webinar is the second in a series of three webinars exploring collaborative care to support Tanya. The third and final webinar in this series will be held on:
  - *Working Therapeutically with Complex Trauma*
    Wednesday, 11th June 2014, 7:15pm – 8:30pm (AEST)

Are you interested in establishing a face-to-face network of mental health professionals in your local area?

MHPN can support you to do so.

Please fill out the relevant section in the exit survey. MHPN will follow up with you directly.

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

Thank you for your contribution and participation