Mental Health Professionals Network Ltd

Tel. 03 8662 6600
Fax. 03 9639 8936
Add. Emirates House,
Level 8 251-257 Collins St
Melbourne VIC 3000
Email. info@mhpn.com.au
Web. mhpn.org.au

mhpn
Mental Health Professionals Network

Webinar

An interdisciplinary panel discussion

A Collaborative Approach to Supporting Adult Survivors of Childhood Abuse

Tuesday, 30th April 2013

"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

Panel

- Dr Cathy Kezelman (Consumer Advocate)
- Dr Richard Benjamin (Psychiatrist)
- Mr Philip Hilder (Psychologist)
- Dr Johanna Lynch (General Practitioner)

Facilitator

- Dr Mary Emeleus (General Practitioner)

Ground Rules

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 professional development activity.
- Please post your comments and questions for panellists in the 'general chat' box. For help with your technical issues, please post in the 'technical help' chat box. Be mindful that comments posted in the chat boxes can be seen by all participants and panellists.
- Your feedback is important. Please provide your feedback by completing the short survey which will appear as a pop up when you exit the webinar.

Learning Objectives

At the end of the session participants will be better equipped to:

- Raise awareness of the prevalence of and indicators for complex trauma
- Identify the key principles of intervention in the featured disciplines' assessment, treatment and support of people who have experienced complex trauma
- Recognise the merits, challenges and opportunities of interdisciplinary collaboration in providing mental health support for people who have experienced complex trauma

Consumer Advocate Perspective

What is complex trauma?

- 'Complex' trauma - ***Cumulative, repetitive, & interpersonally generated***

- Such as ***ongoing abuse within the context of intimate & family relationships***; also includes community violence, war & genocide (Courtois & Ford, 2009:15).

Dr Cathy Kezelman

Consumer Advocate Perspective

Prevalence

- By conservative estimates 4-5 million Australian adults have experienced childhood trauma in one form or another

- *It took me quite a while to accept this [prevalence of childhood trauma] because I kept thinking, `If this were true, people would know. Someone would have told me. Wasn't that what medical school was for?' (Felitti, 2012:4).*

Dr Cathy Kezelman

Consumer Advocate Perspective

Prevalence – mental health

- *`Individuals with histories of violence, abuse & neglect from childhood...make up the majority of clients served by public mental health & substance abuse service systems' (Jennings, 2004:6)*
- *`90% of public mental health clients have been exposed to (and most have actually experienced) multiple experiences of trauma' (Ibid)*
- The current organisation of mental health services does not reflect this reality & is inadequate to cope with it

Dr Cathy Kezelman

Consumer Advocate Perspective

The Adverse Childhood Experiences (ACE) Study

Felitti, Anda et al, 1998

The most comprehensive study to show a relationship between stressful overwhelming experiences in childhood & compromised ***mental and physical health*** in adulthood

- A longitudinal study of over 17000 participants in the US

<u>Yet two major findings are that:</u>

- Adverse childhood experiences are `vastly more common than recognized or acknowledged'
- They powerfully impact both mental and physical health 'a half-century later' (Felitti, 2002:45).

Dr Cathy Kezelman

Consumer Advocate Perspective

'From personal solutions to public health problems': the ACE study, cont.

The ACE Study establishes:

- ***the conversion, over time, of childhood coping mechanisms into adult health problems***
- that childhood coping mechanisms are ***initially protective*** strategies to deal with childhood adversity
- but ***lose their protective function over time*** and threaten emotional and physical health in adulthood (Felitti, Anda et.al., 1998)

Dr Cathy Kezelman

Consumer Advocate Perspective

Unresolved trauma: life-long impacts & affects the next generation

Unresolved trauma:

- Has negative effects **across the life-cycle** for those who directly experience it

- **Intergenerational impacts** on the children of parents whose trauma histories are unresolved (Hesse, Main et al, in Solomon & Siegel, 2003)

Dr Cathy Kezelman

Consumer Advocate Perspective

Recovery is possible

- Research shows that the impacts of even severe early trauma can be resolved, and its negative intergenerational effects can be intercepted

- People can and do recover and their children can do well. For this to occur, ***mental health and human service delivery*** need to reflect the current research insights

Dr Cathy Kezelman

Consumer Advocate Perspective

The case for trauma-informed care

- Is supported by a wide evidence base
- *Experience of relationships registers in the brain, correlates with neural activity, & is crucial to well-being* *(Siegel, 2009; Doidge, 2007; Cozolino, 2002).*
- ***Positive relational experiences have great healing potential*** while negative relational experiences compound emotional & psychological problems
- Since healing is *relational*, positive experiences need to take place ***within services & organisational settings*** accessed by those with trauma histories

Dr Cathy Kezelman

Consumer Advocate Perspective

`Trauma-informed' practice...

- Recognises that many problems, disorders & conditions are ***trauma-related*** (Perry, 2008; Ross & Halpern, 2009)
- Rests on awareness of the ***impacts*** of trauma
- Is sensitive to the ***context*** in which treatment/service is offered
- Is attuned to ***diverse coping mechanisms***
- Minimises the potential for ***re-traumatisation***

Dr Cathy Kezelman

Consumer Advocate Perspective

Changes include:

- A view of trauma as ***pervasive in its effects*** (Jennings, 2004; Fallot & Harris, 2009)
- Understanding client behaviour as ***adaptive attempts to cope***
- A focus on ***what has happened to the person rather than what is wrong with the person*** (Bloom, 2011; Fallot&Harris, 2009)
- Emphasis on ***skill building and acquisition***

Dr Cathy Kezelman

Consumer Advocate Perspective

Working with core principles

- Commit to & act upon the core principles ***of safety, trustworthiness, choice, collaboration & empowerment*** (Fallot & Harris, 2009:3).

Remember:

- Experience of relationships & environment (both positive & negative) ***affects brain structure, functioning & well-being***
- Positive relational experiences - ***including experience of services*** - assists integration
- Integration is the hallmark of well-being, ***& necessary for the healing of trauma***

Dr Cathy Kezelman

Consumer Advocate Perspective

`It makes sense'

- Adult survivors of (complex) childhood trauma may have little experience of the core principles of *safety, trustworthiness, choice, collaboration & empowerment*
- These principles are foundational to well-being and it is important to look for ways to build them into all interactions

Dr Cathy Kezelman

Consumer Advocate Perspective

Providing care to Judy

- Transgenerational complex trauma – compounded and impacts are cumulative

The basics:

- Understanding Judy in the context of what has happened to her, the impacts of traumatic stress on her and her family, and how she has coped and helping her understand herself
- Listening to Judy and helping her to feel safe; building trust
- Sitting with Judy, hearing her and engaging in positive respectful interactions
- Helping her acknowledge her strengths and build on them
- Fostering hope

Dr Cathy Kezelman

Psychiatrist Perspective

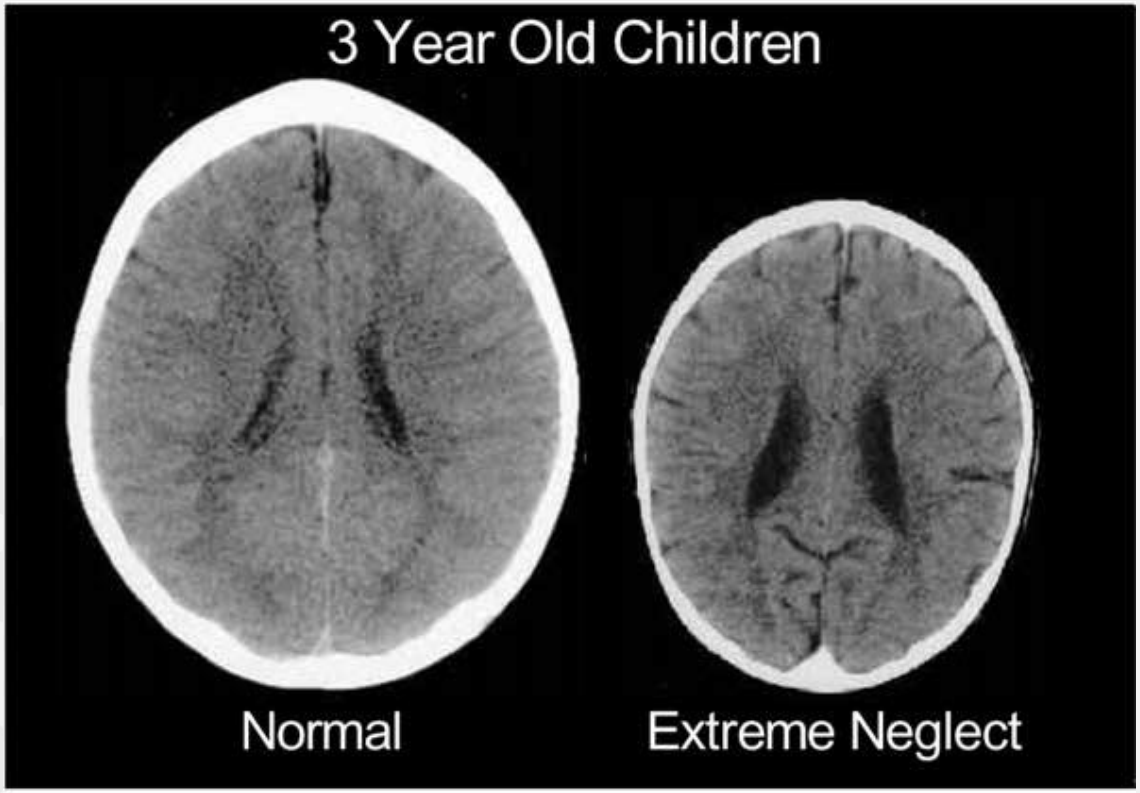
Background

- Primarily a clinician and not an academic, trained in psychiatry and psychotherapy, with over 20 years experience
- Work in a public sector community mental health team, see only those at high risk to self or others
- About half of the patients I see have psychotic illnesses. Treat these patients in the standard fashion, although in my team we recognise that professional human contact and the therapeutic relationship is central to all approaches
- See many of the remaining half with issues subsequent to difficult childhoods – complex trauma

Dr Richard Benjamin

Psychiatrist Perspective

Abuse and trauma cause very severe problems



Dr Richard Benjamin

Psychiatrist Perspective

Child abuse definition

- Child maltreatment is any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child
- There are four major categories: neglect, physical abuse, psychological or emotional abuse, and sexual abuse
- US Centre for Disease Control and the Dept for Children and Families
- All abuse is emotional in one way or another **– infants and children need to be valued and all attacks upon value are destructive**

Dr Richard Benjamin

Psychiatrist Perspective

Long-term effects of trauma

- The long-term effects of child abuse are thought to mimic or cause almost every known psychiatric condition in adulthood
- Low self-esteem, self-hatred, difficult relationships depression and anxiety, suicidal behaviour and DSH, eating disorders, substance abuse, PTSD, BPD, dissociative disorders and psychotic symptoms – **what might be called 'myriad' (or countless) symptomatology**
- But also physical injury, brain injury, developmental delay, multiple medical problems in adulthood, adult criminality, violence and murder, revictimisation and trans-generational victimisation, promiscuity, teenage pregnancy and prostitution, homelessness and premature death

Dr Richard Benjamin

Psychiatrist Perspective

Why a lot of these relationships are missed – the 'Pax Medica' in psychiatry

- A theory described by Linford and Arden in 2009, Psychotherapy Australia, refers to the combined effect of the DSM, Big Pharma, and the rise of the evidence-based therapies
- See this as a paradigm inappropriately founded on theories of **chemical imbalance** of the brain, with an inappropriate emphasis on **symptom-based diagnoses**, and on **specialised treatments and techniques**
- Which together have, **'Medicalised psychology and psychiatry in a way that has become so pervasive it's almost invisible, like the air we breathe'**

Dr Richard Benjamin

Psychiatrist Perspective

What the DSM in particular does

- 'Diagnoses' almost exclusively by 'symptom cluster' only – is simply descriptive, and therefore **does not describe diseases**, unlike the rest of medicine

- Leads to questions being asked about symptoms, and the generation of multiple diagnoses, it is not unusual to see 4 or 5

- **Tends to move clinician away from both the current psychosocial context and from the personal or developmental history, and away from the abuse or trauma**

Dr Richard Benjamin

Psychiatrist Perspective

Complex trauma and the Complex PTSD Diagnosis

- Judith Herman coined the term Complex PTSD in 1992 to help recognise that those with very disparate symptoms do not have multiple different diagnoses but are suffering as a result of childhood trauma
- Complex includes affective disturbances, suicidal ideation, amnesia, dissociative experiences, shame and guilt, sense of defilement, distorted relationships with perpetrators and others, sense of hopelessness etc
- But it is important to look at more than even this level of pathology

Dr Richard Benjamin

Psychiatrist Perspective

Normal and abnormal brain development

- The history of mental illness has largely involved one of two different theories – there are those have thought illness is predominantly secondary to brain disease, and those who thought that it was predominantly secondary to cognitive or emotional causes
- The third theory of mental health is incredibly important but little understood or even taught
- Grew out of work done with infants, emotions, trauma and memory, culminated in Allan Schore's seminal 1994 text, **"Affect regulation and the origin of the self"**

Dr Richard Benjamin

Psychiatrist Perspective

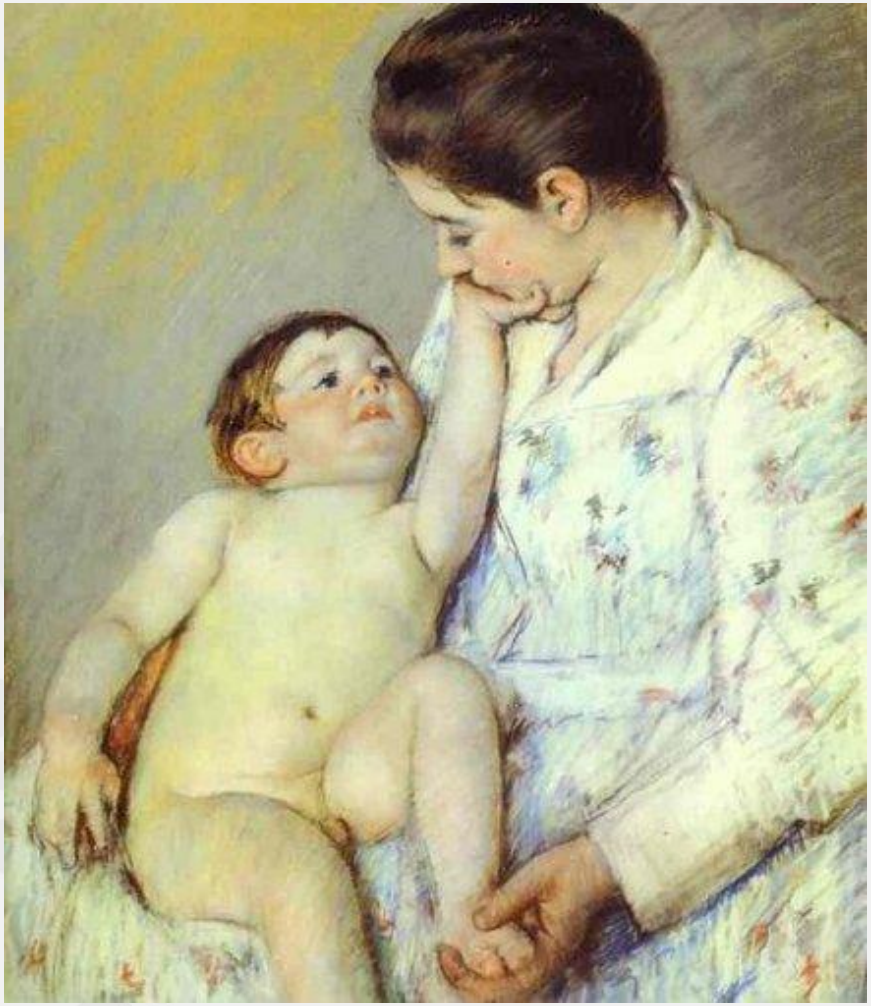
The brain is socially constructed

- The interplay of experience and development are especially important in the early years of life when neural networks are particularly malleable or plastic
- In modulating the infant's expression, the caregiver directly influences the infant's (or child's) later capacity for self-regulation
- All attachment experiences are primarily emotional, and **they become embedded in unconscious, bodily-based memory networks as unconscious relational (between people) memories**
- **This is how we are created, for better or worse, in the context of others – they shape our brains and the way we are with others**

Dr Richard Benjamin

Psychiatrist Perspective

Baby's first caress, Mary Cassatt, 1891



Dr Richard Benjamin

Psychiatrist Perspective

Professor Russell Meares - theory

- Australia's foremost expert on Borderline Personality Disorder is Russell Meares. Developed an evidence-based effective treatment for BPD – the Conversational Model of Psychotherapy
- **A sense of well-being is directly related to feeling valued**
- **This sense of value is lost in the majority of those seeking therapy,** the damage occurring when caregivers have consistently failed to respond to developmental needs, or when trauma has been actively inflicted
- **Works on the understanding that childhood trauma is lodged deeply in the unconscious and manifests throughout life in relationships with others** – so treatment focuses on emotions expressed between the therapist and the patient

Dr Richard Benjamin

Psychiatrist Perspective

Meares - treatment

- Mirrors to an extent the mother's responses to the baby in the protoconversation, but more complex
- **Joining** – an attempt to get into the same space as the patient. Requires the therapist to **abandon** their own agenda, follow the patient and to truly **listen**
- **Representation** – requires the therapist to gently, speculatively, and slowly, **put into words** (and expressions) what the therapist thinks that the patient is feeling, **and to see how the patient responds**
- **Amplification** – an attempt by therapist to follow the patient's emotions and **magnify** any germinal positive feelings. The therapist also sits with and bears witness to the patient's pain

Dr Richard Benjamin

Psychiatrist Perspective

Judy

- In my experience Judy and many patients like her are often seen predominantly cross-sectionally, with a focus on symptom clusters for both diagnosis and treatment
- Very frequently the early or developmental history is not taken, or is not taken comprehensively, and the relationship of early life to current symptoms is not made
- Similarly in the MSE, little attention is given to factors that are often associated with childhood, or the signs are misconstrued
- The end result is that the whole situation may be 'biologised'; it seems lamentable that this scenario – one of at least 4 generations of trauma – is reduced to a 'situational crisis'

Dr Richard Benjamin

Psychiatrist Perspective

Judy

- From my point of view the most important thing to do is to 'grab the ball'; this is not a situational crisis, depression or PTSD (alone)
- The problem includes nightmares and flashbacks and no doubt they have been disabling
- However the intra and inter-personal problems – self-loathing, sensitivity to criticism, inability to be close or tolerate others – will have made her life very painful and difficult indeed

Dr Richard Benjamin

Psychiatrist Perspective

Judy and the Conversational Model

- I think what is most important for Judy are very genuine and very human responses, along the lines of the Conversational Model (and other dynamic therapies)
- She needs someone **to listen** to her, and she needs someone to have the time and the space to do this
- She needs someone **to try and make sense of this with her**; this can happen over one moment or one session or over 300 sessions
- She needs someone **to sit with and bear witness to her negative emotions** (her mother could not do this) and look for and fan any positive emotion
- She needs some-one **to be acutely aware of her sensitivity to and her inability to tolerate others –** and not buy into these problems on an unconscious level like almost everybody else in her environment will
- When the patient is given a real chance to tell their story, and this is listened to very deeply, **they can then begin to heal**

Dr Richard Benjamin

Psychiatrist Perspective

Major points

- Contemporary responses from Mental Health Professionals to patients suffering with complex trauma often overlook the central problem – the trauma itself
- A focus on symptomatic 'diagnosis', theories of chemical imbalance and medication treatment, and a focus on specialised treatments and techniques delivered over short periods can all contribute to this
- Patients with complex trauma need to be deeply listened to and heard. In this way not only can the truth be both said and understood, but healing can begin

Dr Richard Benjamin

Psychologist Perspective

Background

- Holistic and Trauma Informed Psychologist/Somatic Psychotherapist (Hakomi & Sensorimotor)

Mr Philip Hilder

Psychologist Perspective

Assessment Triage

Crisis Intervention: Immediate information and referral support for the following matters:

- Safety?
- Social Welfare?
  - Financial? Accommodation? Other?
- Relationships?
- Medical/Psychiatric?
  - Medicine?
- Work/Study?
- Legal?

- Warm referral and consistent check-in to monitor ongoing progress

Mr Philip Hilder

Psychologist Perspective

Bateson's Propositions

Mind is:

1. Parts organised into a whole
2. The parts communicate
3. Information is coded
4. Energy is collateral, information is key (core beliefs)
5. Understand via embracing complexity, appreciation that behaviour is multiply determined
6. Hierarchy of structure and function

Mr Philip Hilder

Psychologist Perspective

Principles of Tx

Therapeutic assessment/intervention:

- Mindfulness (notice and reflect present experience)
- Attend to implicit memory
- Reorganise the nervous system (The Polyvagal Theory)
- Reorganise the mind (Salvador Minuchin)
- Support defences

Mr Philip Hilder

Psychologist Perspective

Judy

- Warm welcome
- Attend: Comfort/safety?

Interventions (1)

- Mindfully attend/reflect Judy's implicit state: 'sad, flat, worn out'
  - Offer potentially nourishing intervention
  - Experiential Interventions: From 'stressed' chair to 'stress free' chair (get client's agreement/permission)
  - Mindfulness of this experience, process the outcome

Mr Philip Hilder

Psychologist Perspective

Judy (cont.)

Interventions (2)

- Mindfully attend/reflect the parts of Judy's mind that are present
  - "Seems to me that there's a part of you that works so hard and another part of you that is so worn out, sick and tired, suicidal" (reflect parts of mind). "Is that right"? (check out truth of this with the client). "Do you notice these parts of you right now"? (invite mindfulness).
  - Offer a potentially nourishing intervention: "Would it be ok to explore these parts of your mind right now"? (get client's conscious permission). "Can we explore one at a time"? (Zen)…. (Make friends with both sides, attend experientially to the needs of both sides, help your client develop their Self – ultimately interventions are aimed at developing Self leadership (Richard Schwartz)

Mr Philip Hilder

General Practitioner Perspective

Judy's complexity

Complicated relationships – affected by mistrust and alienation – difficulties with intimacy and touch, isolation and lack of protection

Complicated emotions and distorted ways of handling them – extremes of sadness and anger, sudden changes in emotions that she finds difficult to manage, DSH to manage them

Complicated personal history – ambivalence in rel with mum, not being heard, being beaten , being not seen by her father

Complicated connections to her memories – flashbacks, nightmares, feeling trapped, amnesic episodes, confusion about what she remembers

Complicated relationship to herself – not good enough, suicidal, sensitive, helplessness

Complicated relationships to health caregivers – not seen or noticed there too – many disconnected assessments, no understanding of current triggers

Dr Johanna Lynch

General Practitioner Perspective

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 and intimacy)
- Connection with their body (inc somatisation, body memories, or dismissive and ignoring)
- Systems of meaning (hopelessness, despair, feeling punished, deep hope)

Dr Johanna Lynch

General Practitioner Perspective

Integration; Coherence; Being Held

- Growing realisation in my practice – influence by Seigel's research into adult survivors of child abuse – explaining the concept of a 'coherent autobiography' having far reaching effects on ability to parent without intrusions of un-processed memories. He has further expanded these ideas to consider neurobiological processes connecting R and L brain, cortex and limbic systems, mind and body, self and other.

Dr Johanna Lynch

General Practitioner Perspective

Coherence

- In myself – my pain, my reactions, my expertise, my lack of expertise.
- In them - see the whole person – not just the present symptoms – but context and history and body and mind and self and spirit and relational context, seen and hidden
- In the system – more than me, more research and clinical ways of managing, more than symptoms, more than medication, other ways of seeing and responding are important, other carers deserve respect

Dr Johanna Lynch

General Practitioner Perspective

Trauma and neglect divide

- Divide self – civil war
- Divide relationships – betrayal, distrust
- Divide community – alliances and powerbrokers
- Divides mental health system...

- Requires input of energy and active decision to work towards unity and team and mutual respect in the presence of the pain of trauma

Dr Johanna Lynch

General Practitioner Perspective

Dissociation – even the concept divides

- A division of consciousness or personality (onno van der hart)
- Involves a parallel owning and 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 and 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

Transdisciplinarity. – All the different ways we hold.

- Generalism – not reductionism
- Willingness to tolerate not being the expert and uncertainty
- Respecting and learning from other paradigms of care and bodies of research
- Open to the humanities and to being human
- Aware that I cannot see and hear all that needs to be seen and heard
- System working coherently

Dr Johanna Lynch

General Practitioner Perspective

- "Just as no survivor can recover alone, no therapist can work with trauma alone." Judith Herman *Trauma and Recovery*

- "Vulnerability is our most accurate measure of courage" Brene Brown *TED* talk

Dr Johanna Lynch

General Practitioner Perspective

Centrality of safety

- Main body of the work of trauma specific care is helping the person experience feeling safe enough to grieve what has happened to them
- 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

  -in their **mind** – content and quality of thoughts

  -in their **emotions** – understanding and managing hyp 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

- “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

My hopes for Judy

- **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**
- **Notice all of herself** - learn to be kind and caring (including intrapsychic unity).
- **Engage other help** – exercise, health, parenting, grandparent support, COPMI, family therapy
- Be helped by a **team that collaborates –** body focussed mindfulness training, art therapy, mental health nurse, family therapy, GP, psychiatrist, psychologist...

Dr Johanna Lynch

General Practitioner Perspective

WHY?: What are the PRIORITIES of assessment in primary care? *Lynch et al. 2012.*

- Primacy of connecting in therapeutic relationship
- Safe and empowering collaboration
- Communication in a shared language

Dr Johanna Lynch

General Practitioner Perspective

HOW?: What PROCESS of assessment is best in the primary care setting? *Lynch et al. 2012.*

- Establish working relationship
- To understand the people we care for
- To facilitate hope for their recovery and growth
- To check on their physical and psychological safety
- To do no harm

Dr Johanna Lynch

General Practitioner Perspective

WHAT CONTENT is adequate to ensure assessment forms a comprehensive understanding of this person, their problem and their context? *Lynch et al. 2012.*

- Transdisciplinary Integration of many paradigms of mental wellness
- Holistic awareness of context and history
- Assess the patient, their relationships and their sense of meaning

Dr Johanna Lynch

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
- For more information about MHPN networks and online activities in 2013 visit www.mhpn.org.au
- Stay tuned for the next MHPN webinar Monday, 15th May 2013: Collaborative Care and Suicide Prevention

Are you interested in leading a face-to-face network in your local area with a focus on Complex Trauma?

MHPN can support you to do so.

Please fill out the Expression of interest that you'll receive as a link in the webinar follow up email. MHPN will follow up with you directly.

Thank you for your contribution and participation