

## **MHCC Conference – Trauma informed Care and Practice- Meeting the Challenge**

**Title: Trauma informed care and practice – changing the lives of Australian adult survivors of childhood trauma**

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As a group, adult survivors of childhood trauma in Australia have repeatedly been ignored in mental health policy reform and have continually fallen through the cracks in service systems. The reasons for this are many and varied. Factors include the stigma and taboo which exist around abuse, in general, and the legacy of abuse, in particular, as well as a collective denial about the scale of the issue and the long-term complex needs experienced by many survivors. Sometimes, the failure to acknowledge the issues is pure ignorance. Adults traumatised by interpersonal violence in childhood often have severe and persistent mental health, health, behavioural, social and/or substance abuse problems. The international and national research evidence around these impacts is copious and yet has failed to influence policy reform and planning. There remains a prevailing attitude that, as adults, people should be able to put their abusive childhoods behind them – on their own.

The good news is that people **are** resilient and with the right help and psychosocial supports, adult survivors can find their road to recovery. The sad reality however is that this resilience is repeatedly tested by the current appalling lack of investment in a trauma-informed approach to care and support Australia-wide.

Let's define trauma-informed care and practice and put it in context in relation to adult survivors of childhood trauma. "Trauma-Informed Care and Practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment."

The majority of survivors cannot access and/or afford to sustain the holistic support they need to make sense of their histories and work towards recovery. What's more, few service systems or workers have the insight and awareness needed to appropriately acknowledge and support survivors' fundamental needs. These collective failures repeatedly compound the multiple challenges that survivors of childhood trauma, their families and communities experience.

All trauma has the potential to invoke fear, helplessness, and horror, and overwhelm a person's resources for coping. The trauma on which I'm focusing can be caused by all forms of abuse - sexual, physical and emotional including neglect and witnessing or experiencing violence in the home or neighborhood. Often victims of abuse experience several forms of trauma concurrently. While individuals' and society's reactions to trauma vary enormously the trauma of childhood abuse can be especially damaging. There is a multitude of reasons for this.

During childhood the brain grows and develops rapidly, especially in the first 3 to 5 years, with further rapid development during puberty and it continues to grow and develop until a person is in their twenties. During this entire period trauma can and does impact fundamental neuro-chemical processes, and these in turn can affect the growth, structure, and functioning of the brain. If experiences occur when an infant is pre-verbal the impacts can be particularly complex since memory may locate them in inexplicable somatic expression only.

The trauma of child abuse is rarely an isolated incident. Childhood trauma is commonly repeated, prolonged and extreme, characterized by a series of traumatic events starting at a young age and disrupting the earliest of attachments. Its effects are all the more pervasive because children are young, vulnerable and developmentally immature.

Childhood trauma is interpersonal i.e. perpetrated by one human being on another, is most commonly perpetrated by adults on whom the child depends and trusts, the very adults charged with the child's care. The trauma perpetrated is also generally intentional, differentiating it from the trauma

of natural disasters and separation, death and loss. For all these reasons childhood trauma is more prone to cause global consequences than trauma which is experienced in adulthood.

The criteria of a diagnosis of PTSD were developed to capture the impacts of war trauma featuring the triad of intrusive re-experiencing of traumatic memories, emotional numbing and avoidance of reminders of the trauma, including memory loss, and hyperarousal. The characterization of the impacts of childhood trauma in terms of PTSD alone and service responses based solely on the diagnosis fail to capture the often pervasive impacts of childhood trauma.

Without the security of a safe, stable attachment, children who are abused focus on simply surviving and so shift resources normally earmarked for learning and development. This combination of ongoing trauma exposure and the developmental impact of such exposure typifies *complex trauma*, which features an additional array of traumatic stress challenges. Sadly the concept of Complex PTSD was rejected for inclusion in the DSM v.

Secure attachment relationships with attuned, consistent caregivers enable children to internalize key self-regulatory functions and develop a sense of safety and basic trust in the world. The fundamental betrayal and relational damage a child suffers when that child is repeatedly abused and neglected, sets up lifetime patterns of fear and mistrust, impacting personal identity and self-worth, relationships with others and with the world, emotional regulation, self-soothing and stress management. Adult survivors often additionally struggle with somatic symptoms and chronic feelings of hopelessness.

Many adults who have suffered childhood trauma have developed extreme coping strategies as ways of managing the impacts of overwhelming traumatic stress. Many of these strategies are adopted in childhood but persist into adult life. They include suicidality, substance abuse and addictions, self-harming behaviours such as cutting and burning, dissociation, and re-enactments such as abusive relationships. These behaviours are often challenging not only for the survivor but for those seeking to support them. However in the context of trauma they make perfect sense.

Meeting the needs of adult survivors can be challenging for all of the reasons I've outlined (the deep feelings of insecurity, sensitivity of criticism, low self-esteem, difficulties with trust and interpersonal relationships, substance abuse, self-harming, suicidal and risk-taking behaviours with which many survivors struggle).

When a child is abused the child takes on an inappropriate sense of shame and self-blame and these feelings often continue into adult life. Even though survivors may want to talk about their feelings, their own shame as well as fear of how others will respond can stop them from doing so. Child abuse, at its core, is about being and feeling unsafe and survivors try to protect themselves from being hurt again. Hence survivors will tend to withdraw, isolate themselves and not seek help. Strategies such as these combined with the symptoms of hyper-arousal or avoidance that accompany PTSD, can make it particularly hard for survivors to seek help and engage in and sustain treatment.

Fortunately survivors can and do recover and they can go on to live successful and fulfilling lives. They can learn how to trust, to feel safe and relate to others, how to self-regulate. Neuroscience tells us that neural pathways can repair themselves but survivors need support, empathy, understanding and respect. Our current systems of care often fail to respond ignoring the underlying trauma, at the core of survivors' issues, failing to address it. Frequently the possibility of underlying trauma is not on a health professional's radar at all or if known about, is not viewed as pivotal. In fact it can all too readily be invalidated, negated or dismissed. Such responses come at a huge cost, not just to individuals but to families and communities. ASCA witnesses that cost every day in its work.

Every day ASCA receives calls from child abuse survivors who cannot find or afford the care and support they need. They report having experienced a health care professional who has been disempowering, re-victimising or otherwise unhelpful; a GP who was uninformed, who didn't inquire about trauma despite symptoms which were highly suggestive. A worker who didn't know how to respond to a disclosure, a counsellor, psychologist or psychiatrist they felt had minimized or dismissed their feelings and experiences rather than listening empathically and validating them.

It is staggering how often survivors are told by those in health care environments things like "It happened such a long-time ago; there's no value in talking about it. What does it matter? Stop

whingeing about it.” These attitudes parallel the survivor’s experience of being told to keep quiet about their abuse or, on disclosure, being ignored or vilified. Some workers believe that talking about past traumas is irrelevant and self-pitying or imply that the trauma was the person’s fault, that he/she is carrying on about nothing, making things up, exaggerating, or has a personality disorder.

The medical model is designed to diagnose i.e. to apply a label to a disease, a pathology or group of symptoms. Physical diseases fit into symptom profiles and can have labels applied and these labels enable medical practitioners to apply the treatment responses they have learnt to those symptom profiles and diseases. However the repercussions of trauma do not fit neatly into a single diagnosis or even a number of diagnoses. A vast spectrum of disorders can be attributable to prior trauma and survivors may carry any psychiatric diagnosis, and frequently carry a range of diagnoses over time. This is in and of itself is a major issue.

As a survivor of childhood trauma myself, I can attest to the fact that whilst in the midst of dealing with my childhood trauma I could easily have ticked many categories in the DSM IV. Anxiety disorder, depression, suicidality, Chronic PTSD, Dissociative Disorders but none of these diagnoses captured the essence of my struggle. Thankfully I had a therapist who didn’t pathologise me.

The premise of the medical model is the principle that something is wrong with a person rather than highlighting that something wrong was done to or happened to a person. I developed a range of mental health challenges because of what had happened to me. And as one of my medical colleagues at the time so delicately put it: “You’re not becoming one of those mental health patients are you?” Well maybe I was but then maybe I needed to be understood rather than being judged and ostracised.

AS is common to all survivors I needed empathy, compassion and understanding. My mental health challenges were ‘normal’ reactions to extremely ‘abnormal’ circumstances and appreciating this is fundamental to the movement to embrace a trauma-informed approach. Rather than articulating a diagnosis it is critical that anyone interacting with survivors understands the effects traumatic life events have on the development of individuals. For me, finding a therapist who validated my experience, who bore witness to what had happened to me, who I learnt to trust, who gave me unconditional support, who listened empathically and who could contain my angst and help me feel and be safe, was crucial to my recovery.

One of the most pathologising diagnoses is that of Borderline Personality Disorder. Many of the repercussions of complex trauma parallel the symptom profile of the diagnosis of Borderline personality disorder – impulsivity, self-harm, emotional lability, relational instability and instability of sense of self. This diagnosis has carried enormous stigma implying hopelessness, manipulation and resistance to treatment. However understanding the behaviours which characterise it in terms of traumatic stress, disrupted attachment, personal invalidation and adaptive coping strategies help workers understand and empathise with those who they are seeking to support.

In recent years, cognitive-behaviour therapy, exposure and cognitive restructuring have been used extensively as evidence-based responses to PTSD. However the application of such techniques to those who have experienced complex trauma especially prior to the establishment of safety can be fraught. Working through the compounded impacts of complex trauma can take a long time and involves a number of stages including establishing safety, stabilisation, establishing a therapeutic relationship, education and skill building, processing and integration. The failure of practitioners, systems and governments to appreciate these complexities means that many survivors of childhood trauma do not find the care and support they need to reclaim their health and wellbeing.

Sadly in Australia adult survivors with complex needs struggle to find services in which workers are adequately trained around trauma. Systems are overstretched and services tend to focus on crisis and risk management delivering short term rather than the longer-term interventions needed for sustained recovery. In many cities and towns it is hard to access expert long term and affordable counselling/therapy and/or skilled groups and workshops. In rural and regional areas services are virtually non-existent.

Current systems commonly label and pathologise survivors and their presentations. An inherent lack of understanding and awareness around potential triggers leaves survivors open to re-traumatisation.

This means survivors often experience services as being unsafe, disempowering and/or invalidating. Characteristically survivors shop around, presenting to a large number and range of services over a long period of time including government, non-government, public, private and community-managed services. Survivors continually search for a service which will understand them and their behaviours and reactions in the context of their trauma. Often times they are left not knowing where to turn and effectively give up. Of course there are exceptions and some specialist services are sensitive to survivors needs but they are few and far between. Often they depend on an individual rather than a service culture and when the individual leaves, so does the possibility that survivors presenting there will receive the ongoing care and support they need towards recovery.

Trauma survivors with complex needs often experience co-morbid mental health and substance abuse problems and a range of life burdens. These findings are supported by extensive research evidence. That is - the majority of clients presenting to mental health and AOD services have trauma histories integrally intertwined with their substance abuse and/or mental health challenges. Yet despite it being patently obvious that all three issues should be addressed in an integrated way, this rarely happens. Care for survivors with co-morbidity is often fragmented and fails to respond to their multiple needs which can include unemployment, welfare dependency, homelessness and social exclusion. A holistic approach to care and support is needed and yet to date we see little to no co-ordination between services along with poor referral and follow-up pathways.

I am a medical practitioner by training. The Hippocratic oath states: "First do no harm" .However harm is often done to trauma survivors when their trauma goes unacknowledged and when their particular vulnerabilities and sensitivities are disrespected and misunderstood. Harm is done when survivors are labelled and they are negated as human beings and as individuals disaffirming their traumatic experiences at the very core of their being.

At the most basic level, trauma informed care involves the provision of services that do no harm – e.g., that do not re-traumatise victims or blame victims for their efforts to manage their traumatic reactions.

Workers need to recognise the adaptive function of "symptoms;" and work in a collaborative and empowering way. Understanding a symptom as an adaptation reduces guilt and shame, increases self-esteem, and provides a pathway for developing new skills and better adaptations. Validating resilience is important even when past adaptations and ways of coping are causing problems in the present. Survivors need to feel understood, have their experiences heard and validated and find a sense of belonging.

Survivors generally also benefit from making connections between their past experiences and their current situation as part of an integrated recovery journey, enabling them to ultimately view their abuse as part rather than all of them and acknowledge their other social roles and strengths.

However none of this can occur in isolation. Relationships are crucial to the process of recovery but it is the nature of those relationships that is vital. As the relationships which caused the original trauma were disempowering and controlling, relationships of care and support must challenge the beliefs created by the original trauma. They must be safe, consistent and constructive, non-violent, non-blaming and non-shaming, and feature persuasion and not coercion, ideas and not force, and mutuality rather than authoritarian control.

Predictable environments with clear boundaries and well defined roles allow survivors to feel empowered and re-build a sense of self-efficacy and personal control - factors which are essential to recovering from the overwhelming fear and helplessness that is the legacy of victimisation. Approaches should be collaborative and mutually respectful with the survivor setting the pace. This allows survivors to build on their strengths, and resiliency, and to further develop their coping skills while embracing hope and working towards a positive future.

I support the belief that what we need to see is a cultural & philosophical shift to a system that embraces trauma-informed care and practice across the board. This will require sustained commitment and investment in services and programs. Systems will need to integrate awareness and understanding around trauma and traumatic stress in their work and approach people from a trauma informed perspective – that is, to consider the possibility of undisclosed or unaddressed childhood

trauma at the root of presentations. Being cogniscent of the possibility can make an enormous difference to the way a survivor reacts, copes going forward and recovers.

In a trauma informed system, survivors' conditions and behaviours are viewed differently, staff respond differently, and the day-to-day delivery of services is conducted differently. As survivors' needs cross service systems these proposed changes are not limited to mental health but apply to multiple systems. Such change will require collaboration between services and networks of health and allied care professionals i.e. an integrated approach which has survivors at the core in a model of recovery.

The new system will be characterized by safety from physical harm and re-traumatization; an understanding of survivors and their symptoms in the context of their history, culture, sexual orientation, ethnicity and gender and community; open and genuine collaboration between workers and those seeking help at all phases of service delivery; an emphasis on building on strengths and acquiring skills rather than on managing symptoms; an understanding that symptoms represent attempts to cope, regardless of how extreme they may seem; a perception that childhood trauma was a defining experience/set of experiences that forms the core of an individual's identity rather than a single discrete event; and by a focus on what happened to a person i.e. the wrong which was done to the person rather than what is wrong with the person.

For example, agencies should routinely consider the possibility of trauma even when it hasn't been disclosed, and focus on creating safety and increasing access to trauma specific services when supporting people who have disclosed.

A trauma-informed care and practice approach with emerging best practice models provides renewed hope of recovery to clients with complex, severe, and persistent mental health and AOD issues.

A variety of studies and pilot programs, that utilize a trauma-informed model, report a decrease in psychiatric symptoms, substance use and trauma symptoms, as well as an improvement in consumers' daily functioning. Some studies have found decreases in the use of intensive services such as hospitalization and crisis intervention following the implementation of trauma-informed care.

Trauma-informed integrated services do not cost more than standard services and have improved outcomes. Services report greater collaboration with consumers, enhanced skills, and a greater sense of self-efficacy among consumers, as well as more support from their agencies. Supervisors report more collaboration within and outside their agencies, improved staff morale, fewer negative events, and more effective services.

ASCA is a small organisation which advocates for the needs of Australian adult survivors to be better met by means of a trauma-informed approach to care. Callers to ASCA's 1300 line are listened to and heard and their feelings are validated. Establishing safety and maintaining confidentiality is a priority. Some callers to our line are speaking about their abuse for the very first time. The way that disclosure is handled can make all the difference to that person's progress. ASCA has also developed a database of ASCA-endorsed therapists – practitioners and agencies which have met ASCA's minimum criteria of training, skills, qualifications and experience.

Over the last few years ASCA has also developed a set of evidence-based psycho-educational workshops for adult survivors based on national and international best practice. These workshops help survivors and their supporters understand the impacts of abuse, facilitating insight into current and past behaviours and feelings while providing the tools for positive change. ASCA's education and training for community workers and health care professionals is helping to develop a trauma-informed workforce better trained and better informed to support the complex needs of adult survivors of childhood trauma.

“Please, please educate counsellors, psychologists-anyone who comes into contact with survivors of child abuse that it can have life-long effects. We cannot move on until we have dealt with our baggage and it takes a long time and endless patience and support. We don't want to wallow, however we need to deal with and express our pain and anger and go through the stages of grief and loss for our lost childhood. Counsellors etc need to understand the stages of childhood development and realise the impact of not experiencing these important developmental stages. I don't believe there are any quick fixes. We need to be listened to, have our experiences

validated. Counsellors with little experience, despite the best of intentions can do more harm than good. Inappropriate 'help' kept me in denial and isolation for many years."