

NSW Rape Crisis Centre

Working against sexual violence

24/7 state-wide telephone and online crisis intervention, support counselling and referral for: victims of sexual assault whether the assault happened recently or in the past, family and friends of someone who has been sexually assaulted, and anyone who has assisted a person who has been sexually assaulted and needs to debrief.

Counselling 1 800 424 017

www.nswrapecrisis.com.au



Administration

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Disorders Arising from Trauma

- ASD
- PTSD
- Type I Traumas
 - Disaster
 - Combat
 - Adulthood Rape



Type II Traumas

- Type II traumas
 - Prolonged repeated trauma
 - Prolonged repeated trauma during childhood
 - More complex symptoms that are not recognized in DSM IV
-  Herman, 1992 suggests Complex PTSD for inclusion in DSM

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Multiaxial Assessment: Axis IV

Axis IV: Psychosocial and Environmental Problems

“In practice, most psychosocial and environmental problems will be indicated on Axis IV. However, when a psychosocial or environmental problem is the primary focus of clinical attention, it should also be recorded on Axis I, with a code derived from the section “Other Conditions That May be a Focus of Clinical Attention” (pg. 31, APA, 2000).

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to health care services
- Problems related to interaction with the legal system/crime
- Other psychosocial and environmental problems



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Multiaxial Assessment: Axis IV (Cont.)

V61.21 Physical Abuse of Child

Specify 995.54 if focus of clinical attention is on the victim

V61.21 Sexual Abuse of Child

Specify 995.53 if focus of clinical attention is on the victim

V61.21 Neglect of a Child

Specify 995.52 if focus of clinical attention is on the victim

V61.12 Physical Abuse of Adult *(if focus of clinical attention is on the perp and abuse is by partner)*

V62.83 Physical Abuse of Adult *(if focus of clinical attention is on the perp and abuse is by person other than partner)*

995.81 Physical Abuse of Adult *(if focus of clinical attention is on the victim)*

V61.12 Sexual Abuse of Adult *(if focus of clinical attention is on the perp and abuse is by partner)*

V62.83 Sexual Abuse of Adult *(if focus of clinical attention is on the perp and abuse is by person other than partner)*



995.83 Sexual Abuse of Adult *(if focus of clinical attention is on the victim)*

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- So other diagnoses are commonly picked for people who are traumatized
- Connection between trauma and symptoms gets lost
- Responsibility gets located in patient's genes or personality
- Treatment is different



Co-morbidity for 107 Trauma In-Patients

- Mood disorder 98.1%
- Anxiety disorder 89.7%
- Psychotic disorder 65.4%
- Substance Abuse Disorder 65.4%
- Somatoform Disorder 43.9%
- Eating Disorder 38.3%



Co-Morbidity for 103 Trauma In-Patients

- Major Depressive Disorder 97.2%
- Panic Disorder 69.2%
- Substance Abuse 65.4%
- Obsessive Compulsive Disorder 63.6%
- Borderline Personality Disorder 56.3%
- Schizoaffective Disorder 49.5%
- Social Phobia 45.8%
- Somatization Disorder 41.1%



How Many People Does This Affect?

- 70% of psychiatric patients presenting to ER had childhood trauma histories
- 50-60% of psychiatric inpatients and
- 40-60% of psychiatric outpatients report childhood trauma



How Many Diagnoses?

Of 2389 individuals with a psychiatric disorder

- 58.9% had 3 or more diagnosable disorders

And when psychiatric disorder was severe enough to require hospitalization

- 89.5% had 3 or more diagnosable disorders



A Hidden Etiology?

- Extensive co-morbidity is accompanied by high rates of type II trauma
- Hidden etiology = type II trauma



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Classical Medical Model versus Trauma Model

- | | |
|---|--|
| 1. Views presenting problem as abnormal | 1. Views presenting problem as normal reaction to abnormal situation |
| 2. Situates problem within the person | 2. Situations problem in the traumatic event |
| 3. Client as passive | 3. Client as active |
| 4. Focussed on symptom reduction often via medication use | 4. Focussed on skill development, trauma processing etc |
| 5. Focussed on achieving stability and maintenance | 5. Focussed on recovery and growth |
| 6. Targeted interventions | 6. Holistic interventions |



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Case Studies

1. Borderline Personality Disorder and Trauma
2. Factitious Disorder and Trauma



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Case Study: Borderline Personality and Trauma

Robert

- 32 yo male,
- above average intelligence, however school failure,
- impulsive and risk taking behaviours,
- has been described as manipulative and requires a strong need for control,
- minor criminal activity as an adolescent but never convicted,
- unemployed and collects disability support pension,
- difficulty managing relationships (including work and social),
- extremely limited social network,
- CSA history perpetrated by biological mother and father,
- familial history of substance abuse,
- multiple hospital admissions for suicide attempts and self-inflicted injuries,
- describes experiencing severe dissociative symptoms, particularly when stressed.
- multiple treatment failure, aggressive behaviour and threats of harm made to past therapists (especially during periods of service closure/withdrawal),



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Borderline Personality and Trauma

Classical Medical Model Formulation

Presenting Problem:	Therapy interfering behaviours and manipulative behaviour (including parasuicidal behaviour)
Predisposing Factors:	Poor interpersonal skills, past success in avoiding personal responsibility through controlling expectations of self
others, low	
Precipitating Factors:	Feeling lonely or bored, feeling challenged or under threat and resultant sense of vulnerability and need for control
Perpetuating Factors:	Impulsivity (behavioural and emotional), too much pay off for negative behaviour (eg disability support pension, social contacts etc)
Diagnosis:	Borderline Personality Disorder – difficulties and problematic behaviours are long-standing and pervasive



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Borderline Personality and Trauma

Classical Medical Model Intervention

- DBT aimed at skill development to manage interpersonal difficulties, emotional regulation and suicide/self-harming behaviours;
- No medication;
- Case management plan that has a clear crisis intervention response (eg suicide/self-harm management plan) and minimises contact with health services and other opportunity for tertiary gains.




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Borderline Personality and Trauma

Trauma Model Formulation

Presenting Problem:	Therapy interfering behaviours and manipulative behaviour (including parasuicidal behaviour)
Predisposing Factors:	Negative environment during childhood (eg. familial substance abuse, CSA, possible neglect) leading to poor attachment with primary caregivers, difficulty developing trust and feeling safe, sense of feeling powerless
Precipitating Factors:	Event resulting in real or imagined rejection/abandonment (eg. therapist going on leave) or at risk of harm (eg. therapist challenging compromising sense of control)
Perpetuating Factors:	Impulsivity (behavioural and emotional), unprocessed trauma inhibiting effective interpersonal skill development and self-identity
 Diagnosis:	Therapy interfering behaviours and “manipulative” behaviour (including parasuicidal behaviour) are his attempts to regain a sense of control and safety

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Borderline Personality and Trauma

Trauma Model Intervention

- Psycho-education on impacts of childhood trauma and its relationship to current difficulties
- Trauma processing, commencing with the establishment of safety (both internally and externally);
- Skill training to help manage emotional regulation, build interpersonal effectiveness and replace self-harming as a coping strategy with non- harmful strategies (eg DBT);
- No medication;
- Case management plan that enables skill generalisation and supports therapeutic work, including a crisis response plan.



Borderline Personality and Trauma: Case Study Summary

- In this case, intervention does not differ dramatically between the two models;
- However, how the clinician relates to the client different and consequently the client's perspective of intervention is quite different;
-  Dependent upon how the case is conceptualised has a significant impact on how the client/patient is case managed

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Case Study: Factitious Disorder and Trauma

Fran

- 36 yo female
- multiple hospital admissions for injuries (eg. vaginal lacerations, bruises, cuts and scratches) reportedly resulting from multiple sexual assaults
- she reports a CSA history and multiple SAs, however some concerns over inconsistencies in reports, also some concerns over consistent themes in her reports of SA (eg. same perp MO etc)
- no past CSA or SA has ever been substantiated, in fact, she retracted her first claim that she was CSAed by her step-father and has ongoing contact with him and her mother
- she describes experiencing periods of dissociation and flashbacks and engages in self-harming behaviours
- she reports no drug or alcohol history.



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Factitious Disorder and Trauma

Classical Medical Model Formulation

Presenting Problem:	Inconsistencies in report of CSA and SA
Predisposing Factors:	Attachment with mother became disrupted when mother started new relationship with step-father
Precipitating Factors:	Sense of loneliness, feeling detached, unmet emotional needs
Perpetuating Factors:	Positive response from services that validate her claim of being sexually assaulted, provide a sense of being nurtured and connected (even if only momentarily)
Diagnosis:	Factitious Disorder – Fran fabricates events when she becomes emotionally distressed with the specific goal of breaking her isolation and loneliness and to obtain a sense of being nurtured.



Factitious Disorder and Trauma

Classical Medical Model Intervention

- Counselling aimed at addressing attachment disruption and developing pro-social ways of meeting unmet emotional needs;
- No medication;
- Case management plan that minimises contact with health services thus not reinforcing fabrication of events or spending large amount of funds on un-substantiated allegations.



Factitious Disorder and Trauma

Trauma Model Formulation

Presenting Problem:	Inconsistencies in report of CSA and SA
Predisposing Factors:	History of trauma (CSA, perhaps also SA)
Precipitating Factors:	Emotionally distressing event that triggers dissociation, flashbacks etc
Perpetuating Factors:	Unprocessed trauma, unable to process trauma when her claims of being assaulted (as a child or adult) have been discredited.
Diagnosis:	Fran engages in self-harming behaviour while dissociated and reliving a traumatic memory, she cannot recall the self-harming event and attributes the injury to having been assaulted.




Factitious Disorder and Trauma

Trauma Model Intervention

- Establishment of safety (both external and internal)
 - Safety from contact with CSA perpetrator
 - Skills training to help manage dissociation, flashbacks and replace coping strategy of self-harm with non-harmful strategies;
- Trauma processing;
- Anti-anxiety medication may be useful during skills training;
- Case management plan that focuses on achieving internal safety, which may include accessing services when feeling at risk and processing precipitating events that lead to the perception of threat.



Factitious Disorder and Trauma: Case Study Summary

- In this case, intervention differs dramatically dependent upon how the case is conceptualised;
- The trauma model formulation and intervention initially runs the risk of reinforcing the attention-seeking behaviour, though the establishment of safety stage would likely elicit new skills meaning that costly and ineffective attention-seeking behaviour ceases;
- The classical medical model formulation and intervention  invalidates the client's report of trauma and thus further traumatizes the client.

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Key Points

- Co-morbidity may signal an underlying type II trauma
- Type II traumas are not easily recognizable using DSM criteria
- Trauma formulations can usefully inform care planning for clients with co-morbidity or diagnoses that don't quite fit.

