ASCA Practice Guidelines

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adults surviving child abuse

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Dr Cathy Kezelman,
President ASCA

Practice Guidelines

The Last Frontier: *Practice Guidelines for Treatment of Complex Trauma & Trauma Informed Care & Service Delivery*

Dr Cathy Kezelman & Dr Pam Stavropoulos Adults Surviving Child Abuse ('ASCA') 2012

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The Last Frontier: '*Practice Guidelines for Treatment of Complex trauma and Trauma Informed Care and Service Delivery*'

"*These guidelines tackle the last frontier of mental health and medical services, namely, the recognition of the major role of trauma in the development of emotional disorders and medical illnesses and its unacceptably high individual, familial, and social/economic cost*"

Christine A. Courtois, PhD, ABPP

Complex vs `single-incident' trauma

Complex trauma is more *prevalent – interpersonal, developmental*, often *repeated* and *extreme*; impacts *cumulative*

The majority of clients who experience trauma-related problems have complex, rather than `single-incident' trauma

Complex Trauma

- Child abuse – all forms
- Chronic neglect
- Family & community violence
- Other adverse childhood experiences

Complex trauma

'Emotional abuse, loss of caregivers, inconsistency, & chronic misattunement showed up as the principal contributors to a large variety of psychiatric problems'

(Dozier, Stovall, & Albus, 1999; Pianta, Egeland, & Adam, 1996; van der Kolk, ibid)

Complex trauma impacts

When unresolved, complex trauma causes ongoing problems, not only for those who experience it, but for their children (intergenerational effects) and society as a whole.

Unresolved trauma:

(1) has negative effects **across the life-cycle** for those who directly experience it

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

Parents do not need to be actively abusive for their children to be adversely affected. An unresolved trauma history will negatively impact infants via disrupted attachment styles

Complex trauma is complex because….

it places the person at risk not only for *recurrent anxiety* (including increased risk of single-incident [`simple'] PTSD)

but also for:

'*interruptions & breakdowns* in the most fundamental outcomes of healthy psychobiological development'

- *integrity of body*
- *development of healthy identity & coherent personality*
- *secure attachment*, ie ability to have healthy relationships

(Cook et al, 2005; van der Kolk, 2005, in Courtois & Ford, 2009:16)

Complex trauma

- compromises *self-development* (Courtois & Ford, 2009: 16).

- usually involves a *betrayal of trust* in primary relationships (DePrince & Freyd, 2007)

Child abuse is a particularly damaging form of complex trauma: *childhood trauma compromises core neural networks* (Cozolino, 2002:258).

Adverse Childhood Experiences Study

- The most comprehensive study to show a relationship between stressful overwhelming experiences in childhood & compromised *mental* ***and*** *physical health* in adulthood
- US longitudinal study of over 17000 participants
- Cohort members *predominantly white middle-class*; average age 57; had some college education; lacked obvious markers of social disadvantage

Yet two major findings are that:

(1) Adverse childhood experiences are `vastly more common than recognized or acknowledged'

(2) They powerfully impact both mental and physical health `a half-century later' (Felitti, 2002:45).

Prioritising trauma

- Trauma not a priority in health agendas & budgets *(`not on radar')*
- The trauma-related nature of many psychological ***and*** physical problems is scarcely recognized
- That trauma is not just an `individual' misfortune but *a major public health problem* is not widely understood, including in health sector

Research into Practice

A large body of knowledge about the impact of traumatic experience*...on a wide variety of psychological, physical & social problems...is by* ***now well established, yet there is still relatively little application of this science to standard practice'*** **(Bloom, 2011:82).**

Practice Guidelines – 2 sets

- Evidence base to translate research into practice.
- Framework to respond to public health challenge of trauma
- Set the standards in each of the following domains:

A. `*Practice Guidelines for Treatment of Complex Trauma*' are for the clinical context, and reflect growing insights into the role of trauma in the aetiology of mental illness and new possibilities for clinical treatment.

B. `*Practice Guidelines for Trauma-Informed Care and Service Delivery*' are directed to services with which people with trauma histories come into contact.

Practice Guidelines

Substantial gap between knowledge, understanding and practice around complex trauma

Guidelines fill the gap for whole system – practitioners, workers, organisations, systems and policy makers

Trauma presentations

'The majority of people who seek treatment for trauma-related problems have histories of multiple traumas' (van der Kolk, 2003:172)

`*Trauma has often occurred in the service context itself'*

(Jennings, 2004:6; Bloom & Farragher, 2011; Davidson, 1997)

Stakes and challenges

- The majority of people who access the human services sector have undergone many *overwhelming life experiences, interpersonal violence & adversity* (Bloom, 2011; Jennings, 2004:6).
- The current organisation of human services does not reflect this reality & is inadequate to cope with it
- Hence growing calls for implementation of a new paradigm – ***Trauma-Informed Care and Practice (TICP)***

Complex trauma in Australia

- Complex trauma and effects - *unrecognised, unacknowledged, misdiagnosed, unaddressed*
- multiple services over a long period of time; *care fragmented, poor referral, follow-up*
- `merry go round' of unintegrated care, *re-traumatisation, compounding*
- *escalation/entrenchment of symptoms* - psychologically, financially and systemically costly

Lived experience

"People with complex trauma will often respond better to treatment when they are empowered in ways that are unique to them, and the professionals and institutions should not underestimate the patient's ability to be very useful and active in their own treatment. Also more often than not if you begin by treating the patient as an adult with basic human rights, more often than not the patient will rise to fill that adult role. This decreases the need to restrain, over medicate, and treat patients in a punitive way."

Tamara Stillwell, mental health consumer, community worker

Quality mental health care

Need to:

- Address gaps

- Move from symptom remission to personal recovery

- Systematic/coherent response to complex trauma

Growing interest in childhood trauma and consequences, TIC movement , Royal Commission

Trauma survivors can recover

- 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.*

Mental health and human service delivery need to reflect the current research insights.

Survivors' experiences

- Every day ASCA receives calls from child abuse survivors who *cannot find or afford the care and support* they need. They have 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 highly suggestive symptoms. 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. They have been told "*It happened such a long-time ago; there's no value in talking about it. What does it matter? Stop whingeing about it.*"

Current systems

Many trauma survivors have not connected their current problems and behaviours with their past traumatic experiences and *nor have their health workers.*

Responding to public health challenge

- integration of vision and research into practice
- collaboration between consumers, carers, practitioners, service providers, policymakers
- engaging diversity stakeholders to achieve paradigm cultural shift in service delivery
- specialised knowledge, workforce development, cultural reorientation, systemic quality improvement

Lived experience of services

I suffered ill-treatment with medical professionals who **did not recognise or did not know how to effectively handle trauma*****. I suffered 5 years of*** **misdiagnosis, maltreatment and forced hospitalisation*****, in which*** **retraumatisation was prevalent.**

Consumer-centred model

- Move away from stigmatisation of mental distress
- Parallels *trauma informed approach to care*

Recovery

- Moving towards *positive and meaningful sense of identity* separate from condition, disability or its consequences – personal as opposed to clinical
- Goal is *wellbeing*; *true partnerships in decision making* between people with lived experiences and those who support them professionally and personally

Recovery-oriented approach

- Recovery-oriented approach - movement away from a primarily biomedical view of mental illness to a holistic approach to wellbeing that builds on individual strengths Davidson L 2008, *Recovery: concepts and application*, Recovery Devon Group, UK.

- *Recovery-oriented practice emphasises* hope, social inclusion, community participation, personal goal setting and self-management.

Trauma Informed Care - Recovery Oriented Practice

Developing and implementing trauma informed systems of care is one of the first steps toward becoming Recovery Oriented J. Gillece et al, The National Centre for Trauma Informed Care (NCTIC)

Trauma-informed service delivery?

- A *new paradigm* in mental health & human service delivery
- Recognises that many problems, disorders & conditions are trauma-related (Perry, 2008; Ross & Halpern, 2009)
- Rests on awareness of the impacts of trauma
- Requires staff training to act on this awareness

The possibility of trauma in the lives of all clients is a central organising principle (ie irrespective of the service provided)

Trauma informed services

Recognise that the pervasive effects of trauma can include `the way people approach potentially helpful relationships' (Fallot & Harris, 2009:2).

Rest on `a `*do no harm*' approach that is sensitive to how institutions may inadvertently reenact trauma dynamics' (Miller& Najavits, 2012; Harris & Fallot, 2001; Hodes, 2006;)

Minimize the potential for re-traumatization

Do not directly treat trauma or the range of symptoms associated with it. Rather, `they are informed about, & sensitive to, trauma-related issues' (Jennings, 2004:15).

Trauma informed Guidelines – key points

Five foundational principles of trauma-informed practice:

Safety
Trustworthiness
Choice
Collaboration
Empowerment (Fallot & Harris, 2009; Jennings, 2004)

Endorse decentralised models of care, consumer participation, & recovery-oriented practice

Becoming trauma-informed

Trauma seen as a defining & organising experience that forms the *core of an individual's identity* rather than a single discrete event (Jennings, 2004; Fallot & Harris, 2009)

Understanding of client behaviour in the context of their life experiences & history (ie 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*

Trauma informed services

Recognise that the pervasive effects of trauma can include `*the way people approach potentially helpful relationships*' (Fallot & Harris, 2009:2).

Do not directly treat trauma or the range of symptoms associated with it. Rather, `they are *informed about, & sensitive to, trauma-related issues*' (Jennings, 2004:15).

Why is trauma informed practice necessary?

Because of the *high incidence* of unrecognised underlying trauma among people who engage with the mental health sector

(2) Because *re-traumatisation* by & within services is highly prevalent

`***Trauma has often occurred in the service context itself***' (Jennings, 2004:6; Bloom & Farragher, 2011; Davidson, 1997)

Systemic transformation

When a human service program seeks to become trauma-informed, every part of its organisation, management, and service delivery system is assessed and modified to ensure a basic understanding of how trauma impacts the life of an individual who is seeking services

Trauma informed system

A trauma-informed service system affects *all components of the system, &* requires ***`a process of reconstitution within our organizations top to bottom'*** (Bloom, 2006:2).

Systemic change is needed

`Changes to a trauma-informed organizational service system environment will be experienced by all involved as a profound cultural shift in which consumers and their conditions and behaviours are viewed differently, staff respond differently, and the day-to-day delivery of services is conducted differently' (Jennings, 2004: 15)

Benefits of trauma informed system

- Improves client-staff interactions

- Benefits all parties

  `a program cannot be safe for clients unless it is simultaneously safe for staff and administrators' (Bloom, 2006:2)

Positive for staff and clients

Trauma-informed principles:

- *Parallel the requirements for job satisfaction*
  (Bloom, 2011:170)
- *Can't be implemented for clients if they don't also apply for staff!*

- safety
- trustworthiness
- choice
- collaboration
- empowerment

Trauma sensitivity – a win-win

- Where the goal is `sensitization to trauma-related dynamics & avoidance of re-traumatization' (Fallot & Harris, 2009:16).
- ***Staff well-being – which involves both self-care & organisational support – is an indicator of client well-being*:**

  `[I]t is] the shared responsibility of staff & administrators to become `trauma sensitive' to the ways in which past & present overwhelming experiences impact individual performance, leadership style, & group performance' (Bloom, 2006:2)

Clinical guidelines

ALL CONTACT WITH SURVIVORS SHOULD BE `TRAUMA INFORMED' ; INTENSIVE ONE-ON-ONE WORK REQUIRES UNDERSTANDING OF THE SPECIFICS OF `COMPLEX' TRAUMA

`[M]any survivors have been retraumatized by [health professionals] who had inadequate understanding & skills to treat complex trauma-related problems...' (van der Hart et al, 2006:224)

Safety is paramount

Applies to both physical and emotional safety

Typical features of complex trauma client presentation:

- *dysregulated arousal*
- *compromised functioning*
- perceived or actual *loss of psychological &/or physical safety*

The capacity of positive interactions to be soothing & validating (even in the most routine aspects of relating) should not be underestimated

This applies to all of us, & especially to those with trauma histories

Psychotherapy and counselling

- Provide opportunities `to repair affect-regulating structures' (Solomon, 2003:342).

- In furnishing `a secure base', offer `an enriched environment that promotes the development of cognitive, emotional & behavioural abilities' (Cozolino, 2002:23)

Your wellbeing and self-care

Your stress levels impact your clients

Practitioner sensitivities can be ignited in interactions with clients, particularly if both parties have unresolved trauma histories

Vicarious trauma (VT) is `[t]he negative transformation in the helper' from exposure to traumatic material in the context of a helping relationship (Pearlman & Caringi, 2009).

Stress breeds stress & attentiveness to well-being is the antidote: applies to practitioners & clients

Adults Surviving Child Abuse

National peak body for adults who have experienced complex trauma as a result of adverse childhood experiences.

Our vision:

- A world free from the impacts of childhood trauma

Our mission:

- To advance the health and wellbeing of people and communities affected by childhood trauma, for this and future generations

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ASCA Services

- Professional support line

  1300 657 380

- Education & training workshops
- Resources
- Advocacy & health promotion

ASCA Contact Details

Phone

Professional Support Line: 1300 657 380

National Office: 02 8920 3611

Email

Office: info@asca.org.au

Counsellor: counsellors@asca.org.au

Website: www.asca.org.au