

**‘THE LAST FRONTIER’
PRACTICE GUIDELINES
FOR TREATMENT OF
COMPLEX TRAUMA
AND TRAUMA INFORMED CARE
AND SERVICE DELIVERY**



ADULTS SURVIVING CHILD ABUSE (ASCA)

Authors: Dr Cathy Kezelman and Dr Pam Stavropoulos

Practice Guidelines for Treatment of Complex Trauma
and Trauma Informed Care and Service Delivery

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Adults Surviving Child Abuse 2012 *Practice Guidelines for Treatment
of Complex Trauma and Trauma Informed Care and Service Delivery*
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Disclaimer

This document is a general guide to appropriate practice. The guidelines are designed to provide information to assist decision-making and are based on the best available evidence at the time of development of this publication.

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*‘One of the last frontiers of our society is
the lack of realisation about the extent of trauma.’*

Warwick Middleton, cited in Helen Tobler, ‘Early trauma takes a long-term toll’,
The Weekend Australian [Health] 23-24 July 2011, p.13.

*‘It stands to reason that the most devastating types of trauma
are those that occur at the hands of caretakers.’*

Louis Cozolino, *The Neuroscience of Psychotherapy* (New York: Norton, 2002), p.258.



*The Board of Directors of the International Society
for the Study of Trauma and Dissociation commends ASCA,
Dr Cathy Kezelman, Dr Pam Stavropoulos, and the
Department of Health and Ageing of the Federal Government
of Australia for making these guidelines possible.*

Thomas G. Carlton, MD

President, International Society for the Study of Trauma and Dissociation (ISSTD)

ASCA have succeeded in filling a long outstanding gap in the knowledge and understanding of complex trauma and how trauma informed care can be translated into practice. We congratulate them on this comprehensive and ground-breaking resource. This will no doubt have major implications for the workforce and service providers across the public, private and community health, mental health and human services sectors, as well as primary care.

MHCC and the National Trauma Informed Care and Practice Advisory Group

This is a very important initiative which is much needed. The morbidity associated with complex trauma is vast and a great burden not only on these sufferers but on the health system. There are, at the moment, only the most inadequate forms of service delivery available to these people. The guidelines approach an urgent health service delivery requirement.

Professor Russell Meares

Emeritus Professor, Psychiatry, University of Sydney

Failure to acknowledge the reality of trauma and abuse in the lives of children, and the long-term impact this can have in the lives of adults, is one of the most significant clinical and moral deficits of current mental health approaches. Trauma in the early years shapes brain and psychological development, sets up vulnerability to stress and to the range of mental health problems.

Trauma survivors still experience stigma and discrimination and unempathic systems of care. Clinicians and mental health workers need to be well informed about the current understanding of trauma and trauma-informed interventions. With these important guidelines comes an opportunity to develop trauma informed systems of care and to progress approaches to prevention and early intervention.

Professor Louise Newman

Psychiatrist, Director, Centre for Developmental Psychiatry and Psychology, Monash University

The world map on countries that provide understanding and treatment for the most traumatised people with dissociative disorders has now expanded as Australia rigorously, compassionately and robustly provides us with clinical guidelines.

Dr Valerie Sinason, PhD, MACP, MInst Psychoanal, FIPD
Director, Clinic for Dissociative Studies, London

*I just wanted to say how excellent I think the guideline document is.
It is thoroughly researched, well written and draws poignant
conclusions, necessary for the future of mental health care.
I congratulate you all on such an impressive document.*

Dr Martin Dorahy, PhD, MPhil, DClinPsych, BA (Hons), Clinical Psychologist
Associate Professor, Department of Psychology, University of Canterbury

*I would like for my name to be added to the list of practitioners who endorse
the guidelines for ASCA treatment of Complex PTSD. It is an amazing document!
It embodies everything I have come to believe in my over 16 years of working
with clients with complex PTSD, which is the bulk of my practice.
I wholeheartedly wish for these humane and articulate guidelines
to be adopted worldwide.*

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Foreword by Tamara Stillwell

As a complex trauma patient, who has had a long involvement with the Australian mental health system, I am all too aware of its shortcomings and pitfalls that specifically affect someone with my condition at so many professional and institutional levels. For me the ASCA guidelines were extremely validating, as many of the aspects covered in them were things I had personally experienced. As a patient, I had come to the same conclusions about the system, although not in such elegant terms. I felt from the perspective of the patient, you and your colleagues are precise in your recommendations for change.

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.

My journey started with functional depression, where I was treated by a general practitioner with Lovan, and when that did not work I was referred to a psychologist with no specialisation to engage in talk therapy, without any framework and where no skills or management tools were provided. She was the first one I had ever told about the rape, to which her response was, "oh good we have something to work with." She continued to see me and watched as I continued to decline in my ability to live a normal life. I began to self-harm, even once in her office, in a state of disassociation, which she did not recognise, but commented, "I knew you would cut, but I thought you would wait until you got home." She watched as my weight dropped drastically, and finally after several months she decided that maybe my needs were beyond her skills level and she referred me to a psychiatrist to see in tandem with her. She chose this psychiatrist for no other reason than she worked in the same clinic as her sister who was a GP. The psychiatrist was geographically a long way from where I lived in Melbourne, but I was desperate and confused and thought that the medical profession was capable to handle my problems better than I was. The psychiatrist refused to talk to the psychologist even though I gave them permission to have full disclosure about my case, and this psychiatrist's treatment plans revolved almost solely on medications, E.C.T. and ICU hospitalisation to contain my now out of control behaviours.

Being an expert of a sort, because I have firsthand experience about the aspects these guidelines address, I feel confident in saying that by reading them I developed new hope that there are professionals who truly understand the complexities and necessities for change in treatment and services for those of us who suffer complex trauma, and are working to create industry changes to shift and educate the professionals, policy makers and funding bodies through which complex trauma is identified and treated. Coming from the patient perspective I have an enormous amount of respect and confidence in the stated guidelines.

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.

I fully endorse the guidelines and hope that they are put into place to help so many other people, both the consumers and the professionals as well as the country. I think about not only what cost it was to me and my family because professionals did not have the training to understand my issues, but what it cost the government in trying to "deal" with me while I was wrongly diagnosed and medicated and at risk in many ways. The financial cost alone was huge both for us privately and also for the government, as I was using resources at many levels and getting nowhere.

Tamara Stillwell
Mental Health Consumer
Community Worker



Foreword by Dr Christine A. Courtois

'The Last Frontier: Practice Guidelines for treatment of Complex trauma and Trauma Informed Care and Service Delivery is true to its title. 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. The first set of guidelines address the foundations of adequate and state of the art treatment; the second tackle the system of care, long known to be inadequate and stigmatizing to the traumatized. Both guidelines show how treatment and service delivery can be humane, trauma-focused, and trauma-informed to the benefit of all. This document is a singular and pioneering achievement in its depth and scope. While developed for the Australian system, it has global applicability and establishes a model of treatment and care for other countries to emulate. Bravo to all involved in its development!

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Foreword by Professor Warwick Middleton

Numerous studies demonstrate that around two thirds of both inpatients and outpatients in the mental health system have a history of childhood sexual and/or physical abuse.¹ When emotional abuse and neglect are added to the mix, the percentage experiencing some form of adverse/traumatic childhood becomes even higher. The single most significant predictor that an individual will end up in the mental health system is a history of childhood trauma, and the more severe and prolonged the trauma, the more severe are the psychological and physical health consequences.

I entered training in psychiatry in 1980. There was much emphasis in this training on “schizophrenia” as well as on the theory of its presumed causation, the so-called “dopamine hypothesis”. Heavily imbued with a neo-Kraepelian view, much time was spent on the distinctions between schizophrenia and bipolar disorder. There was little emphasis given to the suicide risk and psychological morbidity of those diagnosed with “borderline personality disorder”, and clinical practice often demonstrated a marked caution with respect to engaging such patients.

Prevailing clinical wisdom was that such individuals demonstrated phenomena that lay on the borderline between psychosis and neurosis. They were viewed as prone to attention seeking (including self-harming), splitting, acting out, and other “primitive” ego defences. Registrars were routinely warned about the dangers of admitting such attachment needy individuals to mental health units, lest they “regress”, cause upset and become difficult to discharge.

Etiological ignorance combined with therapeutic nihilism, such that one unfortunately heard consultant psychiatrists giving advice to registrars that the best form of treatment for “borderlines” was “referral”. The implication was that those who endeavoured to engage with such individuals therapeutically were hopeless optimists, soft and gullible, and/or prone to pander to people whose condition was clinically insignificant anyway. The real business of psychiatry, so the reasoning went, was “serious mental illness”, schizophrenia, bipolar disorder, major depression etc.

There was little or no awareness of the etiological significance of childhood sexual and other abuses in the causation of borderline personality, or that untreated, it had a suicide rate as high or higher than schizophrenia and bipolar disorder. While there is a minority of exceptions, ***generally speaking people who fulfil diagnostic criteria for borderline personality disorder have come from markedly traumatic childhoods.*** Typically, they never felt safe growing up, were endlessly entangled in the double-bind communication patterns of their families, and despite fearing abandonment, had learned how risky it was to trust. In spite of ongoing abuse they were instinctually driven to maintain some form of attachment, frequently to the very people most responsible for abusing them.

In 1980 psychiatry training in Australia contained very little more than even an oblique reference to incest and other ongoing developmental traumas of childhood. The then most up to date comprehensive text of psychiatry, the 3rd Edition of the *Comprehensive Textbook of Psychiatry* edited by Freedman, Kaplan and Saddock had only around two pages on incest, and this included a reference to a 1955 paper which gave the prevalence of incest among women as around one in a million.²

At no time during my training in psychiatry did I ever meet a psychiatrist who mentioned diagnosing or treating any individual with multiple personality disorder (now known as dissociative identity disorder). Yet 1980 was a watershed year for psychiatry. Operationalised diagnostic criteria for Post Traumatic Stress Disorder and five different dissociative disorders (including multiple personality disorder) were included in the DSM-III of that year.

All mental illness is shaped by social and cultural factors, which affect its presumed etiology, structure and treatment.³ Freud was the first in the world to publish on the sexual abuse histories of patients

with 'hysteria', and on how such abuses led to the condition. While "hysteria" in its classical 19th century descriptions tends to incorporate fairly marked conversion symptoms, the general picture is of a complex disorder which contains somatoform, dissociative, post-traumatic, affective, and dare I say it, "borderline" symptomatology.

By September 1897 Freud had already embarked on rescinding his "seduction theory" regarding the etiology of hysteria, to be replaced by a theory that gave centre stage to the construct of "Oedipal Fantasy". Hysterics (generally women) were the focus of the backlash against Charcot, a prominent French neurologist of the time, with their symptomatology prominently labeled by Babinski and others as the product of "suggestion".

The descriptor of "suggestible" was soon augmented by that of "fantasy prone", as psychoanalysis progressively became a global field, whose influence reached its high water mark in the USA in the 1950s. It then experienced decline from 1968 onwards,⁴ as it gave ground to a new biological psychiatry tied to the discoveries of mood stabilisers, antipsychotics and antidepressants, and the neo-Kraepelian conviction that mental diseases were brain diseases.

For most of the twentieth century, psychoanalytic journals were filled with references to oedipal fantasies, while papers on the actual sexual abuse of children were almost vanishingly rare. Many writers over the last three decades have commented on the virtual absence, until recent years, of any significant coverage in the psychoanalytic literature of actual child sexual abuse.

In 2003, Masson observed that analysts were claiming, *"[t]hat it is now and has always been a major concern within psychoanalysis. But if we look at the journals, we do not find this to be so. The cumulative index of the authoritative Journal of the American Psychoanalytic Association, more than 600 pages, contains the contents of the journal from its inception in 1953 through 1974 – thus the heyday of psychoanalysis and its influence – and has five columns devoted to the words Oedipus Complex. By contrast, the word abuse is not found in the index. Nor is there a single entry under sexual abuse"*⁵

Complex and ongoing developmental traumas not unnaturally produce psychological conditions that likewise are complex and ongoing. Yet throughout the history of psychiatry, it is both fascinating and alarming that individuals with such conditions have been prominently subjected to invalidating or incorrect diagnoses.

Even when there is an abundance of evidence that delineates the types and extent of abuses of children and others in our society, even when the clinical syndromes experienced by such abuse victims have been meticulously and repeatedly documented, and even when the sorts of symptoms and phenomena encountered make perfect sense in light of the sorts of trauma experienced and their duration, our mental health and child safety systems can rebrand or invalidate to an extent that maintains collective silence.

Our 1998 study⁶ of sixty-two patients meeting diagnostic criteria for Dissociative Identity Disorder (DID), a condition at the severe end of the complex trauma spectrum, demonstrated that 29% of these highly traumatised individuals had at some point in the past been treated for "schizophrenia". Indicative of the complex symptomatology of such individuals, 73% satisfied full diagnostic criteria for Borderline Personality Disorder, 71% met criteria for a current somatisation disorder, 94% had had, or did have, major depression, and 90% satisfied diagnostic criteria for Post Traumatic Stress Disorder.

A salient finding of our study was that 13% of patients with DID reported the experience of ongoing incestuous/physical abuse that extended beyond their 18th birthday. Two subsequent studies (on the international press reporting of such cases, and on a series of ten such individuals seen in Brisbane) indicate that abuse of a duration and severity comparable to that inflicted by Josef Fritzl

on his daughter, Elisabeth, is far from rare in Australia. The median of the prevalence studies on DID in the community found 1.1% of the population meeting diagnostic criteria for DID.⁷

For nearly sixteen years I have directed a trauma unit, the Trauma and Dissociation Unit, Belmont Hospital (in Brisbane) which treats individuals who have survived childhoods characterised by severe and prolonged abuse. Such individuals have trauma spectrum diagnoses that in the great majority of cases would include Dissociative Identity Disorder or its closely related variant, Dissociative Disorder Not Otherwise Specified.

Most would meet diagnostic criteria for PTSD and many would meet diagnostic criteria for Borderline Personality Disorder. Most have a history of significant self-harm and suicidality and many have had problems with addictive substances and/or sleep problems, sexual difficulties, eating disorders, depression and anxiety.

Over the years the Unit has expanded and demand continues to grow. Once patients experience a trauma informed and structured service that meets their needs, they are very affirmed by the concept and see many contrasts with what is the usual milieu and programs of the average acute general mental health unit. Contrary to popular mythology, such a trauma unit is not the “borderline hell” that some might imagine or fear. The unit is almost invariably quiet. It attracts the strong support of a substantial number of core psychiatrists who have active involvement, as well as good general support from the overall consultant body and from the nursing administration.

The unit attracts staff who make it a long-term career choice, such that turnover is very low. Staff members develop and utilise a sophisticated psychotherapeutic skill set, and generally much prefer working in an environment that challenges them and where these skills are always being utilised and developed.

Despite the great majority of patients having issues with various forms of self harm, the incidence of self harming incidents is generally not significantly higher than for the hospital overall, while incidents involving aggression towards staff or other patients are much lower than average. A lot of time and emphasis is directed to the issue of sound boundaries. A powerful factor in maintaining a generally calm ward environment is an emphasis on *active listening*. In so many scenarios involving both short term and long term issues, *the experience of being listened to and heard is fundamental*, and far more constructive and therapeutic than medicating someone just because they are temporarily upset.

Based on clinical experience and the sort of literature that ASCA has so helpfully reviewed here (while also recognising the seriousness of such illnesses as schizophrenia, bipolar disorder and Huntington's Chorea, and the need for initiatives to make early assistance available) I believe that the *single most pathogenic factor in the causation of mental illness is how we humans treat each other. Whilst we adhere to a belief that we live in a democracy, there are many institutions within society where the principles of democratic freedom largely do not apply*. Examples include orphanages, some schools, churches, cults and not infrequently, that institution known as “the family”. Given the yet unfolding details of how such institutions abuse the vulnerable and the powerless, one is forced to conclude that abuse and exploitation *will occur* in any institution in which it *can* occur, or at least that it is not wise to assume otherwise.

Characteristically, abusers use a combination of fear, shaming and conditioning to ensure their victims remain silent. Abusers have a strong interest in denial of abuse and in attempts to discredit the accounts of victims. As evidenced by the fact that it has taken almost a century to even begin to really engage with the issues of widespread incest, abuses in state institutions, boundary violations in therapy, pedophile groups (some of which are now internet based), child prostitution/sex trafficking and the yet unfolding saga of clergy abuse, *society has demonstrated an extreme reluctance to probe into how trauma and abuse fill our mental health units, our drug and alcohol detox services, our prisons and our medical wards*.

The issues have little to do with science: there are many excellent studies which demonstrate the consistent high association between childhood trauma and these outcomes, and which describe in detail the abuse histories and clinical phenomenology of the many so abused. ***The issue is much more about society's willingness to know***, and our at times extraordinary need to believe something other than the unsettling truth.

It is salutary to reflect on how a field of endeavour as centrally focused on inner psychic functioning as psychoanalysis could construct a theoretical framework that largely denied the very reality of complex trauma syndromes, and which marginalised or discredited those few individuals from within its own ranks who were aware of the frequency of incest, other sexual abuse, physical violence and threat in the childhoods of their patients.

The same unwillingness to know that bedeviled psychoanalysis – the preference for silence, the blaming of victims, and denial of the enormous societal cost of complex developmental trauma and its trans-generational dimensions – was, and is, evident in all related fields. For a period of decades, psychoanalysis became the dominant paradigm in American psychiatry, ultimately eclipsed by a biological psychiatry infused with a focus on genetics, neurotransmitters, psychotropic medications and a belief that mental illnesses were “brain diseases”. Yet neither approach started with an understanding or acceptance of the fact that ***most of our mental health patients are traumatised, many grievously so.***

The ASCA Practice Guidelines concerning Complex Trauma bring together a highly credible grouping of well-credentialed and experienced individuals and organisations. They are united in drawing attention to the need for much more awareness on the part of mental health and related services about the complex sequelae of ongoing child trauma, and the related need for implementing effective systems of care that go beyond extrusion, revolving door approaches, or which deny access to services on the troubling logic that “borderline personality disorder” does not represent a “serious mental illness”. (My conceptualisation of “serious” mental illness is equivalent to my conceptualisation of “serious” physical illness, i.e. an illness which, untreated, has a fair chance of killing you).

Individuals who have been deeply hurt by traumatising, silencing, non-validating and blaming abusers need access to systems of care, protection and justice that are knowledgeable, understanding, accepting and validating, and which can offer interventions that become part of the solution rather than part of the problem.

The ASCA Practice Guidelines bring together the congruent perspectives of survivors of extreme childhood trauma, and the knowledge and experience of national and international clinicians/researchers who have worked with such individuals over many years. They represent a very detailed and nuanced overview of complex trauma, and in their origins and detail represent a unique contribution. They also show the presence of many yet unmet challenges for our society.

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- 1 Hussain & Chapel, 1983; Emslie & Rosenfeld, 1983; Mills et al. 1984; Bryer et al., 1987; Jacobson & Richardson, 1987; Craine et al. 1988; Swett et al., 1990. Read et al. (2004) compared 40 studies published between 1984 and 2003 that examined the prevalence of child abuse among female psychiatric inpatients and among outpatients where at least half the patients were diagnosed with a psychosis. Also see V. Sar, 'Epidemiology of Dissociative Disorders: An Overview' (Review Article) *Epidemiology Research International*, Vol 2011 (2011) Art ID 404 538.
 - 2 V. A. Sadock, 'Incest', in A.M. Freedman, H.I. Kaplan, & B.J. Saddock, *Comprehensive Textbook of Psychiatry*, 3rd edition (1980), 1806-1808.
 - 3 R. J. Castillo, *Culture and Mental Illness: A Client-Centred Approach* (Belmont, CA: Brooks/Cole, 1997), p.xv.
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 - 5 J.M. Masson, *The Assault on Truth: Freud's Suppression of the Seduction Theory*, 2003 edition (New York: Ballantine Books, 2003).
 - 6 W. Middleton & J. Butler, 'Dissociative Identity Disorder: An Australian Series; *Australian and New Zealand Journal of Psychiatry* (32) 1998, pp.794-804.
 - 7 P. F. Dell, 'The Long Struggle to Diagnose Multiple Personality Disorder (MPD)', ch.25 in P.F. Dell & John.A. O'Neill, ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond* (New York: Routledge, 2009), pp.403-428.



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- **Jenna Bateman, CEO MHCC**
- **Corinne Henderson, Senior Policy Officer MHCC**
- **Trauma Informed Care and Practice Advisory Working Group**

ASCA also wish to acknowledge the many national and international researchers and professionals whose work has informed the development of these Guidelines and whose ongoing work will continue to advance the evidence base to inform practice around complex trauma and trauma informed care.

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Adults Surviving Child Abuse (ASCA)

www.asca.org.au

ASCA is known for its quality service provision with respect to both its national 1300 professional support line, and workshops for adult survivors, community workers and health professionals. Since its establishment in 1995, its services have assisted large numbers of adults who have experienced diverse forms of child abuse, and research initiatives and inter-sectoral partnerships are an evolving part of its work.

A core component of its work has been to advocate at both a State and National level for recognition of and informed responsiveness to the needs of adults with a lived experience of complex trauma secondary to child abuse in all its forms, neglect, the impacts of living with or witnessing family violence in childhood and of other adverse childhood events.

ASCA has taken a key national role in the area of Trauma Informed Care and Practice, and was a founding member of the Trauma Informed Care and Practice Steering Group. It is continuing this work as a member of the National Trauma Informed Care & Practice Advisory Working Group (TICP AWG). This group, under the leadership of Mental Health Coordinating Council (MHCC), seeks to improve the mental health and wellbeing of people with trauma histories by advocating for a National Agenda for Trauma Informed Care and Practice.

ASCA also has a comprehensive and highly-credentialled Advisory Panel featuring academics, clinicians and researchers with expertise in the dual areas of complex trauma and Trauma Informed Care and Practice.

The current ferment and revised understandings of the many challenges of complex trauma heralds a changing context in which ASCA can draw on the new research to not only ensure optimal operation of its own services, but also to influence the way in which trauma is acknowledged and addressed in a diversity of service systems across Australia. Part of its expanded role is to influence, advise and educate on treatment of complex trauma and implementation of trauma informed care and service more broadly.

Endorsements

Australia – 1. Organisations | Bodies

Organisation Body	Affiliations	State
The Australian Society of Psychological Medicine (ASPM)		National
Cannan Institute		QLD
Centre for Developmental Psychiatry and Psychology	Monash University	VIC
Integrate Place		QLD
Mental Health Coordinating Council (NSW)		NSW
The Occupational Therapy in Mental Health Sensory Approaches Clinical Collaborative in Queensland		QLD
Official Visitors Program (NSW)		NSW
Private Mental Health Consumer and Carers Network		National
Section of Psychotherapy, Royal Australian and New Zealand College of Psychiatrists (RANZCP)		National
Senior Consultants Group, Trauma and Dissociation Unit, Belmont Hospital		QLD
Survivors and Mates Support Network (SAMSN)		NSW
The Delphi Centre		VIC
Trauma Informed Care and Practice Advisory Working Group (TICP AWG)		National
Victims and Witnesses of Crime Court Support (VWCCS)		NSW
Wagga Women's Health Centre		NSW
Westmead Psychotherapy Program	Sydney University	NSW

Australia – 2. Individuals

Name	Role	State Country
Mrs Elizabeth Antcliff	Mental health consumer; Practitioner/Business Director, Heartspace Artspace & Counselling	QLD
Maria E. (Malise) Arnstein, PhD	Psychologist, private practice Secretary, APS College of Clinical Psychologists (ACT) Treasurer, APS POPIG (ACT) (Psychoanalytically Oriented Psychology Interest Group) Member, EMDRAA Former Secretary, Australian and New Zealand Journal of Family Therapy Former President, ACT Family Therapy Association Australia)	QLD
Emeritus Professor Judy Atkinson	Patron We-Ali Emeritus Professor, Indigenous Studies; Director, The Healing Circle Southern Cross University Emeritus Professor, Indigenous Australian Studies; Head of College University of New South Wales	NSW
Dr Richard Benjamin	Psychiatrist, Clarence and Eastern District Adult Community Health Service	TAS

Name	Role	State Country
Robyn Bradey	Mental Health Accredited Social Worker in Private Practice	NSW
Leslie Bursill, OAM, JP	Member, Board of Management Mental Health Association NSW Chairman, Aboriginal Advisory Committee Sutherland Shire Member, Woronora Cemetery Trust Chairman, St George/Sutherland Division of Legacy NSW	NSW
Dr Jeremy Butler	Psychiatrist, Private Practice; Member Senior Consultants Group, Trauma and Dissociation Unit, Belmont Hospital, Brisbane	QLD
Elana Cohen	Psychologist & Psychotherapist in private practice	NSW
Pamela Davidson	Registered Psychologist	QLD
Dr Jan Ewing	Clinical Neuropsychologist, Clinical Psychologist	QLD
Dr Sabin Fernbacher	Project Manager Aboriginal Health/Clinical Engagement Project; Women's Mental Health Consultant; FaPMI Co-ordinator Northern Area Mental Health Service	VIC
Lenore Hall	Registered Nurse, TDU, Belmont Hospital	QLD
Naomi Halpern	Director, the Delphi Centre	VIC
Dr Dominique Hannah	Psychiatrist, Private Practice	QLD
Chris Hartley	Coordinator of the Trauma Informed Care Homelessness Working Group	NSW
Dr Angela Harty	Psychiatrist, private practice	QLD
Christian Heim, FRANZCP, PhD	Psychiatrist	QLD
Corinne Henderson	Psychotherapist; member Mental Health Review Tribunal	NSW
Susan Henry	Director, the Delphi Centre	VIC
Mary-Anne Kate	Researcher, School of Behavioral, Cognitive and Social Sciences, University of New England	NSW
Dr Anthony Korner	Coordinator Westmead Psychotherapy Program; Senior Clinical Lecturer University of Sydney	NSW
Dr David Leonard, AM	Consultant Psychiatrist, University of Melbourne; Member Order of Australia for Services to Psychiatry	VIC
Dr Johanna Lynch	General Practitioner – primary care mental health promotion	QLD
Tamara Mannetje	Naturopath, ATMS	QLD
Nic Marcon	Director/Principal Psychologist, Emotional Balance Pty Ltd	QLD
Mary Matthews	Psychosocial Occupational Therapist Mater Adult Hospital	QLD
Chris McCabe	Contract Statewide Health Educator Sexual Assault & Mental Health Project Education Centre Against Violence	NSW
Professor Russell Meares	Emeritus Professor Psychiatry, University of Sydney	NSW
Dr Catherine Middleton	General Practitioner	QLD

Name	Role	State Country
Adjunct Professor Warwick Middleton	Chair, The Cannan Institute Director, Trauma & Dissociation Unit, Belmont Hospital Fellow, International Society for the Study of Trauma and Dissociation Adjunct Professor, School of Public Health, La Trobe University, Melbourne Associate Professor, School of Medicine, University of Queensland, Brisbane Adjunct Professor, School of Behavioural, Cognitive & Social Sciences, University of New England	QLD
Suzette Misrachi	Mental Health Accredited Social Worker in Private Practice (Victoria) Coordinator of the Northcote (Vic) Mental Health Professional Network (MHPN)	VIC
Professor Louise Newman	Director, Centre for Developmental Psychiatry & Psychology, Monash University	VIC
Associate Professor Carolyn Quadrio	Consultant Psychiatrist, School of Psychiatry UNSW	NSW
Dr Jan Resnick	Senior Psychotherapist	WA
Dr James Scott, PhD	Consultant Psychiatrist (RBWH); Senior Lecturer The University of Queensland; Research Fellow (Queensland Centre for Mental Health Research)	QLD
Lenaire Seager	Area Clinical Co-ordinator Health Care	QLD
Dr Natalie Shockley	Clinical Psychologist	QLD
Dr Sylvia Solinski	Psychiatrist, private practice	VIC
Robyn South-Vukasavic	Trauma Therapist	NSW
Dr Deborah Spermon, PhD	Researcher, School of Social Work and Human Services, The University of Queensland	QLD
Tamara Stillwell	Mental Health Consumer, community worker	VIC
Dr Denise A. N. Wallis, BA(Hons), MA, PhD	Senior Clinical Psychologist	NSW

Endorsement statements (Australia)

The National Trauma Informed Care and Practice Working Group and **Mental Health Coordinating Council (MHCC)**, as the lead member of the Trauma Informed Care and Practice Steering Group and member of National Trauma Informed Care & Practice Advisory Working Group, welcome the publication of the first Australian *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*.

ASCA have succeeded in filling a long outstanding gap in the knowledge and understanding of complex trauma and how trauma informed care can be translated into practice. We congratulate them on this comprehensive and ground-breaking resource. This will no doubt have major implications for the workforce and service providers across the public, private and community health, mental health and human services sectors, as well as primary care.

MHCC and the National Trauma Informed Care and Practice Advisory Working Group are pleased to endorse the Guidelines and recommend that they be widely accepted across all health and human service sectors.

We expect that with the necessary education, training and workforce development surrounding these Guidelines, implementation will foster service and practitioner sensitive cultures and significantly improve outcomes for people who have experienced complex trauma.

Members of the National Trauma Informed Care & Practice Advisory Working Group are:

Organisations:

Mental Health Coordinating Council (MHCC)
Education Centre Against Violence (ECAV)
Private Mental Health Consumer Carer Network Australia (PMHCCN)
Adults Surviving Child Abuse (ASCA)
NSW Official Visitors Program

Individuals:

Dr Richard Benjamin, Consultant Psychiatrist, Clarence and Eastern District Community Mental Health Service, Tasmania
Dr Sabin Fernbacher, CMGANZ, Women's Mental Health Consultant and FaPMI Co-ordinator Northern Area Mental Health Service, Vic
Zan McKendree Wright, Creating Differently NSW
Alan Woodward, Executive Director, Lifeline Foundation, ACT

Dear Drs Stavropoulos and Kezelman

*The Australian Society of Psychological Medicine (ASPM) endorses the final draft of the Australian ASCA **Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.***

The committee of ASPM commends ASCA, Dr Cathy Kezelman, Dr Pam Stavropoulos, and the Department of Health and Ageing of the Federal Government of Australia for making these guidelines possible.

Furthermore we would ask for permission to publish the Executive Summary in our Society Newsletter for future reference for our members.

Yours sincerely

Dr M. M. Smyth, Secretary The Australian Society of Psychological Medicine

International – 1. Organisations | Bodies

Organisation Body		State Country
Clinic for Dissociative Studies		London
International Society for Study of Trauma and Dissociation		International
The National Center on Family Homelessness	Needham Heights, MA	USA
Trauma and Dissociation Israel		Israel

International – 2. Individuals

Name	Role	State Country
Robert Anda, MD, MS	ACE Study Concepts	USA
Peter Barach, PhD	Clinical Psychologist; Senior Clinical Instructor in Psychiatry at Case Western Reserve University School of Medicine in Cleveland, Ohio Past president International Society for the Study of Trauma and Dissociation	USA
Laura S. Brown, PhD, ABPP	Director, Fremont Community Therapy Project	USA
A. Roy Bowden, BA, MSW(Hons), MNZAP, WCPC	Relationship Consultant, New Zealand Representative Board World Council of Psychotherapy Former President, New Zealand Association of Psychotherapists	New Zealand
Bethany Brand, PhD	Professor, Psychology Department, Towson University Primary investigator, Treatment of Patients with Dissociative Disorders (TOP DD) study	USA
Nick Bryant	Journalist, Author, child abuse	
Thomas G. Carlton, MD	President, International Society for the Study of Trauma and Dissociation (ISSTD)	USA
Richard A. Chefetz, MD	Psychiatrist, Private Practice, Washington, DC Past President (2002-3) International Society for the Study of Trauma and Dissociation Distinguished Visiting Lecturer, William Alanson White Institute of Psychiatry, Psychoanalysis, and Psychology, New York Visiting Lecturer, Spiru Haret University, Bucharest, Romania Founding Member, Institute of Contemporary Psychotherapy & Psychoanalysis, Washington, DC	USA
Catherine C. Classen, PhD, CPsych	Associate Professor, Department of Psychiatry, University of Toronto Academic Leader, Trauma Therapy Program, Women's College Hospital Director, Women's Mental Health Research Program, Women's College Research Institute Women's College Hospital	Canada
Christine A. Courtois, PhD	Licensed Psychologist, Private Practice Courtois & Associates, PC, Washington, DC	USA
Lynette S. Danylchuk, PhD	ISSTD Board of Directors ISSTD Professional Training Program Chair ISSTD Volunteer Chair	USA
Paul F. Dell, PhD, ABPP	Clinical Psychologist, Director, Trauma Recovery Center, Psychotherapy Resources of Norfolk Immediate Past President at International Society for the Study of Trauma and Dissociation (ISSTD)	USA

Name	Role	State Country
Martin Dorahy	Associate Professor Department of Psychology University of Canterbury	New Zealand
Nancy Fair, MA	Adult Counselor, Pittsburgh Action Against Rape; Doctoral Candidate Duquesne University; Psychotherapist, Private Practice	USA
Janina Fisher, MD	Clinical Psychologist, Trauma Centre Instructor, psychotherapist	USA
Julian D. Ford, PhD	Professor of Psychiatry Graduate School Faculty University of Connecticut Health Center	USA
Christine Forner	Owner, lead complex trauma therapist/supervisor Associated Counselling, Calgary, Alberta, Canada; Board Member ISSTD; ISSTD Chair of the Student and Emerging Professional Committee	Canada
Steven A. Frankel, MD	Psychiatrist, Psychoanalyst; Associate Clinical Professor, University of California Medical School; Training and Supervising Analyst, Psychoanalytic Institute of Northern California; Certified by the American Psychoanalytic Association; Distinguished Fellow of the American Psychiatric Association; Past President, Past Director & Fellow, ISSTD	USA
Donald Fridley, PhD	Immediate Past President, International Society for the Study of Trauma and Dissociation Conference Chair 2012 Core Conference Committee	USA
Serge Goffinet	Psychiatrist adolescents, Psychoanalyst, Family Therapist , International Director of ISSTD-D, member of ESTD (European Society for Trauma and Dissociation), private practice and director of a trauma unit at Fond'roy Hospital (Brussels)	Belgium
Mindy Jacobson-Levy	Art Psychotherapist, Professional Counselor, Private Practice; Clinical Supervisor Drexel University, Creative Arts Therapy Graduate Program/Art Therapy Division, Philadelphia, PA	USA
Adah Sachs	Psychoanalytic Psychotherapist, Consultant psychotherapist; Forensic Clinical Lead, Clinic for Dissociative Studies	England
Vedat Sar, MD	Professor of Psychiatry, Istanbul University Istanbul Faculty of Medicine; Past President, ISSTD	Istanbul, Turkey
Professor Eli Somer, PhD	Senior Clinical Psychologist, School of Social Work, University of Haifa; Past President, ISSTD	Israel
Dr Jorge L. Tizón	Profesor del Institut Universitari de Salut Mental FV-B Universitat Ramon Llull, Barcelona	Spain
Joan A. Turkus, MD, DLF, APA	Board Certified Psychiatrist, Forensic Psychiatrist; Psychiatric Consultant and Co-Founder THE CENTER: Posttraumatic Disorders Program Psychiatric Institute of Washington; President-Elect, International Society for the Study of Trauma and Dissociation	USA

Name	Role	State Country
Onno van der Hart, PhD	Emeritus Professor Psychopathology of Chronic Traumatization, Utrecht University; Past President, ISTSS; Former President, International Society for Traumatic Stress Studies; Former Vice-President ISSTD	Holland

Endorsement statements (International)

International Society for the Study of Trauma and Dissociation

It is my pleasure to inform you that the Board of Directors of the International Society for the Study of Trauma and Dissociation, upon recommendation of the Scientific Committee of the International Society for the Study of Trauma and Dissociation has passed the following resolutions unanimously.

*The International Society for the Study of Trauma and Dissociation endorses the final draft of the Australian ASCA **Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.***

The Board of Directors of the International Society for the Study of Trauma and Dissociation commends ASCA, Dr Cathy Kezelman, Dr Pam Stavropoulos, and the Department of Health and Ageing of the Federal Government of Australia for making these guidelines possible.

Thomas G. Carlton, MD

President, International Society for the Study of Trauma and Dissociation (ISSTD)

Clinic for Dissociative Studies, London

The world map on countries that provide understanding and treatment for the most traumatised people with dissociative disorders has now expanded as Australia rigorously, compassionately and robustly provides us with clinical guidelines.

Dr Valerie Sinason, PhD

MACP, M Inst Psychoanal FIPD, Director, Clinic for Dissociative Studies

Executive Summary

Over the last two decades research has established a substantive evidence base in relation to trauma. However a huge gap still exists between evidence about the effects of trauma on individuals and possibilities for recovery, as well as in the treatment and service responses which enable sustained recovery.

The ASCA *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (the Guidelines) are informed by this research. They fill the long overdue gap in knowledge, understanding and practice.

Trauma is often solely characterised as a one-off event. Yet repeated extreme interpersonal trauma resulting from adverse childhood events ('complex' trauma) is not only more common, but far more prevalent than currently acknowledged, **including within the mental health sector**.

The effects of complex (cumulative, underlying) trauma are pervasive, and if unresolved, negatively impact mental and physical health across the lifespan.

- The majority of people treated by public mental health and substance abuse services have trauma histories.¹
- Child abuse, in all its forms, and chronic neglect, are the key antecedents of complex trauma. They are not, however, the only causes.
- 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.

Trauma is not simply an individual misfortune. It is a **public health problem of major proportions**.

The costs of unrecognised and untreated complex trauma are enormous. This is not only in terms of reduced quality of life, life expectancy and lost productivity, but in 'significant increases in the utilization of medical, correctional, social, and mental health services.'² In 2007 alone, the cost of child abuse to the Australian community is conservatively estimated to be at least \$10.7 billion, and is almost certainly far higher.³

Currently in Australia:

- Complex trauma and its effects are often unrecognised, misdiagnosed and unaddressed
- people impacted by trauma present to multiple services over a long period of time; care is fragmented with poor referral and follow-up pathways
- a 'merry go round' of unintegrated care risks re-traumatisation and compounding of unrecognised trauma
- escalation and entrenchment of symptoms is psychologically, financially and systemically costly

Research shows that the impacts of even severe early trauma can be resolved, and its negative intergenerational effects can be intercepted.⁴ 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.

Responding to the public health challenge of complex trauma:

- requires *integration of vision and research into practice*
- means engaging an *array of services and professions to achieve a paradigm cultural shift in mental health and human service delivery*
- requires *specialised knowledge, workforce education and training, and collaboration* between consumers, carers, policymakers, and service providers.
- necessitates *national training programs* for systemic quality improvement, cultural re-orientation and workforce development.

The proposed Guidelines *present the evidence base* needed to translate research into practice. They *establish a framework* that responds to the national health challenge of trauma and *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.

In recent years Australian governments have focussed on mental health reform, prioritising early intervention and prevention, incorporation of recovery principles into National Mental Health Standards, the formation of Mental Health Commissions and the appointment of Ministers for Mental Health.

These Guidelines form an integral part of the reform process. *They are proposed to spearhead Australia's evolution towards systematically addressing the substantial public health challenge of unresolved trauma.* Action in this regard will not only transform health and productivity outcomes for the large numbers of Australians affected by complex trauma, but will reap substantial economic, health and welfare benefits for Australian communities. We urgently recommend adoption of these Guidelines, and their comprehensive implementation.

Dr Cathy Kezelman

President, Adults Surviving Child Abuse
Sydney, May 2012

1 Ann Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services', Report produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) United States, 2004, p.6. In the Australian context, psychiatrist Warwick Middleton estimates the figure to be two thirds (see Helen Tobler, 'Early Trauma takes a long-term toll', *The Weekend Australian* (Health section) 23-24 July 2011, p.13.

2 Bessel A. van der Kolk, 'Foreword', in Stephen W. Porges, *The Polyvagal Theory* (New York: Norton, 2011), p.xii.

3 Upper level estimates are \$30.1 billion (*The Cost of Child Abuse in Australia*, Report by Access Economics, Australian Childhood Foundation & Child Abuse Prevention Research Australia at Monash University, 2008, p.viii).

4 Daniel J. Siegel, citing Roisman et al, 2002; Phelps, Belskg & Cmic, 1998, 'An Interpersonal Neurobiology of Psychotherapy', in Marion F. Solomon & Daniel J. Siegel, *Healing Trauma: attachment, mind, body, and brain* (New York: Norton, 2003), p.16.

Introduction

In the current period, a diverse and rapidly growing research base is leading to new understanding of trauma and new possibilities for recovery from it. Correspondingly, it also has major implications for service-provision. This relates to both 'trauma specific' services (which directly address trauma and its effects) and services which do not deal with trauma *per se*, but which are in contact with clients whose trauma may be unrecognised. As the term 'Trauma Informed Care and Practice' (TICP) indicates, services need to be aware of the possibility of trauma in their diverse client groups (ie as distinct from, and in addition to, trauma-*specific* services which directly cater to this need). In both cases, services should not only refine their programs to take account of new insights generated by the unfolding research, but should quality assure the results.

The following sets of guidelines are proposed as standards in both these areas. The first part of the report presents the Guidelines, and the second elaborates the research base on which they rest. Current research clearly establishes that '[t]here is more to trauma than PTSD';¹ yet existing national guidelines for the treatment of trauma do not reflect this reality. Research undertaken for this report shows that current guidelines in relation to both treatment *and* service-delivery require adaptation, extension and overhaul.

'Complex', as distinct from 'single incident', trauma is not well understood or addressed by governments and health systems. While trauma remains underfunded and under prioritised, this is particularly the case with respect to its complex varieties. Understanding of the aetiology and effective treatment of complex trauma is not widespread, *including within the mental health sector*. To the extent that complex trauma is misunderstood and misdiagnosed (ie fragmented into discrete classifications which fail to capture its underlying nature and comprehensive effects) this underlines the need for guidelines appropriate to its detection and treatment.

There exists a wide gap between what is now known at the level of research, and translation of these insights to treatment programs and organisation of service delivery. Recurring themes and principles of the now solid interdisciplinary research base need to be widely accessible, because they are generating more nuanced understanding of the nature, effects and potential treatment of trauma. This includes honed conceptualisations, proposed new trauma classifications, and escalating calls for complex trauma to be differentiated from the PTSD diagnosis with which it is often confused.² Research in trauma-informed practice also has major implications for ways in which traumatised people should be engaged when they seek to access assistance from diverse service settings.

Complex, interpersonally generated trauma is severely disruptive of the capacity to manage internal states. It is particularly damaging if it occurs in childhood. Research establishes that if we cannot self-regulate (ie manage internal states and impulse control) we will seek alternative means of doing so in the form of defences and/or addictions. Complex trauma occurs not only in families in relation to children, but in the context of other social institutions. Indigenous people, survivors of clergy and other institutional abuse, asylum seekers and the 'Forgotten Australians' are some of the diverse groups who have experienced complex trauma, which needs to be seen in these terms if it is to be adequately responded to.

Research now shows that resolution of trauma equates with neural integration. It also shows that longstanding trauma can be resolved, and its negative intergenerational effects intercepted.³ But for this to occur, mental health and human service delivery (ie as well as direct treatments) need to reflect the current research insights. Experience is now known to impact brain structure and functioning,⁴ and in the relational context of healing this includes *experience of services*. Neural integration is not assisted – indeed is actively impeded – by unintegrated human services which are not only compartmentalised, but which lack basic trauma awareness.⁵

Trauma stems from a normal response to overwhelming stress. We are innately equipped with 'survival' mechanisms which only *become* pathological if traumatic experience remains unresolved after the precipitating event/s have passed. But the effects of unresolved trauma are pervasive and cannot be compartmentalised. If unresolved, trauma becomes 'a central reality around which profound neurobiological adaptations occur'.⁶ Pioneering research also tells us that many psychological *and* physical health problems in adults are the negative outgrowth of childhood coping mechanisms *which initially served a protective function*.⁷ This research has major implications for a revised reading of 'symptoms' as *coping mechanisms which have ceased to protect and have become injurious to health*.

Understanding and adequately responding to what happens when people are exposed to overwhelming experiences is a basic requirement of a healthy society. Some argue that such understanding is as critical today as recognition of the role of microbes in infectious diseases two centuries ago.⁸ Supported by diverse but convergent research findings, the potential for both transformed clinical practice and trauma-informed service delivery is now enormous.⁹ But actualising this potential requires systematic change to many current ways of operating. The following guidelines are proposed to assist in this regard.

Dr Pam Stavropoulos

Consultant in Clinical Research, ASCA

May 2012

1 Robin Shapiro, *The Trauma Treatment Handbook: Protocols Across the Spectrum* (New York: Norton, 2010), p.11.

2 As van der Kolk points out, when PTSD became a formal diagnosis in 1980, 'dramatic' single incidents were the sole focus of the sources of emotional breakdown (Bessel van der Kolk, 'Foreword', Stephen W. Porges, *The Polyvagal Theory*, New York: Norton, 2011, pp.xi-xii). Yet gradual realisation emerged that 'the most severe dysregulation occurred in people who, as children, lacked a consistent care-giver' – 'Emotional abuse, loss of caregivers, and chronic misattunement showed up as the principal contributors to a large variety of psychiatric problems' (Ibid, emphasis added). The problematics of current diagnostic categories pertaining to complex trauma are discussed in Part II of this report.

3 Daniel J. Siegel, citing Roisman et al, 2002; Phelps, Belsky & Crnic, 1998; 'An Interpersonal Neurobiology of Psychotherapy', in Marion F. Solomon & Daniel J. Siegel, ed. *Healing Trauma: attachment, mind, body and brain* (New York: Norton, 2003), p.16.

4 It is now recognised that due to neuroplasticity, both the structure and function of the brain can change (Norman Doidge, *The Brain that Changes Itself*, New York: Viking, 2007; Louis Cozolino, *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain*, New York: Norton, 2002). The sophistication of current neuroscientific imaging also means that subjective experience can now be objectively correlated in the brain.

5 A major impetus to calls for introduction of 'trauma-informed' practice is research which substantiates that rather than contributing to recovery, experience of service settings can itself be retraumatising (see ch.5).

6 Roger D. Fallot & Maxine Harris, 'Creating Cultures of Trauma-Informed Care' (CCTIC) (Washington, DC: Community Connections, 2009), p.1.

7 Vincent Felitti, Robert Anda et al. 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine* (14, 4, 1998), pp.245-258.

8 Sandra L. Bloom & Brian Farragher, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (New York: Oxford University Press, 2011), p.90.

9 This is because 'whatever affects a component of the mental health system will reverberate throughout the rest of the human service delivery system because of the interrelated nature of human problems and efforts to resolve those problems' (Bloom & Farragher, *Destroying Sanctuary*, p.39). While the proposed organisational guidelines are addressed to mental health services, the need for collaborative intersectoral links is an explicit underpinning principle which renders many of the recommendations more widely applicable.

The Purpose of the Guidelines

- To inform a diverse audience about new ways of *conceptualising and responding to trauma*
 - ~ in clinical practice
 - ~ in health and human service settings.
- To enable *new possibilities for recovery for survivors of trauma, and their children.*
- To highlight the *need for service and practitioner cultures and practice to be sensitive to the needs of complex trauma consumers.*

Intended Audience

The research conducted by ASCA establishes the need for core principles of practice to be adopted by two sets of stakeholders:

- (I) health professionals who treat complex trauma
- (II) the broad spectrum of service settings to which people with unresolved trauma present

Accordingly, two sets of guidelines are proposed:

A. 'Practice Guidelines for Treatment of Complex Trauma'

These Guidelines are designed for mental health professionals who directly engage in treatment of adults (18 years and over) with the lived experience of complex trauma.

Such practitioners include but are not limited to:

- clinical psychologists
- mental health nurses
- psychologists
- counsellors
- occupational therapists
- psychotherapists
- general practitioners
- psychiatrists
- social workers

and a diversity of health professionals in public, private and community mental health settings.

B. 'Practice Guidelines for Trauma-Informed Care and Service Delivery' are targeted at ***organisations and their workforces***.

The targeted audience is primarily services with which people with unresolved trauma histories come into contact. They are also addressed to policy-makers.

Service settings to which the 'Practice Guidelines for Trauma-Informed Care and Service Delivery' are relevant include:

- Community public and community managed mental health and human service sectors (drug and alcohol, sexual assault, child protection, housing, supported accommodation, refugee services, disability, advocacy, aged care, Indigenous, CALD, GBLTQI)
- Private practice counselling, psychotherapy, psychology and psychiatry
- Primary and allied health care services – general practice
- Public and private hospitals
- Criminal justice, child protection, emergency services, legal services, policing, education, employment and housing

These Guidelines are designed to raise organisational awareness of the unaddressed trauma experienced by many Australians who access human and health services. They include principles, policies and procedures needed for their implementation.

The organisational Guidelines specifically target the mental health sector, given the context of this project and the critical need in that sector. However, the Guidelines advocate for trauma-informed principles and approaches to be introduced across the full spectrum of human services.

Tailoring the proposed Guidelines will enable their adaptation across diverse service settings. While the Guidelines provide a framework for their implementation, workforce training and development is recommended to optimise the integration of trauma informed principles and practice into services and systems.

These Guidelines are intended to inform policy reform, underpin strategy statements and be embedded in action plans.

Existing Standards and Guidelines

Clinical guidelines for the treatment of complex trauma have not previously existed in Australia. While national guidelines for the treatment of trauma relating to ***single-incident*** trauma (PTSD) exist, international research shows these to be inadequate in addressing the range of dimensions ***complex*** trauma involves.

ASCA notes the development of Clinical Guidelines for the Management of Borderline Personality Disorder which are currently approaching completion. While the role of the 'Borderline Personality Disorder' Guidelines in the treatment of extreme presentations of complex trauma is yet to be determined, ASCA's Guidelines provide a framework that highlights the need to ***acknowledge the complex trauma which underlies the majority of mental health presentations***. We propose that this framework be embedded into the principles of Recovery Orientated practice, thereby establishing a holistic approach which addresses the wider needs of those accessing support across a diversity of service settings.

The concept of recovery has been embedded into policy reform platforms nationally, although a framework for its implementation into service delivery and practice remains under development, particularly in public services.

The 4th National Mental Health Plan Mental Health Standards 2009-2014 included as an action, "the promotion and adoption of a recovery-oriented culture within mental health services. It is intended that recovery oriented principles into practice are adopted by practitioners, services and policy makers within public, private and community managed sectors, and across a broad range of service sectors".

An understanding of trauma is integral to a Recovery Oriented approach. Accordingly the principles and practice of the Trauma Informed framework presented within the ASCA Guidelines need to be incorporated into an overarching practice approach that is Trauma Informed and Recovery Oriented.

The integration of a Trauma Informed Recovery Oriented approach into service provision and workplace cultures requires a fundamental shift in philosophy, culture, policy and practice.

ASCA is a member of the national Trauma Informed Care and Practice Advisory Working Group. This group, under the leadership of Mental Health Coordinating Council (NSW) seeks to improve the mental health and well-being of people with trauma histories by advocating for a national agenda for TICP.

A national agenda for TICP is a call for *systemic* reform, and for development of a strategy that both embodies a shift in service delivery culture across mental health and human service sectors, and workforce training and professional development to support the approach. The Practice Guidelines reflect the evidence base to further consolidate policy and practice reform.

Development of Guidelines

The Guidelines were developed in consultation with consumers and carers, and a reference committee which included academics, researchers, and clinicians drawn from ASCA's Advisory Panel and other external and internal stakeholders.

The Guidelines were reviewed by a range of internal and external stakeholders. Feedback was received from members of ASCA's Advisory Panel, members of the national Trauma Informed Care and Practice Advisory Working Group, and a substantial number of individuals with expertise and experience in the trauma field.

ASCA would like to thank all stakeholders who contributed their time and expertise to provide feedback to enable completion of these Guidelines, particularly those survivors who have shared their lived experience in order to ensure that the Guidelines support best outcomes.

At time of publication, the Guidelines reflect the most recent research and practice knowledge available internationally and nationally. Since new research will continue to unfold, it is envisaged that the Guidelines will be a living document, and that future iterations will continue to incorporate the latest knowledge from the evolving evidence base.



PART I – GUIDELINES



Practice Guidelines for Treatment of Complex Trauma (Clinical)

Preamble

While there are many assessment and treatment guidelines on which clinicians can potentially draw when working with clients who experience complex trauma, the difficulties confronting such clients in turn present challenges to standard approaches.¹ It is a continuing anomaly that current established guidelines for the treatment of trauma relate to post-traumatic stress disorder (PTSD) and are inadequate to address the many dimensions of complex trauma. The differences between complex (cumulative, interpersonally generated) trauma and 'single-incident' trauma (PTSD) are significant.

Research also establishes not only that '[t]he majority of people who seek treatment for trauma-related problems have histories of multiple traumas;² but that those who experience complex trauma 'may react adversely to current, standard PTSD treatments.³ There is thus a clear and urgent need for clinical guidelines which are directed to treatment of the multifaceted syndrome which is complex trauma.

While current treatment guidelines for PTSD have some applicability to complex trauma (in that there may be degrees of overlap in symptomatology) such dimensions as affect-dysregulation and dissociation are not included in the diagnostic criteria for PTSD (even as they are noted as 'associated features'). Impairments in functioning unaddressed by the criteria for PTSD are frequently referred to as 'comorbid conditions', which is inadequate to describe the wide-ranging symptom constellations of complex trauma.⁴

The many levels of functioning impacted by complex trauma pose obvious challenges to construction of treatment guidelines. For example, the research base for treatment efficacy is not comprehensive regarding all the impairments involved.⁵ This is part of the reason why formal guidelines for treatment of complex trauma are not yet available. Yet the inadequacy of PTSD and other treatment guidelines when applied to complex trauma is recognised by those who work with complex trauma populations.⁶

Absence of adequate conceptualisation of complex trauma in the current DSM,⁷ and the limits of PTSD and other treatment guidelines in relation to complex trauma do not, however, mean absence of evidence

1 See Christine A. Courtois & Julian D. Ford, 'Introduction', in Courtois & Ford, *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide* (New York: The Guilford Press, 2009), pp.1-9.

2 Bessel A. van der Kolk, 'Posttraumatic Stress Disorders and the Nature of Trauma', in Marion F. Solomon & Daniel J. Siegel, ed. *Healing Trauma: attachment, mind, body, and brain* (New York: Norton, 2003), p.172.

3 Ibid, p.173.

4 The 'limited focus' of PTSD guidelines which renders them insufficient in relation to complex trauma was challenged by Courtois & van der Kolk in 2005. For contextual discussion of the need for more nuanced treatment guidelines in relation to the multifaceted entity of *complex* trauma, see Christine A. Courtois, Julian D. Ford & Marylene Cloitre, 'Best Practices in Psychotherapy for Adults', ch.4 in Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide* (New York: The Guilford Press, 2009, pp.82-103) which is extensively referenced in the following account.

5 Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', p.82.

6 'The critical problem is that even the best-validated evidence-based psychiatric and psychotherapeutic interventions for anxiety disorders (including PTSD) and affective disorders – as well as for their common comorbidities, such as substance use and eating, personality, behavioral (e.g., anger or attention-deficit/hyperactivity disorder), and relational disorders – often seem either ineffective or potentially iatrogenic. Or the patient simply never seems 'ready' to engage in, cope with, and benefit from these treatments' (Courtois & Ford, 'Introduction', *Treating Complex Traumatic Stress Disorders*, p.6).

7 See Part II ch.2 of this report for discussion of the problematic classificatory status of complex trauma within the current *Diagnostic and Statistical Manual of Mental Disorders* (fourth edit. [DSM-IV-TR] Washington, DC: American Psychiatric Association, 2000) and of the moves for inclusion of more nuanced classification/s in the next iteration of this text, ie DSM-5, which is due for release in 2013 <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=59> For contextual discussion of previous attempts to refine the existing DSM classification (ie proposed classification of *complex* PTSD) see Judith L. Herman, 'Foreword', Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders: An Evidence Based Guide*, pp.xiii-xvii.

for effective addressing of complex trauma per se (understanding of which is now sophisticated and continues to evolve). While the range of presentations of complex trauma poses ‘daunting’ challenges to standard guidelines and assessment tools, aspects of existing approaches can also be fruitfully drawn upon. For example, treatment guidelines for the dissociative disorders are found to be ‘highly applicable’⁸

The research base in complex trauma is substantial. At this point there is sufficient evidence to constitute what Courtois, Ford & Cloitre call an ‘evolving evidence-base for preliminary treatment recommendations and provisional best practices for complex traumatic stress disorders.’⁹ In this context, it is also important to emphasise that **while dynamically evolving, the foundational principles for effective treatment of complex trauma are now solid –**

*the core problems of affect dysregulation, structural dissociation, somatic dysregulation, impaired self-development and disorganised attachment are likely to remain the foundation for clinicians working with survivors of complex trauma, regardless of the specific diagnosis or assessment and treatment methodologies in use.*¹⁰

The approach of Courtois, Ford & Cloitre is to present ‘preliminary best practice guidelines based on [the] growing evidence base.’¹¹ This involves ‘an array of approaches to clinical assessment and treatment that includes carefully designed adaptations of familiar evidence-based protocols’ as well as ‘novel assessment tools and therapeutic models’ specifically designed to address the multiple dimensions of complex trauma.¹²

The following guidelines are based on the research and recommendations of key clinicians and theorists of complex trauma. They are extensively informed by the work of Courtois, Ford & Cloitre, Bessel van der Kolk, Babette Rothschild and other research presented in Part II of this report. The degree of overlap and common recurring features of the respective accounts is marked. This in itself underlines the strong foundations from which guidelines for treatment of complex trauma can now proceed.

8 Courtois, Ford & Cloitre, ‘Best Practices in Psychotherapy for Adults’, p.83. In this context also see International Society for the Study of Trauma and Dissociation (2011) ‘Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision: Summary Version’, *Journal of Trauma and Dissociation*, 12: 2, 188-212.

9 Courtois, Ford & Cloitre, ‘Best Practices in Psychotherapy for Adults’, p.84.

10 Ford & Courtois, ‘Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders’, *Treating Complex Traumatic Stress Disorders*, p.13.

11 Courtois, Ford & Cloitre, ‘Best Practices in Psychotherapy for Adults’, p.84.

12 Courtois & Ford, ‘Introduction’, p.6.

Guidelines (Clinical)

(1)

Facilitate client safety

*'[A] first order of treatment is to establish conditions of safety to the fullest extent possible. The client cannot progress if a relative degree of safety is not available or attainable.'*¹

(2)

Recognise the centrality of affect-regulation (emotional management; ability to self-soothe) as foundational to all treatment objectives and consistently foster this ability in the client

Facilitation of effective management of internal states is vital to a felt sense of safety, and as critical to experience outside the therapy session as to experience within it. Fostering of the ability to self-regulate should be a consistent task of therapy, involving, among other things, the teaching of strategies to self-monitor and self-intercept. Note that this task can be compounded in that existence of a coherent sense of self cannot be assumed (see Pt 3)

(3)

Recognise the breadth of functioning impacted by complex trauma and that *acquisition, not just restoration,*² of some modes of functioning may be necessary.

*Particularly if it dates to childhood, complex trauma can entail developmental deficits in self-organisation which do not apply in 'single-incident' PTSD (ie where there is no prior underlying trauma) – 'As a group, clients with complex trauma disorders have developmental/attachment deficits that require additional treatment focus... treatment goals are more extensive than those directed at PTSD symptoms alone'*³

(4)

Regard symptoms as *adaptive* and work from a strengths-based approach which is empowering of the client's existing resources

A view of symptoms as 'expectable and adaptive' reactions to traumatic childhood experiences⁴ (ie as the outgrowth of normal responses to abnormal conditions) should inform clinical work.

1 Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', p. 91.

2 This suggestive distinction is referenced from Courtois, Ford & Cloitre ('Best Practices in Psychotherapy for Adults', p.90) regarding the need for therapeutic fostering of more secure internal working models of attachment.

3 Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', pp. 89-90; see for listing of the range of priority areas which need to be addressed.

4 Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', p. 93. Also note the following comment – 'Negative, undesirable symptoms and behaviours often do not seem to serve any purpose. On closer inspection, however, they do' (Colin A. Ross & Naomi Halpern, *Trauma Model Therapy: A Treatment Approach for Trauma, Dissociation and Complex Comorbidity* (Richardson, TX: Manitou Communications, Inc, 2009), p. 107.

(5)

Understand how experience shapes the brain, the impacts of trauma on the brain (particularly the developing brain) and the physiology of trauma and its extensive effects

Key aspects of this information should be sensitively communicated to the client, with a view to normalising distressing/problematic internal experience and responses for which they may otherwise hold themselves solely responsible. The effects of trauma on the brain, body and subsequent functioning should form part of the psycho-education which is a significant

component of effective trauma therapy.⁵ While self-blame is unlikely to dissolve in the wake of psycho-education alone, current insights into the physiology of trauma and its effects need to be communicated to the client.

(6)

Encourage establishment/strengthening of support networks

Likely impairment of relational capacity may mean that supports are lacking or non-optimal. The therapeutic relationship itself fosters relational capacity as healthy support networks are worked towards.

(7)

Attune to attachment issues at all times and from the first contact point

While different in presentation and levels of functioning (including at different points in their lives) complex trauma clients have sustained assaults to their ability to connect with themselves and others. Attuning to attachment issues is vital to the therapeutic alliance and to effective working within it. It also assists recognition of potential indicators of whether the client is experiencing complex or single-incident trauma. Thus there are significant reasons for therapist sensitivity, from the first contact point, to the relational style of the client (and thereby to the possibility of underlying trauma).⁶

(8)

Understand and attune to the prevalence and varied forms of dissociative responses, the differences between hyper and hypoarousal, and the need to stay within 'the window of tolerance'

Structural dissociation represents an extreme form of defence in the face of extreme (inescapable) threat, and is a frequent feature of complex trauma when abuse begins early in childhood.⁷ Yet there are many and milder forms of dissociative response of which the therapist needs to be aware ('The more you know about dissociation, the more you automatically watch for its markers').⁸

5 John Briere & C. Scott, *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation and Treatment* (London: Sage, 2006).

6 Shapiro's 'Attachment Assessment' and 'Affect Tolerance Assessment' (Robin Shapiro, *The Trauma Treatment Handbook*, New York: Norton, 2010, pp.33-35) combine observational questions for the clinician with questions that can potentially be asked of the client (ie as appropriate). To the extent that these represent informal 'tools' that do not require training to administer, they are helpful both in orienting the clinician to attachment issues in the early stages of client contact, and in sensitising to the ability of the client to tolerate affect (which will need to be consistently gauged in all subsequent contact but early indicators of which can be valuable at several levels).

7 See Warwick Middleton, & Jeremy Butler, 'Dissociative Identity Disorder: an Australian series', *Australian and New Zealand Journal of Psychiatry* (32, 1998), pp.794-804.

8 Shapiro, *The Trauma Treatment Handbook*, p.36. To assist in attunement to dissociative responses, Shapiro provides an informal 'Dissociation Assessment' tool (Ibid); note that there exist several formal and specialist dissociation assessment scales, some of which require formal training to administer. See Colin A. Ross & Naomi Halpern, *Trauma Model Therapy*, pp.227-272. For helpful orienting articles to the subject of dissociation, see relevant papers at <http://www.theclinics.com>

As responses to the experience of extreme anxiety, hyperarousal is characterised by agitation, while hypoarousal manifests as passivity, 'shut down' and withdrawal.⁹ Therapy must always remain within 'the window of tolerance'; ie the threshold of feeling the client can accommodate without becoming either hyper or hypoaroused.¹⁰

(9)

Expect and be prepared to work with a variety of client responses, including a sense of shame which may not be readily apparent but which is frequently present and intense

Inability to self-regulate and to draw upon relationships to regain self-integrity¹¹ engenders deep shame to which therapists should be attuned ('The feeling of shame is about our very selves – not about some bad thing we did or said but about what we are';¹² 'shame also expands the clinician's focus from fear or anxiety to the sense of a damaged self').¹³

(10)

Embed and apply understanding of complex trauma in all interventions

Recognising the limits of standard assessment tools and modalities in relation to complex trauma,¹⁴ but also the extent to which these can be redressed via incorporation of the new clinical and research insights (see Pt 11 below) ensure that all interventions stem from understanding of current clinical and research insights into complex trauma.

(11)

Ensure the therapeutic model/approach promotes integration of functioning, and contains the 'core elements' consistent with research findings in the neurobiology of attachment

These include activation of/engagement with right-brain processes, attentiveness to the role and effects of implicit memory, and engagement with physical as well as cognitive and emotional processes – 'we must attend to all three levels: cognitive processing... emotional processing... and sensorimotor processing (physical and sensory responses, sensations and movement)'.¹⁵ While there are different ways of attending to these dimensions, current research elaborates the need for all three to be addressed therapeutically ('it is important to be able to engage the relevant neurobiological processes').¹⁶

9 As Rothschild highlights, there is a frequent misconception that clients in 'the freeze state' are underaroused, with the ensuing danger that the therapist may attempt to provoke a n obvious response – 'Every trauma client, whether frozen, dissociated, or hypervigilant, is suffering with a nervous system that is in overdrive, already provoked to the highest level' (Rothschild, *Trauma Essentials*, New York: Norton, 2011, p.15; emphasis added). Thus '[r]educing pressure by removing provocation will relieve the nervous system and make mobility, calmness, and clear thinking more possible' (Ibid)

10 Daniel J. Siegel, *The Developing Mind* (New York: The Guilford Press, 1999); *Mindsight* (New York: Random House, 2009).

11 Julian D. Ford & Christine A. Courtois, 'Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders', Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, p.17.

12 Lewis B. Smedes, *Shame and Grace* (New York: HarperCollins, 1993), p.6.

13 Ford & Courtois, citing Feiring, Taska & Lewis, 2002, 'Defining and Understanding Complex Trauma...'; p.17.

14 Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', p.89; also see Preamble.

15 Pat Ogden, Kekuni Minton & Clare Pain, *Trauma and the Body*, p.140 (emphasis added)

16 Diana Fosha, 'Dyadic Regulation and Experiential Work with Emotion and Relatedness in Trauma and Disorganized Attachment', Marion F. Solomon & Daniel J. Siegel, ed. *Healing Trauma: attachment, mind, body, and brain*, New York: Norton, 2003), p.229.

(12)

Recognise the extent to which the above requires *adaptation of, and supplements to, 'traditional' psychotherapeutic approaches (ie insight-based and cognitive-behavioural)*

Research in the neurobiology of attachment establishes the limits, as well as benefits, of 'talk' and the need for active addressing of physical, sensorimotor, and experiential processes as well as cognitions and verbal expression of emotion ('bottom up' and 'top down').¹⁷

(13)

Phased treatment is the 'gold standard' for therapeutic addressing of complex trauma, where Phase I is *safety/stabilisation*, Phase II *processing* and Phase III *integration*.

The ability to tolerate emotion (self-soothe; regulate affect) is a primary task of treatment, and accounts for the importance of Phase I. Attempts to 'process' trauma in the absence of ability to self-regulate can precipitate overwhelm and re-traumatisation. 'Processing' of complex trauma is a Stage II task and should not be encouraged in the absence of the foundational self-regulatory work of Phase I. Hence the critical importance of Phase I to therapeutic outcomes – 'Overstatement of the importance of this step is not possible; it is vital if trauma recovery is to be realised.'¹⁸

(14)

Therapy should be tailored and individualised; 'one size does not fit all'

'Adapt the therapy to the client rather than expecting the client to adapt to the therapy.'¹⁹

(15)

Therapists should be culturally competent and sensitive to gender, sexual orientation, ethnicity, age, and dimensions of 'difference'

Awareness of, and attunement to, the potential impacts of 'difference' in its various forms (age, ethnicity, socio-economic status, and so on) is important for all therapeutic work, including and especially that with complex trauma. To the extent that clients are themselves attuned to therapist ambivalence,²⁰ it is imperative for therapists of complex trauma to be highly attuned to their own responses to perceptions of cultural, gender and other 'differences' in relation to their clients, and to be conversant with some of the valuable resources which can assist in this regard.²¹

17 van der Kolk, 'Foreword', Ogden et al, *Trauma and the Body*, p.xxiv; Fosha, 'Dyadic Regulation and Experiential Work...', pp.229-230 and ch.4 in Part 1 of this report. Note that of the several foci which 'must' comprise therapy for complex trauma, Courtois, Ford & Cloitre include '[b]odily as well as mental functioning, including both sensorimotor integration and neurochemical and psychophysiological integrity' ('Best Practices in Psychotherapy for Adults', p.90).

18 Babette Rothschild, *Trauma Essentials: The Go-To Guide* (New York: Norton, 2011), p.57.

19 Rothschild, *Trauma Essentials*, p. 15.

20 Recall that what is not spoken and consciously articulated tends to be evoked, embodied and enacted (David J. Wallin, *Attachment in Psychotherapy*, New York: The Guilford Press, 2007).

21 For an excellent discussion of this multifaceted topic, see Laura S. Brown, 'Cultural Competence', ch.8 in Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, pp.166-182.

(16)

Engage in regular professional supervision

*'The intensity and complexity of transference-countertransference dynamics in complex trauma relationships are such that working without clinical consultation, at any level of helper experience, can pose great hazards for both clients and therapists.'*²²

(17)

Attend to duration and frequency of sessions

*Therapists should recognise that complex trauma treatment is generally longer than for many other presentations, and that while varying significantly according to the client, is 'rarely...meaningful if completed in less than 10-20 sessions.'*²³ *If economic or other constraints severely limit the number of available sessions, there are strong grounds to confine therapy to the 'stabilisation' (Phase I) stage.*²⁴

*Therapy is recommended to occur on a once or twice-weekly basis, with sessions ranging between 50 and 75 minutes for individual therapy and between 75 and 120 minutes for group therapy.*²⁵ *Therapy should not exceed these recommended standards of frequency in the absence of compelling grounds for doing so, or destabilisation and dependence may result.*

(18)

Recognise the importance of implementation of boundaries

*'Boundaries are particularly salient with clients who have been subjected to violations, exploitations, and dual relationships.'*²⁶ *Boundaries should be mutually negotiated, and care should be taken to ensure that the client understands their significance and does not experience them as punitive. Maintenance of boundaries is also important for therapist self-care; while this is always the case it is especially so in the demanding work of complex trauma.*

(19)

Engage in collaborative care as appropriate

This entails collaboration not only with the client, but with the other professionals and services (eg prescribing physician) with which they may be in contact.

22 Laura Anne Pearlman & James Caringi, 'Living and Working Self-Reflectively to Address Vicarious Trauma', in Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, p.214 (emphasis added).

23 Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', p.96. Here it should be noted that the pervasiveness and depth of the impacts of complex trauma sometimes require the duration of therapy to be extensive: "For some clients, treatment may last for decades, whether provided continuously or episodically" (Ibid).

24 As recommended by Rothschild, *Trauma Essentials*, p.62.

25 Note the qualification of Courtois, Cloitre & Ford that 'when multiple modalities are required (ie, group and individual; substance abuse treatment in addition to psychotherapy; couple and/or family work plus individual therapy; partial hospitalization in addition to or instead of individual therapy) more sessions per week are obviously needed' ('Best Practices in Psychotherapy for Adults', pp.96-97).

26 Philip J. Kinsler, Christine Courtois & A. Steven Frankel, 'Therapeutic Alliance and Risk Management', Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, p.217.

(20)

Facilitate continuity of care as appropriate

Histories of betrayal and abandonment render complex trauma clients vulnerable to feelings of rejection. The ending of therapy (for whatever reason) is itself a process which represents 'a critical opportunity to support and sustain the client's gains in relational, emotional, and behavioural self-regulation.'²⁷ Courtois, Ford & Cloitre note that in the event of client engagement with a new therapist or treatment provider, interventions which encourage a sense of continuity should be integrated into the client's transition process.²⁸

(21)

Diversity of clients means that recovery, too, is diverse

'Therapists must be aware of differences in clients' capacities to engage in therapy and to resolve their symptoms and distress. There are as many degrees of self- and relational impairment as there are of healing capacities and resources, resulting in different degrees and types of resolution and recovery.'²⁹

²⁷ Ibid.

²⁸ Ibid.

²⁹ Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', p.98.

Practice Guidelines for Trauma-Informed Care and Service-Delivery (Organisational)

Preamble

National and international research shows that the majority of people who seek and are referred to mental health services are survivors of multiple kinds of adversity and overwhelming life experiences and interpersonal violence which constitute psychological and emotional trauma.¹ This is also true of clients of the human service sector more broadly.² The current organisation of human services does not reflect this reality, is manifestly inadequate to address it, and is in urgent need of reconfiguration. It is for this reason that there are escalating calls for implementation of a new paradigm of 'trauma-informed care and practice' (TICP) both in health and mental health specifically, and across the full spectrum of human service delivery.

Current research suggests that 'creating a trauma-informed culture in and of itself could help staff and clients make better recoveries than has previously been possible.'³ To the extent that the large numbers of people who experience trauma-related problems access a range of diverse services (ie not only those of health and mental health) it is critical that the full range of service delivery introduces the trauma-informed principles which are supported and advocated in this research.

There are now numerous service-models, the majority developed in the United States, which are trauma-informed as well as trauma-specific. Many of these are not only 'applicable, replicable, and appropriate for use in public sector service settings',⁴ but are specifically tailored to complex trauma.⁵ The guidelines which follow reference some of this material for the Australian context,⁶ while recognising that all protocols are living documents which will themselves evolve as part of the process of implementation.

Core principles of trauma-informed care are 'safety', 'trustworthiness', 'choice', 'collaboration', and 'empowerment'.⁷ These principles underpin the following guidelines, and if comprehensively implemented would effect a major shift in the way human services currently function. Clearly they would need to be tailored to the specific service context in which they would operate. While addressed to the context of mental health, the proposed guidelines also include many recommendations which, subject to the necessary adaptation, could be applied in diverse organisational settings.

1 Bessel A. van der Kolk, 'Posttraumatic Stress Disorders and the Nature of Trauma', in Marion F. Solomon & Daniel J. Siegel, ed. *Healing Trauma: attachment, mind, body, and brain* (New York: Norton, 2003, p.172); Ann Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services', Report produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) United States, 2004, p.6).

2 Sandra L. Bloom & Brian Farragher, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (New York: Oxford University Press, 2011).

3 Bloom & Farragher, *Ibid*, p.15.

4 Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services', p.14.

5 Jennings, *Ibid*, p.5.

6 Also note that a range of materials, including toolkits, protocols and worksheets, are now available for download. See, for example, Kathleen Guarino et al, *Trauma-Informed Organizational Toolkit* (Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation, 2009). Available at www.homeless.samhsa.gov and www.familyhomelessness.org

7 Roger D. Fallot & Maxine Harris, 'Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol' (Washington, DC: Community Connections, 2009), p.3.

Reading the Guidelines (Trauma-Informed; Organisational)

The format in which the following guidelines is presented reflects both the diversity of material relevant to trauma-informed practice, and the diversity of organisational and service settings to which it can be applied.

Section 1, ‘Philosophy and Vision’, outlines the core principles which underlie and infuse care and practice which is trauma-informed.

Section 2, ‘Mapping to Practice’, is divided into two parts –

(A) System level &

(B) Service level⁸

To aid clarity, Guidelines in both these sections are initially presented in summary form, without accompanying comment or detail. Because their practical translation requires consideration, explanation and comment (ie the ‘fleshing out’ which a simple listing does not provide) they are then reiterated and expanded with additional commentary.

In this second more detailed iteration, a number of key points are presented to assist application of trauma-informed principles at system and service levels. Recommended steps are proposed with reference to the concept of domains,⁹ and corresponding steps which may need to be undertaken in relation to these are included.

Additional sections are presented in relation to service policies and screening for trauma. Within each of these sections, questions are posed to aid application to individual service environments.

⁸ As per the protocol of FalLOT & Harris, ‘Creating Cultures of Trauma-Informed Care (CCTIC): Ibid.

⁹ FalLOT & Harris, Ibid.

Guidelines (Trauma-Informed; Organisational) Summary

SECTION 1: PHILOSOPHY & VISION

- (1) Establish service-charters of trauma-informed care
- (2) Emphasise a recovery orientation and establish five foundational principles – 'safety', 'trustworthiness', 'choice', 'collaboration' and 'empowerment' (Fallot & Harris, 2009)
- (3) Promote understanding of the impacts of trauma and the importance of co-ordinated care
- (4) Commit to survivor/consumer driven systems
- (5) Commit to all forms of diversity
- (6) Incorporate a message of optimism and hope into all interactions between service-providers and clients

SECTION 2: MAPPING TO PRACTICE

(A) SYSTEM LEVEL

- (1) Promote co-ordination between and among systems of care and incorporate a life-span perspective
- (2) Revise all policies and procedures to incorporate trauma-informed principles
- (3) Involve consumers in all systems and articulate and uphold trauma-informed rights
- (4) Review education and training to incorporate trauma-informed principles
- (5) Identify funding requirements
- (6) Promote education in trauma
- (7) Promote respect for diversity

(B) SERVICE LEVEL

Step 1: *Identify key formal and informal activities and settings*

Step 2: *Ask key questions about each of the activities and settings*

Step 3: *Prioritise goals for change*

Step 4: *Identify specific objectives and responsible persons*

DOMAIN 1A SAFETY: *Ensure physical and emotional safety*

DOMAIN 1B TRUSTWORTHINESS: *Maximise trustworthiness through task clarity, consistency, and interpersonal boundaries*

DOMAIN 1C CHOICE: *Maximise consumer choice and control*

DOMAIN 1D: COLLABORATION: *Maximise collaboration and sharing of power*

DOMAIN 1E: EMPOWERMENT: *Prioritise empowerment and skill-building*

SERVICE POLICIES: *Ensure formal policies are based on the above principles and are consistently implemented and monitored*

SCREENING FOR TRAUMA: *Ensure a mechanism for screening of underlying trauma that is implemented in a service/organisational context which is fully trauma-informed*

Guidelines (Trauma-Informed; Organisational)

Detailed *(ie expanded version; supplement to above summary)*

SECTION 1: PHILOSOPHY & VISION

(1) ***Establish service charters of trauma-informed care***

Recognising the now considerable research which shows:

- (I) the prevalence of trauma
- (II) the relationship between unresolved childhood trauma and a wide range of health problems, both psychological and physical
- (III) the transgenerational impacts of unresolved trauma
- (IV) the diverse services to which trauma survivors present and the diversity of presentations with which they present
- (V) the extent to which trauma is reproduced by and within mainstream social institutions and services (administrative, educational, legal, medical) *including health services and settings*
- (VI) that experience of mainstream service provision has been re-traumatising for many people with experiences of unresolved trauma

Trauma-informed care (TIC) service charters should be constructed and referenced as sources of guiding principles according to which health services should be designed, developed and delivered.

Such charters should formally acknowledge that unresolved trauma becomes 'a central reality around which profound neurobiological and psychosocial adaptations occur'.¹ They should further acknowledge that services themselves need to adapt to this reality if recovery, rather than re-traumatisation, is to occur.

Service charters of trauma-informed care should also note the comprehensiveness of the service modifications required at informal as well as formal levels. They should stipulate that no aspect of service-delivery (direct or indirect; practice, infrastructural or administrative) should be exempt from requirement to comply with trauma-informed principles.

¹ Roger D. Fallot & Maxine Harris, 'Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol' (Washington, DC: Community Connections, 2009), p.1.

(2) *Articulate and enshrine explicit commitment to service which is recovery oriented and which is predicated on five foundational principles of TIC: ie 'safety', 'trustworthiness', 'choice', 'collaboration' and 'empowerment'*²

Explicitly acknowledge in the service charter the extent to which translation of these principles into practice requires major shifts from the 'pre trauma-informed' era of service delivery. This will require:

- (a) a shift from 'caretaking' to 'collaborative' ways of working*
- (b) movement from an illness/symptom-based model to one of skills acquisition ('strengths-based')*
- (c) replacement of the question 'What's wrong with you?' with 'What happened to you?'*³

Explicitly note within the charter that :

*'Without such a shift in both perspective and practice, the dictum to 'Do no harm' is compromised, recipients of mental health services are hurt and re-traumatized, recovery and healing are prevented, and the transformation of mental health care... will remain a vision with no substance in reality.'*⁴

(3) *Promote as fundamental to health and mental health an understanding of the impacts of trauma, and promote care coordination across service systems*

*Also promote reduction and elimination of disparities in system functioning within, and as far as possible, between collaborating services.*⁵

2 Fallot & Harris, Ibid, p.3.

3 Ann Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services', Report produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) United States, 2004, p.60.

4 Ibid

5 Jennings, 'Trauma-Informed Services...', pp.60 & 62.

(4) Commit to consumer participation at all levels as a defining characteristic of trauma recovery

This involves respect for and attentiveness to the lived experience of clients, and ongoing compliance with the five principles of TIC as noted in Point 2.

(5) Commit to all forms of diversity as foundational to trauma-informed systems of care

This means respect for, and attunement to, issues pertaining to gender, ethnicity, sexual orientation, socio-economic status, age and disability (‘Cultural issues regarding trauma should be addressed for all populations, including refugees, racial and ethnic minorities, and rural populations’).⁶

(6) Incorporate a message of optimism and hope into all interactions between service-providers and clients⁷

*Feedback from adult survivors of child abuse suggests that a sense of optimism regarding the process of recovery is far from common within many areas of existing service provision (this is when childhood trauma is recognised at all).⁸ Indeed, the experience of many survivors is that an opposite message is conveyed. This is not only a harmful message to transmit, but in light of the now solid research findings to the contrary, an illegitimate one. **Resolution of trauma, including of adverse childhood experiences, is now shown to be possible, and best-practice trauma-informed care should consistently convey this message in all respects and at all levels.**⁹*

6 Jennings, ‘Trauma-Informed Services...’, p.66.

7 As is consistent with research findings that insecure attachment can be converted to secure attachment, and that longstanding childhood trauma – not just ‘single-incident’ trauma – can be resolved. See Daniel J. Siegel, ‘An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma’, Siegel & Solomon, ed. *Healing Trauma: attachment, mind, body, and brain* (New York: Norton, 2003), p.16.

8 ‘Every day ASCA receives calls from child abuse survivors who feel they have been failed by the system and don’t know where to turn... Every day consumers call recounting how they have been let down by one arm of the health system or another, by an agency, a worker or a practitioner. By a GP who was uninformed, who didn’t inquire about trauma, despite symptoms which were highly suggestive. By 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’ <http://cathykezelman.com/trauma-informed-care/359/>

9 ‘Today we have the clinical tools to repair deeply embedded and disrupted neural networks. We are living in an age in which an interpersonal neurobiology is becoming a reality’ (Robert J. Neborsky, ‘A Clinical Model for the Comprehensive Treatment of Trauma Using an Affect Experiencing-Attachment Theory Approach’, Siegel & Solomon, *Healing Trauma*, p.319). While relating most obviously to clinical (ie trauma-specific) work, awareness of the potential for healing should also underlie best practice for service provision which is trauma-informed (i.e. so that recognition, appropriate engagement and potential referral can be made).

SECTION 2: MAPPING TO PRACTICE

In implementing the philosophy and vision of trauma-informed care (Section I) it should be noted that:

- *'whatever affects a component of the mental health system will reverberate throughout the rest of the human service delivery system because of the interrelated nature of human problems and efforts to resolve those problems.'*¹⁰
- *'Both administrative and clinical experience suggests that attributes of the system 'as a whole' have a very significant impact on the implementation and potentially the effectiveness of any services offered.'*¹¹

*While noting some potential areas of overlap, the following guidelines for translation of trauma-informed principles to practice distinguish between (A) SYSTEM LEVEL and (B) SERVICE LEVEL.*¹²

(A) SYSTEM LEVEL

(1) **Promote collaboration and coordination across systems of care which serve people with trauma histories, and include a life-span perspective**¹³

- *'Because abuse trauma may result in multiple vulnerabilities and affect many aspects of a survivor's life, coordination across systems is essential. **Integration of trauma, mental health and substance abuse is absolutely critical.***¹⁴
- Collaboration across systems should include 'the full range of human services'¹⁵ (ie health, social services, education and criminal justice systems).

10 Sandra L. Bloom & Brian Farragher, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (New York: Oxford University Press, 2011), p.39.

11 Falot & Harris, 'Creating Cultures of Trauma-Informed Care', p.5.

12 In this they follow the orientation of Falot & Harris, 'Creating Cultures of Trauma-Informed Care'

13 (Slightly reworked) Pt 7 under the heading 'Administrative Policies/Guidelines Regarding the System', in 'Appendix: Criteria for Building a Trauma-Informed Mental Health Service System', Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems...'; p.66.

14 Ibid (emphasis added)

15 Ibid.

(2) Policy and procedure

- Systematically revise all policies and procedures to accord with the principles of trauma-informed care
- Develop and implement mechanisms for compliance with, and quality assurance of, TIC principles
- Hiring of new staff should include interview questions about existing knowledge of trauma (eg. ‘What do you know about child abuse and its potentially long-term impacts? What do you know about different types of trauma?’)¹⁶
- All policies should respect culture, gender, ethnicity, age, disability and socio-economic status (see Pt 7)

(3) Facilitate involvement of consumers in the systems which serve them, and articulate and uphold trauma-informed rights¹⁷

- ‘The voice and participation of consumers, including those who identify themselves as trauma survivors, **should be at the core of all systems activities** – from policy and financing to training and services.’¹⁸
- ‘Consumers with trauma histories should be significantly involved and play a lead role in the creation of State Mental Health Plans,¹⁹ the improvement of access and accountability for mental health services, and in orienting the mental health system toward trauma and recovery.’²⁰
- ‘Special attention should... be paid to the rights of people with trauma histories (eg, right to trauma treatment, freedom from re-traumatisation) and to the ways in which these rights may be systematically violated.’²¹

Institute supportive practice to enable consumers to engage in all governance matters

16 Adapted from Fallot & Harris, ‘Creating Cultures of Trauma-Informed Care, p.17.

17 (Slightly reworked) Pt 5 (Ibid) and as per Pt 4 of Section I (‘Philosophy and Vision’) of these (ASCA) guidelines.

18 Ibid (emphasis added)

19 While the points under this heading are addressed to the context of the United States, their pertinence and applicability to the Australian context should likewise be noted.

20 Jennings, ‘Models for Developing Trauma-Informed Behavioral Health Systems...’, p.66.

21 Ibid (emphasis added)

(4) **Education & training**

- Review education and training to incorporate trauma-informed principles. Education in TIC principles and practice should be an organisational requirement for all employees, volunteers, board members and stake-holders ('bottom up' as well as 'top down')
- 'Trauma sensitivity' should comprise ongoing criteria according to which individual and collective performance are assessed ('[It is] the shared responsibility of staff and administrators to become 'trauma sensitive' to the ways in which past and present overwhelming experiences impact individual performance, leadership styles, and group performance')²²
- All staff (ie including administrative and casual) should receive basic training about trauma and its impact 'with a primary goal of sensitization to trauma-related dynamics and avoidance of retraumatization'.²³
- *All staff should receive basic education in the maintenance of personal and professional boundaries which are also trauma-informed. This should include not only 'standard' training regarding confidentiality, dual relationships, and respect for client diversity, but **respect for diverse coping mechanisms and education in respectful engagement and sensitivity regarding all interactions, including the mundane, with all clients and at all times.** Such education should include cultural competence and gender-sensitivity, sensitivity to sexual orientation, ethnicity, socioeconomic status, age and disability*
- *All staff should understand the relationship between their own awareness, conduct and self-care and the implications for their interactions with clients. This includes understanding of the concept of vicarious traumatization, and the relationship between risk management and ethical conduct ('**a program cannot be safe for clients unless it is simultaneously safe for staff and administrators**').²⁴ Staff should be supported in their work in terms of ongoing access to mechanisms by which issues can be raised, and all clinical staff should receive regular (at least monthly) professional supervision*
- Staff should include identified persons who prioritise translation of trauma-informed principles to the various programs of service-delivery, and with whom workers can consult on an ongoing basis about issues which arise in this process.
- Ongoing education about TIC principles and practice should be central to the service culture, and to all upskilling and professional development

22 Bloom, 'Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation', p.2.

23 FalLOT & Harris, 'Creating Cultures of Trauma-Informed Care', p.16.

24 Bloom, 'Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation', Alexandria, VA: National Technical Assistance Centre, 2006, p.2 (emphasis added) nasmhpd.org

(5) *Identify and review funding requirements*

Development, administration, maintenance, and quality assurance of TIC service-delivery means that funding cannot be regarded as a discrete category. Yet because of its enabling function in most areas, funding requires specific comment. The impact of research and data gathering should be part of infrastructure funding. The cost-effectiveness of implementation of trauma-informed principles should also be part of budgetary assessment.

While clearly necessary, it can be argued that ‘new funds are not necessarily critical to development of a trauma-informed system’²⁵ To the extent that cultural and attitudinal change are independent of financial considerations (and even small attitudinal shifts can have disproportionate effects) it would be wrong to reduce calls for trauma-informed care to the status of ‘a funding drive’. But at the same time, the need for funds to operationalise the envisaged changes in service cultures cannot be minimised (‘[a]ttention to reimbursement and funding issues is key to a successful change strategy’).²⁶

(6) *Promote education in trauma, especially differences between single-incident (PTSD) and complex trauma, via links with universities, colleges and training organizations*

- In light of the need for coordination across a wide spectrum of systems (see Pt 1) intersectoral collaboration between service-providers should also extend to links with institutions of learning and professional training institutes within and outside of the health and mental health systems. These should include research links where appropriate.
- ‘Formal, ongoing efforts should be made to collaborate with institutions of higher education to create new trauma-based curriculum, revise existing curricula, ensure the teaching of evidence-based and emerging best practices in trauma, include consumer/survivors as trainers, and incorporate trauma and violence as a core part of the training of all future... health care workers in all disciplines’.²⁷

25 Jennings, ‘Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services’, p.67.

26 Ibid. In highlighting the need ‘to find necessary sources of funding’, Harris and Falot also note that ‘this sometimes requires going outside the usual funding mechanisms in a creative way’ (‘Creating Trauma-Informed Services’, p.15).

27 From Pt 4, ‘Administrative Policies/Guidelines Regarding the System’, p.66.

(7) *Respect culture, ethnicity, gender, age, sexual orientation, disability, and socio-economic status*²⁸

- In relation to complex trauma, the stakes of attending to 'difference' are high. Research in evolutionary biology and psychology shows that we are 'wired' to notice difference in others whether this is consciously acknowledged or not.²⁹ Sensitisation to how bias affects and is registered by others is thus of major importance in the context of trauma, where limbic system responses are also on high alert. The implications of this for 'dealing with difference' should be addressed in all TIC training material.³⁰
- Some Australian service-providers are attuned to the significance of gender and cultural 'difference' in the context of trauma-informed care.³¹ But such sensitivity remains to be extended and developed systematically on a wide scale

28 Pt 6, Ibid, and as per Pt 3 of these [ASCA] guidelines and Pt 5 of Part A 'Philosophy and Vision' (Ibid)

29 Laura S. Brown, 'Cultural Competence', ch.8 in Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide*, pp.171-172.

30 The previously cited chapter by Laura Brown (Ibid, pp.166-182) provides a valuable orientation to this topic.

31 See, for example, 'Service Guidelines on Gender Sensitivity and Safety: Promoting a Holistic Approach to Wellbeing' (Department of Health, Victoria, 2011). For early and broad consideration of different gendered responses to child abuse, see Briere, *Child Abuse Trauma*, pp.155-158

(B) SERVICE LEVEL

*The protocol for trauma-Informed services developed by Fallot and Harris³² provides organisational guidelines both to assess current work practices and track progress in implementation of trauma-informed service provision. Emphasis is on creation of the cultural change within organisations which needs to take place if trauma-informed service-provision is to occur. An advantage of this ‘Self-Assessment and Planning Protocol’ is that **self-monitoring can be ‘built into the change process’³³** (thus simultaneously addressing quality assurance).*

*The five core principles of trauma-informed care (ie **safety, trustworthiness, choice, collaboration and empowerment**, see Pt 2, Section 1, ‘Philosophy and Vision’) are also elaborated in the assessment and planning protocol developed by Fallot & Harris. ‘Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol’ is helpful in suggesting how these principles might be implemented in the context of service provision. In this protocol, each of the five principles is applied to a specific ‘domain’, and key questions are proposed to assist organisations to review the extent to which objectives of service-provision are being met.*

The following four steps are drawn from the first part of this protocol.³⁴ In ‘mapping to practice’ the core principles of trauma-informed care, the initial part of the first of the domains³⁵ discussed by Fallot and Harris is reproduced in slightly abbreviated form.

Step One: Identify Key Formal and Informal Activities and Settings

These can include:

- (a) listing the sequence of service **activities** in which clients are involved*
 - (b) identification of **staff members** who have contact with consumers at each point in this process*
 - (c) identification of **settings** in which the range of activities takes place (reception, waiting room, telephone, office, etc).³⁶*
-

32 Fallot & Harris, ‘Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol’ (Washington, DC: Community Connections, 2009), pp.1-19. <http://www.annafoundation.org/CCTICSELFASSPP.pdf> Note the qualification that this protocol relates to ‘a specific understanding of trauma-informed services’ (Ibid) and that other interpretations are also possible.

33 Ibid.

34 The protocol of Harris & Fallot is comprehensive, and relates to both systems and service levels. While extensively referenced in the following comments, it is selectively drawn upon with a view to extraction of some of the key measures suggested.

35 Ie Domain 1, A-E which relate the core principles of TICP as they apply to consumers. Note that sections IF-IJ map these same principles as they apply to staff.

36 Fallot & Harris, ‘Creating Cultures of Trauma-Informed Care’, p.6.

Step Two: Ask Key Questions about Each of the Activities and Settings

How do they currently operate and how might they operate differently according to principles which are trauma-informed?

Step Three: Prioritise Goals for Change

Following review of services and development of potential trauma-informed changes, issues to consider when prioritising could include:

- (1) ***feasibility*** (which goals are most likely to be accomplished in light of their scale and the type of change involved?)
 - (2) ***resources*** (which goals are most consistent with the financial, personal and other available resources?)
 - (3) ***system support*** (which goals have the most influential and widespread support?)
 - (4) ***breadth of impact*** (which goals are most likely to have a broad impact on services?)
 - (5) ***quality of impact*** (which goals will make the most difference in the lives of consumers?)
 - (6) ***risks and costs of not changing*** (which practices, if not changed, will have the most negative impact, and according to what criteria?)³⁷
-

Step Four: Identify Specific Objectives and Responsible Persons

*Following prioritisation of goals, specific objectives (along with measurable outcomes and timelines for their achievement) can be articulated. Persons responsible for implementation and monitoring of the corresponding tasks can also be nominated.*³⁸

³⁷ Ibid.

³⁸ FalLOT & Harris, 'Creating Cultures of Trauma-Informed Care', pp.6-7.

DOMAIN 1A SAFETY – ENSURING PHYSICAL AND EMOTIONAL SAFETY

Key Questions:

‘To what extent do the program’s activities and settings ensure the physical and emotional safety of consumers? How can services be modified to ensure this safety more effectively and consistently?’³⁹

Sample Specific Questions:

How would you describe the reception and waiting areas? Are they comfortable and inviting?

Are the first contacts with consumers welcoming, respectful and engaging?

Do consumers receive clear explanations and information about each task and procedure? Are the rationales made explicit? Does each contact conclude with information about what comes next?

³⁹ Fallot & Harris, ‘Creating Cultures of Trauma-Informed Care...’, p.7.

DOMAIN 1B TRUSTWORTHINESS – MAXIMIZING TRUSTWORTHINESS THROUGH TASK CLARITY, CONSISTENCY, AND INTERPERSONAL BOUNDARIES

Key Questions:

To what extent do the program's activities and settings maximise trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program? How can services be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately? How can the program maximise honesty and transparency?⁴⁰

Sample Specific Questions:

Does the program provide clear information about what will be done, by whom, when, why, under what circumstances, at what cost, and with what goals?

When, if at all, do boundaries veer from those of the respectful professional? Are there pulls toward more friendly (personal information sharing, touching, exchanging home phone numbers, contacts outside professional appointments, loaning money, etc) and less professional contacts in this setting?

How does the program handle dilemmas between role clarity and accomplishing multiple tasks?

What is involved in the informed consent process? Is both the information provided and the consent obtained taken seriously? That is, are the goals, risks, and benefits clearly outlined and does the consumer have a genuine choice to withhold consent or give partial consent?⁴¹

40 Fallot & Harris, 'Creating Cultures of Trauma-Informed Care...', p.8.

41 Fallot & Harris, 'Creating Cultures of Trauma-Informed Care...', p8.

DOMAIN 1C CHOICE – MAXIMIZING CONSUMER CHOICE AND CONTROL

Key Questions:

‘To what extent do the program’s activities and settings maximise consumer experiences of choice and control? How can services be modified to ensure that consumer experiences of choice and control are maximised?’⁴²

Sample Specific Questions:

How much choice does each consumer have over what services he or she receives? Over when, where, and by whom the service is provided? (eg time of day or week, office vs home vs other locale, gender of provider)

Does the consumer choose how contact is made (eg by phone, mail, to home or other address?)

Does the program build in small choices that make a difference to consumer-survivors (eg When would you like me to call? Is there some other way you would like me to reach you or would you prefer to get in touch with me?)⁴³

42 Ibid

43 Ibid

DOMAIN 1D COLLABORATION – MAXIMIZING COLLABORATION AND SHARING POWER

Key Questions:

*'To what extent do the program's activities and settings maximise collaboration and sharing of power between staff and consumers? How can services be modified to ensure that collaboration and power-sharing are maximised?'*⁴⁴

Sample Specific Questions:

In service planning, goal setting, and development of priorities, are consumers consulted and their preferences given substantial weight?

Does the program cultivate a model of doing 'with' rather than 'to' or 'for' consumers?

Does the program and its providers communicate a conviction that the consumer is the ultimate expert on her or his own experience?

Are consumers involved as frequently as feasible in service planning meetings? Are their priorities elicited and then validated in formulating the plan?

⁴⁴ Falot & Harris, 'Creating Cultures of Trauma-Informed Care...', p.9.

DOMAIN 1E EMPOWERMENT – PRIORITISING EMPOWERMENT AND SKILL-BUILDING

Key Questions:

‘To what extent do the program’s activities and settings prioritise consumer empowerment and skill-building? How can services be modified to ensure that experiences of empowerment and the development or enhancement of consumer skills are maximised?’⁴⁵

Sample Specific Questions:

In routine service provision, how are each consumer’s strengths and skills recognised?

Do consumer-survivor advocates have significant advisory voice in the planning and evaluation of services?

How can each contact or service be focused on skill-development or enhancement?

⁴⁵ Fallot & Harris, ‘Creating Cultures of Trauma-Informed Care...’, p.10.

SERVICE POLICIES⁴⁶

Key Question:

`To what extent do the formal policies of the program reflect an understanding of trauma survivors' needs, strengths, and challenges? Of staff needs? Are these policies monitored and implemented consistently?'⁴⁷

Proposed indicators:

Policies regarding confidentiality and access to information are clear

Adequate protection of the privacy of consumers is maintained and this communicated to consumers

The program has developed a de-escalation or `code blue' policy to minimise the possibility of retraumatization

The program has developed methods to respect consumer preferences in responding to crises, via `advance directives' or formal statements of consumer choice

Process for crisis management is clearly in place

*The program has a clearly written and easily accessible statement of consumer rights and mechanisms by which complaints and grievances can be lodged*⁴⁸

46 Relates to Domain 2 of the Harris & Fallot Protocol (p.12); note that this `domain' relates to formal (as distinct from informal) policies

47 Fallot & Harris, `Creating Cultures of Trauma-Informed Care...'; p.12.

48 Fallot & Harris, `Creating Cultures of Trauma-Informed Care...'; pp.13.

SCREENING FOR TRAUMA⁴⁹

Key Questions:

‘To what extent does the program have a consistent way to identify individuals who have been exposed to trauma, to conduct appropriate follow-up assessments, to include trauma-related information in planning services with the consumer, and affordable trauma-specific services?’⁵⁰

Proposed indicators:

Staff members have reviewed existing instruments and are aware of the range of possible screening tools

At least minimal questions addressing physical and sexual abuse are included in trauma screening in an appropriate way⁵¹

Screening avoids over-complication and unnecessary detail so as to minimise stress for consumers

The following questions need to be considered:

- How can safety be ensured in the asking of such questions?
- How can questions be addressed most appropriately – for the likely consumers, for the service context, time available, prior relationship, possible future relationship, at various points in the intake/assessment process?
- The need for standardization of screening across sites is balanced with the unique needs of each program or setting
- The screening process avoids unnecessary repetition. While there is no need to ask the same questions at multiple points in the intake or assessment process, there is often a good rationale for returning to such questions after some appropriate time interval.⁵²

49 Relates to Domain 3 of the Fallot & Harris Protocol.

50 Fallot & Harris, ‘Creating Cultures of Trauma-Informed Care’, p.13.

51 The phrasing of such questions, and the many dynamics of screening for trauma, need to be carefully considered. For helpful discussion in this area, see ‘Asking About Abuse’, ch. 6 in Barbara Everett & Ruth Gallop, *The Link between Childhood Trauma and Mental Illness* (CA: Thousand Oaks, 2001), pp.101-116.

52 Fallot & Harris, ‘Creating Cultures of Trauma-Informed Care’, pp.13-14, and see previous footnote.

To facilitate the organisational cultural change required, Fallo and Harris⁵³ also suggest a basic 4-step process which service-providers can instigate, each stage of which could address various dimensions:

- (1) **Initial Planning** (*commitment to the trauma-informed change process; formation of trauma initiative work groups, representation of significant stakeholders, establishment of timeline, etc*)
- (2) **A 'Kickoff' Training Event** (*generally of two days duration; involves presentations on central principles of trauma-informed care, the importance of staff support and care, and the importance of trauma in the specific work of the agency – 'The goal of the kickoff is to motivate and energise the change process while simultaneously providing a beginning sense of direction'*).⁵⁴
- (3) **Short-term Follow-Up** (*application and implementation of resolutions from the training event, feedback, identification of strategies for addressing obstacles, etc*)
- (4) **Longer-term Follow-up** (*suggested to take place after approximately six months, reviews and revisits progress at this point*)⁵⁵

53 Fallo & Harris, 'Creating Cultures of Trauma-Informed Care', pp.3-4.

54 Ibid.

55 Ibid



PART II – RESEARCH BASE



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Introduction to Part II

Over the previous decade, there has been a new and unprecedented convergence of research in a spectrum of fields and disciplines which pertain to mental health. The wide-ranging findings are yet to be reflected in practice on a broad scale. With respect to the exciting and far-reaching implications of 'the neurobiology of attachment' (see chapter 3) there is a wide gap between what is now known at the level of research, and the embedding of these insights into treatment programs and organisation of service-delivery. One clinician and researcher regards translation of current research insights into clinical practice and service provision as a major priority which now needs to be met.¹

It is imperative that the key research findings are clearly described and extrapolated, alongside articulation of the guidelines which are informed by them. For this reason, a 'Glossary' of key terms is also provided. It includes a range of recurring concepts, as well as relevant contextual terms. Since the definitions and commentary it provides are quite detailed, it may be helpful to consult the 'Glossary' (which can be read as an integrative summary in its own right) while reading the main text. The listing of chapter subheadings in the table of contents for Part II is also designed to assist with locating particular topics and themes.

As well as outlining core research findings, Part II contextualises the report by considering the nature of what is at stake. This is important because the field of trauma has had a truncated history, and current research is extending and challenging the ways in which trauma is regarded. While the work of early pioneers in the study of trauma is substantiated in key ways by the advent of neuroscientific research (specifically and especially in the context of simultaneous research in the area of attachment) current diagnostic categories are considerably challenged by the new research insights. Major areas of challenge relate to the understanding of *complex* trauma, which in turn has significant *treatment* implications. This means that sound contemporary guidelines must take account of the innovations of current conceptual debates.

In charting this terrain, Part II introduces common themes to arise from the current research regarding understanding and treatment of complex trauma. It also provides a more detailed account of findings of the current interdisciplinary research (from which recurring principles for construction of the guidelines have been derived). 'Core' or 'necessary' components of optimal practice for the addressing of complex trauma are extrapolated, with reference to both treatment implications and service-delivery.

Chapter 1, 'Surviving child abuse: the stakes and the challenges', considers the nature and dimensions of child abuse, which pose more comprehensive societal challenges than is commonly recognised. The significance of the Adverse Childhood Experiences (ACE) study in the United States is discussed,² both in terms of the decisive links it charts between traumatic early experience and adult ill-health, and its reconceptualisation of this interrelationship. The ACE study finds that '*personal solutions*' in the form of coping mechanisms to deal with childhood trauma are converted over time into adult health problems.³ It establishes that initially protective attempts to deal with adversity in childhood lose their protective function over the years, and actively undermine adult well-being. The ACE study is pioneering in locating the roots of *the major public health problem which is child abuse* in the effects of childhood coping mechanisms which have ceased to protect.

1 Diana Fosha, 'Dyadic Regulation and Experiential Work with Emotion and Relatedness in Trauma and Disorganized Attachment', in Marion F. Solomon & Daniel J. Siegel, *Healing Trauma* (New York: Norton, 2003), p.276.

2 Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS et al, 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study, *American Journal of Preventive Medicine* 14 (4) 1998, pp.245-258.

3 Ibid

Chapter 2 ('Understanding complex trauma: the evolving terrain') locates child abuse as a form of *complex* trauma which 'has as its unique trademark a compromise of the individual's self-development'.⁴ Differences between 'complex' and 'single-incident' trauma are discussed. The many dimensions of complex trauma are not widely acknowledged or adequately represented by standard classificatory and diagnostic systems, including within the extensively referenced *Diagnostic and Statistical Manual of Mental Disorders*.⁵ The implications of inadequate conceptualisation of complex trauma for effective *treatment* of it are considered, and proposed new diagnostic classifications are discussed. Basic psychobiology of trauma, in terms of inability to process and integrate traumatic experience, is explained, and the negative implications for integration 'across many domains of learning and memory'⁶ are elaborated.

Chapter 3 ('New research insights: the neurobiology of attachment') presents some of the major findings from current research in interpersonal neurobiology, with particular reference to the developing mind. Such research is highly pertinent to understanding and addressing child abuse. Indeed, the response of the brain to trauma is now seen as providing 'a window to the general processes of learning and plasticity',⁷ and to the impact of adverse experience on the evolving brain and subsequent development. The crucial role of early care-giving in the context of primary emotional ('attachment') relationships is addressed, and the significance of emerging 'attachment styles' to subsequent health and well-being is explored.

The famous 'Strange Situation' study (first conducted in the 1970s and since replicated many times) delineated three contrasting attachment styles – 'secure', 'avoidant' and 'ambivalent', to which a fourth ('disorganised') variety was added in the 1990s. The significance of attachment styles (and particularly of disorganised attachment, which is correlated with childhood trauma) is described. The longevity of attachment styles and their effects on the next generation via parent-child relationships are discussed, with reference to the disabling consequences of unresolved parental trauma from childhood.

Chapter 4 ('Implications for practice: core components of trauma-specific and trauma-informed care') extends this discussion with reference to exciting current research which shows that complex childhood trauma, even when severe, can be resolved ('earned security').⁸ Correspondingly, its negative impacts on the next generation are intercepted. The role of psychotherapy in providing opportunities for repair of ruptured neural networks is discussed ('all forms of psychotherapy – from psychoanalytic to behavioural interventions – are successful to the extent that they enhance change in relevant neural circuits').⁹

But current research also suggests the *limits* of 'talk-based' therapeutic approaches, and the need for attentiveness to *physical*, somatic and body-oriented processes. This constitutes a challenge to the more traditional emotional and cognitive emphases of established psychotherapeutic practice. With reference to the vital role of the ability to manage emotion ('regulate affect'), the importance of *phased treatment* is discussed, as well as the corresponding need for therapist attunement to affect tolerance and dissociative processes. The significance of the distinction between 'early onset' and 'adult onset' trauma is discussed, along with core features of complex trauma therapy and the question of 'evidence-based' treatment.

4 Julian D. Ford & Christine A. Courtois, 'Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders', Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders: An Evidence-Based Approach* (New York: The Guilford Press, 2009), p.16.

5 The next iteration of which is due in 2013. The current version is the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV-TR) Washington, DC: American Psychiatric Association, 2000.

6 Cozolino, *The Neuroscience of Psychotherapy* (New York: Norton, 2002), p.270.

7 Ibid, p.285.

8 Daniel J. Siegel, 'An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma', Solomon & Siegel, ed. *Healing Trauma*, p.16.

9 Cozolino, *The Neuroscience of Psychotherapy*, p.xiv.

The wealth of research implications applicable to complex trauma means that there is no 'one size fits all' in either trauma-*specific* interventions or models of trauma-*informed* care and service-delivery. Yet attentiveness to ongoing themes in the current research reveals a coincidence of core principles which should underlie all interventions pertaining to complex trauma, and which apply at both individual and collective (organisational) levels. This is further elaborated in chapter 5, with reference to discussion of both trauma-specific and trauma-informed practice.

Understanding of brain neuroplasticity reveals the devastating and long-term effects of unresolved trauma. This is for individuals, families and society as a whole. But it also reveals the corollary of this – that new, different, and positive experiences can activate positive neurological change and pathways to recovery. As Bloom and Farragher argue, understanding the psychobiology of trauma 'restores context to what has increasingly become a decontextualised meaning framework in mental health, substance abuse, and other service practice'.¹⁰ If the sources of so much dysfunction and distress lie in adverse childhood experiences which are highly prevalent, this requires reconfiguration of both our conceptual frameworks and current ways of operating.

Despite the enormity of the challenges, both the stakes of recognising and resolving trauma, and the multiple levels at which this is beneficial, are now clear. So, too, are the steps which need to be taken, and new ways in which it is now possible to proceed.

10 Sandra L. Bloom & Brian Farragher, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (New York: Oxford University Press, 2011), p.223.

1. Surviving child abuse: the stakes and the challenges

The relationship between child abuse and compromised adult well-being is now well established.¹¹ But currently unfolding research, specifically in the field of affective neuroscience (‘the neurobiology of attachment’)¹² is providing new insights in relation to it. This includes enhanced understanding of the effects of trauma on the developing brain, the implications across the life-cycle, and even the impacts on the next generation. For these reasons, it is crucial that the main tenets of this research are delineated, and that they inform the care, treatment and service-provision guidelines which must evolve correspondingly. It is also imperative that they inform policy construction and development.

Before consideration of the new research, however, a striking anomaly needs to be noted. Increased *recognition* of child abuse is not the same as effective and systematic *addressing* of it. The extent to which the reality, prevalence¹³ and effects of child abuse pose ongoing challenges at all levels (ie not only to those who directly experience such abuse, but to health systems, governments and society as a whole) must be confronted at the outset. Why does child abuse pose such wide-ranging challenges, and what are the stakes in relation to it?

Child Abuse Trauma: many challenges, multiple effects

That many adult problems might be ‘the logical consequences of childhood maltreatment’¹⁴ is not difficult to grasp at one level. Yet notwithstanding its logic and well established empirical support, recognition of this connection – as distinct from acknowledgement of the *existence* of child abuse – is not widespread. The contention that ‘much (if not most) of what we think of as adult psychopathology actually reflects long-term reactions to child abuse’¹⁵ suggests some of the reasons for this. *Child abuse is challenging in ways that affect the extent to which its prevalence and many effects are fully countenanced even as the evidence base is solid and continues to expand.*

Ambivalence about the extent and ongoing effects of child abuse is present throughout many levels of society, and is as much a reality as the abuse which elicits it. This needs to be borne in mind and confronted in any attempt to address its many and ongoing effects. For example, in her introduction to Briere’s 1992 text, Berliner remarks that it is ‘curious’ that ‘major texts in psychopathology have so

11 See opening comments and references in Brian Draper et al, ‘Long-Term Effects of Childhood Abuse on the Quality of Life and Health of Older People: Results from the Depression and Early Prevention of Suicide in General Practice Project’, *Journal of American Geriatric Society* (2007), pp.1-10. For an overview of the nature, prevalence and impact of child sexual abuse, see Paul E. Mullen, Neville J. King & Bruce J. Tonge, ‘Child Sexual Abuse: an Overview’, *Behaviour Change* (Vol.17, No.1, 2000), pp.2-14. Also see discussion of the pioneering Adverse Childhood Experiences (ACE) Study later in this chapter, and the accompanying diagram which pertains to it.

12 Also described as ‘interpersonal neurobiology’; see Daniel J. Siegel, ‘An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma’, ch. 1 in Siegel & Marion F. Solomon, ed. *Healing Trauma: attachment, mind, body, and brain* (New York: Norton, 2003), pp.1-56.

13 Data pertaining to both the prevalence and incidence of child abuse tends to be conservative in that it relates only to the number of children who come to the attention of child protection services. While the most common types of child abuse are *neglect, physical abuse, emotional abuse and sexual abuse*, definitions of what constitutes child abuse and neglect also vary across Australian states and territories. In 2009-10, the total number of substantiated cases of ‘primary substantiated maltreatment types’ in Australia was 46, 187. Of this figure, 28.7% pertained to neglect, 22% to physical abuse, 37% to emotional abuse and 12.7% to sexual abuse (Alister Lamont, ‘Child abuse and neglect statistics’, Resource Sheet [referencing AIHW, 2011, p.68] National Child Protection Clearinghouse, Australian Institute of Family Studies, February 2011, pp.1-7) <http://www.aifs.gov.au/nch/pubs/sheet/rs1/rs1/pdf>

14 Lucy Berliner, ‘Foreword’, John N. Briere, *Child Abuse Trauma: Theory and Treatment of the Lasting Effects* (Newbury Park, CA: Sage, 1992), p.ix (‘Whether the abuse suffered is sexual, physical, or psychological makes a certain difference, but it is being abused that seems to matter most’; *Ibid*).

15 *Ibid*.

seldom identified child abuse as the source of adult difficulties.¹⁶ It is not, she says, 'that childhood maltreatment is not implicated, but that it is not explicitly the focus of the various explanatory models.'¹⁷ In the context of the far-reaching *challenges* posed by child abuse, however, the reasons for such gaps become more apparent:

One might speculate that it is the belated recognition of the prevalence of child maltreatment in our society that accounts for this failure to make the connection. And much has been said about *the powerful societal and personal forces, still in existence, that have served as obstacles to the acceptance of child abuse.*¹⁸

Psychiatrist and complex trauma specialist Warwick Middleton recalls that when he began training in psychiatry in 1980, the most widely used psychiatry reference book (the *Comprehensive Textbook of Psychiatry*, third edition, edited by Friedman, Saddock and Kaplan) estimated the prevalence of incest to be one in a million women (the source of this estimate being a 1955 paper).¹⁹ By the mid 1980s, he notes that 'community studies had established that the true prevalence of incest was around 16% of the female population and that the prevalence of child sexual abuse in all its forms was substantially higher.'²⁰

Professor Middleton comments that '[i]t is hard to find a comparable example in society where something so damaging to so many could exist undisturbed for decades under the gaze of those professional bodies who would be assumed to have qualifications and motivations to bring clarity and to be at the forefront of addressing such a pervasive threat to the mental and physical health of fellow citizens'.²¹ Strikingly, he draws a parallel between child abuse and 'another notable issue of our times, climate change... an issue of immense ramifications, yet [which] in day to day life may be remote, something that is relatively invisible, and certainly not something that on the face of it represents a crisis'.²²

Controversy surrounding the prevalence of child sexual abuse dates to the work of Freud. Freud's much discussed abandonment of 'the seduction theory' (predicated on the apparent extent of incest as conveyed by his predominantly female patients) in favour of a theory emphasizing childhood wishes, fantasies and *internal representations* of seduction²³ is emblematic here. It marked what many came to regard as a problematic 'turning away' from the objective reality of child sexual abuse in ways which still inflect both professional culture and social attitudes.

16 Berliner, 'Foreword'; Briere, *Child Abuse Trauma*, p.x. For a pioneering study on the mental health impacts of child sexual abuse, see Paul E. Mullen & Jillian Fleming, 'Long-term effects of Child Sexual Abuse' Issues in Child Abuse Prevention (No.9, 1998) National Child Protection Clearinghouse, Australian Institute of Family Studies www.aifs.gov.au/nch This study elaborates the hypothesis 'that, in most cases, the fundamental damage inflicted by child sexual abuse is to the child's developing capacities for trust, intimacy, agency and sexuality, and that many of the mental health problems of adult life associated with histories of child sexual abuse are secondary order effects' (a hypothesis also found to run 'counter to the post-traumatic stress disorder model' and to suggest 'different therapeutic strategies and strategies of secondary prevention'; *Ibid*)

17 *Ibid*.

18 *Ibid* (emphasis added) As Briere notes, 'the connection between child maltreatment and later dysfunctional or 'pathological' behaviour has often been overlooked and/or trivialized, partially as a result of cultural acceptance of physical violence, verbal aggression, and exploitation in the training and control of children' (Briere, *Child Abuse Trauma*), p.xvii.

19 Professor Warwick Middleton MB BS, FRANZCP, MD; ASCA Parliamentary Briefing Session address, Parliamentarians Against Child Abuse, Bipartisan Committee chaired by Senator Helen Kroger and Senator Catryna Bilyk (23 November 2011), p.1.

20 *Ibid*

21 *Ibid* (emphasis added)

22 *Ibid*. Also see Richard P. Kluff, 'On the Apparent Invisibility of Incest: A Personal Reflection on Things Known and Forgotten', ch.2 in Kluff, *Incest-Related Syndromes of Adult Psychopathology* (Washington, DC: American Psychiatric Association, 1990), pp.11-34.

23 This departure in Freud's thinking is widely discussed and noted; see, for example, John Bowlby, 'Psychoanalysis as Art and Science' [1978], in Bowlby, *A Secure Base* (London: Routledge, 2006), pp.48-49; Bessel van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma', in Solomon & Siegel, ed. *Healing Trauma*, p.176; Jeffrey Masson, *The Assault on Truth: Freud's Abandonment of the Seduction Theory* (New York: Random House, 1984), and Stuart D. Perlman, *The Therapist's Emotional Survival* (NJ: Jason Aronson, 1999), pp.8-9 & 223-224.

This is not the place for commentary on Freud's complicated legacy. The key point is *the far-reaching challenges child abuse, and particularly child sexual abuse, has long posed to a wide range of interests and attitudes*. This extends not only to aspects of societal organisation, but to the very *language and categories of thought by which the challenges are conceptualised*.

Warwick Middleton is explicit regarding the extent to which both professional bodies and society at large 'have buried the etiological significance of developmental trauma by devising rationales for ignoring it, re-diagnosing trauma caused conditions as some form of biological/genetic disorder or by assigning diagnoses that mitigate against an individual's trauma being taken seriously'.²⁴ His comments regarding what he calls '[t]he endemic nature of 're-badging' of conditions caused by severe developmental trauma'²⁵ have their disturbing correlate in both minimisation of the prevalence of child abuse, and the absence of services to assist and treat the many who experience it.²⁶

A further insidious effect of the 're-badging' of symptoms and conditions associated with childhood trauma is upholding of the 'culture of silence'²⁷ that continues to surround child abuse. This further compounds the already endemic myopia which seriously distorts both perceptions and current treatment of those whose underlying trauma is not recognised:

...for the most part, the issue of trauma is simply screened out organizationally and systemically... the reality of the traumatic origins of mental illness go unaddressed. And the patient, frequently diagnosed with chronic depression, borderline personality, or some other 'axis II' disorder, is labelled, everyone in the system colludes to support the reality and meaningfulness of the label in determining future behaviour and outcomes, *and the patient's more fundamental – and treatable – trauma conditions go untreated*.²⁸

The many constraints which still militate against open discussion of child abuse compound recognition and addressing of violations the scale and magnitude of which, were they to be acknowledged and confronted, would both raise questions of complicity and comprise grounds for deep national shame.²⁹

24 Middleton, ASCA Parliamentary Briefing Session address, p.3.

25 Middleton, ASCA Parliamentary Briefing Session address, pp.3-4.

26 'For reasons that defy logic and the data on mortality, much of the mission statement of the public mental health services is predicated on providing services for patients with 'serious mental illness' usually defined as those suffering with 'schizophrenia' and 'bi-polar disorder'. The services such patients receive revolve around maintaining follow up and monitoring anti-psychotic and mood-stabilizing medication. Patients with serious life-threatening trauma-spectrum disorders are frequently denied any access to community mental health services on the basis that they are deemed by regard to their diagnosis as not suffering from a 'serious' mental illness' (Middleton, ASCA Parliamentary Briefing Session address, pp.4-5).

27 For powerful explication of the many dimensions comprising what Bloom calls the 'traumatic amnesia' not only of individuals but of social groups and whole societies, see Sandra Bloom & Brian Farragher, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (New York: Oxford University Press, 2011), p.236.

28 Bloom & Farragher, *Destroying Sanctuary*, p.224.

29 Middleton is also explicit both that '[s]ociety has been, and is threatened by the full extent of the trauma of its citizens being exposed' (Middleton, ASCA Parliamentary Briefing Session address, p.3) and that '[t]here are many individuals or groups that have a vested interest in blocking or discrediting such disclosures' (Ibid, pp.5-6). He further contends that '[t]he reality is that our society is not fully democratized and that child abuse is likely to occur in closed hierarchical organizations where there is limited or no real access to the sorts of protections usually associated with democratic conventions' (Ibid, p.8). To the extent that such organizations 'can include orphanages, churches or schools *but the commonest example is that societal grouping known as 'the family'* (Ibid; emphasis added) the stakes and challenges of comprehensive addressing of child abuse are clearly underlined.

From 'personal solutions' to public health problems: the Adverse Childhood Experiences (ACE) study

Of the many studies which show a relationship between a variety of suboptimal childhood experiences and compromised mental and physical health in adulthood, the most comprehensive and systematic is the Adverse Childhood Experiences (ACE) study conducted in the United States.³⁰ This longitudinal study draws on over 17000 participants, and with reference to various categories of 'adverse' childhood experience and household dysfunction,³¹ explores the extent to which such experience affects subsequent adult health.

Cohort members of the ACE study are *predominantly white middle-class*, have generally had some college experience, and do not show any obvious markers of social disadvantage. Yet the two major findings of this study are that adverse childhood experiences are 'vastly more common than recognised or acknowledged', and that they powerfully impact both mental *and* physical health 'a half-century later'.³²

In fact the ACE study charts the translation of traumatic childhood experience into both emotional disorder and organic disease later in life. The study establishes 'that time does *not* heal some of the adverse experiences [found to be] so common in the childhoods of a large population of middle-aged, middle class Americans. One does not 'just get over' some things'.³³

In correlating decisive links between adverse childhood experience and subsequent adult health problems, the epidemiological results of the ACE study are authoritative in their magnitude. The study also elicited health information which had not previously been sought, and which, in the words of its key convenor, is generally 'well protected by social convention and taboo'.³⁴ For this reason, and because of the acknowledged discomfort discussion of traumatic early experiences can evoke among doctors and health professionals, authors of the study recommend *routine* screening for such information when patients present to health service-providers, lest such key client history continue to be overlooked.³⁵

A further key finding of the ACE study is the extent to which adult health problems on the part of those who had adverse experiences as children *stem from strategies, coping mechanisms and behaviour which were initially protective attempts to deal with the adversity experienced*. Hence convenors of the study speak of the conversion of 'personal solutions' into 'public health problems'.³⁶ This striking insight describes how what might have been effective coping mechanisms in childhood (eg weight gain as a response to sexual abuse)³⁷ become major health risks later in life (and thus national health problems with which health systems must deal).

30 The ACE Study is described on its webpage as 'perhaps the largest scientific research study of its kind, analysing the relationship between multiple categories of childhood trauma (ACEs), and health and behavioural outcomes later in life' <http://www.acestudy.org> It represents 'an ongoing collaboration' between the Center for Disease Control and Prevention and Kaiser Permanente, and is led by Vincent J. Felitti, MD and Robert F. Anda, MD, MS. See Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS et al. 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine* 14 (4) 1998, pp.245-258.

31 Seven categories of adverse childhood experiences were studied, including physical, psychological and sexual abuse, violence in the household, and living with household members who were substance abusers, mentally ill, or who had been suicidal or imprisoned. The number of categories was then compared to measures of adult risk behaviour, health status and disease. More than half the respondents reported experience of at least one of these categories, and one fourth upwards of two.

32 Vincent J. Felitti, 'The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead', *The Permanente Journal* (Vol.6, No.1, 2002), p.45. A graded relationship was found between the number of categories of childhood exposure and each of the adult health risk behaviours and diseases studied; this relationship was found to be long lasting.

33 Ibid, p.44.

34 Ibid, p.47.

35 Felitti, 'The Relationship of Adverse Childhood Experiences to Adult Health...', p.47.

36 Vincent Felitti, 'The ACE Study: Childhood Trauma and Mental Health' Cavalcade Productions, 2004.

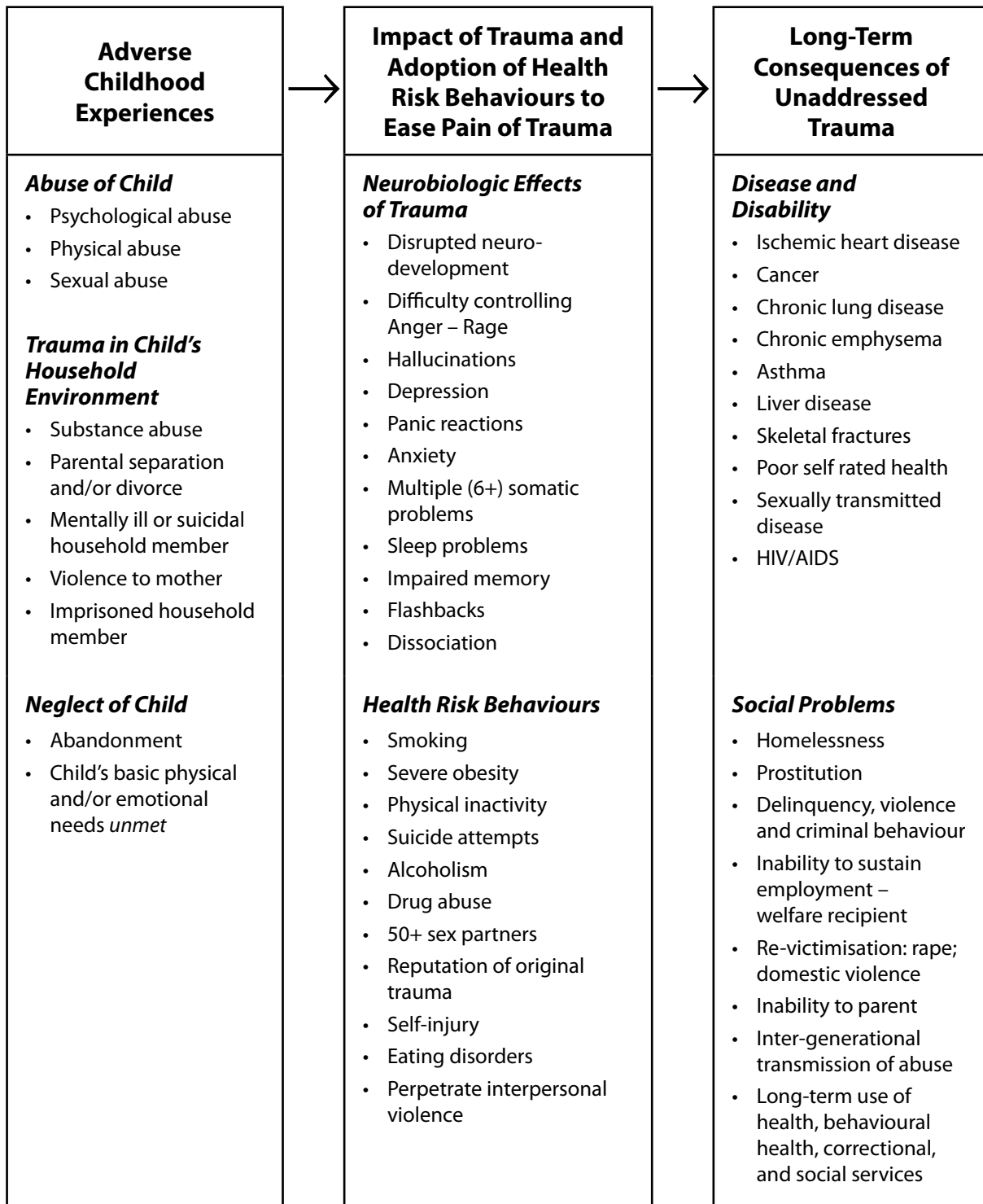
37 In fact the ACE Study was precipitated by observations made in relation to an obesity program of the mid-1980s, which while having a high success rate at one level (ie weight loss on the part of the participants) also had an unexpectedly high drop-out rate. As Felitti ('The Relationship...', p.44) describes, this unanticipated outcome led to realisation of the extent to which obesity could also serve as a protective factor in the wake of sexual abuse (as illustrated by the cited comment of one woman that 'Overweight is overlooked and that's the way I need to be').

Description of transformation of *'personal solutions'* (initial coping mechanisms) into subsequent adult health risks (and thereby *'public health problems'*) is arresting. It is also a valuable summary of the dynamics which operate. It succinctly conveys not only the dimensions of what is at stake for the individuals directly concerned (and the many who have contact with them) but for the national challenges of public health *per se*. It is also de-pathologising of the many people whose adult health problems are too often regarded as the product of personal weakness or lack of *'will power'*, rather than as the outgrowth of initially *protective* childhood attempts to cope with adversity (*'PTSD, borderline personality disorder, and self-harm can all reflect complex adaptation to early trauma'*).³⁸

³⁸ Louis Cozolino, with reference to Saxe et al & van der Kolk et al, 1996, 'The Impact of Trauma on the Brain', *The Neuroscience of Psychotherapy* (New York: Norton, 2002), p.268.

Adverse Childhood Experiences and Health and Well-Being Over the Lifespan

This chart shows the sequence of events that unaddressed childhood abuse and other early traumatic experiences set in motion. Without intervention, adverse childhood events (ACEs) result in long-term disease, disability, chronic social problems and early death. 90% of public mental health clients have been exposed to multiple physical or sexual abuse traumas. Importantly, intergenerational transmission that perpetuates ACEs will continue without implementation of interventions to interrupt the cycle.



Data supporting the above model can be found in the *Adverse Childhood Experience Study* (Center for Disease Control and Kaiser Permanente, see www.ACEstudy.org) and *The Damaging Consequences of Violence and Trauma* (see www.NASMHPD.ORG). Chart created by Ann Jennings, PhD. www.annafoundation.org

The findings of the ACE study also raise urgent and disturbing questions about the construction and operation of health service provision:

If the origins of so much dysfunction are to be found in the adverse experiences of childhood that a majority...³⁹ apparently experience... then what exactly is the role of the mental health professional, the substance abuse counsellor, the domestic violence advocate? What should social service institutions focus their efforts upon? Can we stay comfortably settled in our offices or is advocacy for fundamental change a moral necessity? What exactly do all the diagnostic categories mean when someone diagnosed with posttraumatic stress disorder is six times more likely to be diagnosed with three or more psychiatric disorders?⁴⁰

In fact the *prevalence of unrecognised and untreated underlying trauma* raises disturbing questions not only about health systems. It has disturbing implications for the full spectrum of service delivery, and raises critical questions about societal organisation *per se*.

39 While this quotation makes explicit reference to a majority `of Americans', its potential application to the Australian context is no less striking (see previous discussion in relation to the points of Warwick Middleton).

40 Bloom & Farragher, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems*, pp.223-224.

'The last frontier?' Child abuse, the lens of trauma and the limits of individualistic frameworks

The challenges posed by trauma relating to child abuse are not, then, solely 'clinical', 'personal', 'psychological' or the preserve of 'the helping professions'. *They are social, national and political in the broadest sense.*⁴¹ Both because of its prevalence and ongoing effects, child abuse in its various forms comprises *a major public health problem*, and widespread recognition of this by policy-makers, as well as by the public, comprises one of the major challenges that needs to be met.

The corresponding corollary is the need both for specific *services* to survivors of child abuse and the many affected by it, and *advocacy* around a topic the reality and dimensions of which are still not widely apprehended and understood. Acknowledgment of the need for both these priorities is prerequisite to comprehensive addressing of what is at stake.

This point is salient in relation to ASCA, the core business of which comprises not only direct support of adult survivors, but education of health professionals and frontline workers and community advocacy in a societal context which still and in many ways remains ambivalent. Importantly, this also involves national advocacy to influence thinking about appropriate services and policy reform (*'It's not about providing extra proof, it's about society's willingness to know'*).⁴² It is for this reason that Warwick Middleton (who also directs the only dedicated trauma and dissociation unit in Australia) describes realisation of the extent of trauma, particularly as it relates to child abuse, as '[o]ne of the last frontiers of our society'.⁴³

That *childhood coping mechanisms* in response to experience of abuse subsequently become *adult health problems* (ie as substantiated by the ACE study) is a major fact of which to be aware. Realization that 'much of what seems pathological is really creative, albeit ultimately dysfunctional, strategy for survival',⁴⁴ and that '[e]ven the most disturbing behaviours have functional meaning when conceptualised in this fashion',⁴⁵ paves the way both for reconceptualisation of the problems faced by adult survivors of child abuse, and treatment innovations. In its several varieties, child abuse is also a form of *complex* trauma, which involves a range of dimensions which need to be delineated.

41 'Clearly, we have shown that adverse childhood experiences are both common and destructive. This combination makes them one of the most important, if not the most important, determinants of the health and well-being of the nation' (Felitti, 'The Relationship of Adverse Childhood Experiences to Adult Health...'. p.46).

42 Comment by Warwick Middleton, presenter at the Mental Health Professionals Network (MHPN) webinar, 'Complex trauma: working together, working better to support adult survivors of child abuse', 20 September 2011 <http://www.mhpn.org.au/News/Events/ComplexTrauma.aspx>

43 Warwick Middleton, cited in Tobler, 'Early trauma takes a long-term toll', *The Weekend Australian* (health section), 23-24 July, 2011, p.13. The trauma and dissociation unit Middleton directs is located at Belmont Private Hospital in Queensland.

44 Berliner, 'Foreword'; Briere, *Child Abuse Trauma*, p.x.

45 Ibid.

Chapter summary of key findings and themes

- The relationship between child abuse and adult health problems is clearly substantiated. Yet the many implications of this remain to be comprehensively acknowledged and addressed both by health systems and society at large.
- A landmark longitudinal study into adverse childhood experiences (the ACE study) found such experiences to be *extremely prevalent even in the absence of obvious markers of social disadvantage*. It also found that the adult health problems experienced by the over 17000 participants *stemmed from coping mechanisms which were initially protective strategies to deal with experience of childhood adversity*. Thus a major insight generated by the ACE study is that *'personal childhood solutions' to deal with early adverse experiences subsequently become adult and public health problems*.
- The challenges posed by trauma related to child abuse are not solely 'clinical', 'psychological' or the preserve of 'the helping professions'. Because of its prevalence and ongoing effects, child abuse comprises *a major public health problem*, recognition of which is one of the major social and political challenges that needs to be met.

2. Understanding complex trauma: the evolving terrain

*'There is more to trauma than PTSD'*⁴⁶

Trauma of any kind is serious, and its effects are damaging and need to be addressed. While various expressions of it may not necessarily be easily recognised or understood, trauma is never 'simple' in the minimising sense that this term might imply. What is increasingly called *complex* trauma, however – of which child abuse is a particularly insidious form – has different antecedents, evolution and potential effects than trauma in the unqualified sense. This is notwithstanding the fact that it may share features with other varieties of trauma and conditions (indeed, and as will be explained, is likely to do so).

For example, post-traumatic stress disorder (PTSD) is now widely acknowledged and recognised. Yet as the above quotation indicates, it does not exhaust the varieties of trauma which exist. Complex trauma, which may coexist with PTSD, is not adequately described by this classificatory label (although is widely conflated and confused with it). Complex trauma occurs in many forms. There have also long been calls for a distinct variety of *complex* post-traumatic stress disorder to be recognised (see below). When and why is trauma 'complex', and why does the distinction matter?

What are we talking about? Defining complex trauma

Complex trauma can be defined relatively simply, although the history of attempts to achieve its formal classification and recognition is far from simple, and is ongoing. A stark and basic definition is that complex trauma *'is a subset of the full range of psychological trauma that has as its unique trademark a compromise of the individual's self-development'*.⁴⁷ What is distinctive about complex trauma is its pervasive effects; it is not only a range of functions which are negatively impacted but development and functioning of the self *per se*.

In contrast to what is often referred to as 'single incident' trauma (which relates to an unexpected and 'out of the blue' event such as a natural disaster, traumatic accident, terrorist attack or single episode of assault, abuse or witnessing of it) *complex* trauma is cumulative and repetitive. It is the product of overwhelming stress which is interpersonally generated, such as ongoing abuse, *including within the context of intimate and familial relationships*, and includes community violence, war and genocide.⁴⁸ 'Single incident' (also described as 'Type 1' or 'large-T') trauma is 'simple' in the sense of being the potential result of an unexpected and 'one off' overwhelming event. By contrast, *complex* ('Type II' or 'small-T') trauma is cumulative, repetitive and occurs in interpersonal contexts.⁴⁹

The contrast between complex and single-incident trauma is stark. Unlike a 'one off' event, the *cumulative impact of intentional, premeditated and multiple abusive episodes* (which are frequently

46 Robin Shapiro, *The Trauma Treatment Handbook: Protocols Across the Spectrum* (New York: Norton, 2010), p.11.

47 Christine A. Courtois & Julian D. Ford, 'Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders', in Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide* (New York: The Guilford Press, 2009), p.16 (emphasis added)

48 Courtois & Ford, 'Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders', p.15.

49 Courtois & Ford, citing Terr (1991), 'Defining and Understanding Complex Trauma...'; p.15. Note the contention of Neborsky (referencing Kahn, 1963) that '[a]ttunement failures between parent and child always are, by definition, small-T traumas. If they are repetitive, fixed, and rigid, there is no way to process the negative emotions that the trauma creates, and the effects become cumulative' (Robert J. Neborsky, 'A Clinical Model for the Comprehensive Treatment of Trauma Using an Affect Experiencing – Attachment Theory Approach', in Solomon & Siegel, ed, *Healing Trauma*, p.290).

extreme, and which often occur over many years at the hands of a care-giver from whom protection would ordinarily be expected) involves particular, and particularly damaging, dynamics. The term ‘betrayal trauma’⁵⁰ captures the depth of some of what is involved, and itself highlights a key point of difference from single-incident PTSD.

Complex trauma is more prevalent than is generally recognised.⁵¹ It often occurs in combination (‘polyvictimization’) and is associated with higher risk for development of PTSD.⁵² If occurring at critical periods of development, it *can radically compromise psychobiological, social and emotional development*, and ‘usually involves a fundamental betrayal of trust in primary relationships, because it is often perpetrated by someone known by or related to the victim.’⁵³ For these reasons, complex traumas are also described as ‘developmentally adverse interpersonal traumas.’⁵⁴ They are ‘complex’ because they place the person at risk for not only recurrent anxiety (eg. PTSD; other anxiety disorders) but also *interruptions and breakdowns in the most fundamental outcomes of healthy psychobiological development.*⁵⁵

The inadequacy of a PTSD diagnosis to encompass the full dimensions of *complex* trauma is clearly apparent from the above descriptions. Unlike ‘single incident’ trauma, complex trauma involves ‘cumulative adversities.’⁵⁶ Complex traumatic stress reactions ‘are those that are most associated with histories of multiple traumatic stressor exposures and experiences, *along with severe disturbances in primary caregiving relationships.*’⁵⁷ Thus ‘PTSD alone is insufficient to describe the symptoms and impairments that follow exposure to complex trauma.’⁵⁸

Contested categories: DSM typologies and the status and stakes of formal classification

In her Foreword to *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide*,⁵⁹ pioneer traumatologist Judith Herman begins with the statement that ‘[s]ometimes the whole is greater than the sum of its parts.’⁶⁰ She goes on to provide the contextual history and background to her 1992 proposal of the concept *complex posttraumatic stress disorder* (which was an attempt, she says, ‘to bring some kind of order to the bewildering array of clinical presentations in survivors who had endured long periods of abuse’).⁶¹ The advantage of this concept lies in ‘its integrative nature’, in that rather than ‘a simple list of symptoms, it is a coherent formulation of the consequences of prolonged and repeated trauma.’⁶²

Despite achieving the status of examination in field trials for the fourth edition of the *Diagnostic Manual of Mental Disorders* (DSM-IV)⁶³ and Herman’s own participation in the PTSD Working Group,

50 DePrince & Freyd (2007), in Courtois & Ford, ‘Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders’, p.18.

51 Courtois & Ford note that complex trauma affects ‘as many as 1 in 7 to 1 in 10 children’ (‘Defining and Understanding Complex Trauma and Complex Traumatic Stress Disorders’, p.15). Also see discussion in the previous chapter regarding the findings of the ACE study.

52 Courtois & Ford (citing Finkelhor et al 2007), ‘Defining and Understanding Complex Trauma...’, p.15.

53 Ibid (emphasis added)

54 Ford (2005); cited in Courtois & Ford, ‘Defining and Understanding Complex Trauma...’, pp.15-16.

55 Courtois & Ford, ‘Defining and Understanding Complex Trauma...’, p.16 (emphasis added).

56 Courtois & Ford, ‘Defining and Understanding Complex Trauma...’, p.17.

57 Ibid.

58 Courtois & Ford, ‘Defining and Understanding Complex Trauma...’, p.18; Bessel A. van der Kolk, ‘Posttraumatic Stress Disorder and the Nature of Trauma’, Solomon & Siegel, ed. *Healing Trauma*, pp.170-171.

59 Ibid.

60 Judith L. Herman, ‘Foreword’, Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, p.xiii.

61 Ibid and see Herman, *Trauma and Recovery: the aftermath of violence from domestic abuse to political terror* (New York: Basic Books, 1992, 1997).

62 Ibid.

63 *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV-TR) Washington, DC: American Psychiatric Association, 2000.

inclusion of a separate and distinct diagnosis of *complex* post-traumatic stress disorder did not ensue. This was notwithstanding the finding of *somatisation, dissociation* and *affect dysregulation* ('three cardinal symptoms of complex PTSD') as particularly apparent 'in survivors of childhood abuse, less commonly in those abused in adolescence or adulthood, and rarely in people who had endured a single acute trauma that was not of human design.'⁶⁴ These three groups of symptoms were also found to be 'highly intercorrelated.'⁶⁵

As Herman goes on to relate, demonstration of 'the prevalence and internal consistency' of the complex PTSD diagnosis seemed to constitute strong grounds for its inclusion in the DSM (as the PTSD Working Group concurred).⁶⁶ Yet proponents of this view 'were overruled at higher levels.'⁶⁷ Herman's stated hypothesis as to why this was the case (an omission which persists, although various remedial proposals continue to be advanced) also remains revealing: '*We can't include complex PTSD as part of the trauma spectrum because it does not fit neatly under the category of anxiety disorders. It might fit equally well under dissociative disorders, or somatisation disorders, or even personality disorders.*'⁶⁸ This, Herman ironically remarks, 'was, of course, exactly the point.'⁶⁹

The result was DSM-IV relegation of the constellation of symptoms to 'Associated Features' of PTSD, and the also minimising classification 'Disorders of Extreme Stress Not Otherwise Specified' (DESNOS). Complex trauma, and the challenges it poses to standard classification of PTSD, was – and remains – lost within the subtypes. This remains a continuing problem not only for adequate *conceptualisation* of complex trauma, but for widespread *recognition* and appropriate *treatment* of it.

Herman rightly notes that the concept of complex PTSD is supported by 'a vast body of clinical observation and experience', and has 'since taken on a life of its own.'⁷⁰ This is also because it has assisted clinicians to make sense of what they were observing, and, importantly, 'helped patients to make sense of themselves.'⁷¹ Omission of reference to complex trauma as a distinct entity and in its own right from the DSM (the diagnostic 'bible' which, notwithstanding its many limitations,⁷² retains enormous influence) continues to compound misunderstanding of its multifaceted presentation and effects, as well as of its seriously disabling legacy.

Crucially, omission from the DSM of explicit delineation of complex trauma also obscures understanding of appropriate treatment options for those experiencing it.⁷³ Omission of clear elaboration of complex trauma from the DSM in fact increases the likelihood of diagnosis of a 'bewildering array' of conditions and disorders⁷⁴ for which different treatment paths are indicated, which miss and compound the complex, pervasive and underlying trauma, and which are stigmatising and pathologising.⁷⁵

64 Herman, 'Foreword', p.xiii.

65 Herman (citing van der Kolk, 1996) 'Foreword', p.xiii.

66 Ibid.

67 Ibid.

68 Ibid.

69 Ibid.

70 Herman, 'Foreword', p.xiv.

71 Ibid.

72 For a critique of the DSM on cultural grounds, see Richard Castillo, *Culture and Mental Illness* (Pacific Grove, CA: Brooks/Cole, 1997).

73 'Recent studies... [have shown] that these patients may react adversely to current standard PTSD treatments, and that effective treatment needs to focus on self-regulatory deficits rather than 'processing the trauma' (Bessel A. van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma', in Solomon & Siegel, ed. *Healing Trauma*, p.173).

74 Middleton points out that '[v]irtually no patient with severe developmental trauma will meet diagnostic criteria for only one disorder. Most will meet criteria for 10-12 DSM-IV 'disorders', but this is really only another way of saying that virtually all aspects of their life, affect, personality and system of belief is affected by chronic inescapable childhood trauma' (Middleton, ASCA Parliamentary Briefing Session address, p.4).

75 This is a critique which is made strongly by many survivors of complex trauma, particularly in relation to the diagnosis of borderline personality disorder (which implies something to be 'wrong' with the personality, rather than that the person has had to adapt to the experience of complex trauma). See, for example, the comments of Merinda Epstein cited in Tobler, 'Early trauma takes a long-term toll', p.13. A number of studies have shown a relationship between child abuse and subsequent characteristics associated with BPD; see John Briere, *Child Abuse Trauma*, pp.75-76. For discussion of the relationship between borderline personality disorder and early trauma, see Cozolino, 'The Brain and Borderline Personality Disorder', in *The Neuroscience of Psychotherapy*, pp.279-283).

The point that problematic symptoms, behaviours and conditions can be *the outgrowth of initially protective attempts to deal with trauma* needs to be reiterated and emphasised. Such initial coping mechanisms may have been both resourceful and creative (as discussed in the previous chapter). *But with the passage of time, they have ceased to serve a protective function, and themselves become undermining of health.* This means that complex trauma can underlie a range of otherwise diverse presentations, which in turn receive diverse diagnoses that fail to account for the underlying trauma

This point is critical precisely because of *the breadth of responses generated by the comprehensive nature of complex trauma.* In a recent text, Ross and Halpern explicitly emphasise the response of *dissociation*⁷⁶ ‘because it is a core component of the trauma response, and because dissociation is not as widely understood and recognised as depression, anxiety, psychosis, substance abuse, eating and personality disorders.’⁷⁷ Understanding of the diverse manifestations of complex trauma is crucial both to recognition and appropriate treatment of it. Yet such understanding is unassisted by the standard diagnostic categories which themselves fragment the pervasiveness and totality of the effects of complex trauma.

Conceptual challenges and the momentum for change: ‘developmental trauma’ and the subjective correlates of complex trauma

Ongoing refining of, and challenges to, existing classifications continues. Notable in this context are attempts to capture the *subjective* dimensions of complex trauma, which are marked in cumulative interpersonal contexts, which can radically and negatively impact selfhood, and which again remain unaddressed in standard conceptions of PTSD. For example, the nature of the threat involved in complex traumas ‘often encompasses features that go beyond obvious instances of a threat of death or violation of bodily integrity as currently defined in Criterion A1 of the PTSD diagnosis in the DSM-IV-TR.’⁷⁸

Long-term biological and psychosocial stress can occur even in the absence of a threat to life or violation of bodily integrity (*‘complex trauma constitutes objective threats not only to physical survival – but also to the development and survival of the self’*).⁷⁹ Such threats to self-development are especially dangerous and damaging in the context of young children, for whom the self is fragile because still developing.

In order to more accurately describe this trajectory, Bessel van der Kolk has proposed a new diagnosis of *Developmental Trauma Disorder (DTD)*.⁸⁰ Criteria for DTD stem from exposure to ‘developmentally adverse interpersonal trauma’ (eg abuse, betrayal and abandonment) and provide a diagnostic category for children which mirrors the complex trauma incorporated in the DESNOS (DSM) criteria for adults (subsequently included as associated features of PTSD). Significantly, DESNOS has been empirically shown to be linked to childhood exposure to interpersonal psychological trauma.⁸¹

76 Dissociation is the act of disconnection from immediate experience, and operates on a continuum from mild to severe. Because serving a protective function as a defence against overwhelming threat, it is commonly present to varying degrees as a dimension of trauma. In this context, its most serious expression is that of Dissociative Identity Disorder (DID) a treatable condition in which parts of the self fragment and detach (and in the case of young children, before the self has developed and cohered). The relationship between trauma and dissociation will be discussed more fully in the next chapter; also see the ‘Glossary’ of this report.

77 Colin A. Ross & Naomi Halpern, ‘Introduction’, *Trauma Model Therapy: A Treatment Approach for Trauma, Dissociation and Complex Comorbidity* (Richardson, TX: Manitou Communications, Inc., 2009).

78 Courtois & Ford, ‘Defining and Understanding Complex Trauma...’, p.16.

79 Ibid (emphasis added)

80 Bessel A. van der Kolk, B. A. (2005) ‘Developmental Trauma Disorder: Towards a Rational Diagnosis for Chronically Traumatized Children’, *Psychiatric Annals*, pp.1-18.

81 van der Kolk et al (2005) cited in Courtois & Ford; also van der Kolk, ‘Posttraumatic Stress Disorder and the Nature of Trauma’, p.173.

Building on these findings, '[t]he proposed DTD diagnosis for children with complex traumatic stress symptoms is even more specific in identifying 'rage, betrayal, fear, resignation, defeat and shame' as the subjective (A2) criterion for childhood complex traumatic stress disorders.⁸² This new elaboration of the subjective dimensions of complex trauma presents a more nuanced account of what is at issue than currently figures in the standard classification of PTSD. But it also goes further. As Ford and Courtois discuss, inclusion within the DTD diagnosis of such dimensions as 'shame', 'rage' and 'betrayal'⁸³ simultaneously widens clinical focus from the traditional emphasis on 'fear' and 'anxiety' to 'the sense of a damaged self'.⁸⁴

In so doing, the proposed new diagnosis of *developmental trauma disorder* (DTD) is not only more nuanced, but stark in its depiction of the comprehensive and damaging dimensions of the effects it describes:

...[i]dentifying complex trauma as a distinct subset of psychological traumas provides the clinician and researcher with a basis for identifying individuals who have experienced not only the shock of extreme fear, helplessness, and horror but also disruption of the emergent capacity for psychobiological self-regulation and secure attachment. In addition to hyperarousal and hypervigilance in relation to *external* danger, complex trauma poses for the person the *internal* threat of being unable to self-regulate, self-organise, or draw upon relationships to regain self-integrity.⁸⁵

In addition to the new conceptualisations of DTD (developmental trauma disorder) and 'developmentally adverse interpersonal trauma', references to 'betrayal trauma'⁸⁶ and 'relational trauma'⁸⁷ (particularly in the context of the now frequent references to 'attachment disorders') are increasingly common. These attempt to elucidate and convey the multifacetedness and enormity of complex trauma, and the massive, wide-ranging impairments with which it is associated. Some respected trauma specialists explicitly utilise the new conceptualizations.⁸⁸ In light of the increasingly recognised deficits of DSM typologies, it is also significant that a new 'dissociative' subtype of PTSD may be included in the upcoming DSM-5,⁸⁹ although it is unlikely at this point that *complex* post-traumatic stress disorder ('CPTSD') will receive specific classification.⁹⁰

82 van der Kolk (2005:405); referenced in Courtois and Ford, 'Defining and Understanding Complex Trauma...', p.17.

83 This point is elaborated with reference to Freyd, DePrince & Gleaves' conception of 'betrayal trauma' (2007); Courtois & Ford, 'Defining and Understanding Complex Trauma...', p.17.

84 Discussed with reference to Feiring, Taska & Lewis (2002); Courtois & Ford, 'Defining and Understanding Complex Trauma...', p.17 (emphasis added).

85 Ibid

86 DePrince & Freyd (2007); see previous discussion and footnote.

87 Note that while interpersonally generated, relational trauma can occur outside the family and not necessarily with people to whom one is attached. Examples of relational trauma include bullying, humiliation and shaming, rejection by a love object, having to keep a secret which sets one apart, and having one's needs ignored, at any age (Robin Shapiro, *The Trauma Treatment Handbook: Protocols Across the Spectrum* (New York: Norton, 2010, pp.203-4).

88 Noting that DSM-IV definitions are 'incomplete', and drawing on van der Kolk and Courtois & Ford respectively, Robin Shapiro elects to 'add descriptions that fit the newest research' (Shapiro, *The Trauma Treatment Handbook*, p.2). In her own recent trauma handbook, Rothschild specifically elaborates Attachment Disorder, noting that '[a]ttachment theory is probably the fastest-growing area of study in the psychotherapy branch of psychology' (Babette Rothschild, *Trauma Essentials: The Go-To Guide*, New York: Norton, 2011, p.29).

89 Damien McNamara, 'Dissociative PTSD May Become DSM-V Subtype', *Clinical Psychiatry News* (13/6/11) <http://www.clinicalpsychiatrynews.com/newsletter/the-cognoscenti/singleview40709/dissociative-ptsd-may-become-dsm-5-subtype/95a627bf9b.html>

90 For proposed revisions of PTSD related and dissociative disorders respectively, see <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=59>

The current situation is anomalous in that increased clarity and more sophisticated conceptualisation of complex trauma is still not yet reflected within a standard DSM diagnosis which encompasses the many dimensions of this ‘spectrum of conditions’⁹¹ (and which thereby continues to fragment their interrelationship). To the extent that clinicians and service-providers reference the DSM as an authoritative diagnostic source, its inadequacy with respect to complex trauma also fails to assist appropriate *treatment* of complex trauma. Yet research and clinical insights into complex trauma are now rapidly expanding, and generating exciting new developments and treatment possibilities.

What we know about trauma: ‘psychobiology’ and the impairment of integration

‘It has long been recognised that moderate amounts of stress enhance learning and memory by increasing vigilance and heightening attention, whereas high levels impair learning and memory (Yerkes & Dodson, 1908). Trauma is a state of high arousal that impairs integration across many domains of learning and memory.’⁹²

It would be wrong to imply, however, that there was no research base on trauma prior to the current period, or that the need to address the combination of dimensions involved in *complex* trauma renders research into trauma *per se* irrelevant. In fact not only has trauma been addressed by a number of clinicians and theorists at various historical points, but key findings of the ‘early’ trauma research are now being validated.⁹³ Striking illustration of this is van der Kolk’s discussion of the 1899 observations of French pioneer Pierre Janet, which are supported by the current research, and which ‘confirm the notion that what makes memories traumatic is a failure of the CNS [central nervous system] to synthesise the sensations related to the trauma memory into an integrated memory’.⁹⁴

In its simplest formulation, and as is now well-known, trauma stems from activation of the instinctive ‘fight-flight’ response to an overwhelming threat. Mobilization of this biological ‘survival’ response leads to a third-‘freeze’-response when the danger cannot be escaped, and the normal coping mechanism for action is arrested and overwhelmed.⁹⁵ While the associated incapacitating effects

91 Herman (1992), cited in Courtois & Ford, p.124. Reference should also be made to other classificatory systems than the DSM (for example, the International Classification of Diseases, 10th Revision, 2007 (ICD-10). The (British) National Institute for Health and Clinical Excellence (NICE) publishes guidelines pertinent to this topic, though, these, too, are markedly lacking – ‘The NICE guidelines do not provide adequate guidance in relation to the assessment and treatment of Complex PTSD. This results in lack of appropriate provision, resources and training to treat people with Complex PTSD, and ensuing limited access to effective treatment services’ (Position statement on Complex Post-Traumatic Stress Disorder’, www.uktrauma.org.uk/cptsd.doc) In this context, the latter response recommends ‘that a review of the literature on complex PTSD is urgently needed...’ (Ibid)

92 Louis Cozolino, ‘The Impact of Trauma on the Brain’, Cozolino, *The Neuroscience of Psychotherapy* (New York: Norton, 2002), p.270 (emphasis added)

93 This is not the place to discuss the truncated nature of the study of trauma over time, which is an interesting and revealing point in itself. As early as the post Second World period, one prominent student of trauma lamented that investigators in the field seemed to ‘start from scratch and work at the problem as if no one has ever done anything with it before’ (Kardiner cited in van der Kolk, ‘Posttraumatic Stress Disorder and the Nature of Trauma’, p.177). For a brief account of the ‘rediscovery’ of trauma in the 1970s with the combined but diverse developments of the return of Vietnam War veterans and the Women’s Movement, see van der Kolk, ‘Historical Background’, in ‘Posttraumatic Stress Disorder and the Nature of Trauma’, pp.174-177.

94 van der Kolk, ‘Posttraumatic Stress Disorder and the Nature of Trauma’, p.183.

95 ‘For human beings the best predictor of something becoming traumatic seems to be a situation in which they no longer can imagine a way out; when fighting or fleeing no longer is an option and they feel overpowered and helpless’ (van der Kolk, ‘Foreword’, in Pat Ogden, Kekuni Minton & Clare Pain, *Trauma and the Body*, New York: Norton, 2006, p.xxii). As van der Kolk goes on to explain, Darwin had previously noted that many emotions ‘are signals to communicate to others to back off or protect’ – ‘When a person is traumatized, these emotions do not produce the results for which they were intended. The predator does not back off, desist, or protect, and whatever action the traumatized person takes fails to restore a sense of safety’ (Ibid).

have long been recognised, *the processes by which this occurs, and how they correlate with activity in the brain*, are new areas in which current research is making rapid advances (see chapter 3).

A key and consistent finding, however, is *the relationship between lack of processing and integration of traumatic memory and ongoing impairments across a wide range of functioning*. Unable to process and 'move on' from the precipitating trauma(s), the traumatised person is incapacitated not only by the catalysing events or experiences (of which they may have no conscious recollection) but by various attempts to avoid potential reminders of what has been so injurious to them. Thus they are 'caught in a loop' in which attempts to escape the trauma amount to an unwitting revisiting of its effects. This occurs in the form of various debilitating symptoms and coping mechanisms, which massively affect not only the *quality* of life but which can endanger life itself.

Chapter summary of key findings and themes

- Trauma stems from activation of the instinctive ‘fight-flight’ response to overwhelming threat, in which a ‘freeze’ response occurs when the perceived danger cannot be escaped. It is ‘a state of high arousal that impairs integration across many domains of learning and memory.’⁹⁶
- Child abuse comprises *complex trauma*, which differs from ‘single incident’ trauma in being *cumulative and interpersonally generated*.
- Complex trauma ‘constitutes objective threats not only to physical survival – but also to *the development and survival of the self*.’⁹⁷ Such threats are especially dangerous in relation to children, for whom the self is fragile because still developing.
- Problematic symptoms, behaviours and conditions associated with complex trauma are frequently the outgrowth of coping mechanisms which were *initially protective*, but which have lost their protective function over time and have become injurious to health
- Complex trauma (and thus the multiple negative impacts of child abuse) is not well described in the current DSM-IV, and the diagnosis of PTSD does not capture the many dimensions involved. The current situation is anomalous in that increasing sophistication in understanding of complex trauma (such as is proposed by addition of the diagnoses *complex PTSD* and *developmental trauma disorder, DTD*) is not reflected in a standard DSM diagnosis which encompasses this ‘spectrum of conditions’ (and thereby continues to fragment their interrelationship).
- One effect of the above is that survivors of child abuse (ie those who experience forms of complex trauma) can accumulate a range of discrete diagnoses which both fail to recognise the underlying trauma, and the extent to which ‘surface presentations’ of pathology can represent adaptations to child abuse (*‘PTSD, borderline personality disorder, and self-harm can all reflect complex adaptation to early trauma’*).⁹⁸
- In the diverse presentations of complex trauma, the role of *dissociation* is not widely known by health professionals. Ross and Halpern (2009) explicitly emphasise dissociation ‘because it is a core component of the trauma response, and because dissociation is not as widely understood as depression, anxiety, psychosis, substance abuse, eating, and personality disorders’.

96 Cozolino, *The Neuroscience of Psychotherapy*, p.270.

97 Ford (2005), in Courtois & Ford, *Treating Complex Traumatic Stress Disorders*, p.16.

98 Cozolino, *The Neuroscience of Psychotherapy*, p.268.

3. Core research insights: the neurobiology of attachment

*'The central idea of interpersonal neurobiology is that integration is at the heart of well-being.'*⁹⁹

Understanding of complex trauma as *interpersonally generated* and *cumulative* (as distinct from 'single-incident') reveals the scope of the challenges at issue. Such challenges relate not only to the many people who experience and are affected by complex trauma, but to public health systems *per se*. Bessel van der Kolk notes that '[t]he majority of people who seek treatment for trauma-related problems have histories of multiple traumas'.¹⁰⁰ This underlines the current disparity between the *prevalence* of complex trauma, and the risks of its lack of detection (and thus compounding effects). Inadequate classification and diagnosis, failure to routinely screen for *prior, underlying* trauma, and lack of understanding and preparedness to address 'past' adverse experience are powerful impediments to effective treatment and care.

It is reassuring, however, that innovative interdisciplinary research directly relevant to complex trauma is expanding rapidly. Not only do we now know *that* adverse childhood experiences are directly linked to compromised adult health and functioning (as distinct from widely operationalising this knowledge). New insights into *how* (ie the processes by which) this occurs are now being generated. The findings of such research are crucial to effectively address the needs of adult survivors of child abuse, and to formulation of effective guidelines which can assist in this regard.

Towards a paradigm shift

The significance of the new research in challenging previous understandings cannot be overstated. To this extent, it is possible to speak of nothing less than a paradigm shift:

*The field of mental health is in a tremendously exciting period of growth and conceptual reorganization. Independent findings from a variety of scientific endeavours are converging in an interdisciplinary view of the mind and mental well-being.*¹⁰¹

A plethora of publications and fora are now elaborating 'the unity of knowledge, or 'consilience', that emerges with the translation of findings from numerous domains of study into a common language or conceptual framework'.¹⁰²

Findings of neuroscience in the context of emotional ('attachment') relationships are crucial. Increasingly sophisticated understanding of brain plasticity, and of the vital role of early care-giving relationships in this regard, is leading to realisation of the formative power of social experience in

99 Daniel J. Siegel, 'Series Editor's Foreword', Pat Ogden, Kekuni Minton & Clare Pain, *Trauma and the Body* (New York: Norton, 2006), xiv

100 van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma', p.172.

101 Prefatory note to Siegel & Solomon, ed. *Healing Trauma: attachment, mind, body, and brain* (New York: Norton, 2003).

102 Ibid.

creation of the self (hence reference to ‘the social brain’).¹⁰³ Babette Rothschild refers to work in the area of attachment disorder as ‘probably the fastest growing area of study in the psychotherapy branch of psychology’.¹⁰⁴ Such research is vital to understanding and treatment of complex trauma, and to guidelines for addressing it.

Specifically, the new field of ‘interpersonal neurobiology’ (‘the neurobiology of attachment’) leads to understanding that ‘the structure and functioning of the mind and brain *are shaped by experiences*, especially those involving emotional relationships’.¹⁰⁵ The implications in terms of the impact of *adverse* experience – as for potential healing of such impact – are profound.

We have noted the finding that the earlier the onset of trauma and the longer its duration, the greater the likelihood of people experiencing in severe form ‘all the symptoms that comprise the DESNOS diagnosis’¹⁰⁶ (ie the diagnostic category by which complex trauma is currently described in the DSM). We have also noted that interpersonal trauma, ‘*especially childhood abuse*’¹⁰⁷ predicts both a high risk for this diagnosis, and a higher risk for PTSD than does ‘single-incident’ trauma. *Early onset trauma pertains especially and particularly to trauma experienced in childhood*. And it is here that current research on the developing brain – in the context of early attachment relationships with caregivers – is revealing many new insights.

The impact of experience: ‘the social brain’

‘The brain is neither predetermined nor unchanging, but rather is an *organ of adaptation*’.¹⁰⁸

That human beings develop in interaction with significant others and with their environment is not a new understanding. But as neuroscientific findings are establishing, it is now possible to go further. It can now be shown that social and environmental factors *impact brain development and functioning*; ie the very formation of the self.

Transcending longstanding debates about ‘nature’ and ‘nurture’, neuroscientific research illuminates the constitutive role of social and environmental impacts in *activating neural mechanisms*. From the moment of birth, experience not only *influences* the self (which implies the effects of ‘external’ environment on already intact subjectivity) but actively *shapes* and *formulates* it. Experience becomes ‘a physical reality in the brain’ via organisation of neural networks – ‘*In a very real sense, the sociocultural environment becomes physically structured in the brains of individuals*’.¹⁰⁹ As Castillo describes, ‘people walk around with their culture and their personal history literally inside their heads’; experience has ‘psychobiological correlates’ in the organisation of our brains.¹¹⁰

New evidence that the brain is neurologically ‘plastic’ and malleable rather than ‘hard-wired’ and fixed (ie that its structure changes with different experiences, and that contrary to longstanding

103 See Louis Cozolino, *The Neuroscience of Psychotherapy: Building and Rebuilding the Human Brain* (New York: Norton, 2002) and Norman Doidge, *The Brain that Changes Itself: Stories of Personal Triumph from the Frontiers of Brain Science* (New York: Viking, 2007).

104 Rothschild, *Trauma Essentials*, p.29.

105 Cozolino, *The Neuroscience of Psychotherapy*, p.179.

106 Van der Kolk, ‘Posttraumatic Stress Disorder and the Nature of Trauma’, p.173

107 Ibid (emphasis added)

108 Cozolino, *The Neuroscience of Psychotherapy*, p.xv (original emphasis)

109 Richard Castillo, *Culture and Mental Illness* (Pacific Grove, CA: Brooks/Cole, 1997), p.268.

110 Ibid.

belief, new neurons can grow) radically expands the possibilities for learning, change and healing.¹¹¹ At the same time, it provides new insights into the negative effects of *adverse* experiences, which, particularly if occurring early in life, can compromise development of the self *per se*.

Insights from the new field of affective neuroscience¹¹² ('interpersonal neurobiology'; 'the neurobiology of attachment') which focus specifically on development of self and identity in the context of early emotional (attachment) relationships¹¹³ *need to inform all current work in relation to complex trauma*. This includes updated understanding of the legacy of child abuse, and revised guidelines for service-provision to survivors of it.

The extent to which emotional and psychological experience can now be *physiologically correlated with neurological functioning* represents enormous opportunities for revised practice across a range of disciplines and services. Yet it needs to be reiterated that while novel in its utilisation of technological advances unavailable to previous eras, contemporary neuroscientific research also bears out key insights of early work on trauma.¹¹⁴ This includes aspects of the pioneering and multilayered work of Freud, who is now credited as having laid important scientific and neurological groundwork.¹¹⁵ That *subjective experience can now be objectively correlated in the brain* constitutes a research innovation of major proportions, the many implications of which are now beginning to unfold.

For example, it can now be shown that trauma is 'biochemically encoded' in the brain, which includes changes in availability and operation of neurotransmitters.¹¹⁶ Prolonged or chronic stress is correlated with alterations 'in the baseline, production, availability, and homeostatic regulation' of neurochemicals, which illuminates the neurological activity corresponding to 'long-term behavioural and psychological alterations'.¹¹⁷ In effectively narrowing the gap between 'subjective' and 'objective' dimensions, neuroscientific research allows extraordinarily nuanced elaboration of the dynamics of trauma in ways which were simply not possible before – '*The speechless terror, which has been recognised as part of posttraumatic reactions since ancient times, now has a neural correlate consistent with what is known about brain functions*'.¹¹⁸

Neuroscientific 'mapping' of the subjective components of trauma (as of subjective components of experience *per se*) is groundbreaking. This is not only because it gives depth and dimension to previous understandings of trauma and its many effects. In providing *the objective correlates of adverse experience*, current neuroscientific findings pave the way for enhanced treatments of the negative effects, and even for their interception and pre-emption.

111 The 'stories of personal triumph' elaborated by Doidge (*The Brain that Changes Itself*) are inspiring in this regard; also see case vignettes in Daniel J. Siegel, *Mindsight* (New York: Random House, 2009).

112 Also described as 'interpersonal neurobiology'; 'the neurobiology of attachment'; see previous discussion.

113 Key exponents of this field include Allan Schore, Daniel J. Siegel and Louis Cozolino, among others; see subsequent discussion.

114 As van der Kolk points out, with 'rediscovery' of trauma in the 1970s (following the combined but diverse legacies of returned servicemen from the Vietnam War and the Women's Movement) 'many of the early formulations that had long since been forgotten proved to be remarkably accurate'. The advent of neuroscience in the context of attachment thus represents a further evolution in understanding (van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma', p.177).

115 Cozolino, *The Neuroscience of Psychotherapy*, pp.xv & 15. This is even to the extent of psychotherapeutic principles now being seen not only as compatible with neuroscientific principles, but as convergent with them. (Cozolino, *The Neuroscience of Psychotherapy and Doidge, The Brain that Changes Itself*). This is also to underline the diverse legacy of Freud, which, as discussed in chapter 1, is more ambivalent with respect to the objective reality of child abuse.

116 Cozolino, *The Neuroscience of Psychotherapy*, p. 258.

117 Cozolino, *The Neuroscience of Psychotherapy*, p.262.

118 Cozolino, *The Neuroscience of Psychotherapy*, p.277.

Significantly, they also underline the illegitimacy of ‘blaming the victim’, whose traumatic experience and subsequent impaired functioning have too often been stigmatised as ‘personal weakness’. The following summary of key research findings makes this point clearly:

Endogenous opioids, which relieve pain in fight-or-flight situations, can have a profound effect on reality testing and memory processing when released in response to a variety of emotional situations unrelated to danger. Higher opioid levels result not only in analgesia, but also in emotional blunting and difficulties with reality testing. More likely, they are also involved with dissociative reactions, and the experience of depersonalization and derealisation, both of which provide an experience of distance from the traumatised body (Shilony & Grossman, 1993). Opioids are also related to self-harm in *adults abused as children* (van der Kolk, 1994).¹¹⁹

In the above description, we have a catalogue of key markers of complex trauma. Specific reference to ‘adults abused as children’ also underlines the direct relevance of current neuroscientific research to adult survivors of child abuse. In this context, and in elaborating how ‘the social brain’ develops, affective neuroscience (‘the neurobiology of attachment’) is particularly valuable.

Becoming a person: early care-giving and the process of self formation

‘Each of us is born twice: first from our mother’s body over a few hours, and again from our parents’ psyche over a lifetime... *the organization of the social brain is initially sculpted via parent-child interactions.*’¹²⁰

The exciting corollary of the now recognised neuroplasticity of the brain is that neural growth and change can occur *across the lifespan*. This possibility was precluded by previous readings of the ‘fixed’ brain, according to which less than optimal brain functioning might be compensated for but could not be modified. What is now termed ‘the social brain’ is built over time. But a ‘critical’ or ‘sensitive’ period occurs very early in life, between the ages of eighteen and twenty four months, via attunement between the right brain hemisphere of the caregiver and the right brain hemisphere of the child.¹²¹

The right hemisphere of the brain (variously termed the ‘right’ or ‘emotional’ brain) is contrasted with the left hemisphere (popularly known as the ‘left’, ‘cognitive’ or ‘thinking’ brain). Dominant in the early years of life, the right brain hemisphere is also linked to *pre-verbal experience*. Right-brain functioning is critical in ways that extend well beyond initial understandings of it, and which can

119 Cozolino, *The Neuroscience of Psychotherapy*, p.262 (emphasis added). For a clear description of the relationship between ‘endogenous opioids’ and the self-harm often associated with eating disorders, see Kate Middleton, *Eating Disorders: The Path to Recovery* (Oxford: Lion, 2007), p.78.

120 Cozolino, *The Neuroscience of Psychotherapy*, p.217 (emphasis added)

121 See Cozolino, ‘The Interpersonal Sculpting of the Social Brain’, ch. 9 in *The Neuroscience of Psychotherapy*, pp.172-214. The process by which this takes place is explicated in detail by Allan Schore; see, for example, *Affect Dysregulation and Disorders of the Self* (New York: Norton, 2003).

only now be articulated. For example, it is now seen as important not only to the ability to recognise the emotional states of others (empathy) but to the crucial capacity to *regulate the self*. Effective right-brain functioning – which is heavily dependent on attachment experience in the first years of life – is crucial not only to self-recognition and maintenance of a coherent and continuous sense of self, but '*centrally involved in the control of vital functions supporting survival*'.¹²²

Ability to interact and connect is crucial to healthy development. Impairment or absence of such ability comprises not simply negative 'effects', but *suboptimal development per se*. If the capacity of the infant to engage with caregivers is not 'mirrored' or 'modelled' in an attuned way, this is damaging because the child absorbs and learns patterns of interaction that negatively affect their own relational ability to connect with themselves and others.¹²³ With reference to the pioneering research on oxytocin by Sue Carter, Patricia Churchland¹²⁴ elaborates the role of this hormone in the physiology of early attachment experience, the relationship between oxytocin and the endogenous opioids, and the implications for subsequent experience of trust, safety and empathy.

Experience with caregivers during early critical periods of development gives rise to *implicit memories*, also called 'schemas', within networks of the brain ('*all aspects of the self are forms of implicit memory stored in neural networks that organise emotion, sensation, and behaviour*').¹²⁵ Research also shows that attachment patterns formed in childhood not only *endure* into adult life, but actively shape our experience of it.

Elaborating 'the Strange Situation'

This is most powerfully substantiated by research stemming from the so-called 'Strange Situation',¹²⁶ a study of reunion behaviour of infants with their care-givers which has been replicated on countless occasions. This now famous study was first conducted in the 1970s by Canadian developmental psychologist Mary Ainsworth in relation to the research of John Bowlby ('the father of attachment theory').¹²⁷ A key outcome of this study was delineation of contrasting 'attachment styles' – 'secure' and two varieties of 'insecure' (*avoidant* and *ambivalent*) to which a fourth ('*disorganised*') attachment style¹²⁸ was subsequently added in the 1990s by UC Berkeley-based psychologist Mary Main.¹²⁹

In all cases, the role of parental attachment to their children was (and is) shown to be decisive: '*[a]ttachment research has objectively demonstrated the crucial importance of the parent's focus on the child's subjective experience for the development of the child's well-being*'.¹³⁰ It further suggests 'that

122 Schore, *Affect Dysregulation and Disorders of the Self*, p.86 (emphasis added); also p.240.

123 Recall the contention of Neborsky that '[a]ttunement failures between parent and child always are, by definition, small-T traumas. If they are repetitive, fixed or rigid, *there is no way to process the negative emotion that the trauma creates, and the effects become cumulative* (Kahn, 1963). Ideally, small and even large-T traumatizing experiences are processed in the parent-child dyad. However, *where there is impairment of parental empathy, these affects are not processed interpersonally, they are stored*' (Neborsky, 'A Clinical Model for the Comprehensive Treatment of Trauma Using an Affect Experiencing-Attachment Theory Approach', p.290, emphasis added). The negative effects on infants of parental attunement deficits are also borne out by studies of maternal depression; see Cozolino, *The Neuroscience of Psychotherapy*, p.260.

124 Patricia S. Churchland, *Braintrust: What Neuroscience Tells Us About Morality* (NJ: Princeton University Press, 2011).

125 Cozolino, *The Neuroscience of Psychotherapy*, p.233. For detailed explication of some of the many dynamics at issue, see 'Biobehavioral Regulation During Early Development', Part II in Stephen W. Porges, *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation* (New York: Norton, 2011), pp.63-130.

126 The initial 'Strange Situation' considered the responses of infants to their mothers after being left for short periods both alone and in the company of a stranger (ie within the same sequence of events). It has now been conducted 'thousands of times by the original researchers and replicated hundreds of times by scientists throughout the world' (Siegel, *Mindsight*, p.168).

127 John Bowlby [1988] *A Secure Base: Clinical Applications of Attachment Theory* (London: Routledge, 2006).

128 Daniel Siegel has recently noted that disorganised attachment 'appears in about 10 per cent of the general population but in up to 80 per cent of high-risk groups such as the children of drug addicted parents' (Siegel, *Mindsight*, p.169; emphasis added). For reasons which will be discussed, the 'disorganised' attachment style is also closely correlated with experience of childhood trauma and abuse (see subsequent discussion).

129 Note that Main also went on to devise a now widely used 'Adult Attachment Interview' (AAI) which accurately predicts both the resilience of early attachment styles in adults and the subsequent effects of these on the next generation (see subsequent footnote).

130 Siegel, 'An Interpersonal Neurobiology of Psychotherapy', p.6.

the parents' own subjective internal experience... is the most robust predictor of their child's security of attachment to them'.¹³¹

Evidence of both the persistence of childhood attachment styles into adult life, and their transmission – via the corresponding parental styles to which they have been found to correlate – to the next generation of children raises serious questions. It also suggests the potential for *interception* of patterns of relating which are less than optimal; a possibility which is now spawning a wide range of interest, publications and parenting programs.¹³² Clearly this potential has urgent and particular application to cases of parental trauma. Were it possible to 'break the cycle of trauma' in this way, the benefits and ripple effects could be multiple.¹³³

Attachment and child development in the context of trauma

In contexts of security, the majority of early learning experiences are incremental and unconscious. But early experience of trauma is severely disruptive of this subtle process, in ways which do not situate the child favourably for the neural development and integration which is the mark of mental health –

'Because of the importance of a context of safety and bonding in the early construction of the brain, childhood trauma compromises core neural networks'.¹³⁴

Early onset trauma can lead to compromised functioning in a wide range of areas. In fact the response of the brain to trauma is now seen as providing 'a window to the general processes of learning and plasticity',¹³⁵ and to *the impact of adverse experience on both the evolving brain and subsequent development.*

While all trauma is damaging, current neuroscientific findings in relation to the developing brain reveal why early onset trauma – particularly when it is *prolonged, repetitive* and *unrepaired* – is especially so. The process by which early relational trauma takes place in the context of early caregiving is now an area into which we have considerably more insight. In light of the increasingly understood centrality of the right-hemisphere of the brain to social connectedness, self-regulatory capacity and development *pe se*, *parental attunement to the emotional needs of the infant is no less vital than is attentiveness to physical needs.*¹³⁶

Parents who, due to developmental deficits in their own backgrounds, are unable to connect with their infants (and/or who connect according to 'insecure' attachment styles) are at serious risk of transmitting impaired functioning to their infants. *This is most obviously the case when parents*

131 Ibid. For elaboration of the 'Adult Attachment Interview' (AAI) developed by Mary Main, and the proven correlations between childhood attachment style and the parenting styles to which they correspond, see Daniel J. Siegel and Mary Hartzell, *Parenting from the Inside Out* (New York: Penguin, 2004).

132 See, for example, Daniel J. Siegel & Tina Payne Bryson, *The Whole-Brain Child: 12 Revolutionary Strategies to Nurture Your Child's Developing Mind* (New York: Delacorte Press, 2011) and Siegel & Hartzell, *Parenting from the Inside Out*.

133 In the Australian context, Louise Newman (Professor of Developmental Psychiatry and Director of the Monash University Centre for Developmental Psychiatry and Psychology) is a key figure in this area. See, for example, 'Trauma and Ghosts in the Nursery: Parenting and Borderline Personality Disorder', ch.17 in Anne Sved Williams & Vicki Cowling, ed. *Infants of Parents with Mental Illness* (Bowen Hills, Qld.: Australian Academic Press, 2008), pp.212-227.

134 Cozolino, *The Neuroscience of Psychotherapy*, p.258.

135 Cozolino, *The Neuroscience of Psychotherapy*, p.285

136 Ie in terms of fostering the affect regulation which is critical to healthy development. It is also for this reason that '[m]odern attachment theory focuses on the process of attunement, which is largely a nonverbal, right-hemisphere mode of communication between care-giver and child' (Robert J. Noborsky, referencing Schore, 1997, 'A Clinical Model for the Comprehensive Treatment of Trauma Using an Affect Experiencing Attachment-Theory Approach', p.316

*themselves have an unaddressed trauma history.*¹³⁷ As experience need not literally be life-threatening to qualify as traumatic, and as neuroscientific research into the vulnerability of the developing brain bears out, unrepaired parental misattunement to infants can itself be traumatic, and lead to significant developmental compromise.

Put simply, childhood environments which do not provide comfort and support (ie even when not overtly 'abusive') generate insecure attachment. Deficient care-giving relationships require recruitment of support and comfort from other sources, whether within and/or outside the self.¹³⁸ In contrast to securely attached people, who metabolise stress well, those who are insecurely attached metabolise it less well; an impaired capacity which in turn leads to vulnerability to a range of health problems.¹³⁹ Both life challenges in general and subsequent intimate relationships in particular can also unwittingly mobilise the early attachment system, leading to problematic re-enactments of early experience.¹⁴⁰

From the earliest moments of life, experiences of stress shape the brain in ways that lead us to 'remember experiences most important for survival'.¹⁴¹ Since our earliest experiences are pre-verbal, this raises obvious questions about the way in which early childhood is recalled. Current neuroscientific research is also leading to more sophisticated understanding of the workings of memory. This relates not only to *how* we remember, but to the different types of memory involved.

Because early experience occurs when the right-brain hemisphere is dominant, it is remembered *implicitly* rather than consciously (ie in contrast to conscious memory which is linked to subsequent development of the left-brain hemisphere). Thus early (pre-verbal) experience is not accessible to conscious articulation – 'Attachment relationship information is recorded in an unconscious state which is stored in implicit memory'.¹⁴² Given its 'storing' in implicit, rather than conscious, memory, early attachment experience also tends to be *enacted* and *embodied* rather than expressed in words.¹⁴³

Stemming from its crucial links to right-brain self-regulatory capacity, implicit attachment memory is also 'in effect, our stress-processing mechanism'.¹⁴⁴

In light of the ongoing need for comfort and support throughout life, and the failure of insecure early attachments to reliably supply such necessities, it is ironic that the search for these paves the way for defences and addictions which can further corrode and jeopardise well-being.

If insecure early attachment of various kinds can generate the above trajectory, the effects of early onset trauma in the context of child abuse are particularly stark. Here it is important to understand '*the evolutionary links between attachment behaviour, fear, and survival*'.¹⁴⁵ Viewed through this lens, the depth of the trauma of child abuse becomes more apparent. When such abuse is early onset, it generates an attachment style different from the 'insecure' categories of *avoidant* and *ambivalent*, which, while far from optimal, nevertheless are organised responses:

137 As distinct from a history which is engaged with and thereby 'resolved'; see subsequent discussion. For a landmark paper in transgenerational transmission of trauma in this regard, see Selma Fraiberg et al 'Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships', *Journal of the American Academy of Child Psychiatry* (Vol. 14, No.3, 1975), pp.387-421.

138 Robert J. Neborsky, 'A Clinical Model for the Comprehensive Treatment of Trauma Using an Affect Experiencing-Attachment Theory Approach', p.287.

139 Ibid.

140 Neborsky, 'A Clinical Model for the Comprehensive Treatment of Trauma...', p.286.

141 Ibid.

142 Ibid.

143 For detailed discussion of the ways in which implicit attachment memory is 'evoked', 'enacted' and 'embodied', see David Wallin, *Attachment in Psychotherapy* (New York: The Guilford Press, 2007) and subsequent discussion.

144 Neborsky, 'A Clinical Model for the Comprehensive Treatment of Trauma...', p.285.

145 Erik Hesse, Mary Main, Kelley Yost Abrams, and Anne Rifkin, 'Unresolved States Regarding Loss or Abuse Can Have 'Second-Generation' Effects: Disorganization, Role Inversion, and Frightening Ideation in the Offspring of Traumatized, Non-Maltreating Parents', in Siegel & Solomon, ed. *Healing Trauma*, p.66.

[A]s long as the infant is not directly frightened by the parent, 'insensitive' parenting will not lead to disorganization, but rather to the formation of 'organised' (avoidant or resistant/ambivalent) insecure attachments... *Fear of the parent*, in contrast, is anticipated to lead to disorganised attachment.¹⁴⁶

It is correspondingly clear why *disorganised attachment* is closely correlated with experience of the complex trauma which is child abuse.¹⁴⁷ When the primary attachment figure on whom the child depends is also someone who engenders fear, the child is effectively unable to connect to them (disorganised attachment is the product of 'a collapse in coping ability').¹⁴⁸ Note, again, that such a response can also be generated in a child by a primary care-giver who is not actively abusive, but whose inability to manage their own responses (likely legacy of their own childhood trauma) is itself frightening to the child.¹⁴⁹ The risk of ongoing developmental deficits is major:

The sustained attention [the child] must pay to environmental threats inevitably *pulls energy and focus away from the developmental task of self-awareness*. At a time when loved and well-treated children are becoming acquainted with self – celebrating a developing sense of discovery, autonomy, and fledgling impressions of self-efficacy – *the abuse victim is absorbed in the daily task of psychological and physical survival*.¹⁵⁰

In neuroscientific terms, the trauma of child abuse requires movement from a 'learning brain' to a 'survival brain',¹⁵¹ with the catastrophic developmental effects this entails. *Adaptation to trauma, at an early and vulnerable developmental point, becomes a 'state of mind, brain and body' around which all subsequent experience organises*.¹⁵²

In short, insights from the now burgeoning field of affective neuroscience ('the neurobiology of attachment') show in stark relief the multiple negative effects of trauma. These effects are particularly incapacitating with early onset (childhood) trauma, due to the vulnerability of the developing brain. The research leaves little doubt about the severity of the legacy of complex trauma in general and of child abuse in particular. Fortunately and correspondingly, the implications for *intercession* and *addressing* of such legacies, as well as for prior interception of their transmission, are no less dramatic.

146 Ibid (referencing Main, 1990, 2000; original emphasis).

147 An early paper on this relationship was Carlson et al, 'Disorganized/disoriented attachment relationships in maltreated infants', *Developmental Psychology* (Vol. 25, No. 4, 1989), pp.525-531 (and recall Fraiberg et al, 'Ghosts in the Nursery...'). Also see Siegel, Mindsight, and Cozolino, 'The Self in Exile: Narcissism and Pathological Caretaking' (ch.10 in Part 1V, 'The Disorganization of Experience and Psychopathology') *The Neuroscience of Psychotherapy*, pp.217-234.

148 Daniel J. Siegel, *Mindsight*, p.169. As Fosha also elaborates, 'when even defensive efforts are overwhelmed by the disruptive emotions resulting from unreliable caregiving, we are in the realm of disorganized attachment (Main, 1995, 1999). The only way both self and relationship can be maintained is through momentary immobility – the individual can neither *feel* (dissociation) nor *deal* (paralysis)' (Fosha, 'Dyadic Regulation and Experiential Work with Emotion and Relatedness in Trauma and Disorganized Attachment', p.229).

149 'Disorganized attachment results when parents show a severe and terrifying lack of attunement, when they are frightening to their infants, and when they themselves are often frightened. The children in the other three patterns [ie 'secure', 'insecure-avoidant', or 'insecure-ambivalent'] have developed organized strategies for dealing with a sensitive, disconnected, or inconsistent caregiver. But here the child cannot find any effective means to cope. His attachment strategies collapse' (Siegel, *Mindsight*, p.169).

150 Briere, *Child Abuse Trauma*, 45-46 (emphasis added)

151 Julian D. Ford, 'Neurobiological and Developmental Research', Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, p.35.

152 Cozolino, *The Neuroscience of Psychotherapy*, p.259.

Chapter summary of key findings and themes

- While the negative effects of trauma and adverse childhood experiences have been known for some time, research in the new field of affective neuroscience is yielding new and important understandings. When married to insights from 'the neurobiology of attachment', particularly as these relate to the developing brain, existing understanding of the multiple effects of trauma is now being enlarged to the point of ability to correlate such effects *across the life-cycle*.

Key findings from the field of affective neuroscience relevant to child abuse include:

- *Neuroplasticity*: the brain is capable of change in structure and function.
- Experience not only *influences* the brain, but *shapes and is constituent to its evolution*. Social and environmental factors impact brain development and functioning ('the social brain') and thus *formation of the self*
- Organisation of the brain is initially 'sculpted' by parent-child interactions, and particularly by the emotional ('attachment') relationship. Attunement of the right brain of the care-giver to the right-brain of the infant is crucial to this process
- The right brain hemisphere is critical not only to emotion and empathy, but to *sense of self, self-regulation, and 'control of vital functions supporting survival'* (Schore, 2003:86). Early experience with care-givers radically affects the capacity of the child to connect both with self and others
- The right brain is dominant in the early years of life, and linked to *pre-verbal* experience. Such experience is unconscious, stored in *implicit* (rather than explicit, conscious) memory, and is unwittingly activated by subsequent life experiences. Because pre-verbal and implicitly stored, it tends to be *enacted* and *embodied* rather than articulated in spoken language and words
- Adverse and traumatic experience, particularly in the context of infancy and childhood, is deeply disruptive of the developing brain. Early onset trauma requires a shift from a '*learning*' brain to a '*survival*' brain (Ford, 2009:35).
- The subjective dimensions of trauma can now be objectively correlated in brain activity, including changes in neurotransmitter activity and operation, as well as with long-term impairments across a spectrum of functioning.
- Attachment styles generated in early care-giving relationships ('*secure*', '*insecure-avoidant*', '*insecure-ambivalent*' and '*disorganised*'; where the latter is correlated with early onset trauma) are longstanding. They are also transmitted to the next generation via subsequent parent-child relationships. *But neuroplasticity also means that they are amenable to change* (see chapter 4).

4. Implications for practice: effective treatment of complex trauma

*'[I]t is important to be able to engage the relevant neurobiological processes'*¹⁵³

*'[E]ffective therapy for trauma involves the facilitation of neural integration'*¹⁵⁴

The neuroplasticity of the brain accounts for both mental flexibility *and* mental rigidity.¹⁵⁵ This means that even though the effects of adverse and traumatic experience – particularly in the early years – are unequivocally negative, they are not beyond healing. *Understanding of the neuroplasticity of the brain is at odds with deterministic readings.* While the current research is stark in its depiction of the damaging legacies of childhood trauma, it is exciting that new understanding of brain functioning (ie as malleable rather than fixed) suggests far more capacity for growth, healing and change than previously thought possible.

Breaking the cycle: healing from child abuse via 'earned security'

One of the most dramatic findings of research in the neurobiology of attachment is that healing can take place even after experience(s) of childhood trauma. This is according to the major criteria with which healing is associated – ie. restoration of a sense of safety and well-being, capacity to engage in healthy relationships with others, and general ability to enjoy life. Such capacities have their neuroscientific correlates in *repair and integration of ruptured neural networks.*

It can now be established that with appropriate working through of even severely traumatic early experience, *trauma can be resolved.* This even includes conversion of 'insecure' attachment generated by adverse childhood experiences into 'secure' attachment – a transition now referred to as 'earned security'.¹⁵⁶ Strikingly and correspondingly, transmission of insecure attachment to the next generation can also be avoided when parental trauma is resolved via achievement of a coherent perspective on childhood experience:

These are adults who appear to have had difficult childhoods, but have come to create a coherent narrative. *They have made sense of their lives.* The children attached to these adults have secure attachments and do well! History is not destiny – if you've come to make sense of your life. It isn't just what happened to you that determines your future – it's how you've

153 Fosha, 'Dyadic Regulation and Experiential Work with Emotion and Relatedness in Trauma and Disorganized Attachment', in Siegel & Solomon, ed. *Healing Trauma*, p.229.

154 Siegel & Solomon, *Healing Trauma*, p.xviii.

155 Doidge, *The Brain that Changes Itself*, p.244.

156 Daniel J. Siegel, citing Roisman et al, 2002, Phelps, Belskg, & Cmic, 1998, 'An Interpersonal Neurobiology of Psychotherapy', in Siegel & Solomon, ed. *Healing Trauma*, p.16. As Siegel underlines, '[s]tudies have shown that individuals can move from what was an insecure childhood attachment to a secure adult attachment status' (Siegel, *Parenting from the Inside Out*, New York: Penguin, 2004, p.123).

come to make sense of your life that matters most. Moreover, the experience in later relationships *can actually change the future development of the mind.*¹⁵⁷

Positive possibilities for healing – even after the pervasive damage wrought by complex trauma – are the corollary of the new research on 'the changing brain'.

Given that experience changes the brain, this goes both ways – *just as damaging experiences change the brain in ways that are negative for subsequent functioning, new, different and positive experiences also change the brain in ways that are conducive to health.* This is even when the damaging experience has been traumatic, early onset and formative, as in contexts of child abuse. The challenge, then, is translation of this path-breaking research into practice – from health interventions and therapy to organisational functioning and service-provision.

Implications for treatment: reappraising psychotherapy

Current ability to correlate subjective experience with activity in the brain is leading to reconceptualisation across a wide spectrum of practices. Necessarily, it has radical implications for the process of healing, and of how best to facilitate it. In this context, the field of psychotherapy is undergoing something of a renaissance, as its central principles are themselves found to correlate with neuroscientific findings.¹⁵⁸

With respect to healing from trauma (as from many psychological conditions and experiences of distress) the new research is leading to concerted reappraisal of the benefits psychotherapy can provide. It is even claimed that psychoanalysis (the original 'talking cure') is 'a neuroplastic therapy'.¹⁵⁹ As Doidge points out, it was long thought that 'serious' treatment required medication, and that 'talking about' thoughts and feelings had little impact on the brain and on character.¹⁶⁰ The advent of neuroscience is now showing otherwise.

The importance of key neurotransmitters to psychological health and emotional well-being is now increasingly understood. In the frontal cortex of the brain, the neurotransmitters of serotonin, dopamine and norepinephrine are highly influential, and are stimulated by positive experiences and social interactions.¹⁶¹ *In the context of psychotherapy, there are many possibilities for neurotransmitters central to the experience of well-being to be stimulated in positive ways.* Psychotherapy *per se* thus provides opportunities 'to repair affect-regulating structures'.¹⁶²

In its provision of 'a secure base' which did not exist in the childhoods of many, psychotherapy is now regarded as 'an enriched environment that promotes the development of cognitive, emotional and behavioural abilities'.¹⁶³ *The capacity of psychotherapy to assist realignment of disrupted neural pathways can now be shown to register in the brain.* In its provision of a safe, supportive environment in which problems are addressed, psychotherapy *per se* can assist healing which is both *subjectively experienced* (feeling better from functioning in a more integrated way) and *objectively correlated*

157 Siegel, 'An Interpersonal Neurobiology of Psychotherapy...', p.16 (emphasis added)

158 'When one or more neural networks necessary for operational functioning is underdeveloped, underregulated, or underintegrated, we experience the complaints for which people seek psychotherapy' (Cozolino, *The Neuroscience of Psychotherapy*, p.16). See Cozolino (Ibid) for discussion of the extent to which neuroscientific imaging can now corroborate the capacity of psychotherapy to realign disrupted neural pathways.

159 Doidge, *The Brain that Changes Itself*, p.218.

160 Ibid.

161 Cozolino, *The Neuroscience of Psychotherapy*, p.316

162 Solomon, in Siegel & Solomon, ed. *Healing Trauma*, p.342.

163 Cozolino, *The Neuroscience of Psychotherapy*, p.23.

(neuroscientific observation of neural realignment and change). For this reason, Cozolino makes the case that ‘all forms of psychotherapy – from psychoanalysis to behavioural interventions – are successful to the extent to which they enhance change in relevant neural circuits.’¹⁶⁴

For effective addressing of trauma, therapy must be directed towards integration and coherence of functioning (‘Effective therapy for trauma involves the facilitation of neural integration’).¹⁶⁵ What, then, are optimal ways of achieving this? And how well situated is the field of psychotherapy to facilitate neural integration in light of new insights from the evolving research? As Fosha points out, to facilitate healing, ‘it is important to be able to engage the relevant neurobiological processes’¹⁶⁶ Research in the neurobiology of attachment underlines priority requirements in this regard, to which psychotherapy must itself attune if its full healing potential is to be operationalised.

Room for improvement: harnessing psychotherapeutic potential in the age of neuroscience

‘To make meaning of the traumatic experience usually is not enough. Traumatised individuals need to have *experiences* that directly contradict the emotional helplessness and physical paralysis that accompany traumatic experiences.’¹⁶⁷

The ‘making of meaning’ (as in insight-based psychotherapeutic approaches which utilise the role of interpretation) can be a key element of trauma resolution. Yet as van der Kolk suggests, it is not necessarily sufficient. Nor is the contrasting modality of cognitive behavioural therapy (CBT) better equipped to address some of the dynamics of trauma – ‘[n]either CBT nor psychodynamic therapeutic techniques pay much attention to the experience and interpretation of physical sensations and preprogrammed physical action patterns.’¹⁶⁸ Yet such ‘action patterns’ are increasingly recognised to be a consistent feature of trauma.

In light of the role of *implicit* memory both in traumatic and early attachment experiences, trauma therapy needs to be attuned to unconscious processes.¹⁶⁹ Given the increasingly recognised importance of right-brain functioning to relationship with both self and others, activation of ‘right-brain mediated emotional processes’ is necessary.¹⁷⁰ But *because* crucially linked to operation of the right-brain hemisphere, this also highlights the limits of ‘talk-based’ therapies in activating these processes.

While psychotherapy *per se* represents a rich avenue by which traumatic experience might be resolved, *it is unlikely to be sufficient when practised in its more traditional forms.* To the extent that

164 Cozolino, *The Neuroscience of Psychotherapy*, xiv.

165 Siegel & Solomon, *Healing Trauma*, p.xviii Also note Siegel’s contention that healing, in the sense of ‘becoming whole’, can itself be regarded as ‘a process of integration, linking the internal neural networks that have become disconnected during the overwhelming events in a person’s life’ (Siegel, ‘Foreword’, Shapiro, *The Trauma Treatment Handbook*, p.iii).

166 Diana Fosha, ‘Dyadic Regulation and Experiential Work with Emotion and Relatedness in Trauma and Disorganized Attachment’, Siegel & Solomon, *Healing Trauma*, p.229.

167 van der Kolk, ‘Posttraumatic Stress Disorder and the Nature of Trauma’, p.188

168 van der Kolk, ‘Foreword’, Ogden et al *Trauma and the Body*, p.xxii

169 Note the contention that ‘any serious remedial therapy must be directed towards the unconscious’ (Neborsky referencing Schore, ‘A Clinical Model for the Comprehensive Treatment of Trauma...’, Siegel & Solomon, *Healing Trauma*, p.316).

170 Fosha, ‘Dyadic Regulation and Experiential Work with Emotion and Relatedness in Trauma and Disorganized Attachment’, in Siegel & Solomon, *Healing Trauma*, p.230.

neuroscientific research reveals the centrality of *non-verbal* experience to trauma and resolution of it, this requires some reappraisal and adaptation of psychotherapy and its established modalities.

Trauma and/in the body: implications for healing

*'Modern neural science clearly points to the central role of the body...'*¹⁷¹

Current research suggests potential need for psychotherapy to supplement its established modalities with ways of working which more directly engage bodily experience. In stark repudiation of the mind/body dichotomy, new research is confirming the extent to which *'physical, bodily feelings'* underlie and shape not only the process of decision-making, but attempts to address problems of all kinds.¹⁷² Indeed, as van der Kolk underlines, it is becoming increasingly clear that *'response'* refers to an action we are *impelled* to take – that is, how we are *physically* inclined to move after receiving any particular stimulus.¹⁷³ Such findings have particular application to enhanced understanding of trauma, and to potential new interventions in its healing.

Capacity to respond with flexibility occurs gradually in human development, and as van der Kolk explains, is *'easily disrupted'*.¹⁷⁴ Just as young children are limited in their ability to control their emotional responses when upset or excited, so adults revert to automatic responses when experiencing strong emotion.¹⁷⁵ Significantly, we tend to *'execute whatever 'action-tendency' is associated with any particular emotion'*,¹⁷⁶ whether this be the joyful impulse to embrace a loved one or to become paralysed with fear. Moreover, van der Kolk notes that since the work of Janet in 1889, it has been observed *'that traumatised individuals are prone to respond to reminders of the past by automatically engaging in physical actions that must have been appropriate at the time of the trauma but that are now irrelevant'*.¹⁷⁷

171 Siegel, 'Senior Editor's Foreword', Ogden et al. *Trauma and the Body*, p.xv; for detailed discussion of the '[n]europhysiological foundations of emotions, attachment, communication, and self-regulation', see Porges, *The Polyvagal Theory*.

172 van der Kolk, 'Foreword', Ogden et al *Trauma and the Body*, p.xviii (original emphasis)

173 Ibid (original emphasis)

174 van der Kolk, 'Foreword', Ogden et al, *Trauma and the Body*, p. xix.

175 Ibid.

176 van der Kolk, 'Foreword', Ogden et al *Trauma and the Body*, xix-xx.

177 van der Kolk, 'Foreword', Ogden et al *Trauma and the Body*, p.xx (emphasis added)

Irrelevant in the present, but which – *prevented from physical expression at the time of the trauma* – remain dormant. And which are inappropriately expressed *in* the present, via unwitting reactions and enactments which express implicit memories:

Once sensory triggers of past trauma activate the emotional brain to engage in its habitual protective devices, the resulting changes in sympathetic and parasympathetic activation interfere with effective executive function... Without well-functioning rational brains, individuals are prone to revert to rigid ‘fixed action patterns’: *the automatic behavioural flight, fight, or freeze responses that are our evolutionary heritage of dealing with threat, and our individual implicit memories of how our own bodies once attempted to cope with the threat of being overwhelmed.*¹⁷⁸

The implications for potentially healing interventions are profound. What might be highly beneficial to a traumatised person is assistance to execute the *physical movement* which, unable to be expressed at the time of the traumatic experience, has been arrested and remains incomplete.

‘Bottom Up’ as well as ‘Top Down’: integrating the body in psychotherapy

*‘The body, for a host of reasons, has been left out of the talking cure.’*¹⁷⁹

The above insights suggest a level of understanding with which the field of psychotherapy needs to come to grips. If talking in a safe therapeutic environment is consistent with promotion of integration (where the latter is increasingly confirmed to be the hallmark of healing) the new research also suggests the *limits* of talk if unaccompanied by ongoing attention to bodily movement and somatic experience.¹⁸⁰ This is particularly in cases of trauma, which have long posed challenges to diverse therapeutic modalities.¹⁸¹ *‘Talking about the trauma’ does not necessarily assist its processing, and indeed can precipitate experience of overwhelm and retraumatisation.*¹⁸²

The propensity of many traumatised people to *dissociate* and *compartmentalise* means that reminders of trauma can precipitate (‘trigger’) immobilisation and even collapse. This is also when people may be otherwise competent and highly functioning (with which the capacity to compartmentalise and dissociate can also assist). While some people retain awareness of what is going on around

178 van der Kolk, ‘Foreword’, Ogden et al *Trauma and the Body*, pp.xx-xxi (emphasis added)

179 Ogden et al. *Trauma and the Body*, p.xxvii.

180 Also see Mary Sykes Wylie, ‘The Limits of Talk’ (feature article on the approach of van der Kolk) *Psychotherapy Networker* (19 October 2010) www.psychotherapynetworker.org/.../trauma/485-the-limits-of-talk

181 As Ogden notes, ‘[t]herapists of all disciplines are often puzzled and frustrated by the limitations of existing treatment modalities to resolve the symptoms of trauma in their clients’ (Ogden et al, *Trauma and the Body*, pp.xxix-xxx).

182 ‘Describing traumatic experiences in conventional verbal therapy is likely to activate implicit memories in the form of trauma-related physical sensations, physiological dysregulation, involuntary movements, and the accompanying memories of helplessness, fear, shame, and rage, without providing the resources to process these nonverbal remnants of the past’ (van der Kolk, ‘Foreword’, Ogden et al, *Trauma and the Body*, p.xxiv).

them, others 'space out' and lose contact with awareness of both external environment and internal sensations.¹⁸³ When assessing for dissociative problems, many clinicians confine their focus to emotions and behaviours. Thus they miss the *bodily and somatic dimensions* which are no less important to intercept.¹⁸⁴

In her introduction to *sensorimotor psychotherapy* (an approach which specifically incorporates somatic interventions used by psychotherapists of the body)¹⁸⁵ Pat Ogden explains that traditional therapeutic approaches are premised on belief 'that change occurs through a process of narrative expression and formulation in a 'top-down manner'.¹⁸⁶ This assumes that change in emotions and cognitions will effect change in the embodied or physical experience of the client's sense of self.¹⁸⁷ Thus the emphasis tends to be on (spoken) language.

By contrast, body-attuned interventions are 'bottom up', and address the somatic dimensions of experience not directly accessed by traditional psychotherapeutic approaches:

To these already useful cognitive and dynamic practices and techniques, we propose the addition of 'bottom-up' interventions that address the repetitive, unbidden *physical* sensations, movement inhibitions, and somatosensory intrusions characteristic of unresolved trauma.¹⁸⁸

In providing guidelines by which therapists unused to working directly with the body can start to incorporate such interventions into their practice, Ogden and her colleagues offer valuable and calibrated suggestions.¹⁸⁹ Their approach is respectful of existing ways of working, and gentle as well as thorough in introducing interventions by which traditional 'talk-based' psychotherapies can begin to rectify somatic deficits in their more established modalities.

Here it should be reiterated that the field of psychotherapy is now very diverse, and that while not necessarily specifically 'body oriented', many approaches now include varying degrees of attentiveness to physical processes and states. Basic mindfulness techniques and attention to breathing are a feature of many otherwise contrasting modalities, and the importance of *the client-therapist relationship* needs to be consistently emphasised.

183 van der Kolk, 'Foreword', Ogden et al *Trauma and the Body*, p.xxiv.

184 '[S]ensorimotor psychotherapy specifically deals with dissociative symptoms that involve bodily sensations, movement disorders, dysregulated physiological arousal, lack of body sensations, and reexperiencing the trauma in somatosensory fragments' (Ibid)

185 Other prominent therapists who should be noted in this context include Peter Levine and Janina Fisher. It is important to note that sensorimotor psychotherapy is both an approach which incorporates somatic interventions used by psychotherapists of the body and a school which has developed body psychology theory with respect to the use of somatic interventions (ie in a distinctive way; see Ogden et al, *Trauma and the Body*, p.xxviii).

186 Ibid

187 Ibid

188 Ogden et al, *Trauma and the Body*, p.xxix

189 Ogden et al *Trauma and the Body* is comprehensive in introducing many somatic principles and suggesting ways in which they can be incorporated into practice by therapists who are not familiar with them.

At the same time, the challenge body-based approaches represent to traditional ways of working in psychotherapy cannot be underestimated. van der Kolk makes this point clearly in his discussion of how sensorimotor approaches attune to people's perception of themselves and of how they position themselves in the world:

Rather than focusing on how people make meaning of their experience – their narrative of the past – the focus is on clients' physical self-experience and self-awareness. Body-oriented therapies are predicated on the notion that past experience is embodied in present physiological states and action tendencies... *The role of the therapist is to facilitate self-awareness and self-regulation, rather than to witness and interpret the trauma.*¹⁹⁰

In place of interpretation, therapy entails 'working with sensations and action tendencies in order to discover new ways of orienting and moving through the world'.¹⁹¹

This point is also made strongly by Fosha, who contends that what is required is

...the bottom-up processing approach of experiential therapies, *rather than the top-down approach of most cognitive and insight-focused therapies...* There is a premium on activating right-brain mediated emotional processes through techniques that focus on sensory, somatic, and motoric experience, and that *involve reliving and picturing, rather than narrating, interpreting, and analysing.*¹⁹²

In this context, the potential of *expressive therapies* (which may include, for example, artwork, sandplay and creative dance) is also immense.

The importance of the client-therapist relationship, and, in this context, the contributions of relational and psychodynamic schools of psychotherapy in particular, need to be noted.¹⁹³ The working through of the typically strong dynamics of transference and countertransference which are operative with respect to complex trauma¹⁹⁴ can itself assist both stabilisation and integration. There are many paths to healing, and more direct attention to the body in no way diminishes the significance of the relational context between therapist and client in which effective psychotherapy takes place. But to the extent that autonomic and physiological responses maintain and exacerbate

190 van der Kolk, 'Foreword', *Trauma and the Body*, p. xxiv (emphasis added)

191 Ibid.

192 Fosha, 'Dyadic Regulation and Experiential Work...', pp.229-230 (emphasis added)

193 For example, the 'Conversational Model' of Russell Meares is highly effective in attuning to right brain processes. See Meares, 'The Conversational Model: An Outline', *American Journal of Psychotherapy* (Vol.58, No.1), pp.51-66.

194 'Transference' and 'countertransference' are key themes of psychodynamic approaches. They refer to the unconscious responses of a client to their therapist and therapist to their client respectively, based on past relationships and associations which are evoked in the therapy session. In light of the violation of trust which is a hallmark of complex ('betrayal') trauma, transference dynamics are often especially intense in this context, and require skilful negotiation on the part of the therapist. See entries for 'transference' and 'countertransference' in the Glossary for further detail on the significance of this point.

psychological symptoms, the absence of direct interventions to assist clients to regulate bodily states may be regarded as an omission.¹⁹⁵

Effective trauma therapy, then, should incorporate movement and body-based awareness – *'we must attend to all three levels: cognitive processing (thoughts, beliefs, interpretations, and other cognitions), emotional processing (emotion and affect), and sensorimotor processing (physical and sensory responses, sensations and movement).'*¹⁹⁶ By illustrating how trauma-specific therapy should include body-based interventions which can be layered and embedded in existing ways of working,¹⁹⁷ the work of Ogden and her colleagues represents an important supplement to traditional psychotherapeutic approaches.

Phased treatment: the centrality of safety

Enhanced understanding of defence mechanisms of the brain and body, particularly under conditions of extreme stress, has a number of implications for effective trauma treatment. It also suggests potentially significant differences between optimal treatment of complex and 'single-incident' trauma respectively. Recollection that *'[t]he majority of people who seek treatment for trauma-related problems have histories of multiple traumas,'*¹⁹⁸ but that *this may not necessarily be apparent from the 'presenting problem';* underlines the stakes of these differences.

In contrast to the traumatised person who has experienced a sense of safety and well-being prior to the onset of the (single-incident) trauma, the survivor of *complex* trauma does not start with this advantage. The radical impairments in self-regulatory capacity associated with complex trauma – particularly when it is early onset as in the case of child abuse – present a very different starting-point for treatment. This is as important to recognise as it is widely missed (ie when complex trauma is mistaken for, and conflated with, standard PTSD).

Studies now show, as van der Kolk underlines, that those who experience complex trauma *'may react adversely to current, standard PTSD treatments, and that effective treatment needs to focus on self-regulatory deficits rather than 'processing the trauma.'*¹⁹⁹ The importance of the capacity to self-regulate – ie as *a vital precondition to capacity to process and integrate the trauma* – accounts for the emphasis on *phased* treatment which is now best practice in complex trauma treatment.²⁰⁰

To the extent that the experiences of complex trauma survivors render them unprepared to engage in immediate 'processing'²⁰¹ (the longstanding emphasis of standard trauma therapy) it is crucial that treatment is *structured* and *graduated*. Three distinct stages are now widely endorsed in the complex trauma field, even as a degree of fluidity and overlap between them is also acknowledged. Primary to the first stage, *and central at all times, is establishment of a sense of safety,* which may be tenuous to

195 Janina Fisher & Pat Ogden, 'Sensorimotor Psychotherapy', in Ogden et al, *Trauma and the Body*, pp.312-313. Both *hyper* and *hypo*arousal are trauma responses, and clients need to be able to self-regulate prior to the 'processing' of trauma (see subsequent subsection 'Phased treatment: the centrality of safety'). Also see Stephen W. Porges, 'The Polyvagal Theory: New Insights into Adaptive Reactions of the Autonomic Nervous System', ch. 3 in Porges, *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation* (New York: Norton, 2011), pp.52-59.

196 Ogden et al *Trauma and the Body*, p.140 (emphasis added)

197 In noting the 'natural' hesitation and concerns many therapists feel with respect to incorporation of interventions with which they are unfamiliar, Ogden is reassuring – 'attuning to body cues is something that is already built into virtually every therapist's method of working with clients and their internal states. The majority of human communication is not through verbal language but rather through body language: facial expression, eye contact, movement, behaviour, posture, autonomic arousal, gestures, muscular tension, and so forth' (Ogden et al *Trauma and the Body*, p.xxxiii).

198 van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma', p.172.

199 van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma', p.173.

200 Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, p.91.

201 One prominent clinician estimates that as few as 5% of her traumatised clients are immediately ready to engage in trauma work (Shapiro, *The Trauma Treatment Handbook*, p.37).

the point of non-existence in cases of complex trauma, and which current research indicates to be as physiologically essential as it is a precondition for effective therapeutic work.

The three phases of treatment (which date to the work of Janet in the late nineteenth century, and which current research findings endorse) are broadly described as follows:

- (1) Safety and stabilisation
- (2) Processing
- (3) Integration²⁰²

Each of these phases is structured according to its own particular goals and principles, subsequent phases build on previous ones, and points of earlier focus can be returned to if and as necessary. But as Rothschild and others emphasise, *the importance of Phase I (safety and stabilisation) cannot be overstated.*²⁰³ This point is critical to highlight and reiterate, because it has not been well understood in many standard trauma treatments –

Many clients and therapists are in such a hurry to get to the work of phase II that they shortchange phase I or skip it altogether... There are those who mistakenly disregard phase I as not being a legitimate part of trauma therapy or treatment per se because the focus is not on the traumatic incidents. However, successful accomplishment of this stage is a critical step... It is a central part of trauma treatment, at least equal to the relevance of phase II.²⁰⁴

Because it stems from the overwhelming of coping mechanisms, the intensity of traumatic experience risks being evoked in the absence of a supportive structure and context. *Trauma cannot begin to be processed, much less 'confronted', in the absence of ability to tolerate and regulate affect.* Thus conditions conducive to development of self-regulation are crucial to survivors of complex trauma – particularly when the trauma dates to childhood – because a *sense of safety and development of the capacity to self-regulate may not have developed in the first place.*

Here is where *guidelines for complex trauma will differ from standard guidelines for (single-incident) PTSD*, in which the task of *processing* is not explicitly preceded by the safety, stabilisation and achievement of ability to self-regulate which are the primary tasks of Phase I²⁰⁵ (and which, as Rothschild underlines, have tended to be minimised by approaches which emphasise 'processing' at the expense of such important preliminary work).

202 Courtois, Ford & Cloitre, 'Best Practices in Psychotherapy for Adults', pp.91-95. With minor variation in terminology, these three phases figure prominently in contemporary treatment of complex trauma; see for example, Rothschild, *Trauma Essentials*, pp.57-61, and Shapiro (referencing Steele et al 2005, and van der Hart 2006), *The Trauma Treatment Handbook*, p.163.

203 Rothschild, *Trauma Essentials*, p.57.

204 Ibid

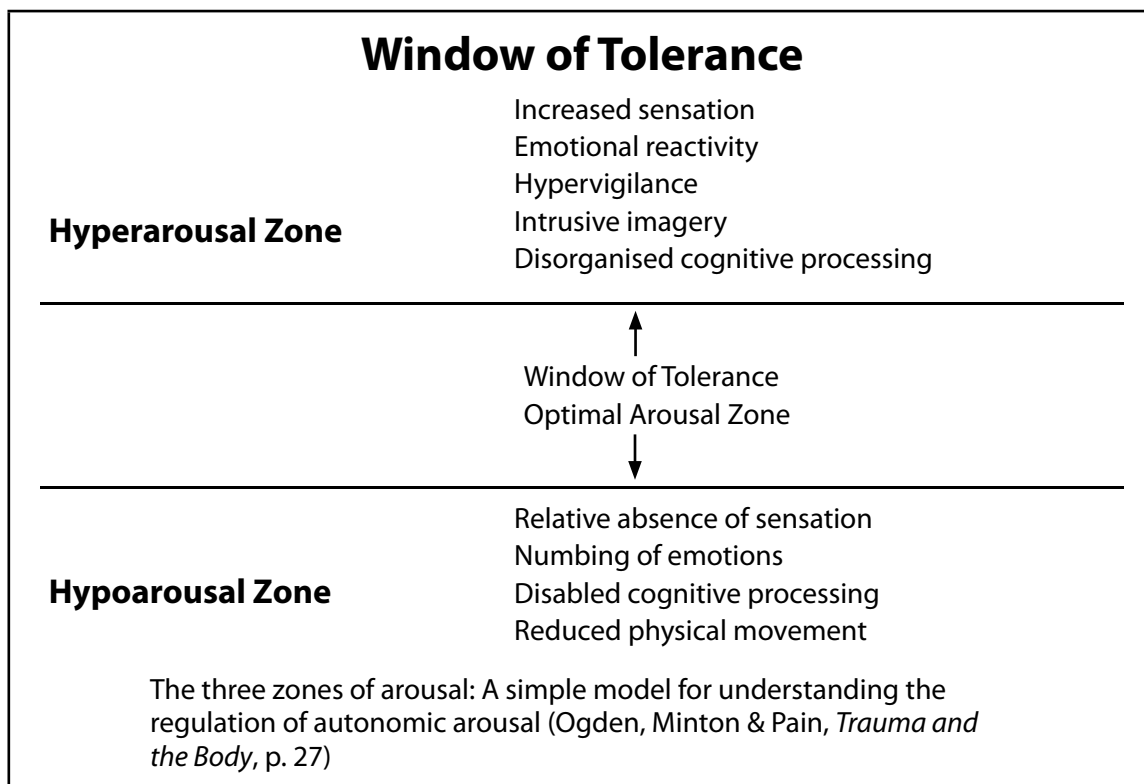
205 'Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder', Australian Centre for Posttraumatic Mental Health (ACPMH) Melbourne, 2007. <http://www.acpmh.unimelb.edu.au> While noted to be addressed to the Australian context, these guidelines also reference those developed both in the UK (by the National Institute for Clinical Excellence [NICE] 2005) and the US (by the American Psychiatric Association [APA, 2004] and Departments of Veterans Affairs and Defence [2004]). Under the heading 'Interventions for Adults with PTSD' (p.xviii) it is contended that '[f]ollowing diagnosis, assessment and treatment planning, 8-12 sessions of trauma-focused treatment is usually sufficient' (4.7). It is also contended that '[w]here adults have developed PTSD and associated features following exposure to prolonged and/or repeated traumatic events, more time to establish a trusting therapeutic alliance, more attention to teaching emotion regulation skills and a more gradual approach to exposure therapy may be required' (4.9; Ibid)) but this begs many questions in light of the guidelines which are offered. The suitability of 'exposure therapy' per se is problematic in cases of complex trauma, as distinct from the 'dual attention' (ie 'hold[ing] the trauma in mind... while maintaining focus in the current time and place'; Shapiro, *The Trauma Treatment Handbook*, p.2 and see 'Core features of complex trauma therapy' in subsequent discussion).

The centrality of Phase I work to clients with complex trauma is also underlined in situations where time and funding are limited. Rothschild advises that in such conditions, it is wise 'to stick to phase I treatment' ('Short-term therapy success with phase II is only possible with a single, uncomplicated trauma in a person who is relatively stable to begin with').²⁰⁶

The role of assessment and the 'window of tolerance'

While always important, the role of assessment (a task of Phase 1) is particularly so in the context of trauma. This is because it can potentially reveal *whether complex trauma underlies the 'presenting' problem/s*. As Shapiro points out, (single-incident) PTSD can dysregulate 'the calmest, most well-raised person'.²⁰⁷ This means that unless the initial assessment is attentive and nuanced, the likelihood of failure to detect *prior underlying* trauma is high (and the risks of inappropriate treatment correspondingly increased).

Assessment should be geared, among other things, to learning whether affect and dysregulatory problems 'are specific to recent trauma or chronic manifestations of temperament or attachment issues'.²⁰⁸ This, in turn, allows early insight into the client's 'window of tolerance' – ie the threshold at which they can tolerate emotion without becoming either agitated and anxious (hyperaroused) or 'shut-down' and numb (hypoaroused).²⁰⁹ Treatment ceases to be therapeutic if the 'window of tolerance' is exceeded (in which case re-traumatisation is also a risk). Thus attentiveness to the possibility of underlying trauma – *via attunement to attachment issues* – is the optimal point from which treatment should begin.



206 Rothschild, *Trauma Essentials*, p.62.

207 Shapiro, *The Trauma Treatment Handbook*, p.34.

208 Ibid

209 The 'window of tolerance' is described as an 'optimal arousal zone' which falls between 'the two extremes of hyper- and hypoarousal' (Ogden et al citing Wilbarger & Wilbarger, 1997, and Siegel, 1999; *Trauma and the Body*, pp.26-27. Also see Shapiro, *The Trauma Treatment Handbook*, p.34.

Attunement to attachment issues *at the first contact point and in the initial assessment*, is not a standard feature of all trauma therapy. But it is a valuable and logical recommendation to arise from the current research. In her comprehensive handbook of treatments for trauma, Shapiro includes an ‘Affect Tolerance Assessment’²¹⁰ which can assist with this task. This assessment tool includes ‘observational’ questions to be considered by the therapist (‘*Is his affect appropriate to the material?*’; ‘*Does she space out or freak out when a feeling begins to arise?*’) as well as potential questions to ask the client (‘*What were your feelings like before the event?*’ [in cases of recent trauma], ‘*... do you ever feel shut down?/so agitated you can’t stand it?*’)²¹¹

Clearly there are many ways in which attachment issues can be manifested, observed and explored. Also obvious is that all such information should be addressed and handled with high sensitivity to client and context. The key point is that attentiveness to such issues *as a routine part of the initial assessment* could be enormously valuable both in indicating the potential presence of complex trauma (and thus ability to distinguish it from single-incident PTSD) and ways in which treatment might productively proceed.

Attuning to dissociation

*‘...dissociation, **the escape when there is no escape**, is inscribed into the right hemisphere, which is specialised for withdrawal and avoidance.’²¹²*

Attentiveness to signs of dissociation²¹³ is also necessary. Dissociative symptoms vary markedly in type and intensity. At one end of the spectrum is Dissociative Identity Disorder (DID); a severe but treatable condition in which parts of the self have fragmented and detached.²¹⁴ But dissociation can occur in unremarkable forms such as day-dreaming and mild trancing. It is a device we all deploy to a degree, but which we generally do not regard as significant (or think of in those terms) because it is not necessarily disabling.²¹⁵ Because its signs can be subtle, it is important to attune to the possibility of dissociation in the initial assessment.²¹⁶ The rationale for this is that dissociation is a frequent dimension of trauma, and commonly present, to varying degrees, in its complex varieties.

210 Shapiro, *The Trauma Treatment Handbook*, p.35.

211 Ibid

212 Schore (referencing Davidson & Hugdahl, 1995), ‘Early Relational Trauma...’, Siegel & Solomon, *Healing Trauma*, p.129 (emphasis added)

213 As prefigured in chapter 2, dissociation is the act of disconnecting from immediate experience and occurs on a continuum from mild to severe. The dynamics of dissociation are discussed above.

214 For helpful orientating discussion on both Dissociative Identity Disorder and dissociation *per se*, see Warwick Middleton & Jeremy Butler, ‘Dissociative Identity Disorder: an Australian series’, *Australian and New Zealand Journal of Psychiatry* (32) 1988, pp.794-804, and Middleton, Dorahy & Moskowitz, ‘Historical Conceptions of Dissociation and Psychosis: nineteenth and early twentieth century perspectives on severe psychopathology’, ch.1 in Andrew Moskowitz, Ingo Schafer & Martin J. Dorahy, ed. *Psychosis, Trauma and Dissociation* (Oxford: John Wiley, 2008), pp.9-20.

215 And indeed in mild form can be highly functional in allowing us to deflect from ‘attention overload (which is also to underline the enormity of experience which can lead to severe forms of dissociation, most particularly DID, in which traumatic overwhelm occurs before the self has developed and cohered). See Lisa D. Butler, ‘Normative Dissociation’, *Psychiatric Clinics of North America*, Vol. 29 (1) 2006, pp.45-62.

216 As distinct from attempts to determine this, which would be problematic at the first contact point for a range of reasons. For helpful orientation to the area of dissociation and its assessment, see ‘Assessment of Dissociation’, in Colin A. Ross & Naomi Halpern, *Trauma Model Therapy: A Treatment Approach for Trauma, Dissociation and Complex Comorbidity* (Richardson, TX: Manitou Communications, Inc., 2009), pp.2-54. Recognizing that the majority of mental health clinicians lack formal training in dissociation and dissociative disorders, the *Psychiatric Clinics of North America* website also offers a range of valuable papers. See <http://www.theclinics.com>

Dissociation involves complex neural processes, and occurs beyond conscious awareness and control.²¹⁷ It is a defensive response to what is unbearable (*'the escape when there is no escape'*). It can also be reflexively deployed subsequent to the trauma in the absence of apparent threat (ie it can be activated by seemingly innocuous cues which serve as *'reminders'* of the trauma). *Effective treatment of complex trauma requires knowledge of dissociation, ability to recognise it, and skilful means of intercepting and working with it.* As with attachment issues and *'the window of tolerance'*, the earlier it can be attuned to – including within the initial assessment – the better.

Screening for dissociative tendencies, whether formally or informally, is optimal. This does not necessarily mean via administration of specific *'tools'* (of which there are several, and not all of which, for a range of reasons, it may be appropriate to use).²¹⁸ *Attunement* and *attentiveness* – as well as general openness to the possibility – is the therapeutic orientation to cultivate. As Shapiro relates, *'[t]he more you know about dissociation, the more you automatically watch for its markers.'*²¹⁹ In addition to her *'Affect Tolerance Assessment'*, she provides a general *'Dissociation Assessment'* which is likewise an informal means by which clinicians can begin to attune to potential signs. Therapists, she suggests, will *'notice'* if, for example, a new client:

- Spaces out easily.
- Loses coherency when speaking about childhood events (Main, 1991; Siegel, 1999, 2007)
- Can't remember much of childhood years
- Abruptly switches from calm discussion to a hostile, terrified, shut-down, or disorganised state
- Shows inappropriate affect when discussing distressing events
- Speaks in the third person about the self²²⁰

Other potential *'markers'* of dissociation might include changes in voice tone and pitch, and frequent forgetting of appointments. Attuning to the potential significance of such indicators is a responsible way of proceeding from the first point of client contact. It also assists in the honing of observational skills and attentiveness to a wide range of potential *'cues'*, which, in light of their frequent subtlety, risk going undetected.

217 *'When a trauma is big enough or happens often enough, we may develop strong, reflexive pathways of response that act separately from our most conscious, thinking planning brain. Trauma-based reflexively triggered neural networks of emotional (Panksepp, 1998) or action-oriented (van der Hart, Nijenhuis, & Steele, 2006) neural systems are the basis of dissociative responses'* (Shapiro, *The Trauma Treatment Handbook*, p.17).

218 Not all clinicians/therapists/health professionals who work with complex trauma will feel comfortable – or be qualified – to use the various assessment scales which exist..Care should also be taken with administration of any formal tool in a first interview/session, particularly if the client is distressed, and where rapport-building is central. With respect to the range of dissociative screening/assessment tools available (and which include *'The Dissociative Experiences Scale'*, *'The Somatoform Dissociation Questionnaire'* and *'The Dissociative Disorders Interview Schedule'*, see *Appendices* in Ross & Halpern, *Trauma Model Therapy*, pp.227-272.

219 Shapiro, *The Trauma Treatment Handbook*, p.36 and see the previous footnote.

220 Ibid.

Early onset `versus' adult onset trauma: implications for treatment orientation

Optimal approaches to treatment of complex trauma need to combine various dimensions (as per previous and subsequent discussion). But the significance of the difference between *early onset* (child) and *adult onset* trauma needs to be emphasised. This is not to deny the variety which can exist within each of these categories, or degrees of overlap in the problems and symptoms experienced. Rather it is to underline the risk of the two being conflated, which heightens the risk of childhood trauma going undetected in light of diverse adult presentations (a risk which, in the absence of nuanced approaches to assessment and treatment, remains ongoing). The differences between `early onset' and `adult onset' trauma also affect the treatment and therapy approach which is appropriate, even as no single modality is necessarily preferable.

If assessment and ongoing professional contact with the client does not indicate attachment difficulties prior to experience of the presenting trauma, the indications for proceeding are clear. Treatment can be more straightforward, more directed to processing of the trauma, and less focused on repair of prior dysregulated self and other relating (the need for which will be less indicated).

By contrast, with indication of *early onset* trauma – and particularly in cases of adults who were *sexually* abused as children – approaches which address child states need to be utilised:

Early sexual and physical abuse, coupled with poor attachment experiences, are direct routes to dissociation. Few children stay present and whole while being raped by an adult. When the abuse is pervasive, the dissociation deepens, and the child becomes socially, behaviourally, and emotionally disrupted... When working with adult-onset rape survivors, clinicians must deal directly with the visceral experiences... disrupted trust, and distorted cognitions. *When working with people who were sexually abused as children*, clinicians must use therapies that can deal directly with child states and deep disruptions of self-cohesion and self-acceptance.²²¹

As the above comments make clear, both the pathway to trauma and the treatment implications may be very different according to whether the trauma experienced is *adult onset* or *early onset*. This is notwithstanding shared and overlapping symptoms such as `disrupted trust'. *For optimal treatment, it matters whether trust was disrupted as a result of adult-onset trauma, or the complex trauma of child abuse in which the capacity to experience trust was impeded.*

Similarly and correspondingly, the different pathways of adult onset and early onset trauma suggest contrasting implications for *the client-therapist alliance* (because absence or presence of prior experience of trust is a key indicator of *the pace by which therapy can proceed*, as well as of *the modalities and treatment approaches* which may be called for). While the outcomes of healing are the same for both groups (ie sense of safety and absence of shame, end to flashbacks, at ease in one's body, ability to enjoy life etc) the *process* by which this occurs and *the methods used to achieve it* may differ substantially. Once again, it is crucial for effective treatment that the onset of trauma (ie early or adult) is not only detected, but attuned to as early as possible and ideally from the first contact point.

221 Shapiro, *The Trauma Treatment Handbook*, p.200 (emphasis added)

Core components of complex trauma therapy

*There is no one perfect trauma therapy...
There is a broader way of thinking.*²²²

Key requirements of therapy for complex trauma have already been noted – ie *attunement to the relevant neurobiological processes* with a view to their integration, *capacity to engage the right-brain*, attentiveness to, and ways of working with, *implicit memory*, attentiveness to *physical movement and the body* as well as to (spoken) 'talk', and *phased treatment*). In light of the diversity of treatment modalities which exist (and which are also rapidly developing) what other 'common elements' need to feature in optimal treatment of complex trauma?

While effective treatment of complex trauma needs to address several key dimensions (ie irrespective of the particular approach used) the current literature also advises of the need for *knowledge of more than one modality*. Siegel notes the need for therapists to have 'a spectrum of interventions' at their disposal 'in order to create the most effective and individually sculptured therapeutic experiences'.²²³ Rothschild likewise advises clients to check that their prospective therapists have training 'in at least three methods'.²²⁴

Given the current paucity of training which is trauma-specific (and that initiatives to foster trauma-informed service provision are recent) ability to work proficiently in more than one modality may remain an aspirational best practice benchmark in the short to medium term. *Demonstrated capacity to combine certain 'core' elements of effective trauma treatment in whatever modality that is used* should, however, be an immediate priority for all complex trauma therapy, and is an emerging best practice requirement. Whether this be via synthesis of aspects of several approaches, or the 'layering' and embedding of evolving insights on/into 'standard' therapeutic modalities (as per the suggestions of Ogden et al in relation to sensorimotor movement and the body) *all treatment of complex trauma needs to address all three levels of cognitive, emotional and physical (sensory, somatic) processing*.²²⁵

In her comprehensive introduction to the now vast range of trauma therapies, Shapiro advises of the need to look for 'five threads' in whatever approach is being considered.²²⁶ These core elements may be implicit or explicit, but *should all feature*, she suggests, if the modality is to be effective. To the extent that it serves as a helpful guide, and while mindful of the 'core elements' we have noted already, Shapiro's 'five threads' of good trauma therapy are as follows:

1. *Presence* (defined as '[g]etting into the here-and-now experience of body, affect, and thought')
2. *Dual attention* ('hold[ing] the trauma in mind (exposure), while maintaining focus in the current time and place')
3. *Affect (emotion) while in relationship* ('It's not that the affect is discharged, though it might be. It's that it's felt and not avoided [ie within the 'window of tolerance'] then witnessed and survived, then transformed into a memory and no longer a developmental catastrophe')

222 Shapiro, *The Trauma Treatment Handbook*, p.1.

223 Daniel J. Siegel, 'Foreword', Shapiro, *The Trauma Treatment Handbook*, p.xiii

224 Rothschild, *Trauma Essentials*, p.106.

225 Ogden et al *Trauma and the Body*, p.140 (emphasis added)

226 Shapiro, *The Trauma Treatment Handbook: Protocols Across the Spectrum*, p.2.

4. *Relationship with self and other* ('Clients gain tolerance and acceptance of their own affect and history and the capacity for relating to others')
5. *Making meaning of the traumatic events* ('often accompanied by anger, then grief, then great relief')²²⁷

Locating these 'threads' within otherwise diverse modalities (in which they might feature in varied ways) is a potentially valuable way of orienting to what is now a rich, expanding but also contrasting and potentially confusing landscape of therapeutic approaches.

In her elucidation of the issues raised by these themes, Shapiro further suggests that the following questions should be asked in relation to any modality being considered:

- How does this therapy see clients or problems?
- What would I do with a particular client using this therapy?
- How must I [adapt] this treatment to accommodate a particular client?
- Is this the best treatment for this client? If not, what therapy or therapies will do the job?
- Are there parts of this modality that dovetail with other work that I already do?²²⁸

As these questions convey, Shapiro's style is informal and 'user-friendly'.

To the extent that she provides valuable discussion of assessment and client preparation, components of the 'three phases' of complex trauma treatment, and broad introduction to treatments for 'simple' and 'complex' trauma respectively, her handbook is an excellent introduction to applying the clinical insights which she operationalises via illustration but does not engage with in theoretical detail.²²⁹

227 Shapiro, *The Trauma Treatment Handbook*, pp.2-3.

228 Shapiro, *The Trauma Treatment Handbook*, p.3.

229 Shapiro is explicit that research *per se* 'is beyond the scope of most of [her] book' (p.4). She is also refreshingly frank about the 'battles' which can be waged by proponents of various approaches, 'using research studies to win their arguments'. In marked contrast, she admits to 'staying out of the fray', and to using 'phenomenological research. If a therapy makes the symptoms change quickly and permanently, without causing further distress, I'll do it again' (Ibid). Here it should also be noted that Daniel Siegel has written the foreword to this text.

The costs (as well as rewards) of connection: therapist well-being, the importance of boundaries, supervision and mindfulness

*Your ability to connect is your best therapeutic tool.*²³⁰

As Shapiro reiterates, '[m]yriad studies show that the strength of the therapeutic relationship is the strongest predictor of a good outcome.'²³¹ But the ability to connect with complex trauma clients (who *because* of their cumulative trauma, may be experiencing healthy connection for the first time) also underlines the importance of *therapist* self-care, and the high and many stakes of this.

It is now well recognised that working with, as distinct from directly experiencing, trauma is highly demanding. The literature on 'vicarious trauma'²³² is expanding and widely available (although greater awareness of the associated risks does not guarantee that they will be circumvented or effectively addressed). But if all therapeutic work is demanding, treatment of complex trauma is particularly so.

In this context, it has been noted that while the goal is to facilitate a new existence for the client, 'the treatment can also profoundly change the therapist.'²³³ To the extent that this view may be less familiar than is the now frequent emphasis on the need for 'self-care', it suggests particularly challenging problematics and risks in relation to the treatment of complex trauma. It also suggests potential pitfalls which may not initially be apparent. It follows that guidelines need to address the many complexities in this area, both to safeguard therapist well-being (which in turn benefits clients) and to conform to high standards of ethical and professional practice (one component and requirement of which is professional supervision).²³⁴

The importance of *boundaries* in effective treatment of complex trauma is crucial (where 'boundaries' also apply to aspects of relating which again may not always be readily detectable). The new prevalence of 'mindfulness' as a technique and strategy, both in therapy and the wider society, is highly valuable here. Note that 'mindfulness' is also much *more* than a 'strategy', and as its links with Buddhism suggest, it is hardly 'new'. As Rothschild explains, mindfulness is 'an active process that simply involves a purposeful focus of awareness or attention.'²³⁵

While often linked to the practice of meditation (for which, in the context of trauma treatment, there are some important caveats)²³⁶ cultivation of a mindful stance towards experience is now a recurring theme of the current psychotherapeutic literature. It is also actively incorporated into diverse therapeutic approaches and modalities.²³⁷ The therapeutic (and many other) benefits of mindfulness

230 Shapiro, *The Trauma Treatment Handbook*, p.47.

231 Shapiro citing Lambert & Barley, 2001; Schore, 2009, *The Trauma Treatment Handbook*, p.3. Also see 'common factors research' in the Glossary.

232 'Vicarious trauma' is described as 'the negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them' (Laurie Anne Pearlman & James Caringi, 'Living and Working Self-Reflectively to Address Vicarious Trauma', in Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, pp.202-203; original emphasis). Also see this chapter by Pearlman and Caringi for helpful differentiation of vicarious trauma (VT) from *countertransference*, *burnout* and *compassion fatigue* (related concepts with which VT nevertheless should not be conflated).

233 Stuart D. Perlman, *The Therapist's Emotional Survival* (NJ: Jason Aronson, 1999), p.xiii.

234 See Allyson Davys & Liz Beddoe, *Best Practice in Professional Supervision: A Guide for the Helping Professions* (London: Jessica Kingsley, 2010). For valuable texts which discuss supervision in the more particular context(s) of complex trauma, see Laurie Anne Pearlman & Karen W. Saakvitne, *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors* (New York: Norton, 1995), and Saakvitne, Sarah Gamble, Laurie Anne Pearlman & Beth Tabor, *Risking Connection: A Training Curriculum for Working with Survivors of Child Abuse* (Brooklandville, MD: Sidran Press, 2000).

235 Rothschild, *Trauma Essentials*, p.91.

236 See Rothschild, *Trauma Essentials*, p.96. Once again, this is also to underline the importance of Phase 1 work (safety/stabilisation) in terms of ability to self-regulate in the face of traumatic experience which, in the context of meditation, might 'rise up' and otherwise overwhelm the client.

237 For a helpful account of the relationship between mindfulness and attachment theory in the context of its clinical implications, see Wallin, *Attachment in Psychotherapy*.

are widely attested to, and mindfulness is itself an ally to therapist well-being as well as to that of the clients they see.

The limits (and potential) of medication

Medication does not treat complex trauma directly, and is optimally used in combination with psychotherapy.²³⁸ Among clinicians of complex trauma, perspectives on psychopharmacology can differ.²³⁹ But there is little dispute that, of itself, medication is not a routine ‘treatment of choice’ for this multidimensional condition.

At the same time, this does not mean that there is no role for medication in cases of complex trauma, especially if the state of the client is such as to impair ability to participate in therapy.²⁴⁰ Particularly, but not exclusively, in the early stages of treatment, judicious use of medication can assist stabilisation while safety and nascent self-regulatory capacity are beginning to cohere. A collaborative care model, in which the therapist is in contact with the prescribing physician, is advisable.

In *Trauma Essentials*, Rothschild cites the limits of medication in treatment of PTSD,²⁴¹ and use of medication can be especially problematic in relation to complex trauma varieties. To the extent that it is indicated, clients who experience complex trauma may require ‘more complex medication regimes’, which can involve ‘a prolonged and complicated process’²⁴² (which again underlines the role of collaborative care). Thus current research reveals the role of medication to be ancillary, rather than ‘treatment of choice’ for the addressing of complex trauma.

‘Evidence based’ treatment and complex trauma

Our understanding of the neurobiology of attachment and trauma is unfolding with increasing pace. Now, our understanding of the neurobiology of healing has to catch up so that the therapeutic interventions by which the suffering of trauma and disorganised attachment are relieved can continue to grow in precision and effectiveness.²⁴³

The question of treatment which is ‘evidence-based’ is highlighted by the above comment. While the evidence base for interpersonal neurobiology is substantial and expanding, its translation to therapeutic practice and implications for complex trauma and trauma-informed care are much less advanced. Given the inevitable ‘cultural lag’ between paradigmatic shift and its widespread

238 Ie. psychotherapy of the phased, right-brain activating variety which combines attentiveness to emotional, cognitive and sensorimotor processing (thereby moving beyond the limits of ‘traditional’ insight and/or cognitively-based therapeutic approaches to activate full psychotherapeutic potential). At the same time as highlighting the limits of medication, van der Kolk underlines the limits of ‘[t]raditional psychotherapies’, which ‘also do not offer much immediate relief, since being unable to manage emotional arousal interferes with being able to benefit from treatments such as cognitive behavioral therapy’ (van der Kolk, ‘Foreword’, Porges, *The Polyvagal Theory*, p.xii).

239 As between, for example, Rothschild who, with some qualified exceptions, sees medication as ‘not particularly effective’ for PTSD (Ibid, p.85), Courtois et al who see complex trauma clients as potentially benefitting from medications which may be able to treat some PTSD symptoms (‘Best Practices in Psychotherapy for Adults’, p.99) and van der Kolk who contends that ‘routine psychiatric interventions are quite ineffective in helping people manage their emotions’, and that ‘the best that medication generally can do is to dull emotional arousal of any kind, thereby robbing people of pleasure and of pain simultaneously’, (‘Foreword’, Porges, *The Polyvagal Theory*, p.xii).

240 And may clearly be indicated in instances of, for example, suicidality and/or substance abuse. See Courtois et al ‘Best Practices in Psychotherapy for Adults’, p.99.

241 Rothschild, *Trauma Essentials*, p.85.

242 Courtois et al, ‘Best Practices in Psychotherapy for Adults’, Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, p.99.

243 Fosha, ‘Dyadic Regulation and Experiential Work with Emotion and Relatedness in Trauma and Disorganized Attachment’, p.276.

application, this raises obvious questions about verification of treatment practice and service-provision which attempt to reflect the new insights and findings.

Yet it also raises wider questions about the status of 'evidence based' treatment *per se*. A key question is what *counts* as evidence, particularly in a social context where 'scientific' method is accorded preeminent status. *There are many types of research.*²⁴⁴ How research is *interpreted* is also pivotal, although this may not always be clear in a culture which routinely equates science with 'knowledge' and 'truth'.²⁴⁵

In her discussion of 'research bias', both generally and with respect to trauma, Rothschild notes the *economic* and *professional* investments which condition how research is conducted and read.²⁴⁶ Particularly pertinent in this context is the widespread practice of restricted eligibility criteria for participation in research studies. This is also a practice which has particular implications for studies of trauma:

In the vast majority of trauma method outcome studies, subjects are not random – they are carefully chosen. In general, acceptable subjects will be relatively stable and have only a single trauma... *People with multiple traumas, especially with complex issues or complicating personality disorders, are rarely accepted in outcome studies.*²⁴⁷

To the extent that the majority of those who seek treatment for trauma have multiple unresolved traumas,²⁴⁸ Rothschild considers treatment outcome research to be 'virtually useless' because little of it is conducted 'with a truly random population'.²⁴⁹ Courtois, Ford and Cloitre note that outcome data is available for treatment of complex posttraumatic stress disorders, but that the empirical base remains limited.²⁵⁰

244 For example, qualitative research clearly differs from quantitative, and is itself a legitimate form which encompasses many varieties (see Denzin & Lincoln, 'The Discipline and Practice of Qualitative Research', ch.1 in *The Sage Handbook of Qualitative Research*, Thousand Oaks, CA: Sage, 2005). For a helpful text in research methods of counselling and psychotherapy, see John McLeod, *Qualitative Research in Counselling and Psychotherapy* (London: Sage, 2005).

245 For a powerful critique of the privileging of the scientific paradigm, see Sandra Harding, *Whose Science? Whose Knowledge?* (New York: Cornell University Press, 1991). Also see Sandra Harding & Robert Figueroa, ed. *Science and Other Cultures* (New York: Routledge, 2003).

246 Rothschild, *Trauma Essentials*, p.71.

247 Rothschild, *Trauma Essentials*, p.71 (emphasis added)

248 Rothschild, *Ibid*; van der Kolk, 'Posttraumatic Stress Disorder and the Nature of Trauma', p.172.

249 Rothschild, *Trauma Essentials*, p.71. Among specialists in complex trauma this is not an isolated view. The exclusion criteria for clinical trials severely restrict participation of the very people for whom improved treatments are urgently needed. This is also a point which has more general application – 'If you have a drug or alcohol problem, serious medical problems, are actively suicidal, or have other Axis I disorders, you are not allowed into an antidepressant study. This excludes almost all the people admitted to psychiatric hospitals for depression, and almost all the people treated by psychiatrists. That is why psychiatrists have to advertise in newspapers and on the radio to recruit people for drug studies – they can't find them in their practices' (Ross & Halpern, *Trauma Model Therapy*, p.64). As Ross & Halpern go on to note, '[o]ne can read the entire psychiatric literature and find almost no treatment outcomes or follow-up data on complicated, highly comorbid psychiatric inpatients, even as the majority of people with DID have been inpatients at some point, and/or suicidal, and all have other Axis I disorders and addictions. The treatment outcome data for DID are as strong as any other body of data for any treatment method involving highly comorbid inpatients... This is the context in which the treatment outcome data for DID should be evaluated; not the ideal standard of drug studies funded by multi-billion dollar drug companies, but the actual data available for real-world treatment of difficult, highly comorbid clients' (Ross & Halpern, *Ibid*, p.65).

250 Christine Courtois, Julian Ford & Marylene Cloitre, 'Best Practices in Psychotherapy for Adults', *Treating Complex Traumatic Stress Disorders*, pp.83-84. Note that treatment outcome research on group work for adult survivors of child sexual abuse (CSA) was first published in 1978 (Jane Davidson [citing Marotta & Asner, 1999] *Looking to a Future: A Research Report on the Jacaranda Project*, St Leonards: Northern Sydney Sexual Assault Service, 2007), p.5. As Davidson goes on to note, since the 1978 research there have been many published studies assessing the effectiveness of group therapy for CSA survivors, very few of which have included outcomes for male survivors (*Ibid*). Also note that the research authored by Davidson into the group work program for adult CSA survivors conducted by the Northern Sydney Health Sexual Assault Service between 2002 and 2004 ('the Jacaranda Project') remains a pathbreaking research study in Australia; 'unique in the literature in that it comprises both quantitative and qualitative methodologies' (Davidson, 'Preface', *Looking to a Future: A Research Report on the Jacaranda Project*).

The anomaly that outcome research is problematic in many respects is glaring on consideration (although not immediately apparent in a context in which outcome studies are extolled as authoritative). It clearly raises queries about ‘evidence-based’ treatment so-called.

For example, cognitive behavioural therapy (CBT) is widely endorsed as one of the most ‘evidence-based’ treatments.²⁵¹ Yet this is in part because it is one of the most *funded* therapies. Large amounts of money are required to engage in the research and testing of treatments according to formal ‘scientific’ protocols. Many such approaches are less accessible to ‘measurement’, and many existing treatments will not be the subject of formal research not only because of funding constraints, but because the majority of clinicians, by virtue of being practitioners, do not engage in research in any case.

For these legitimate reasons, *lack of the status of ‘evidence-based’ does not itself equate to suspect treatment*. At the level of public uptake, the fact that CBT is both a short-term therapy and one which attracts the Medicare rebate is also significant in accounting for its affordability, accessibility and popularity.

Insistence that treatments be ‘evidence-based’ can also wrongly imply the superiority of treatments which new research insights are calling into question. This is dramatically underlined in the current period where, fuelled by the research base in the neurobiology of attachment, new therapies ‘are beginning to open up entirely new perspectives on how traumatised individuals can be helped to overcome their past.’²⁵²

Authorities in the field of trauma are noting the extent to which ‘new’ therapy orientations may yield benefits beyond those of more established approaches (note that CBT is in the latter category).²⁵³ Should such potential not be incorporated in the absence of the imprimatur of ‘evidence-based’, particularly in light of the limits of this claim both in relation to treatment in general and trauma treatment more specifically? As Fosha and others are highlighting, the challenge is to operationalise the substantial evidence base of affective neuroscience into a ‘neurobiology of healing.’²⁵⁴ This suggests need for reconceptualisation of the existing formulation of ‘evidence-based’ treatment, particularly in light of the many other limits with which this ‘standard’ is associated.²⁵⁵

Just as the DSM remains inadequate in its classification of complex trauma, so do standard ‘evidence-based’ measures of what constitutes effective treatment also require reconsideration.²⁵⁶ For this reason, the contrasting formulation of ‘practice-based evidence’, and emphasis on *client outcomes*

251 ‘Through the 1970s and early 1980s a series of studies appeared apparently confirming the equivalent efficacies of cognitive and drug therapies and indeed pointing to a possible extra benefit of cognitive therapy in postponing or reducing the likelihood of relapse’ (David Healy, *The Anti-Depressant Era* (Cambridge, Mass: Harvard University Press, 1999), p.239).

252 van der Kolk, ‘Posttraumatic Stress Disorder and the Nature of Trauma’, p.189.

253 ‘New’ approaches in this context include body-oriented approaches, Dialectical Behaviour Therapy (DBT) and Eye Movement Desensitization and Reprocessing (EMDR); van der Kolk, ‘Posttraumatic Stress Disorder and the Nature of Trauma’, p.188. In this context (as as noted previously) van der Kolk is explicitly critical of both CBT and insight-oriented psychotherapies on the ground that both pay insufficient attention to physical processes and the body in the resolution of trauma (van der Kolk, ‘Foreword’, Ogden et al, *Trauma and the Body*), p. xxii.

254 Fosha, ‘Dyadic Regulation and Experiential Work...’, p.276

255 ie that standard forms of ‘evidence-based’ criteria favour some modalities and approaches over others, that ability to conduct randomised control trials requires levels of time and funding not accessible to all, and that absence of ‘evidence’ of this kind does not equate with absence of effectiveness. For discussion of the biases which exist even in ‘scientific’ research, see McGauran et al ‘Reporting Bias in Medical Research – a Narrative Review’, *Trials* (11:37) 2010, <http://www.trialsjournal.com/content/11/1/37>

256 In the context of psychotherapy, it is also suggested that debate may have moved beyond the merits of ‘evidence-based practice’ (EBP) to those of ‘empirically supported treatments’ (EST) where the latter relates to interventions which have shown ‘robust efficacy over several independent and well-conducted trials in treatment of specific populations or disorders.’ (King 2010:35) Yet as the latter definition also suggests, there are many reasons why varieties of therapy may be effective in the absence of recognised ‘empirical support’ (sample size/composition and access to funding being but two). In further striking illustration of the frequent complexity of the implications of research findings, King notes that *even if an approach is found to be ‘empirically supported’, there are reasons why it is ‘far from clear that mandating treatments considered empirically supported will benefits for consumers’* (Ibid, emphasis added) Thus the problematics of calls for ‘evidence-based’ and ‘empirically supported’ treatments need to be constantly reiterated (which, in light of current understandings of professionalism, is also consistently difficult to do). See King & Moutsou, ed. *Rethinking Audit Cultures: A Critical Look at Evidence-Based Practice in Psychotherapy and Beyond* (PCCS Books, 2010).

rather than pre-determined 'one size fits all' treatments, present powerful alternative measures of treatment effectiveness.²⁵⁷

Neborsky writes that we live in an age in which 'interpersonal neurobiology is becoming a reality' ('Today we have the clinical insights to repair deeply embedded and disrupted neural networks... It is an exciting time for the practice of psychotherapy').²⁵⁸ It is also significant that Daniel Siegel has warmly endorsed a trauma treatment handbook which actively draws on the insights of affective neuroscience even as it is avowedly not a research-based work.²⁵⁹

Comprehensive translation of research insights in the neurobiology of attachment to clinical and health care practice will take time. In the *meantime*, current research indicates need for the presence of common and 'core' elements for any treatment approach to complex trauma to be regarded as optimal. 'Core' elements include phased treatment, engagement of right-brain processes and implicit memory, and attentiveness to *physical* as well as emotional and cognitive processes.

257 In the field of psychotherapy, Scott Miller has long proposed the benefits of 'practice-based evidence', which take account of client feedback which itself guides the therapy. The large body of 'common factors' research in psychotherapy – which finds the particular modality or technique to be less indicative of treatment effectiveness than other factors such as client-therapist rapport – is also significant here. See Duncan, Miller & Wampold, & Hubble, ed. *The Heart and Soul of Change: Delivering What Works in Therapy*, 2nd edit. (Washington, DC: American Psychological Association, 2010).

258 Neborsky, 'A Clinical Model for the Comprehensive Treatment of Trauma...', p.319.

259 Siegel, 'Foreword' to Shapiro, *The Trauma Treatment Handbook*, pp.xiii-xiv. Siegel endorses this text as 'a practical guide to a wide range of treatment strategies for trauma', and describes how his initial reservations about the relative lack of reference to research gave way to reflection on his own development as a therapist, and to finding himself 'soaking in the author's sensitivity, her directness, her compassionate reflections on the therapeutic process, and her skill at extracting the best from a range of clinical strategies to help the healing process evolve and be more likely to find a window of opportunity to make lasting change possible' (Ibid)

Chapter summary of key findings and themes

- Clinical and research findings substantiate that it is possible to heal from adverse early experiences, including childhood trauma. It is possible for trauma to be resolved.
- The ‘insecure’ attachment generated by adverse childhood experience can be converted to ‘secure’ attachment; a transition described as ‘*earned security*’
- Transmission of insecure attachment to the next generation can likewise be avoided when trauma is resolved via achievement of a coherent, integrated perspective on early experience (*‘History is not destiny – if you’ve come to make sense of your life’*)²⁶⁰
- Trauma therapy should be directed towards *integration and coherence* of functioning (*‘Effective therapy for trauma involves facilitation of neural integration’*)²⁶¹
- Psychotherapy has been found to correlate with neuroscientific findings, in assisting realignment of disrupted neural pathways. Psychotherapy can be regarded as ‘an enriched environment that promotes the development of cognitive, emotional and behavioural abilities.’²⁶² But to the extent that neuroscientific research reveals the centrality of *non-verbal* experience to trauma and its resolution, this also suggests the *limits* of ‘talk-based’ therapies and the need for established psychotherapeutic modalities to attune more closely to bodily experience (see below)
- Current research suggests the need for trauma treatment which is attuned to right-brain functioning, and which can engage somatic and bodily experience. This in turn suggests that psychotherapy needs to supplement its more traditional modalities (insight-based and CBT) to facilitate addressing of these domains. While ‘talking about’ experience can promote integration, it is not necessarily sufficient, is not oriented to implicit memory, and can even be re-traumatising.
- Therapy must be ‘bottom up’ as well as ‘top down’, where the former requires experiential approaches ‘rather than the top-down approach of most cognitive and insight-focused therapies.’²⁶³ (*‘It is possible that some of the newer body-oriented therapies, dialectical-behavior therapy, or EMDR may yield benefits that traditional insight-oriented therapies may lack’*).²⁶⁴
- In their activation of right-brain processes, *expressive therapies* (which may include creative art, dance and sandplay) can also be powerfully therapeutic.
- In *Trauma and the Body*,²⁶⁵ Pat Ogden et al introduce important supplements to traditional psychotherapeutic approaches, explaining how trauma-specific therapy can incorporate body-based interventions which can be layered into existing ways of working.
- *Phased treatment* represents the ‘gold standard’ in treatment of complex trauma. The radical impairments in self-regulatory capacity associated with complex trauma – particularly when early onset as in cases of child abuse – present a different starting point for treatment than does (single-incident) PTSD.

260 Siegel, ‘An interpersonal Neurobiology of Psychotherapy’, p.16 (emphasis added)

261 Siegel & Solomon, ed. *Healing Trauma*, p.xviii.

262 Cozolino, *The Neuroscience of Psychotherapy*, p.23.

263 Fosha, ‘Dyadic Regulation and Experiential Work with Emotion and Relatedness in Trauma and Disorganized Attachment’, p.229

264 van der Kolk, ‘Posttraumatic Stress Disorder and the Nature of Trauma’, p.188.

265 Ogden et al, *Trauma and the Body*.

- The capacity to self-regulate is the precondition for processing and integration of trauma. Since the experiences of *complex* trauma survivors render them ill prepared to engage in immediate processing, this underlines the critical role of Phase I (stabilisation) as prelude to Phase 2 (processing) and Phase 3 (integration). (*'Short-term therapy success with phase II is only possible with a single, uncomplicated trauma in a person who is relatively stable to begin with'*).²⁶⁶
- Assessment should be attuned to attachment issues as potential indicator of underlying trauma. Attunement to attachment issues *at the first contact point and in the initial assessment* is not a standard feature of all trauma therapy, and needs to be incorporated both to sensitise clinicians to the possibility of underlying (complex) trauma and to gain insight into client capacity to tolerate feeling/s.
- The 'window of tolerance' is the threshold at which a person can tolerate emotion without becoming either agitated (*hyperaroused*) or 'shut down' (*hypoaroused*). Therapy must stay within the window of tolerance at all times (which underlines the centrality of *safety* and the importance of Phase I work).
- Dissociation (*'the escape when there is no escape'*) occurs beyond conscious awareness and control. It ranges from mild to severe, and is a frequent dimension of complex trauma. Effective treatment of complex trauma requires knowledge of dissociation, ability to recognise it, and skilful means of intercepting and working with it.
- The differences between *early onset* and *adult onset* of trauma influence the treatment and therapy approach which is appropriate. This is even as there may be overlap in the symptoms and problems experienced
- While there is no single modality for treatment of complex trauma, whatever approach is used must be able to address the three dimensions of *cognitive, emotional, and physical/sensory/somatic processing*
- Connection and the quality of the therapeutic alliance are essential components of psychotherapy, and widely substantiated to be reliable indicators of its effectiveness
- The importance of boundaries should be understood and respected at all times, particularly with complex trauma clients for whom safety has been compromised (*'Boundaries are particularly salient with clients who have been subjected to violations, exploitations, and dual relationships'*)²⁶⁷
- Therapist self-care is crucial, in turn benefits clients, and is a pre-requisite to high standards of ethical and professional practice. 'Mindfulness' is an ally to self-care, with the coinciding advantage that fostering of a mindful stance towards experience is also a component of effective therapy
- Professional supervision on a regular basis is essential when working with complex trauma
- Medication is ancillary to, rather than 'treatment of choice' for trauma. Medication cannot treat complex trauma *per se*, though may be a valuable adjunct to psychotherapy depending on client, context and symptom severity

266 Rothschild, *Trauma Essentials*, p.62.

267 Philip J. Kinsler, Christine Courtois & A. Steven Frankel, 'Therapeutic Alliance and Risk Management', Courtois & Ford, ed. *Treating Complex Traumatic Stress Disorders*, p.217.

- The research base in the neurobiology of attachment has yet to be systematically translated at the level of clinical and health care practice. This raises the issue of appropriate criteria according to which treatment for complex trauma can be seen to be effective.
- While seemingly reassuring, the description ‘evidence-based’ is problematic in a number of ways. For example, it privileges a scientific paradigm which is not questioned, fails to account for different varieties of evidence, and is dependent upon levels of funding which are inaccessible to many. *Treatment which is not ‘evidence-based’ is not the same as treatment which is deficient or ineffective* (what counts as ‘evidence’ is an important question to bear in mind).
- Requiring all treatments to be ‘evidence-based’ is ill-advised and unrealistic in light of both the many problems associated with this ‘standard’, and its more specific limitations in the context of complex trauma. For example, restricted entry criteria largely preclude people who experience complex trauma from participation in trauma method outcome studies. To the extent that the majority of those who seek treatment for trauma-related problems have multiple unresolved traumas (Rothschild, 2011:71; van der Kolk, 2003:172) outcome studies cannot serve as authoritative measures of treatment effectiveness.
- Current neurobiological findings indicate that the presence of certain core elements (ie *phased treatment*, engagement of *right-brain* and *implicit memory*, attentiveness to *physical* as well as emotional and cognitive processes) is required for any treatment approach to complex trauma to be regarded as optimal. The combined presence of these elements would seem to constitute the best evidentiary criteria for treatment effectiveness

5. Translating the insights: implications for Trauma-specific and Trauma-informed practice

*All trauma-specific service-models, including those that have been researched and are considered emerging best practice models, should be delivered within the context of a relational approach that is based upon the empowerment of the survivor and the creation of new connections.*²⁶⁸

*Trauma-informed services are designed specifically to avoid retraumatizing those who come seeking assistance...*²⁶⁹

The current research pertaining to complex trauma has major implications both for treatment of the diversity of trauma-related presentations and general service-delivery. Specifically, the practical potential of the research base in the neurobiology of attachment necessitates revised practice in two major regards. These are updated treatment of trauma in its many presentations (trauma-specific) and (2) comprehensive implementation of service-wide principles which are underpinned by the new insights (trauma-informed). Guidelines are required for both these areas if the insights of this pioneering research are to be applied.

Guidelines are clearly necessary in relation to direct treatment of those who have experienced complex trauma. But growing emphasis on care and practice which is trauma-`informed' has many implications *for organisational practice and service-provision per se*. This is because of both the high incidence of unrecognised underlying trauma among people who engage with various services of the health system,²⁷⁰ and the risk of their *re-traumatisation* by services which are not `trauma-informed'.

While confronting to contemplate, the re-traumatisation of already traumatised people *by and within diverse services of the health sector* is highly prevalent. Research establishes that service practices which lead to re-traumatisation rather than recovery are not exceptional, but pervasive and deeply entrenched.²⁷¹ In fact research which supports this disturbing claim is growing.²⁷² Recognition of the reality that *`[t]rauma has often occurred in the service context itself'*²⁷³ is a major impetus for introduction of `trauma-informed' practice.

268 Ann Jennings, `Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services', Report produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) United States, 2004, p.16 <http://www.annafoundation.org/MDT.pdf>

269 Roger D. Fallot & Maxine Harris, `Creating Cultures of Trauma-Informed Care (CTIC): A Self-Assessment and Planning Protocol' (Washington DC: Community Connections, 2009), p.2. <http://www.annafoundation.org/CCTICSELFASSPP.pdf>

270 `Individuals with histories of violence, abuse and neglect from childhood onward make up *the majority of clients served by public mental health and substance abuse service systems*' (Jennings, `Models for Developing Trauma-Informed Behavioral Health Systems...', p.6 (emphasis added). In relation to the context of the United States, Jennings notes that `90% of public mental health clients have been exposed to (and most have actually experienced) multiple experiences of trauma', and that `75% of women and men in substance abuse treatment report abuse and trauma histories' (Ibid) As startling as these figures may seem, they are not inconsistent with the contentions of van der Kolk et al as discussed in the first part of this report.

271 Ibid.

272 See, for example, Sandra L. Bloom & Brian Farragher, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (New York: Oxford University Press, 2011). While addressed to the context of the United States (where the introduction of `managed care' has been particularly destructive in a range of respects) this analysis is also relevant to the Australian context. See, for example, Jane Davidson, *Every Boundary Broken: Sexual Abuse of Women Patients in Psychiatric Institutions* (NSW Department for Women and the NSW Health Department, 1997).

273 Jennings, `Models for Developing Trauma-Informed Behavioral Health Systems...', p.6.

Practice models of trauma-specific and trauma-informed care are themselves evolving in light of current and ongoing research. For this reason, guidelines cannot be regarded as finished or fixed. At the same time, there is ample research evidence from which core principles and recommendations can now be derived, even as their continuous refining will also take place. Thus a strong foundation exists for articulation of guidelines which can be operationalised in practice, in which task ASCA is highly qualified to take a leading advisory role.

Trauma *informed* and trauma-*specific*: the emerging themes

Increased understanding of the role of *experience*, including traumatic experience, on development and evolution of the brain heralds a seismic perceptual shift which is in turn shaping new approaches to health care. The corollary of brain neuroplasticity is that *positive relational experiences have enormous potential for recovery*. Calls for ‘trauma-informed’ care and practice seek to utilise these insights.

It is striking that the research implications for trauma-*specific* treatment of *individuals* have their correlate in the organisational shifts required for health *systems* to operate as trauma-*informed*. Paralleling the ‘bottom-up’ as well as ‘top down’ approach to optimal psychotherapy for trauma,²⁷⁴ is the suggestion that achievement of ‘a truly trauma-informed’ health system requires no less than ‘*a process of reconstitution within our organizations top to bottom.*’²⁷⁵ In an arresting illustration of the applicability of insights of trauma-specific approaches to potential *institutional* change, Bloom contends ‘that *applying concepts from trauma theory to organizational function can serve multiple purposes.*’²⁷⁶

Australia has no equivalent to the National Centre for Trauma Informed Care (NCTIC) which exists in the United States.²⁷⁷ In common with other western countries, however, initiatives towards health care which is ‘trauma-informed’ are growing and ongoing.²⁷⁸ The development of national guidelines in this area is following the momentum for services which are ‘trauma-informed’ (as well as services designated as ‘trauma-specific’). But *omission of trauma as a public health policy priority in this country, and of the requisite funding for the spectrum of services this would entail*, remains lacking, and in urgent need of redress. In the absence of both the prioritising of trauma and informed operationalisation of the now solid research insights which relate to it, the prevalence of unrecognised complex trauma – and the stakes in terms of the distress and multiple individual and public health costs which stem from this – will continue.

In the meantime, the characteristics of ‘trauma-informed’ and ‘trauma-specific’ care need to be considered, along with the differences between them and potential areas of overlap.

274 Diana Fosha referencing van der Kolk, ‘Dyadic Regulation and Experiential Work with Emotion and Relatedness in Trauma and Disorganized Attachment’, Siegel & Solomon, ed. *Healing Trauma*, p.229.

275 Sandra L. Bloom, ‘Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation’ Alexandria, VA: National Technical Assistance Centre, 2006, p.2 (emphasis added) nasmhpd.org

276 Ibid

277 The National Center for Trauma Informed Care (NCTIC) <http://www.nasmhpd.org/NCTIC.cfm>

Also note existence of The Trauma Center, which is Brookline based (and of which Bessel van der Kolk is the Medical Director and founder <http://www.traumacenter.org>) In stark contrast, the Melbourne-based Trauma Centre of Australia (traumacentre@iinet.net.au) offers ‘rapid response on site counselling’ and does not provide services for complex trauma.

278 The Mental Health Coordinating Council (MHCC) in partnership with ASCA, the Education Centre Against Violence (ECAV) and the Private Mental Health Consumer Carer Network Australia (PMHCCN) are advocating ‘for a cultural and philosophical shift to promote Trauma-informed Care and Practice’, and adoption of such principles ‘across a range of service systems in Australia’ <http://www.mhcc.org.au/TICP> To assist in this process, a conference on TICP was sponsored by this coalition of partners in Sydney in June 2011. MHCC has also made available a microsite in relation to trauma-informed care www.mhcc.org.au

What are 'trauma-informed' services?

Trauma-informed services 'are informed about, and sensitive to, trauma-related issues'.²⁷⁹ They do not directly treat trauma or the range of symptoms with which its different manifestations are associated. The *possibility* of trauma in the lives of all clients/patients/consumers is a central organizing principle of trauma-informed care, practice and service-provision. This is Irrespective of the service provided, and of whether experience of trauma is known to exist in individual instances.

A trauma-informed service is one which:

- Commits to and acts upon the core organising principles of *safety, trustworthiness, choice, collaboration and empowerment*²⁸⁰
- Has reconsidered and evaluated *all components of the system* 'in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services'²⁸¹
- Applies this understanding 'to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent re-traumatization and... facilitate consumer participation in treatment'²⁸²
- Requires ('to the extent possible') close 'collaborative relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical experience in 'traumatology'²⁸³

The contrast between 'traditional' and 'trauma-informed' health and welfare settings and systems is dramatic. Understanding that trauma underpins the presentations of many people who present to diverse services *requires completely different ways of operating*. For example, the pervasive impacts of trauma can include *'the way people approach potentially helpful relationships'*.²⁸⁴ If this is not understood, the potential for negative experiences, and active re-traumatisation *by and within* health services, will remain high.

Widespread lack of understanding of trauma *including within the health system as it currently operates* means not only that clients may themselves be unaware of the links between 'past' traumatic experience and current problems of living, but *so too may their health-workers*.²⁸⁵ Since people living with the impacts of trauma often present to multiple services over a long period of time, care received is frequently fragmented and lacking in co-ordination between services. Referral and follow-up pathways are often deficient. The resulting 'merry go round' of unintegrated care risks re-traumatisation and compounding of unrecognised trauma, in ways that are costly in all respects

279 Ann Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services', p.15.

280 Fallot & Harris, 'Creating Cultures of Trauma-Informed Care', p.3.

281 Ibid (citing Harris & Fallot, 2001)

282 Ibid

283 Ibid

284 Fallot & Harris, 'Creating Cultures of Trauma-Informed Care...', p.2 (emphasis added)

285 In 2010, ASCA completed a research study (the first of its kind) which explored the intersection between childhood abuse, alcohol and drug use. It identified a lack of ability to identify and treat abuse-related trauma in both the mental health and AOD sectors (J. Breckenridge et al. 'Use and Abuse: understanding the intersections of childhood abuse, alcohol and drug use and mental health' (Adults Surviving Child Abuse and the Centre for Gender Related Violence Studies, University of New South Wales, Sydney, 2010).

– emotional, financial and systemic; ie not only to the individuals directly affected but to society as a whole.²⁸⁶

Movement towards more *decentralised models of care, community-based services, consumer participation and recovery-oriented practice* have been evolving themes of successive National Mental Health Strategies.²⁸⁷ They are now embedded principles in mental health care, and in the National Mental Health Plan. But the gap between these goals and their implementation is also consistently reiterated. To the extent that envisaged principles and practice are not *simultaneously and explicitly trauma-informed* – ie *embedded into both the philosophy and functioning of all levels of service-delivery* – co-ordinated assistance towards client recovery will remain lacking.

What are ‘trauma-specific’ services?

Trauma-specific services are designed to directly treat ‘the actual sequelae’ of trauma experiences and related symptoms and syndromes. Interventions of services which are trauma-specific include provision of ‘grounding techniques which help trauma survivors manage dissociative symptoms, desensitization therapies which help to render painful images more tolerable, and behavioural therapies which teach skills for the modulation of powerful emotions.’²⁸⁸

Trauma-specific services (among which programs designed for survivors of child abuse would be included) are ‘consistent’ in emphasising:

- Client and worker safety, both physical and emotional
- The importance of respect for clients, provision of information, possibilities for connection and instillation of hope
- Recognition of symptoms as *adaptive* rather than pathological
- The need for collaborative work with clients which is affirming of their strengths and resources²⁸⁹

Trauma-specific services recognise the extent to which childhood trauma, abuse and neglect can lead to relational impairment, enduring fear, betrayal, and distrust. They operate from the premise that ‘[r]ecovery cannot occur in isolation’,²⁹⁰ and that it needs to be assisted in a context which does not replicate elements of the initially traumatising experience(s).

286 The following comment encapsulates all these dimensions – ‘The personal cost of childhood trauma to the individual, families, and communities, and of not adequately meeting the needs of consumers with a history of childhood trauma, in health, welfare and economic terms is immense. This group is persistently over-represented in community, health and criminal justice systems as a result <http://cathykezelman.com/trauma-informed-care/359/>

287 In reviewing the ten years between 1993 and 2003, with reference to both the first and second national mental health plans, the *National Mental Health Report 2005* noted that ‘[i]nitial concern during the Strategy revolved around concepts of protection from human rights abuses, but progressively, these concerns evolved to incorporate more modern concepts of consumer empowerment and participation’. Also noted was a shift towards ‘a recovery orientation in service delivery’.

288 Jennings, ‘Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services’, p.16.

289 Jennings, ‘Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services’, p.16.

290 Ibid (emphasis added)

Charting the links between trauma-specific and trauma-informed

Trauma-specific services clearly intersect with the philosophy and practice of care which is trauma-informed (most notably in emphasising *the centrality of a context which is facilitative of healing*, and which operates in 'a trauma-integrated manner').²⁹¹ The systemic reforms that this requires (ie across all aspects of service-delivery) reveal both the *intersectoral links* necessary for environments which are supportive of healing, and the range and scope of the changes required.

The following quote encapsulates the magnitude of what is at issue:

*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.***²⁹²

With respect to the nature and specifics of the changes themselves, the remainder of the quote is cited in full:

*The new system will be characterised by safety from physical harm and re-traumatization; an understanding of clients and their symptoms in the context of their life experiences and history... open and genuine collaboration between provider and consumer at all phases of the service-delivery; an emphasis on skill building and acquisition rather than symptom management; an understanding of symptoms as attempts to cope; a view of trauma as a defining and organizing experience that forms the core of an individual's identity rather than a single discrete event, and by a focus on what has happened to the person rather than what is wrong with the person... **Without such a shift in the culture of an organization or service system, even the most 'evidence-based' treatment approaches may be compromised.***²⁹³

A shift in *service culture* raises enormous conceptual and practical challenges. But emerging research indicates how these challenges can be addressed.

291 The National Center for Trauma Informed Care (NCTIC) <http://www.nasmhpd.org/NCTIC.cfm>

292 Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma Specific Services, p.15 (emphasis added)

293 Ibid, referencing Saakvitne, 2000; Harris & Fallot, 2001).

Parallel Processes: ‘individuals’ and ‘institutions’²⁹⁴

While often counterposed, ‘individuals’ and ‘institutions’ (organisations) are connected in various ways. This includes in relation to health and service-provision. Yet conceptual and experiential gaps between service-users and service-providers (in combination with the wider context of competing priorities, funding considerations, administrative benchmarks and diverse measures by which service ‘effectiveness’ is gauged) can serve to obscure the links. If a process of the scope of trauma-informed care and practice is to be realised in practice, *reformulation of existing approaches to service-provision* is required (ie understandings which are adequate to the scope of the goal being proposed).

In this context, Bloom’s highlighting of ‘*the interaction between organizational dysfunction and individual dysfunction*’²⁹⁵ is highly suggestive. In linking concepts from trauma theory to the operation of health organisations and systems,²⁹⁶ Bloom argues ‘*that organizations are living systems themselves and as such they manifest various degrees of health and dysfunction, analogous to those of individuals*’.²⁹⁷ This represents not only a wide-ranging reading of health systems through the lens of trauma, but a striking reconceptualisation of familiar approaches to ‘system change’ *per se*.

The ‘parallel process’ whereby mental health services *mirror and reproduce the trauma of the clients they ostensibly assist* can have catastrophic effects. The following chart compiled by Ann Jennings was constructed prior to Bloom’s elaboration of ‘organisational trauma’, but powerfully attests to the human costs and casualties it entails:

294 For elaboration of both this concept and process as it applies in relation to trauma, see ‘Parallel Processes and Trauma-Organized Systems’, ch.4 in Sandra L. Bloom & Brian Farragher, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* (New York: Oxford University Press, 2011), pp.131-154.

295 Bloom, ‘Organizational Stress...’, p.2 (emphasis added)

296 Bloom, ‘Organizational Stress...’, p.2.

297 Ibid

From 'On Being Invisible in the Mental Health Systems', by Ann Jennings, PhD. Published in *The Journal of Mental Health Administration* 21(4): 374-387, 1994

TABLE 1: INSTITUTIONAL RETRAUMATIZATION

	<i>Early Childhood Trauma Experience</i>	<i>Common Mental Health Institutional Practices</i>
<i>Unseen and unheard</i>	<p>Anna's child psychiatrist did not inquire or see signs of sexual trauma. Anna misdiagnosed.</p> <p>Anna's attempt to tell parents and other adults meet with denial and silencing.</p> <p>Only two grade school psychologists saw trauma. Their insight ignored by parents.</p> <p>Secrecy: those who knew of abuse did not tell. Priority was to protect self, family relationships, reputations.</p> <p>Perpetrator retaliation of abuse revealed.</p> <p>Abuse occurred at a preverbal age. No one saw the sexual trauma expressed in her childhood artwork.</p>	<p>Adult psychiatry does not inquire into, see signs of sexual trauma. Anna misdiagnosed.</p> <p>Reports of past and present abuse ignored, disbelieved, discredited. Interpreted as delusional. Silenced.</p> <p>Only two psychologists saw trauma as etiology. Their insight ignored by psychiatric system.</p> <p>Institutional secretiveness replicates that of family. Priority is to protect institution, jobs, reputations. Patent abuse not reported up line. Public scrutiny not allowed.</p> <p>Patient or staff reporting of abuse is retaliated against.</p> <p>No one saw the sexual trauma expressed in her adult artwork with the exception of on art therapist.</p>
<i>Trapped</i>	<p>Unable to escape perpetrator's abuse.</p> <p>Dependant as child on family, caregivers.</p>	<p>Unable to escape institutional abuse. Locked up.</p> <p>Kept dependant. Denied education or skill development.</p>
<i>Sexually violated</i>	<p>Abuser stripped Anna, pulled T-shirt over her head to hide her face.</p> <p>Stripped by abuser to "with nothing on below."</p> <p>"Tied up" held down, arms and hands bound.</p> <p>Abuser "blindfolded me with my little T-shirt."</p> <p>Abuser "opened my legs."</p> <p>Abuser was "examining and putting things in me."</p> <p>Boundaries violated. Exposed. No privacy.</p>	<p>Stripped of clothing when secluded or restrained, often by or in presence of male attendants.</p> <p>To inject with medications, patent's pants pulled down, exposing buttocks and thighs, often by male attendants.</p> <p>"Take down," "restraint." Arms and legs shackled to bed.</p> <p>Cloth would be thrown over Anna's face if she spit or screamed while strapped down in restraints.</p> <p>Forced four-point restraints in spread-eagle position.</p> <p>Medication injected into body against patient's will.</p> <p>No privacy from patients or staff. No boundaries.</p>
<i>Isolated</i>	<p>Taken by abuser to places hidden from others.</p> <p>Isolated in her experience: "Why just me?"</p> <p>"I thought I was the only one in the world."</p>	<p>Forced, often by male attendants, into seclusion room.</p> <p>Separated from community is locked facilities.</p> <p>No recognition of patients' sexual abuse experience.</p>
<i>Blamed and shamed</i>	<p>"I had this feeling that I was bad... a bad seed."</p> <p>She became the "difficult to handle" child.</p> <p>She was blamed, spanked, confined to her room for her anger, screams and cries.</p>	<p>Patients stigmatised as deficient, mentally ill, worthless. Abusive institutional practices and ugly environments convey low regard for patients, tear down self-worth.</p> <p>She became a "noncompliant," "Treatment-resistant," difficult-to-handle patient.</p> <p>Her rage, terror, screams and cries were often punished by medications, restraint, loss of "privileges," and seclusion.</p>

TABLE 1: INSTITUTIONAL RETRAUMATIZATION

	<i>Early Childhood Trauma Experience</i>	<i>Common Mental Health Institutional Practices</i>
<i>Powerless</i>	<p>Perpetrator had absolute power/control over Anna.</p> <p>Pleas to stop violation were ignored: "It hurt me. I would cry and he wouldn't stop."</p> <p>Expressions of intense feelings, especially anger directed at parents, we often suppressed.</p>	<p>Institutional staff have absolute power/control over patients.</p> <p>Pleas and cries to stop abusive treatment, restraint, seclusion, over medication, and so forth, commonly ignored.</p> <p>Intense feelings, especially anger at those with more power (all staff), suppressed by medication, isolation, restraint.</p>
<i>Unprotected</i>	<p>Anna was defenseless against perpetrator abuse. Her attempts to tell went unheard. There was no safe place for her, even in her own home or room.</p>	<p>Mental patients defenseless against staff abuse. Reports disbelieved. No safeguards effectively protect patients. Personnel policies prevent dismissal of abusive staff. No safe place in institution.</p>
<i>Threatened</i>	<p>As a child, constant threat of being sexually abused.</p>	<p>As mental patient, constant threat of being stripped, thrown into seclusion, restrained, over medicated.</p>
<i>Discredited</i>	<p>As a child, Anna's reports of sexual assault were unheard, minimised, or silenced.</p>	<p>As a mental patient, Anna's reports of adult sexual assault were not believed. Reports of child sexual abuse were ignored.</p>
<i>Crazy-making</i>	<p>Appropriate anger at sexual abuse seen as something wrong with Anna. Abuse continued, unseen.</p> <p>Anna's fear from threat of being abused was not understood. Abuse continued, unseen.</p> <p>Sexual abuse unseen or silenced. Message: "You did not experience what you experienced."</p>	<p>Appropriate anger at abusive institutional practices judged pathological. Met with continuation of abusive practices.</p> <p>Fear of abusive and threatening institutional behaviour is labelled "paranoia" by institution producing it.</p> <p>Psychiatric denial of sexual abuse. Message to patient: "You did not experience what you experienced."</p>
<i>Betrayed</i>	<p>Anna violated by trusted caregivers and relatives.</p> <p>Disciplinary interventions were "for her own good."</p> <p>Family relationships fragmented by separation and divorce. Anna had no one to trust and depend on.</p>	<p>Patients retraumatized by helping professionals and psychiatrists.</p> <p>Interventions presented as "for the good of the patient."</p> <p>Relationships of trust arbitrarily disrupted based on needs of system. No continuity or care or caregiver.</p>

Service models

Known within the trauma field for her 'Sanctuary' model of therapeutic community care and service-provision,²⁹⁸ Bloom has recently co-authored a book which develops 'a trauma-informed, whole system approach to organizational change.'²⁹⁹ Contending that the literature of organisational development 'is far ahead of the social service world in applying group concepts to the workplace',³⁰⁰ Bloom's marriage of trauma theory and organisational psychology challenges and expands conceptions of what 'whole system' change might look like.³⁰¹

In fact a range of service models now exist for clients of public mental health and substance abuse services who have been traumatised by interpersonal abuse in childhood and/or adolescence. Many of these models have been specifically designed to address complex traumatic stress issues.³⁰² As Jennings describes, they include:

- Models for Developing Trauma-Informed Service Systems and Organizations
- Individual Trauma-Informed Service Models
- Trauma-Specific Service Models for Adults
- Manualised Adaptations to Trauma-Specific Service Models for Adults
- Trauma-Specific Models for Parenting
- Trauma-Specific Service Models for Children
- Trauma-Specific Peer Support and Self Help Models³⁰³

In her 2004 study, Jennings describes 'over 50' such service models reported to be implemented in the United States. While not all researched fully, in combination they suggest 'a significant increase in the number of trauma-informed and trauma-specific services and models *which are applicable, replicable, and appropriate for use in public sector service settings*'.³⁰⁴ In this context, she speaks of 'emerging best practices' applicable to public mental health and substance abuse systems; a formulation which captures the dynamic evolution of work in this area as well as the 'positive client outcomes' which some service models have been found to achieve.³⁰⁵

Mindful of the different national context of the United States (in which the majority of such service models operate, and to which Jennings' report findings apply) guidelines for trauma-informed and trauma-specific care and practice are proposed in Part I of this document. They are informed by a range of relevant material, which include planning protocols potentially applicable to the Australian national context but which may themselves require some adaptation in light of contrasting treatment settings.

298 Bloom, Sandra L. *Creating Sanctuary: Toward the Evolution of Sane Societies* (New York: Routledge, 1997).

299 Sandra L. Bloom & Brian Farragher, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems*. (New York: Oxford University Press, 2011).

300 Bloom, 'Organizational Stress...', p.2.

301 Such chapter headings as 'Organizational Learning Disabilities...' and 'Miscommunication, Conflict and Organizational Alexithymia' convey the flavour of the striking 'individual'-'organizational' links which are forged.

302 Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services', p.5.

303 Ibid.

304 Jennings, 'Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services', p.14 (emphasis added)

305 Ibid.

While some Australian services are beginning to embrace trauma-informed principles, it is 'early days' as far as their widespread implementation is concerned. Such principles have yet to be adopted by mental health services, and in the public health system the medical model remains dominant. There is now, however, a wide range of materials in the area of trauma-informed care, particularly from the US, including toolkits, protocols and worksheets which are available for download.³⁰⁶ The *Practice Guidelines for Trauma-Informed Care and Service-Delivery* (organisational) reference some of this material.

³⁰⁶ See, for example, Kathleen Guarino et al, *Trauma-Informed Organizational Toolkit* (Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation, 2009). Available for download at www.homeless.samhsa.gov and www.familyhomelessness.org

GLOSSARY

adaptation to trauma – Responses to overwhelming experience entail physiological, psychological and behavioural shifts; adaptation to trauma, particularly at an early and vulnerable developmental stage, becomes a 'state of mind, brain and body' around which all subsequent experience organises' (Cozolino, 2002). This means that a range of otherwise diverse symptoms and conditions can be regarded as serving adaptive purposes ('PTSD, borderline personality disorder, and self-harm can all reflect complex adaptation to early trauma'; *Ibid*).

In the context of trauma, a revised reading of 'symptoms' as 'adaptive coping mechanisms' moves away from the implication of pathology, and towards recognition that the person is responding, often resourcefully, to events or situations which are highly damaging to health (and which in the case of complex trauma are often actively abusive). This reading is powerfully upheld by the Adverse Childhood Experiences (ACE) Study, which charts the longstanding connections between 'personal solutions' (coping mechanisms to deal with adverse childhood experiences) and 'public health problems' (which stem from coping mechanisms which have ceased to protect). Current moves towards 'trauma-informed' care are non-pathologising in asking not 'what is wrong with you?' but 'what happened to you?', and in emphasising the need for skills acquisition rather than 'symptom management' (Jennings, 2004). See 'Adverse Childhood Experiences Study', 'coping mechanisms', 'strengths based', 'trauma informed'.

adult onset trauma – Trauma which, in contrast to that experienced in childhood ('early onset trauma') occurs when the person has reached adulthood. Both the pathways to trauma and the implications for treatment can be very different according to whether trauma is adult onset or early onset. Experience of attachment difficulties prior to the presenting problem is a frequent indicator of early onset (complex) trauma, for which graduated ('phased') treatment is necessary. By contrast, in treatment of adult onset trauma there is generally less need for repair or establishment of affect regulation (Shapiro, 2010). See 'affect regulation', 'early onset trauma', 'trauma treatment', 'phased treatment'.

Adult Attachment Interview (AAI) – A widely used questionnaire developed by psychologist Mary Main which accurately predicts the effects of adult attachment styles on parenting. The proven correlations between childhood attachment style and the parenting styles to which they correspond are discussed by Siegel & Hartzell (2004). Note that despite their longevity, attachment styles can be modified (Siegel, 2003). This is a highly significant finding in terms of both the reworking of less than optimal adult attachment styles and interception of their negative effects on the next generation. See 'attachment', 'attachment styles', 'the Strange Situation', 'earned security'.

Adverse Childhood Experiences (ACE) Study – A pioneering longitudinal study which establishes the relationship between significantly unfavourable ('adverse') experiences in childhood and subsequent emotional and physical ill health. Conducted in the United States, the study included over 17000 participants, the majority of whom were white middle-class. Major findings of the ACE study are that adverse childhood experiences are 'vastly more common than recognised or acknowledged', and that such experiences negatively impact both physical and emotional adult health up to fifty years later (Felitti, Anda et al, 1998). A further finding is that childhood coping mechanisms developed to defend against adversity cease their protective function over time and become actively subversive of health (a process described as conversion of 'personal solutions' into 'public health problems')

affective neuroscience – Study of the neurobiological processes involved in the formation and mediation of emotion, with particular reference to the role of the right-brain hemisphere. See 'interpersonal neurobiology', 'neurobiology of attachment', 'right brain', and 'social brain'.

affect regulation – Management of emotion, also described as ‘self-soothing’. The capacity to tolerate and regulate emotion is central to well-being, and to the ability to deal with life challenges. Affect regulation is mediated by processes of the right hemisphere of the brain, and is crucially shaped by early attachment experience with primary care-givers (Schoore, 1994; Siegel, 1999). Complex trauma is highly disruptive of affect regulation, which accounts for the emphasis on ‘phased’ treatment which is now best practice in complex trauma treatment. Phase 1 focuses on safety and stabilisation, because the capacity to regulate affect is thereby fostered, and is the vital precondition to capacity to process and integrate trauma (Phases II and III respectively). Trauma cannot be processed, much less ‘confronted’ in the absence of ability to tolerate and regulate affect. See ‘attachment’, ‘complex trauma’, ‘early onset trauma’, ‘phased treatment’.

attachment – Originally conceptualised by British psychiatrist John Bowlby, attachment relates to the emotional bonds initially forged between infant and primary care-giver/s. Attachment is described as ‘a fundamental form of behaviour with its own internal motivation, distinct from feeding and sex, and of no less importance for survival’ (Bowlby [1981] 2006). Serving the biological function of protection, attachment to care-givers is critical to the developing infant in multiple ways which the advent of affective neuroscience is increasingly illuminating. Bowlby argued that attachment behaviour is in different ways seen in all human beings, is wrongly regarded as ‘dependence’ (which has a pejorative connotation), and is to varying degrees shared by humans with members of other species. While most obvious in early childhood, attachment behaviour is also apparent throughout the life-cycle. See ‘attachment theory’, ‘attachment styles’, ‘The Strange Situation’.

attachment theory – The large and growing body of research which, building on the original work of John Bowlby, Mary Ainsworth and Mary Main, explores the pivotal role of emotional connection and relationship to human development and well-being. In combination with research in affective neuroscience, attachment theory is described as ‘probably the fastest-growing area of study in the psychotherapy branch of psychology’ (Rothschild, 2011).

Research in attachment has ‘objectively demonstrated the crucial importance of the parent’s focus on the child’s subjective experience for the development of the child’s well-being’ (Siegel, 2003). It has further established ‘that the parents’ own subjective internal experience... is the most robust predictor of the security of the child’s attachment to them’ (Ibid) and that the effects are transgenerational. Also see ‘attachment’, ‘attachment styles’, ‘The Strange Situation’, ‘transgenerational trauma’.

attachment style/s – Modes of relating to others which stem from our early experience of relating to primary care-givers. The concept of ‘attachment style’ dates to the ‘Strange Situation’ study of the 1970s, which drew on the original research of John Bowlby, and which identified three distinct styles of infant reunion behaviour with their mothers after short periods of separation. The initially identified attachment styles were labelled ‘secure’, ‘avoidant’ and ‘ambivalent’ (ie one secure and two varieties of insecure attachment style). A fourth attachment style – ‘disorganised’ – was added in the 1990s.

Attachment styles have been shown to be longstanding, and to be transmitted intergenerationally via parental interaction with their infants. Yet studies also show that it is possible for attachment styles to be modified (ie for insecure attachment styles to be converted to secure ones), a process known as ‘earned security’. See ‘attachment’, ‘the Strange Situation’, ‘disorganised attachment’ and ‘earned security’.

betrayal trauma – Term which describes the complex trauma which involves a major violation of trust because perpetrated by caregivers, someone known to the victim, or those who would ordinarily be expected to serve in a protective capacity. First elaborated by DePrince & Freyd (2007) the term captures the depth of the psychological violation of complex trauma.

blaming the victim – Defensive psychological response whereby the wronged party is held to be responsible for the injury they have received. To the extent that the sources (interpersonally generated) and prevalence of complex trauma pose both individual and collective challenges, ‘blaming the victim’

serves the function of psychological protection from recognition of the level of violence which is tolerated within liberal democratic societies. Neuroscientific research also reveals the extent to which trauma becomes encoded in the brain, thereby precipitating responses for which traumatised individuals cannot be held responsible. See 'coping mechanisms', 'endogenous opioids', 'Adverse Childhood Experiences Study', 'social defense mechanisms'.

body – Neuroscientific research is illuminating the inextricable relationship between physiological and psychological processes, with major implications for understanding and treatment of trauma ('Modern neural science clearly points to the central role of the body'; Siegel, 2007). To the extent that 'talk therapy' takes insufficient account of bodily experience, current research suggests that traditional psychotherapeutic approaches need to attune more closely to physical experience and expression (van der Kolk, 2003; Ogden, 2006). See 'sensorimotor psychotherapy', 'traditional psychotherapy', 'expressive therapies'.

Borderline Personality Disorder (BPD) – A diagnostic category which describes severe difficulty with integration of emotional states, in which seemingly extreme feelings of anger, emptiness and abandonment frequently coexist with volatile and self-harming behaviours. To the degree that this diagnosis masks underlying trauma, and the term 'borderline' is applied in a derogatory way to people whose relational impairments make them challenging to be with, both the diagnosis and the label are contested by many. Ross & Halpern (2009) note that '[t]oo often, the mental health field inflicts more abuse, neglect, devaluation, and rejection on top of the life experience that gave rise to the borderline criteria to start with'. Also see 'blaming the victim', 'complex trauma', 'coping mechanisms', 'trauma-informed'.

burnout – '[A] collection of symptoms associated with emotional exhaustion and generally attributed to increased workload and institutional stress' (Bloom, 2011). Initially regarded in the 1970s and 1980s as a problem of individuals, the contextual role of the environment is now seen to be significant. Thus burnout is increasingly seen as 'the result of repetitive or chronic exposure to vicarious traumatization that is unrecognised and unsupported by the organizational setting' (Ibid). See 'secondary trauma', 'vicarious trauma', 'supervision', 'trauma-informed'.

CBT – See cognitive behavioural therapy

child abuse – Mistreatment of a child/children, which can take a range of forms. The typical forms of child abuse are neglect, physical abuse, emotional abuse and sexual abuse, and also include the witnessing of interpersonal violence. Note that the data pertaining to the incidence of child abuse is conservative in that it relates only to the number of children who come to the attention of child protection authorities. Also note that childhood experiences which are in various ways adverse have been found to be both highly prevalent and longstanding in their effects on subsequent emotional and physical health in adulthood (ACE Study). Current neuroscientific research in the context of early care-giving ('attachment') relationships reveals the effects of child abuse on the developing brain to be profound. See 'Adverse Childhood Experiences Study', 'early onset trauma', 'survival brain', 'child sexual abuse'

child sexual abuse (CSA) – A pernicious form of child maltreatment which involves sexual violation and which is correlated with pervasive negative impacts including and especially on mental health (Mullen et al, 2000; Everett & Gallop, 2001). Repeated episodes of child sexual abuse comprise severe childhood trauma which, if occurring at critical periods of neural vulnerability, can impair not only general development but development of the self per se. See 'early onset trauma', 'survival brain', 'developmental trauma', 'Developmental Trauma Disorder' (DTD).

clinical supervision – A key component of ethical and professional practice in counselling, psychotherapy and psychology, whereby clinicians consult about their client work on a regular basis with a (usually) more experienced practitioner. Clinical supervision differs from 'de-briefing' in involving facilitated

self-reflection, while also including the dimensions of support, encouragement of self-care, and psychoeducation. Also see 'ethical practice', 'supervision', 'self-care', 'risk management'

cognitive behavioural therapy (CBT) – A form of psychotherapy which is explicitly directed to interception of negative thinking and thought patterns, and which is commonly used in the treatment of depression. As a widely promoted 'evidence-based' treatment, cognitive behavioural therapy is generally short-term, its principles and techniques are relatively easy to learn, and therapy sessions in Australia attract the Medicare rebate under the MBS scheme. Note, however, that in its emphasis on cognition and 'faulty thinking', CBT is less suited to the addressing of deep emotional issues and childhood trauma, for which it is less indicated as the 'therapy of choice' (although potentially relevant to the latter phases of treatment – following stabilisation and processing – when distorted thinking is more directly addressed). Note, too, that current research which shows the centrality of sensorimotor processes in the context of trauma suggests the limits of CBT in the absence of attentiveness to physicality and the body (van der Kolk, 2007). See 'traditional psychotherapy', 'expressive therapies'.

common factors research – The now considerable body of research which shows that the particular type of psychotherapy is less significant to the effectiveness of the therapy than are other factors involved in the process (Duncan, Miller, Wampold & Hubble, 2010). In 'common factors' research, dimensions which pertain to the client and the quality of the therapeutic alliance are more reliable determinants of effective therapy than the approach or technique deployed. This is in stark contrast to so-called 'evidence-based' treatment and practice, in which such dimensions are regarded as irrelevant to treatment effectiveness. See 'evidence-based practice', 'practice based evidence'.

comorbidity – A medical term for coexistence of more than a single disorder or disabling condition. Because of its comprehensive effects, complex trauma entails high comorbidity (Ross & Halpern, 2009).

compassion fatigue – Formerly known as secondary traumatic stress disorder (Figley, 1995); refers to the negative though predictable and treatable psychological consequences of working with, and proximity to, suffering people (Bloom, 2011).

complex trauma – '[A] subset of the full range of psychological trauma which has as its unique trademark a compromise of the individual's self-development' (Ford & Courtois, 2009). In contrast to 'single-incident' trauma, complex trauma is cumulative, repetitive and interpersonally generated, and includes ongoing abuse which occurs in the context of the family and intimate relationships.

Complex trauma 'usually involves a fundamental betrayal of trust in primary relationships, because it is often perpetrated by someone known to the victim'; Courtois & Ford, 2009). Unlike a one-off event, the cumulative impact of premeditated and multiple episodes of abuse involves compounded dynamics and entails pervasive effects. Complex trauma places the person at risk 'for not only recurrent anxiety (eg PTSD; other anxiety disorders) but also interruptions and breakdowns in the most fundamental outcomes of healthy psychobiological development' (Ibid). See 'betrayal trauma', 'complex post-traumatic stress disorder'.

complex post-traumatic stress disorder – Concept first proposed in 1992 by psychiatrist Judith Herman to more accurately describe the range of clinical presentations of survivors of long periods of abuse. Complex traumatic stress reactions 'are those that are most associated with histories of multiple traumatic stressor exposures and experiences, along with severe disturbances in primary caregiving relationships' (Courtois & Ford, 2009). The advantage of the concept 'complex post-traumatic stress disorder' (CPTSD) is that it integrates in a single and coherent formulation 'the consequences of prolonged and repeated trauma' (Herman, 2009).

Despite the strong case for its inclusion as a formal diagnostic category in the DSM-IV (following examination in the preceding field trials and the recommendation of the PTSD Working Group) this outcome did not occur. It is also unlikely that the diagnosis of complex PTSD will be included in the upcoming DSM-5 (due for release in 2013). This is a serious anomaly because 'PTSD alone is insufficient

to describe the symptoms and impairments that follow exposure to complex trauma' (Courtois & Ford, 2009; van der Kolk, 2003).

Omission of classification of complex trauma as a distinct entity in its own right in the DSM has problematic implications. Not only does it lead to compartmentalised and pathologising diagnoses which fail to address the underlying trauma, but it increases the likelihood of inappropriate treatment. Also see 'Diagnostic and Statistical Manual of Mental Disorders' (DSM), 'Disorders of Extreme Stress Not Otherwise Specified' (DESNOS) and 'complex trauma treatment'.

complex trauma treatment – In contrast to single-incident trauma (PTSD) in which the traumatised person has generally experienced a sense of safety prior to the onset of the trauma, the survivor of complex trauma does not start with this advantage. The radical impairments in self-regulatory capacity associated with complex trauma, particularly when it is early onset as in cases of child abuse, present a different treatment starting point. This is as important to recognise as it is widely missed (ie when complex trauma is mistaken for, and conflated with, PTSD). Recommended treatment for complex trauma is phased treatment. See 'affect regulation', 'complex trauma', 'complex post-traumatic stress disorder', 'phased treatment'.

consilience – Convergence of diverse findings, ideas and approaches. As research in the neurobiology of attachment attests, consilience is now strikingly apparent in understanding of the interrelationship between brain, body and mind ('Independent findings from a variety of scientific endeavours are converging in an interdisciplinary view of the mind and mental well-being'; Solomon & Siegel:2003). This has major implications for understanding of trauma and the field of mental health. See 'trauma', 'body', 'right brain', 'sensorimotor psychotherapy'.

coping mechanisms – Methods and strategies for dealing with adverse experience/s. As the Adverse Childhood Experiences (ACE) Study establishes (Felitti, Anda et al, 1998) traumatic childhood experiences are highly prevalent even in the absence of overt markers of social disadvantage. As it also shows, there is a direct relationship between the coping mechanisms which initially serve a protective function in relation to such experiences, and their conversion over time into active risks to emotional and physical health. Thus 'personal solutions' in the form of coping mechanisms not only become individual health problems in adulthood, but public health problems. See 'adaptation to trauma', 'Adverse Childhood Experiences (ACE) Study', 'symptoms', 'pathology', 'trauma-informed'.

countertransference – The largely unconscious responses of a therapist to their client, based on previous relationships and associations. Because psychotherapy involves power differentials which it is the responsibility of the therapist to manage, clinical supervision is a necessary and valuable forum in which therapist countertransference to their clients can be explored.

The phenomenon of abuse-related countertransference (Briere, 1992) also needs to be noted. This relates to the additional dimensions of countertransference which are operative when the therapist, in common with the client, has an abuse history. While the prevalence of child abuse means that this scenario is not unlikely (and while some research suggests childhood trauma to be disproportionately prevalent in the backgrounds of therapists (Elliott, 1990 in Briere, 1992) there is still comparatively little discussion of this topic in the psychotherapeutic literature. Subject to having addressed their own histories, personal experience of trauma does not preclude the conducting of effective therapy. But there are also potential pitfalls which, while not confined to therapists with a trauma history, need to be attuned to and negotiated (Briere, 1992). See 'implicit memory', 'supervision'.

developmental trauma – A form of complex trauma which, because occurring at early and critical periods of development, can radically compromise psychobiological, social and emotional development. In comprising threats not only to physical survival but to survival of the self (see 'complex trauma') such threats are especially damaging to young children for whom the self is fragile because still developing.

Also described as 'developmentally adverse interpersonal trauma' (Ford, 2005) See 'Developmental Trauma Disorder' (DTD), 'early onset trauma'

Developmental Trauma Disorder (DTD) – A new diagnosis proposed by van der Kolk (2005) for children who experience complex trauma. Criteria for DTD stem from exposure to 'developmentally adverse interpersonal trauma'. See 'developmental trauma'.

diagnosis of trauma – Lack of reference to complex trauma as a distinct entity within standard classificatory and diagnostic systems does not assist recognition of the trauma which can underlie otherwise diverse client presentations (and which can therefore receive multiple and contrasting diagnoses). The current formal diagnosis of trauma relates to single-incident PTSD, which is contested by many for its restrictiveness, and because complex trauma represents 'a defining and ongoing experience that forms the core of an individual's identity rather than a single discrete event' (Jennings, 2004).

To the degree that trauma represents a normal response to overwhelming events, and complex trauma is unrecognised and misdiagnosed, diagnosis can also be pathologising in ways which many regard as stigmatising of those who live with complex trauma histories. Current calls for care and practice which is 'trauma-informed' are implicitly challenging of formal diagnostic categories which fail to recognise the complex trauma that underlies a plethora of symptoms, health problems and conditions. See 'complex trauma', 'post-traumatic stress disorder', 'complex post-traumatic stress disorder', 'Diagnostic and Statistical Manual of Mental Disorders', 'trauma informed'.

Diagnostic and Statistical Manual of Mental Disorders (DSM) – Widely cited publication of the American Psychiatric Association for classification and diagnosis of psychological problems and conditions. The current (fourth) edition is the DSM-IV-TR (Washington, DC: American Psychiatric Association, 2000) and the fifth edition (DSM-5) is due for release in 2013.

Despite the proliferating number and nature of DSM diagnoses, it is anomalous that complex trauma is not included in its own right (see 'Disorders of Extreme Stress Not Otherwise Specified' [DESNOS] and 'complex traumatic stress disorder'). As Courtois & Ford (2009) highlight, 'in the absence of a formal diagnosis for complex traumatic stress disorders, there is the potential mis- or overdiagnosis of severe disorders (eg. bipolar or schizophrenia spectrum disorders, BPD, conduct disorder)'. As they further underline, experts on complex traumatic stress disorders argue that 'a sophisticated trauma-based approach to conceptualizing and classifying these disorders is essential to prevent complexly traumatised clients from being burdened with stigmatizing diagnoses and to provide these clients with treatment that is informed by current scientific and clinical knowledge bases'(Ibid). See 'diagnosis of trauma'.

Dialectical Behavior Therapy (DBT) – A form of psychotherapy developed by American psychologist Marsha Linehan (1993) that is primarily used to treat borderline personality disorder (BPD). Dialectical Behavior Therapy involves various stages of treatment, and focuses on development of self-regulatory capacity and skills acquisition and training.

Disorders of Extreme Stress Not Otherwise Specified (DESNOS) – The DSM diagnostic category by which, along with the classification 'Associated Features' of PTSD, the constellation of symptoms associated with complex trauma is currently defined. As its title conveys, DESNOS is a minimising and reductionist classification which is inadequate to describe the magnitude and comprehensive effects of the syndrome that is complex trauma. It is thus in urgent need of revision. Also see 'complex trauma', 'complex traumatic stress disorder' and 'Diagnostic and Statistical Manual of Mental Disorders' (DSM).

disorganised attachment – A variety of attachment which occurs when the primary attachment figure on whom the child depends is also someone who engenders fear, such that the child is effectively unable to connect with them. Disorganised attachment stems from 'a collapse in coping ability' (Siegel, 2010). Note that this response can be engendered in a child by a primary care-giver who is not actively abusive, but whose inability to manage their own responses (the frequent legacy of their own unresolved trauma) is itself frightening to the child (Hesse, Main, et al, 2003). Disorganised attachment is closely correlated

with experience of the complex trauma which is child abuse (Carlson et al, 1989; Siegel, 2010). Also see 'attachment styles', 'borderline personality disorder', 'early onset trauma', 'the Strange Situation'.

dissociation – The act of separation or disconnection from immediate experience. Dissociation varies in type and intensity, and operates along a continuum. For example, it occurs in unremarkable forms such as daydreaming and mild trancing. But it also operates in more severe forms. As a defensive response to overwhelming threat ('the escape when there is no escape'; Schore:2003) dissociation is commonly present to varying degrees as a dimension of trauma.

Its most serious expression receives the diagnosis of Dissociative Identity Disorder (DID), a treatable condition in which parts of the self fragment and detach (and in the case of young children, when traumatic overwhelm occurs before the self has developed and cohered). Dissociation occurs beyond conscious awareness and control. It can also be reflexively deployed subsequent to the precipitating trauma in the absence of apparent threat (ie it can be activated by seemingly innocuous cues which serve as 'triggers' of the trauma). Because of its prevalence as a feature of trauma (particularly in sexual abuse and complex trauma varieties) effective trauma treatment requires knowledge of and ability to work with dissociative responses. Also see 'implicit memory', 'right brain'.

Dissociative Identity Disorder (DID) – Diagnosis for the condition which represents the most serious form of dissociative traumatic response to overwhelming threat, in which the person exhibits separate and distinct identity states. In DID, alternate identity states assume control of the body at different times, some variety of amnesia occurs between the different identities, and this 'cannot be explained by imaginary companions, alcohol blackouts or medical conditions' (Ross & Halpern, 2009). DID is a treatable disorder which is generated by trauma. Also see 'dissociation', 'early onset trauma', 'implicit memory', 'right brain'.

DSM – See Diagnostic and Statistical Manual of Mental Disorders

early onset trauma – Trauma which is experienced in childhood. Current research on the developing brain in the context of early attachment relationships substantiates that early onset trauma – particularly when it is prolonged, repetitive, and unrepaired – is highly damaging. In light of the increasingly understood centrality of the right brain hemisphere to social connectedness, self-regulatory capacity, and development per se, parental attunement to the emotional needs of the infant is no less vital than attentiveness to physical needs (ie in fostering the ability to manage emotion, which is crucial to healthy development). Also see 'affect regulation', 'developmental trauma', 'Developmental Trauma Disorder'.

earned autonomy – See 'earned security'

earned security – The conversion of 'insecure' attachment to 'secure' attachment via the working through, processing and resolution of adverse childhood experience. The exciting corollary is that when earned security takes place (via attainment of a coherent perspective on childhood experience) this also benefits the next generation in terms of positive modifications of parenting styles – 'These are adults who appear to have had difficult childhoods, but... have made sense of their lives. The children attached to these adults have secure attachments and do well! History is not destiny – if you've come to make sense of your life' (Siegel, 2003). The possibility and multiple positive effects of earned security (sometimes called 'earned autonomy') powerfully attest to the neuroplasticity of the brain. See 'attachment styles', 'attachment theory', 'neuroplasticity', 'psychotherapy'.

EMDR – See 'Eye Movement Desensitization and Reprocessing'

endogenous opioids – Neurochemicals which relieve pain in 'fight or flight' situations, and which are also implicated in maladaptive coping strategies in post-traumatic reactions. Endogenous opioids are now recognised to be potentially operative in relation to dissociative responses (Cozolino, 2002) the self-harm often enacted by adults who have experienced child abuse (van der Kolk, 1994) and in relation to eating disorders (Middleton, 2007).

Enhanced understanding of the operation and function of endogenous opioids strengthens the case for a revised understanding of post-traumatic `symptoms' as post-traumatic `coping mechanisms', including and especially in contexts of child abuse. Also see `symptoms', `coping mechanisms' and `Adverse Childhood Experiences Study'

epigenesis – *The process whereby early experiences can alter the long-term regulation of genetic functioning within the nuclei of neurons – `If early experiences are positive... chemical controls over how genes are expressed in specific areas of the brain can alter the regulation of our nervous system in such a way as to reinforce the quality of emotional resilience. If early experiences are negative, however, it has been shown that alterations in the control of genes influencing the stress response may diminish resilience in children and compromise their ability to adjust to stressful events in the future' (Siegel, 2010). Also see `affect regulation', `attachment theory', `attachment styles.'*

ethical practice – *the code of conduct, both implicit and explicit, by which responsible and professional practice is carried out. Ethical practice in psychotherapy requires several dimensions, which include clinical supervision and self-care as well as adherence to such principles as client confidentiality (subject to some limited exceptions) and informed consent. Ethical practice can also be regarded as a component of effective risk-management. See `risk-management', `self-care', `supervision.'*

evidence-based practice – *A description and endorsement accorded to the application of treatments and therapies which have undergone scientific testing and research. While seemingly unexceptionable, the requirement that treatments be `evidence-based' is problematic in a number of respects (for example in privileging a scientific paradigm the applicability of which is not questioned). Absence or paucity of research into a particular treatment does not of itself mean that a therapy `doesn't work', as research in relation to it may not have been carried out. This is an important point to underline in a culture in which `lack of evidence' (which routinely equates to scientific evidence) can wrongly imply a treatment approach to be ineffective. By contrast, `practice-based evidence' suggests a different reading of what `evidence' comprises.*

Requiring all treatments to be `evidence-based' is ill-advised and unrealistic in light of both the many problems associated with this `standard', and its more specific limitations in the context of complex trauma. For example, restricted entry criteria largely preclude people who experience complex trauma from participation in trauma method outcome studies (Rothschild, 2011). Calls for practice and care which is `trauma-informed' also highlight the limits of the imprimatur of `evidence-based' as a necessary and sufficient measure of treatment effectiveness: `Without such a shift [towards trauma-informed care]... even the most `evidence-based' treatment approaches may be compromised' (Jennings, 2004). Note that the neurobiology of attachment now comprises a strong evidence base. See `common factors research'; `neurobiology of attachment'; `practice-based evidence.'

explicit memory – *Conscious memory which is linked to development of the left brain hemisphere. This is in contrast to `implicit' memory, which is pre-verbal, linked to the right brain hemisphere, and largely inaccessible to conscious awareness. See `implicit memory', `re-enactment.'*

expressive therapies – *Neuroscientific research which shows the centrality of physiological processes to emotional experience also suggests the limits of psychotherapeutic approaches which privilege `talk' and the spoken word (`To make meaning of the traumatic experience usually is not enough. Traumatized individuals need to have experiences that directly contradict the emotional helplessness and physical paralysis that accompany traumatic experiences'; van der Kolk, 2003). For this reason, and in contrast to both cognitive and insight-based approaches, `expressive' therapies which can engage right-brain processes and physicality may be highly beneficial. Expressive therapies are numerous and varied, and include bodywork, drawing and sandplay. See `affective neuroscience', `body', `right brain', `sensorimotor psychotherapy.'*

Eye Movement Desensitization and Reprocessing (EMDR) – A therapeutic form of bilateral stimulation which has been found to be effective in treating a broad range of trauma, and which, subject to client ability to tolerate affect, can achieve dramatic results in a single session (Shapiro, 2010). Note that while directed to the eyes, other forms of bilateral stimulation (eg alternating hand taps or headsets playing alternating tones or music) have also been found to be effective (Ibid)

flashbacks – Intrusive and disturbing memories in the form of images and/or sensory inputs which are indicators of unprocessed traumatic experience. See 'post-traumatic stress disorder' (PTSD)

gender – While trauma is not gender-specific, and while exposure of the extent of clergy abuse reveals that sexual abuse of children is not limited to girls, there are also senses in which this crime remains gendered. Courtois (2010) attests that on beginning to counsel in relation to sexual assault in the 1970s, and prior to the contributions of feminism, there was little in the professional journals which could assist ('We searched the literature for guidance and found articles highly biased against women – they were blamed or treated as though they were irreparably damaged, and their experiences were minimised'). The misogyny which long existed in the mental health profession has also been widely corroborated (McLeod, 2009). For broad consideration of the gendered dimensions of trauma in the context of child abuse, see Briere (1992).

hyperarousal – Physiological and psychological agitation which stems from over activation of the central nervous system and which can be a key indicator of trauma. See 'trauma treatment', 'window of tolerance'.

hypoarousal – Emotional numbing or 'shut down'. In contrast to the generally visible signs of hyperarousal, hypoarousal is also an indicator of trauma ('Emotional numbing alternating with periods of high arousal is characteristic of PTSD'; Bloom, 2011). It is extremely important that hypoarousal is recognised and understood as a trauma response. This is because it can be misperceived as a simple lack of expressiveness which risks being wrongly challenged to elicit a visible reaction (a major error which can lead to re-traumatisation) See 'trauma treatment', 'window of tolerance'.

implicit memory – Pre-verbal recollection which derives from early attachment experience with caregivers, and which is stored in neural networks which are central to organisation of sensation, emotion and behaviour (Cozolino, 2002; Schore, 2003). Because early experience occurs when the right brain hemisphere is dominant, it is remembered implicitly as 'schemas' rather than explicitly (ie in contrast to conscious memory which is linked to subsequent development of the left brain hemisphere). Since it is 'stored' as implicit, rather than conscious memory, early attachment experience tends to be enacted and embodied rather than expressed in words. See 'affect regulation', 'attachment theory', 're-enactment'.

individualism – A conceptual framework by which individuals are privileged at the expense of the social context in which they are always embedded and by which they are profoundly shaped. Individualism is a central tenet of western liberal societies, notwithstanding the fact that we are profoundly relational beings. The inherently relational nature of human beings is now powerfully illuminated by neuroscientific findings which establish the crucial role of experience in activating neural networks (and thereby 'the social brain'; Cozolino, 2002; Siegel, 1999; Doidge, 2007).

Neuroscientific findings have radical implications for a range of areas, and notably for the field of mental health. They also go far beyond 'social model of health' frameworks which have challenged the individualist paradigm since the 1970s. If subjectivity is inherently relational – and the brain itself is 'social' – this requires reconceptualisation of the very categories by which we structure our perceptions. Correspondingly, it requires recognition of the extent to which problems conventionally described as 'personal' and 'individual' are also social and political. This likewise has major implications for the ways in which social policy is constructed and funding is allocated. See 'social brain', 'social defense mechanism', 'adaptation to trauma', 'Adverse Childhood Experiences (ACE) Study', 'organisational trauma', 'self-harm', 'trauma-informed', 'violence'.

integration – Coherence between different levels of functioning, which requires the linked operation of neural pathways in the brain. Neuroscientific research is revealing integration to be the hallmark of well-being (Siegel, 1999, 2010; Cozolino, 2002). Basic requirements of integration are linked activity between the brain stem, limbic region and cortex ('vertical integration') and between the left and right brain hemispheres ('horizontal integration'). Trauma is profoundly disruptive of integration. In neuroscientific terms, effective trauma therapy entails repair and realignment of disrupted neural pathways (Cozolino, 2002).

intergenerational trauma – See transgenerational trauma

interoception – sensitivity to stimuli from within the body

interpersonal neurobiology The processes by which experience activates neural mechanisms in formation of mind and self ('the structure and functioning of the mind and brain are shaped by experiences, especially those involving emotional relationships'; Cozolino, 2002). Also see 'affective neuroscience', 'neurobiology of attachment' and 'social brain'.

learning brain – Development of neural networks in infancy fosters what has been called the 'learning brain' (Ford 2009). Necessary for the developmental task of self-awareness, the learning brain requires sufficient support from care-givers and the external environment to sustain it. In the absence of such support, there is a shift to a 'survival' brain, which is highly damaging in impeding both learning and development. See 'affect regulation', 'survival brain'.

mindfulness – A state of focused attention. Inspired by the Buddhist practice of mindful meditation, the benefits of cultivating attuned awareness are now widely endorsed not only for spiritual practice but for general health and well-being. A mindful approach to experience fosters inner coherence and integration, and is currently encouraged by diverse schools of psychotherapy. See 'affect regulation', attachment theory', 'integration'.

mirror neurons – Neurons which are activated through observation of the goal-directed behaviour of others ('Our brains use sensory information to create representations of others' minds, just as they use sensory input to create images of the physical world'; Siegel, 2010). Initially identified in relation to monkeys, the 'mirror neuron system' is now recognised to operate in human beings, and is regarded as 'the root of empathy' (Ibid) Also see 'affective neuroscience', attachment', 'attachment theory', 'attachment styles'

neurobiology of attachment – Convergent findings from the fields of affective neuroscience and attachment theory, which show 'how the developing mind is shaped by the interaction of interpersonal experience and neurobiological processes in the creation of the human mind' (Siegel, 2003). Also see 'affective neuroscience' and 'interpersonal neurobiology'.

neuroplasticity – The capacity of the brain to reorganise and form new neural connections in light of environmental stimuli. Contrary to long-standing belief that the brain is 'hard-wired' or 'fixed', neuroscientific findings reveal it to be malleable, and that it changes both structurally and functionally in relation to social experience (Siegel, 1999; Cozolino, 2002; Doidge, 2007). This is a fundamental and pathbreaking recognition which has implications for a wide range of fields and practices, and notably in relation to mental health. Neuroplasticity means that experience changes the brain, and this goes both ways – just as damaging experiences change the brain in ways that impair subsequent functioning, different and positive experiences also change the brain in ways that are conducive to health. Studies now show that it is possible for trauma to be resolved, and that 'experience in later relationships can actually change the future development of the mind' (Siegel, 2003).

organisational trauma – While generally applied to describe the experience of individuals, the operation of trauma has many dimensions. The relational context of trauma (particularly in its complex varieties) requires attentiveness to the relational context of healing, and this includes at the level of organisations. Research in the neurobiology of attachment also highlights that positive experiences have

healing potential, which in turn underlines the need for services to facilitate healing at operational and organisational levels. With respect to 'parallel process', Bloom (2011) argues that trauma occurs at the organisational, as well as individual level, and applies concepts from trauma theory to organisational functioning. She further argues that trauma-specific treatment of individuals has its correlate in the organisational shifts required for health systems to operate as trauma-informed (Ibid) See 'parallel process', 'trauma-informed'

oxytocin – Hormone which plays a significant role in childbirth, and which is now recognised to be important in the physiology of early attachment with respect to the experience of safety and the development of empathy and trust (Carter & Ahnert, 2005; Churchland, 2011)

parallel process – A psychoanalytic concept which has traditionally been applied to the psychotherapy supervisory relationship when it mirrors what is occurring in the relationship between therapist and client. Bloom (2011) extrapolates this concept to the context of organisations, which she argues can become dysfunctionally 'trauma-organised' in relation to the trauma experienced by their clients. See 'organisational trauma', 'trauma-informed'

pathology – Commonly defined as the opposite state to health, the notion of pathology is intrinsic to biomedical frameworks of understanding, which notwithstanding acknowledgment of 'biopsychosocial' factors, tend to locate pathology within the individual. In establishing the unequivocal relationality of human growth and development, neuroscientific findings about 'the social brain' pose stark challenges to individualist readings of health and pathology. See 'neurobiology of attachment', 'Adverse Childhood Experiences (ACE) Study', 'symptoms', 'trauma-informed'

phased treatment – Effective trauma treatment cannot proceed in the absence of the client's ability to tolerate affect. Since impairment in affect regulation is a hallmark of complex trauma, graduated or 'phased' treatment is the best practice recommendation for treatment of trauma in its complex forms. The three stages of phased treatment are (I) safety and stabilisation, (II) processing, and (III) integration (Courtois, Ford & Cloitre, 2009).

The importance of Phase I to successful treatment of complex trauma cannot be overstated (Rothschild, 2011; Courtois, Ford & Cloitre, 2009; van der Kolk, 2003). Yet it is minimised in standard trauma treatments which are directed to (single-incident) PTSD, and which emphasise 'processing' (Phase II) at the expense of the crucial preliminary work of Phase I (safety and stabilisation as precursors to the ability to tolerate affect). See 'affect regulation', 'complex trauma treatment', 'early onset trauma'

politics of trauma – While currently not a common phrase, there is considerable evidence to suggest that failure to recognise and respond to the prevalence of trauma (much less prioritise it as a public health problem) reveals a 'politics of trauma' to be operative. Bloom (2011) argues that far from screening for trauma, human service organisations actively screen it out. Middleton (2011) also criticises the 're-badging' of a range of psychiatric problems to effectively conceal the trauma which underlies them.

That some cases of 'inability to see' the prevalence of trauma may be unconscious is not contested (as Bloom's concept of 'social defence mechanisms' allows). But it is also the case that some powerful professional interests are safeguarded by failure to confront the pervasiveness of trauma, and that vested interests which may themselves operate unconsciously are protected by such myopia. See 'individualism', 'diagnosis of trauma', 'borderline personality disorder', 'blaming the victim', 'organisational trauma', 'social defence mechanisms', 'trauma-informed'

post-traumatic stress disorder (PTSD) – A disabling condition of unresolved trauma which can follow experience or witnessing of an event or events involving actual or threatened death or serious injury to oneself or others (or threat to the physical integrity of oneself or others; DSM-IV-TR). As Rothschild (2011) highlights, diagnosis of PTSD is '100% event dependent', and does not apply in the absence of an identifiable event. It is for this reason that PTSD can be described as 'single-incident' trauma (which might follow a motor vehicle accident, natural disaster, combat experience or single incident of assault)

in contrast to ‘complex’ trauma (which is multiple, cumulative and interpersonally generated (such as experience of recurrent abuse).

To qualify for the diagnosis of PTSD, symptoms need to have been present for at least one month (if less than this period the diagnosis is Acute Stress Disorder, ASD). Symptoms for diagnosis of PTSD need to include persistent hyperarousal, avoidance of reminders of the traumatic event, involuntary recall of the incident (eg via intrusive images or flashbacks) and compromised quality of life. Notwithstanding the current prevalence of the term, the condition of PTSD does not follow all direct or indirect experience of traumatic incidents; it is estimated that approximately 20–25% of people who have such experiences go on to develop PTSD (Rothschild, 2011). Those who experience complex trauma are at higher risk for development of PTSD.

‘Complex’ (ie cumulative and interpersonally generated) trauma is widely conflated and confused with (single-incident) PTSD. This is including among health professionals, because complex trauma is not recognised as a distinct entity in the DSM, and receives diverse and compartmentalised diagnoses. Complex trauma is, however, the more prevalent (‘[t]he majority of people who seek treatment for trauma-related problems have histories of multiple traumas’; van der Kolk, 2003:172).

It is extremely important that the prevalence of cumulative underlying trauma becomes widely known, because the differences between PTSD and complex trauma also involve different treatment paths. One clinician has estimated that as few as 5% of her traumatised clients are immediately ready to engage in trauma work (Shapiro, 2010). See ‘trauma treatment’, ‘complex trauma’ and ‘phased treatment’.

practice-based evidence – An inversion of, and alternative to, the paradigm of ‘evidence-based practice’. In contrast to the latter, ‘practice-based evidence’ gauges treatment effectiveness with reference to client feedback which in turn guides the treatment (Miller, 2005). Correspondingly, it recognises the input of the clinician (who might otherwise be remote from a research culture) to the therapies being applied. Practice-based evidence also converges with belief that the most valuable measure of treatment effectiveness is client outcomes (on which there is comparatively much less emphasis when evidence-based practice is regarded as definitive). See ‘common factors research’, ‘evidence-based practice’.

psychotherapy – The practice by which a trained professional assists clients to address emotional and psychological problems. Following the initial dominance of psychoanalysis (the original ‘talking cure’ pioneered by Freud in the late nineteenth century) psychotherapy has become a diverse field which includes an expanding range of approaches and modalities. It is also a field undergoing reappraisal and renaissance, as its central tenets have been found to correlate with neuroscientific principles (Cozolino, 2002; Doidge, 2007; the latter describes psychotherapy as ‘a neuroplastic therapy’).

Psychotherapy is now regarded as ‘an enriched environment that promotes the development of cognitive, emotional and behavioural abilities’; Cozolino (2002). The latter argues that ‘all forms of psychotherapy – from psychoanalysis to behavioural interventions – are successful to the extent to which they enhance change in relevant neural circuits’ (Ibid).

Note, however, that current research in the physiology and psychobiology of trauma also suggests ‘the limits of talk’ in relation to the resolution of trauma (Ogden et al, 2006; van der Kolk, 2003; Porges, 2011). This in turn suggests the need for supplementation of traditional psychotherapeutic orientations with approaches which can directly engage somatic and ‘right brain’ processes. See ‘body’, ‘expressive therapies’, ‘right brain’, ‘traditional psychotherapy’, ‘sensorimotor psychotherapy’.

psychodynamic psychotherapy An interpretive and insight-based variety of psychotherapy which is directly traceable to Freudian psychoanalysis. Neuroscientific research suggests the limits of psychotherapies which fail to attend to bodily experience, and there are now a range of therapeutic approaches which focus on areas which psychodynamic approaches do not (‘It is possible that some of the newer body-oriented therapies, dialectical behaviour therapy, or EMDR may yield benefits that

traditional insight-oriented therapies may lack'; van der Kolk, 2003). See 'body', 'expressive therapies', 'traditional psychotherapy'.

recovery – *As applied to the field of mental health, the belief 'that a person's disability is based on more than diagnosed pathology or the intensity of symptoms, [and] is the product of interactions between the individual and the environment' (Anthony, Cohen & Farkas, 1990, in Jacobson & Curtis, 2000). In contrast to the domain of physical illness, application of the term 'recovery' to psychological conditions is more recent. It also contains an implicit critique both of longstanding assumptions that recovery from mental illness is not possible, and of the systems and institutions which are organised around this belief.*

In the language of psychiatric rehabilitation, 'recovery' refers primarily to functional ability. But for those who identify with the grass roots ex-patient movement, the concept has both personal and political implications – 'to recover is to reclaim one's life, to validate one's self in order that one may be validated as an autonomous, competent individual in the world' (Ibid) In this latter sense, recovery is centrally related to the concept of empowerment, which is an underpinning principle of trauma-informed care. See 'resilience', 'strengths based', 'trauma-informed care'.

re-enactment – *The repetition of previous experience which is an expression of implicit memory, and which is particularly marked in the context of trauma. Traumatic re-enactment has long been observed as a response to trauma, and was described by Freud (1920) as 'the compulsion to repeat'. It is also increasingly recognised to have strong biological foundations, and to be 'part of the innate and programmed behavioral repertoire of the traumatised person' (Bloom, 2011). It is for this reason that contemporary research suggests the need for traditional psychotherapy to take more direct account of physical movement and the body, as in sensorimotor approaches (van der Kolk, 2003, 2007).*

The relationship between traumatic re-enactment and unresolved grief is emphasised by some – 'The person continually re-enacts what he or she has not been able to resolve... unresolved loss becomes another dynamic that keeps an individual stuck in time, unable to move ahead, and unable to go back. Compounded and unresolved grief is frequently in the background of lives based on traumatic reenactment' (Bloom, 2011). See 'trauma', 'complex trauma', 'body', 'sensorimotor psychotherapy'.

relational trauma – *Interpersonally generated trauma which is not necessarily the product of experience within the family or with people to whom one is attached (Shapiro, 2010). Examples of relational trauma include bullying, humiliation and shaming, rejection by a love object, having to keep a secret which sets one apart, and having one's needs ignored at any age – 'All of these situations can create trauma. Any of them, chronically experienced, can root deeply into human neurology, creating a distorted view of the self ('I'm not worth caring about'; 'I'm bad'; 'Anything I try to do is futile..') (Ibid)*

resilience – *The capacity to sustain and respond positively to life stress, setback and difficulty. While initially conceptualised in individualistic terms, recent research emphasises the importance of social, cultural and environmental processes in fostering and supporting this capacity (Liebenberg & Ungar, 2009).*

resolution of trauma – *The processing, coming to terms with, and 'working through' of traumatic experience such that it ceases to be disabling. Clinical and neuroscientific research show that it is possible for trauma to be resolved, and its negative effects on the next generation (via transmission of unresolved parental trauma) to be positively intercepted (Siegel, 2010). See 'attachment style/s', 'Adult Attachment Interview' (AAI), 'earned security', 'trauma treatment', 'recovery'.*

retraumatisation – *Recurrence and re-experience of trauma. Research shows that re-traumatisation of clients takes place within the mental health system itself (Jennings, 2004; Fallot & Harris, 2009). It further shows that service practices which contribute to re-traumatisation rather than recovery are not exceptional, but pervasive and deeply entrenched. This underlines both the limits of individualist frameworks, and the need for introduction of care and practice which is 'trauma-informed'. See 're-enactment', 'trauma-informed'.*

right brain – The right brain hemisphere, also known as the ‘emotional’ brain, is critical to the processing of emotion and the regulation of affect. In contrast to the left or ‘cognitive’ brain, the right brain is dominant in infancy, ‘indicating the essentially affective nature of mental functioning in the first years of life’ (Fosha, 2003). Also see ‘affect regulation’ and ‘early onset trauma’.

risk-management – The suite of policies, strategies and methods by which professional practice is safeguarded and maintained. Effective risk management in psychotherapy entails several components, of which respect for and implementation of boundaries, professional indemnity insurance, regular clinical supervision, and attentiveness to self (ie as well as client) care are some. Compliance with the relevant ethics codes and ethical practice per se are also part of risk-management. In organisational settings, risk-management entails maintenance of a context which is conducive to the conducting of ethical practice at all times. See ‘ethical practice’, ‘self-care’, ‘supervision’.

safety – The foundational principle in treatment of complex trauma, which may require active facilitation in that it might not previously have been experienced by those with complex trauma histories. A sense of safety is prerequisite to the ability to regulate affect, which is itself critical to the capacity to process and integrate trauma. Safety is also a key concept of trauma-informed care and practice (the others being trustworthiness, choice, collaboration and empowerment; Falloot & Harris, 2009). See ‘trauma-informed’, ‘phased treatment’, ‘affect regulation’.

screening for trauma – The process by which questions are posed, whether spoken or written, for the purpose of eliciting whether trauma is or has been experienced by a client. Though potentially valuable, screening for trauma can be highly problematic (and can precipitate re-traumatisation) in the absence of appropriate safeguards and sensitivity. For this reason, all trauma screening should be conducted in a context which is trauma-informed. See ‘trauma-informed’.

secondary trauma – A variety of ‘indirect’ overwhelming experience which can stem from proximity to trauma; and which includes ‘the parallel trauma symptoms that helpers may develop in working with traumatised clients’ (Pearlman & Caringi, 2009). Also previously known as secondary traumatic stress disorder (Figley, 1995) it is commonly now known as compassion fatigue. See ‘compassion fatigue’, ‘burnout’, ‘risk-management’.

self-care – Attentiveness to one’s own needs, especially for rest and relaxation, and to the general ‘looking after’ of self. Ability to self-care is an indicator of healthy self-respect, and is very different from ‘selfishness’. Self-care is a key component of professional and ethical therapeutic practice, both in fostering the therapist’s well-being in light of the intensity of psychotherapeutic work, and in modelling this ability for clients. See ‘affect regulation’, ‘ethical practice’, ‘risk management’ and ‘supervision’.

self-harm – Harm inflicted on the self via damaging thoughts and behaviours. Self-harm can take a variety of forms, and is a frequent response to trauma, particularly when the trauma is sexual and early onset. See ‘adaptation to trauma’, ‘blaming the victim’, ‘coping mechanisms’, ‘early onset trauma’, ‘endogenous opioids’, ‘trauma-informed’.

self-soothing – Management of emotion; particularly the ability to establish or restore inner calm when experience is stressful. The capacity to self-soothe is a vital precondition to processing and integration of trauma. See ‘affect regulation’, ‘attachment theory’, ‘phased treatment’, ‘right brain’, ‘safety’.

sensorimotor psychotherapy – Both an approach which incorporates somatic interventions used by psychotherapists of the body, and a school which has developed psychological theory with respect to the use of somatic interventions (Ogden, 2006). Neuroscientific research has established the inextricable relationship between physiological and psychological processes, as well as the centrality of movement and the body in relation to trauma. This in turn suggests that traditional psychotherapeutic approaches need to incorporate awareness of sensorimotor processes (Ogden, 2006; van der Kolk, 2003, 2006). See ‘body’, ‘expressive therapies’.

shame – While guilt relates to feelings of culpability for actions, shame applies to feelings about the self (ie `our very selves – not about what we did or said but about what we are'; Smedes, 1993). In complex trauma, inability to self-regulate and to regain self-integrity in relationships (Courtois & Ford, 2009) means that shame frequently assumes an extreme (or `toxic') form.

single-incident trauma – See post-traumatic stress disorder (PTSD)

social brain – Term which reflects neuroscientific findings that social and environmental factors impact brain development and functioning. In illuminating the constitutive role of social experience in activating neural mechanisms and processes, findings from affective neuroscience transcend longstanding debates about `nature' and `nurture'. From the moment of birth, experience not only influences the self (which implies the effects of `external' environment on already intact subjectivity) but actively shapes and formulates it. Experience has `psychobiological correlates' in the organisation of our brains (Castillo, 1997; Cozolino; 2002; Doidge, 2007).

social defence mechanisms – While defence mechanisms are widely regarded as the preserve of individuals (ie in protecting from recognition of an unpalatable reality) they serve a similar function collectively. Bloom (2011:11) argues that basic assumptions underlie and reassure groups and organisations no less than the individuals which comprise them. Thus `challenges to these basic assumptions... are likely to give way to anxiety and to `social defence mechanisms' (Ibid). A powerful illustration of a `social defence mechanism' is the medicalisation of what are actually social problems (Ibid) See `blaming the victim', `politics of trauma', trauma-informed'.

somatisation – Expression of psychological states and processes as physical symptoms. Implicit memories of trauma can emerge in the form of bodily ailments and pain (Cozolino, 2002; Siegel, 2010). In some cases surgery is sought or recommended because the emotional and psychological sources of somatic symptoms are not recognised. See `symptoms', `coping mechanisms', `screening for trauma', `trauma-informed'.

The Strange Situation – A study of reunion behaviour between infants and their care-givers which yields multiple insights into primary emotional bonds (`attachment') and the varying forms they assume. First conducted in the 1970s by developmental psychologist Mary Ainsworth in relation to the research of John Bowlby, the Strange Situation has been consistently replicated and validated. Its findings are now being further clarified and extended by research in affective neuroscience. A key outcome of the study was delineation of contrasting `attachment styles' – `secure', `avoidant' and `ambivalent' – with a fourth variety (`disorganised') added in the 1990s by psychologist Mary Main. The Strange Situation is powerful in establishing not only the critical role of parental attachment for child well-being, but for subsequent adult health and parental capacity (ie transgenerational effects). See `attachment theory', `attachment style/s', `Adult Attachment Interview'.

strengths-based – An approach to treatment which emphasises the existing resources of the client, which fosters client options and empowerment, and which is explicitly non-pathologising. See `coping mechanisms', `trauma-informed'.

structural dissociation – `[A] division of the personality as a biopsychosocial system into two or more subsystems of personality that should normally be integrated' (Steele & van der Hart, 2009). Also see `Dissociation Identity Disorder' (DID) and `dissociation'.

supervision – A process of oversight and monitoring which takes different forms depending on the diverse contexts to which it is applied. In the context of counselling and psychotherapy, it takes the form of `clinical supervision', does not function in an authoritarian way, and generally assumes the form of a conversation. Supervisees also generally select their own supervisor.

Clinical supervision is a key component of professional and ethical practice, whereby (usually) less experienced practitioners consult in relation to their client work with a more senior clinician on a

formal but also democratic basis. Ethical psychotherapeutic practice requires clinical supervision to be undertaken by all practising therapists, irrespective of their level of experience See `clinical supervision`, `ethical practice`, `self care`, `risk management`.

survival brain – In contrast to the `learning` brain (which develops naturally under conditions of adequate care-giving and environmental support) the `survival` brain is suboptimal. Rather than being open to experience and new learning, it becomes `fixated on automatic, nonconscious scanning for and escape from threats` (Ford, 2009). The shift from a `learning` to a `survival` brain radically impedes the developmental task of self-awareness, and is particularly prevalent in contexts of child abuse (Ibid). See `early onset trauma`, `developmental trauma`, `Developmental Trauma Disorder`.

symptoms – Physical or mental indicators of unwellness according to which health problems are classified and diagnosed. To the extent that a range of diverse symptoms can stem from adaptations to trauma, a `trauma-informed` approach challenges the conventional understanding of symptoms, which is linked to a medical model and which is implicitly pathologising. By contrast, a trauma-informed perspective is strengths-based, and regards symptoms as the outgrowth of coping mechanisms which are adaptations to trauma, and which can be utilised as resources in the process of recovery. See `adaptation to trauma`, `coping mechanisms`, `Adverse Childhood Experiences (ACE) Study`, `pathology`, `strengths based`, `trauma informed`.

traditional psychotherapy – As the original `talking cure`, psychoanalysis bequeathed a legacy of emphasis on verbal articulation to the many psychotherapeutic modalities which followed. To this extent, approaches as diverse as psychodynamic and cognitive behavioural therapy have in common the privileging of spoken language at the expense of physicality (`[n]either CBT nor psychodynamic therapeutic techniques pay much attention to the experience and interpretation of physical sensations and preprogrammed physical action patterns`; van der Kolk, 2007). Current neuroscientific research suggests the need to `put the body back` in the practice of psychotherapy, that optimal trauma treatment needs to engage right-brain processes, and that physical as well as cognitive and emotional experience needs to be attended to (Ogden et al, 2006). See `sensorimotor psychotherapy`, `somatisation`, `expressive therapies`.

transference – The unconscious responses of a client to their therapist, based on past relationships and associations which are evoked in the therapy session. Because complex trauma clients have experienced betrayal and abuse from care-givers, their transference to therapists can be particularly strong (eg negative, idealising, or a combination of the two). This means that therapy with such clients can be particularly intense for both parties, and therapists need regular clinical supervision to ventilate and explore the range of their responses to their clients (ie the `countertransference`) See `complex trauma`, `countertransference`, `supervision`.

transgenerational trauma – The process by which trauma is transmitted to the next generation via the attachment style associated with unresolved parental trauma. Note that studies now show that it is possible for traumatic childhood experience to be resolved, and thus for the negative effects on parenting and the next generation to be positively intercepted. See `Adult Attachment Interview` (AAI), `attachment style/s`, `disorganised attachment`, `earned security`.

trauma – `[A] state of high arousal that impairs integration across many domains of learning and memory` (Cozolino, 2002). Trauma stems from activation of the instinctive `fight-flight` response to an overwhelming threat. Mobilisation of this biological `survival` response leads to a `freeze` response when the danger cannot be escaped, and the normal impulse for action is arrested. Experience need not literally be life-threatening to qualify as traumatic. Neuroscientific research also establishes the vulnerability of the developing brain to early experience of care-givers. Repeated and unrepaired parental misattunement to infants can itself be traumatic, and can lead to significant developmental compromise. See `attachment`, `complex trauma` `developmental trauma`.

trauma diagnosis – See 'diagnosis of trauma'

trauma-informed – A reconceptualisation of traditional approaches to health and human service delivery whereby all aspects of services are organised around the prevalence of trauma throughout society (particularly as complex trauma is not necessarily apparent from diverse diagnoses and client presentations). Services which are 'trauma-informed' are aware of and sensitive to the dynamics of trauma, as distinct from directly treating trauma per se (the appropriate term in the latter case is 'trauma-specific'; note that there can also be overlap between the two).

Trauma-informed services are alert to the possibility of the existence of trauma in the lives of all clients/patients/consumers, irrespective of whether it is known to exist in individual cases. The contrast with 'traditional' health and welfare settings is profound: '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). Key principles of trauma-informed care include safety, trustworthiness, choice, collaboration and empowerment (Fallot & Harris, 2009).

trauma-specific – Treatment approaches and services which are directly addressed to the treating of trauma in its various forms.

trauma treatment Effective trauma therapy entails facilitation of neural integration ((Solomon & Siegel, 2003; van der Kolk, 2003). The importance of the capacity to manage emotion (affect regulation) is a precondition to capacity to process and integrate trauma. In contrast to standard (single-incident) PTSD, the cumulative impact of complex trauma is severely disruptive of self-regulatory capacity which has implications for appropriate trauma treatment.

Studies show that people who experience complex trauma 'may react adversely to current, standard PTSD treatments, and that effective treatment needs to focus on self-regulatory deficits rather than 'processing the trauma' (van der Kolk, 2003). It is for this reason that best practice treatment for complex trauma is phased treatment. See 'complex trauma treatment', 'phased treatment'

treatment of complex trauma – See 'complex trauma treatment'; 'phased treatment'

treatment of trauma – See 'trauma treatment'

vicarious trauma (VT) – '[T]he negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them' (Pearlman & Caringi, 2009). Vicarious trauma is situationally inherent in exposure to traumatic material over time, and does not reflect weakness or fault on the part of the helper ('VT goes with the territory'; Ross & Halpern, 2009). Thus the challenge is one of recognition and appropriate addressing.

violence – While largely conceptualised in individualist terms within western societies, recognition of the extent to which violence is structural and systemic allows a broader perspective by which a range of social practices and institutions can be seen to be implicated. Bloom (2011) argues for a view of violence as 'a public health problem, instead of simply an individual problem'. See 'individualism', 'organisational trauma', 'politics of trauma', 'social defence mechanisms'

window of tolerance – The threshold at which emotion can be tolerated without the person becoming either agitated and anxious (hyperaroused) or 'shut down' and numb (hypoaroused) [Siegel, 1999]. It is essential that trauma therapy is conducted within 'the window of tolerance', which, if exceeded, can precipitate re-traumatisation. See 'affect regulation', 'complex trauma', 'phased treatment'.

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I think this is one of the most comprehensive analyses of the subject that I have read; ASCA is to be congratulated on having produced such a marvellous resource.

Associate Professor Carolyn Quadrio | Consultant Psychiatrist | School of Psychiatry, UNSW

I am enjoying how beautifully written and organised the document is and how it integrates neuroscience, social policy, and a therapeutic understanding of trauma.

Janina Fisher, PhD | Oakland, CA

It's thorough, grounded in the latest knowledge of the field of trauma, complex trauma, and dissociation, and it's respectful of both the clients seeking help and the care providers. Having worked in this field for almost 30 years, and having been involved in my own country's trauma-informed education program, I can see and thoroughly appreciate all the work that went into these guidelines. It's not only competent in what it says, but the language used models the approach. I am very impressed. This is stunningly well done, and I would be honoured to endorse it.

Lynette S. Danylchuk, PhD | Director, ISSTD

Each time any of us takes a significant step, the field benefits, and your step is remarkable.

Adah Sachs | Psychoanalytic Psychotherapist, Consultant Psychotherapist
Forensic Clinical Lead, Clinic for Dissociative Studies, London

It's a brilliant document and a wonderful summation of the important insights that have emerged from neuro-science and psychotherapy...it's hard to fault the text.

Jan Resnick | Senior Psychotherapist, WA

'It is with great pleasure that I endorse your guidelines. What an achievement--congratulations!'

Christine A. Courtois, PhD, ABPP



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Adults Surviving Child Abuse