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Enhancing the wellbeing and safety of women with complex trauma

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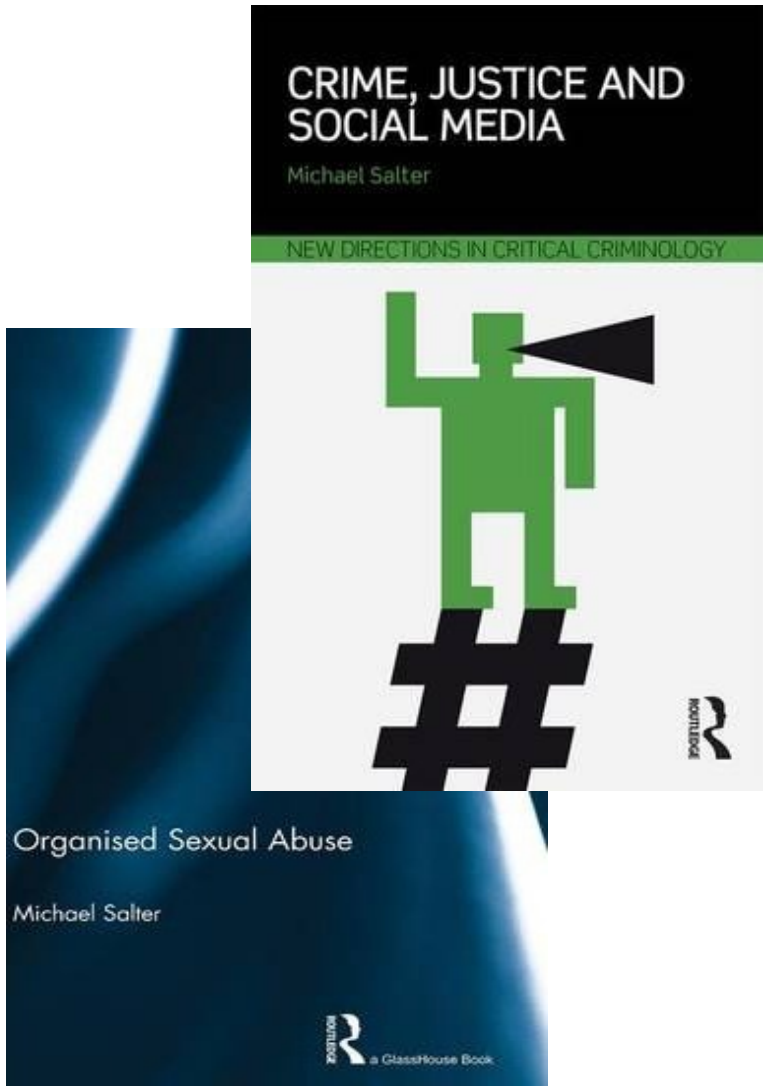
Enhancing the wellbeing and safety of women with complex trauma



- While undertaking a range of projects on gendered violence, my research has focused on organised sexual abuse and extreme forms of violence against women and children.
- This has involved attention to a) the criminal acts, b) the contexts that make those acts possible, c) the social and health consequences of those acts for survivors, and d) responses of education, health, welfare and justice systems.
- Background research: 40+ interviews with women with Dissociative Identity Disorder and 20+ interviews with specialist mental health workers.
- Consistent finding: A lack of shared understanding of complex trauma and dissociation between the multiple agencies responding to victimised women and children.

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Rosie's story

- Rosie is a woman in her mid 40s diagnosed with Dissociative Identity Disorder by her psychiatrist.
- Rosie reports ongoing abuse by the group who abused her in childhood but her psychiatrist believes her reports of current abuse are flashbacks.
- Nonetheless, he referred Rosie to Leona, an art therapist, due to lack of therapeutic progress.
- Rosie continued to make detailed complaints of ongoing abuse to Leona, in which she was being taken to a property and victimised.

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They would come up to her in the car park, when she was getting back into her car to leave from the shops. And as soon as she saw them, there would be a part [dissociated self-state] that would get out of the car and go.

And the other thing was that they would sometimes stop her on the road, because she has to travel quite a distance from work to home, and she said they worked with two cars. One car would go in front of her and slow down. Another would come up behind her and force her to the side.

Leona

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- Over a number of months, Leona came to conclude that Rosie was describing actual events.
- Rosie's presentation in therapy after these events was profoundly traumatised and she had strange injuries.
- Her reports of stalking and abduction were consistent and coherent, and some external verification was available.
- Leona and Rosie have tried to develop strategies to stop Rosie dissociating and complying when confronted by the men e.g. calling Leona to 'ground' herself.
- It emerged that Rosie had made an 'agreement' with the abusive group that she will comply with their demands if they no longer use electroshock.

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Police

The police came round to the house and discovered she was a woman in her thirties, just dismissed the whole thing. After that, she never trusted them again. That was it. She must have been just so wounded by that experience.

Medical care

I got her to agree to come to a GP [general practitioner] with me, because she was talking about stuff that was being done internally. And wounding her, and there ought to be evidence there. And I said, 'Well, if I came with you, would you allow a GP to look at you?'

And she said, yes, she would, because she trusted me. We got to this GP in the clinic that I go to, who I thought I could trust, and as soon as we started telling the story, she said, 'Well you know I have to report this'. And I said, 'No you don't, she's an adult'. She said, 'Yes, I do. I have to report this, you know that. I'm sorry, I have to report this'. I was furious. So Rosie of course walked out and said, 'That's it, I'll never go do that again'.

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Rosie in many ways is so receptive to the therapeutic process, and I see her make improvements, I see her make strides, I see her being able to work on something, and then it all just gets torn down. No matter what we do, it gets undone.

… A lot of the time the session is just keeping her alive. Is just comforting her, helping her nervous system to have at least two hours where she's not in a state of terror, where she feels safe, and held, and cared about. A lot of the therapy is just spent doing that. It's just band aids, survival therapy.

Leona

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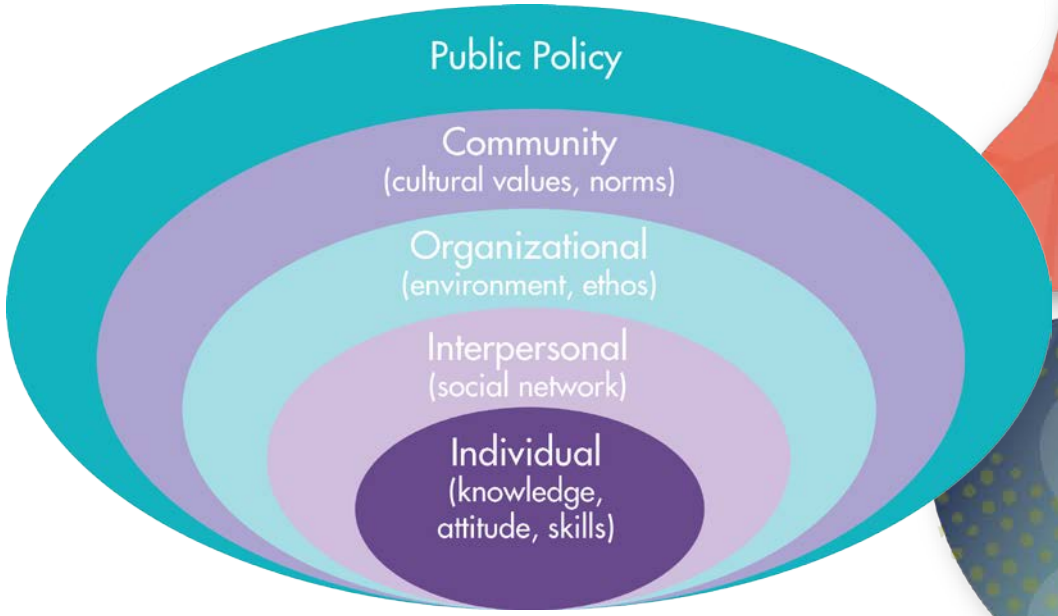
Rosie's story from an ecological perspective

- Individual: Dissociative disorder as well as related traumatic symptomology, emotional dysregulation, self-blame and shame.
- Interpersonal: Embedded within abusive network since childhood and socially and emotionally isolated as an adult, with limited financial resources.
- Organisational: Multiple institutional failures to protect Rosie since childhood: Child protection? School? Medical services? Police? Courts?
- Community: Lack of community and professional awareness of complex abuse, dissociation and trauma leading to isolation and fragmentation of response across multiple agencies.
- Public policy: Lack of specialised policing or health response to complex trauma and dissociation.



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What is trauma?

- 'Trauma' refers to 'injury' (distinct from 'illness'). The concept of psychological trauma introduced the revolutionary idea that particular experiences and acts can injure the mind.
- Two parts to the definition: Trauma describes both the injurious act and its consequences e.g. a car accident is a trauma and also a cause of trauma.
- Post-Traumatic Stress Disorder was introduced in the DSM III in 1980 after agitation from Vietnam veterans and treating clinicians.
- PTSD was controversial because it wasn't neutral about the aetiology of symptoms and ascribed a causative role to violence and fear.
- Traumatic experiences are common e.g. childhood adversity, interpersonal violence, car accidents, sudden deaths.

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What is complex trauma?

- 'Complex trauma/PTSD' formulated in 1992 by Judith Herman to describe the experience and symptoms of those subject to repeated interpersonal violation in the context of powerlessness and betrayal.
- Two parts to the definition: Complex trauma describes the violent act/s as well as resultant symptoms (inc PTSD but also dissociation, chronic alterations to identity, memory and relationships with others, as well as psychosocial problems).
- Complex trauma often intersected by social inequalities such as sexism and racism that increase the risk of trauma and compound its harms (Herman 1992).
- Uncertain clinical status: Multiple Personality Disorder recognised in DSM III (now Dissociative Identity Disorder) with cPTSD now recognised in the ICD 11, and PTSD in the DSM V increasingly formulated as a dissociative disorder.
- Approximately 1% of the population meets the diagnostic criteria for complex trauma (Sar 2011): that is almost 250 000 people in Australia.

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Responses to complex trauma

- Lack of mental health workforce planning: Training on trauma and dissociation is minimal in psychology and psychiatry curricula; social work and counseling are better.
- Western, middle class models of care: Focus on one-to-one therapy and medication rather than somatic/embodied approaches or community driven solutions.
- Lack of interagency collaboration: The multiple needs of women with complex trauma cannot be met by a single service/professional but non-specialist services often cannot be trusted to respond to this group appropriately.
- System abuse: Women with complex trauma are routinely retraumatised in service and agency contexts and have experienced multiple failures to intervene.
- Increased focus on trauma-informed practice is promising but it is implemented with varying degrees of skill and commitment while demand for specialist trauma care outstrips supply.

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Constructions of complex trauma and implications for women's wellbeing and safety from violence

Dr Michael Salter, Dr Elizabeth Conroy, Prof Jane Ussher, Dr Jackie Bourke, Prof Warwick Middleton, A/Prof Molly Dragiewic

The guiding question of the study is "How can agencies and services improve collaboration to meet the health and safety needs of women with complex trauma?". This question informs four key aims:

1. Analyse how complex trauma experienced by women is constructed in public policy at a national, state and territory level,
2. Examine institutional approaches to women's complex trauma in the mental health, alcohol and other drug and sexual assault/domestic violence sectors in New South Wales and Queensland,
3. Document how women with complex trauma understand complex trauma, and their experiences and encounters with agencies while seeking help, with a focus on Aboriginal women, refugee and migrant women, and polyvictimised women, and
4. Develop models of improved and collaborative responses to enhance the wellbeing and safety of women with complex trauma and their children.

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Why undertake the study?

- Psychological treatment for complex trauma has progressed considerably but:
  - Treatment remains inaccessible and unaffordable to most who need it, and is not necessarily culturally safe or appropriate, and
  - Women with complex trauma frequently have multiple needs that cannot be met in clinical settings and require involvement from multiple stakeholders.
- We need a blueprint for policy change that is grounded in women's experiences and the practice wisdom of those working in the complex trauma field.
- There are a multiplicity of understandings of complex trauma; what do these multiple perspectives offer us?

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Multiple definitions of complex trauma

- Diagnosis: PTSD, cPTSD, dissociative disorders, Borderline Personality Disorder, bipolar and psychosis
- Presentation: Multiple, chronic, high needs client with trauma history.
- Trauma history:
  - Childhood: Age of onset, child sexual abuse, disrupted attachment.
  - Adulthood: Multiple forms of victimisation – IPV, sexual assault, stalking.
- Extremity of abuse: Organised abuse, prolonged incest, torture, sexual exploitation.
- Aboriginal and First Nations understandings of intergenerational, transgenerational, collective, historical, communal and cultural trauma.

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We conceptualise complex trauma according to three key axes of complexity:

- Complexity of victimization, including:
  - Frequency and severity of abuse, early onset, and duration;
  - Multiplicity of abuse types (i.e. physical, sexual, emotional) and multiplicity of perpetrators;
  - Abuse ongoing at the time of presentation.

- Complexity of presentation, including:
  - Mental illness such as post-traumatic stress disorder (dissociative subtype) and other comorbid mental illness;
  - Psychosocial problems such as substance abuse, self-harm and suicidality;
  - Other needs including housing, poverty and child protection concerns.

- Complexity of context, including:
  - Pre- and post-abuse context (inc chaotic, invalidating, shaming, silencing environments)
  - Inequality, disadvantage and discrimination (inc racism, misogyny, heterosexism, ableism, poverty)
  - Intergenerational and collective trauma.

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Complex trauma compromises wellbeing *and* safety, setting in train individual, collective and intergenerational cycles of trauma.

Service and system responses are deeply implicated in these cycles through inappropriate, punitive or retraumatising responses to complex trauma.

How can we ensure that policy and practice promotes the virtuous rather than vicious cycle?

What are the opportunities to expand interventions in complex trauma from the individual/clinical to the community and systemic levels?