Living with and Healing from Complex Trauma

Prepared by Blue Knot Foundation and BEING - Mental Health Consumers on behalf of the National Mental Health Commission.

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Being Mental Health Consumers

blueknot empowering recovery from complex trauma

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ACKNOWLEDGEMENTS

We acknowledge and thank the lived experience participants in this project. It is only through their courage in sharing insightful and rich information that we are better able to strengthen the voices and perspectives and understand the journeys of people who experience complex trauma.

We also acknowledge the collaboration of Blue Knot Foundation – National Centre of Excellence for Complex Trauma, and BEING – Mental Health Consumers who jointly produced this publication. This report is informed by the lived experience of mental health consumers with complex trauma experiences within different systems alongside a summary of the current research and practice evidence around complex trauma.

BLUE KNOT FOUNDATION – National Centre of Excellence for Complex Trauma is Australia's leading organisation empowering recovery and building resilience for the more than 1 in 4 Australian adults impacted by complex trauma. We do this by supporting survivors and those who support them, using research and practice evidence to inform complex trauma treatment, building a trauma-informed community and an extensive training and services program to build the capacity of the workforce to respond appropriately to Australians affected by complex trauma.

BEING – Mental Health Consumers is the independent, NSW peak organisation speaking with and for people with lived/living experience of mental health issues and emotional distress. Our primary focus is to ensure the voices of people with mental health issues are heard by decision makers, service providers, and the community, and leads and influences systemic change in services and systems. BEING – Mental Health Consumers is committed to human rights principles of diversity, inclusion, and equity and believes that recovery is possible for all people who live with mental health issues and emotional distress.

Blue Knot Foundation and BEING worked together on this important work. Our collegiality on the subject and our mutual understanding of the impacts of complex trauma on individuals and broader communities underpins the findings in this report. We would also like to thank the National Mental Health Commission for their vision and leadership in commissioning this important project in a critical area of mental health literacy which has long been ignored.

EXECUTIVE SUMMARY

Given the prevalence of complex trauma across all communities and the breadth of its impacts on mental and physical health as well as on everyday functioning, it is important for all consumers, carers, workers and practitioners to recognise and understand more about its dynamics and impacts on the brain, body and mind. Mental health consumers and those experiencing mental distress and other challenges, are often unable to access trauma-informed supports and treatments based on the most recent research and practice-based evidence and pathways to healing and recovery.

Despite the significant advances in research over recent decades into the impacts of repeated complex trauma on mental health and wellbeing, these advances have not adequately informed understanding of the presentation and needs of consumers accessing the mental health system and related systems and services. This report aims to better inform practitioners and services within the mental health and related sectors about the lived experience of complex trauma and its relationship to mental distress by targeted discussions to map consumer experiences.

This Spotlight Report was commissioned by the National Mental Health Commission in recognition that there is a significant need to build awareness and understanding of the often chronic and largely unmet needs of people living with the long-term impacts of complex trauma.

Blue Knot Foundation – National Centre of Excellence for Complex Trauma (Blue Knot) and BEING – Mental Health Consumers (BEING) NSW have collaborated to bring the lived experience of complex trauma front and centre on this project.

This report reviews the current research and practice into complex trauma and experiences of people with a lived experience of complex trauma – how they have engaged with the system and how the systems have responded to their needs. It highlights the chasm between needs and the system's capacity to meet them, to support healing and recovery, minimise experiences of re-traumatisation and to be heard, respected and supported to live meaningful participating connected lives.

The public health issue of complex trauma has long been ignored. It is time for the knowledge from lived experience, practice and research to inform services and practice in order to reduce the mental distress and sense of hopelessness and helplessness so many people diagnosed with mental illness, with unrecognised complex trauma can experience. We hope that this report will provide the impetus and insight which drives the investment, training and systems change needed for every person who has been abused, violated, neglected or exploited during their lives to find a sense of safety, hope, healing and wellbeing.

While this report addresses the public health challenge of complex trauma, and is informed by a substantial research and practice base, we acknowledge that the findings of this report are limited by the small number of participants involved in the focus groups that have informed this report.

INTRODUCTION

When people think of trauma they often think of a one-off event. However, most people with trauma-related issues have experienced multiple traumas. These multiple traumas can occur as a child, an adult or at different stages across the life cycle. The term `complex trauma' describes exposure to multiple traumas, including childhood trauma, as well as to the impacts of that exposure. Childhood trauma is common and by conservative estimates affects 1 in 4 adult Australians.[i] More than 1 in 4 adult Australians are living with complex trauma and its impacts.

Many people with complex trauma experience mental distress. A history of childhood trauma is `[t]he single most significant predictor' of subsequent contact with the mental health system'.[ii] A leading medical journal[iii] recently identified that childhood trauma may be "psychiatry's greatest public health challenge." Complex trauma often has multiple significant, long-lasting impacts on mental and physical health, relationships and daily functioning.[iv]

Complex trauma is far more prevalent than the trauma of one-off events and more common than most people realise. The underlying trauma often goes unrecognised, unidentified and hence inadequately treated. This often means long-term impacts on mental health and well-being. Two thirds of mental health inpatients and outpatients have experienced childhood sexual and/or physical abuse[v] and up to 90% of public mental health clients experience trauma.[vi] The majority have histories of multiple traumas.[vii]

This Spotlight Report aims to increase complex trauma and trauma-informed literacy to enhance outcomes for people with cumulative trauma histories and their mental health impacts. It is informed by those who participated in focus groups with lived experience of complex trauma and mental distress as well as the latest evidence and practice.

Our report is designed to inform practitioners and services within the mental health and related sectors about complex trauma and its relationship to mental distress. Healing and recovery are possible with the right support and information. However, if people do not receive the right support, complex trauma can cause ongoing mental distress. The time for a public health response to complex trauma is long overdue if more people with trauma experiences are to live contributing lives.

BACKGROUND

Understanding complex trauma

The term complex trauma describes exposure to multiple traumas, and also, refers to the impacts of that exposure. Complex trauma is distinct from the trauma of a 'one off' event such as a bushfire, flood, sexual or physical assault in adulthood, or from fighting in a war. Single incident trauma is commonly associated with Post Traumatic Stress Disorder (PTSD).

Complex trauma commonly occurs with repeated trauma in childhood, for example, child abuse in all its forms, neglect, family and community violence, exploitation and other adverse childhood experiences. Sometimes a parent or caregiver has experienced their own trauma, and it is still affecting them, for example, in situations of mental illness, drugs and alcohol misuse, or when caregivers are physically or emotionally unavailable. Living in poverty, being marginalised or chronically disadvantaged also make experiences of complex trauma more likely, severe or protracted.

Complex trauma is not always the result of childhood trauma. It can also occur as a result of adults' experience of violence in the community for example, domestic and family violence, civil unrest, war trauma or genocide, refugee and asylum seeker trauma, sexual exploitation and trafficking, extreme medical trauma and/or re-traumatisation.

Impacts

Adults who are traumatised as children, or who experience complex trauma across the life cycle, are more likely to engage with the criminal justice[viii], healthcare[ix] and welfare systems[x], complete or attempt suicide[xi] and/or engage in self-harm or substance misuse[xii] and so forth. Complex trauma affects the way people feel about themselves and their capacity to trust, feel safe, build healthy relationships, and seek support.[xiii]

Many people experiencing complex trauma are or feel isolated and alone, often with multiple co-morbid mental health diagnoses as well as physical health challenges. Lived experience participants in this project called for holistic approaches to provide support with both mental and physical health issues. This includes the need to understand the social contexts of trauma, which enables a greater sense of meaning and understanding. Adopting a trauma-informed approach which seeks to understand *what happened to* people along life's journey (rather than what is `wrong' with them) brings a psychosocial lens to our understanding and the care we can provide.

Healing and recovery

Research shows that people can recover from the impacts of even severe early trauma.[xiv] People can and do recover and their children can do well. For more people to be able to embrace recovery, mental health and human service delivery needs to

reflect the current research and clinical treatment insights into complex trauma and the dissociation which accompanies it.[xv]

Many practitioners and services across the health and human services sectors are not well informed about complex trauma and its impacts. This limits opportunities for healing and increases the likelihood of additional trauma experiences *within services* which are the very places that people seeking support and care turn to for assistance.

METHOD

This report is informed by two focus groups that were facilitated by BEING and supported by Blue Knot. These focus groups captured qualitative information on the experiences of mental health consumers from diagnosis through to the provision of care across different support systems. The report is additionally informed by knowledge from practice and recent evidence, articulated in a range of Blue Knot publications.[xvi]

Participants were recruited from BEING's membership base and the broader community through BEING's newsletter, website and social media platforms. A total of 14 people participated in the focus groups, including 12 people who identified as female, one who identified as male, and one who identified as transgender non-binary.

The focus groups, initially planned to be held face-to-face, were conducted via teleconference due to the impact of COVID-19. Discussions were recorded using video, with agreements that all data reported would be de-identified and that the recordings would be kept confidential and not distributed to third parties.

Questions for the focus groups were jointly designed by BEING and Blue Knot. They were distributed the day before the focus groups to allow participants time and space to prepare and reflect on the questions. The participants' safety was prioritised, with discussions facilitated by BEING and grounding and safety supported by Blue Knot. Participants were encouraged to engage with and respond to each other as well as the facilitator/s during the sessions.

The two video recordings of the focus groups were used as the data source for the qualitative analysis in this report. The data was sorted into key thematic areas and the opinions expressed were extracted accordingly. These are discussed below through the lens of diagnosis; the mental health system; lived experience of services; and treatment.

Focus group participants and diagnosis

All participants in the focus groups had experienced a range of complex challenges including self-harm, suicidality and eating disorders related to their trauma. Several people had also had long journeys of diagnosis and misdiagnosis. Discussions identified that people's diagnostic categories significantly impacted their journeys through the mental health system and their own self-understanding and relationship to themselves. This report uses the language of diagnostic categories used by participants and does not represent the views or judgements of Blue Knot or BEING.

DIAGNOSIS

Complex trauma and diagnosis

> *"(F)or 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."*[xvii]

People with complex trauma histories, particularly from childhood, often receive a range of psychiatric diagnoses as their trauma presents in many forms, with severe, wide-ranging and comorbid symptoms. The new diagnosis of Complex PTSD adopted for the International Classification of Diseases – 11 (ICD-11),[xviii] and first suggested by Judith Herman in 2009, is a step forward in understanding complex trauma. Research by Green et al. found child abuse was associated with between 26 and 32% of adolescent and adult psychiatric disorders.[xix] Seventy-six per cent of adults reporting child physical abuse and neglect experience at least one psychiatric disorder in their lifetime and nearly 50% have been diagnosed with three or more psychiatric disorders.[xx] The more severe and prolonged the trauma, the more severe the psychological and physical health consequences[xxi], including severe mental illness.[xxii]

Mental health diagnoses commonly applied to people with the lived experience of complex trauma include PTSD[xxiii], Borderline Personality Disorder (BPD), Depression[xxiv] or other Affective Disorders, Anxiety Disorders or psychosis[xxv] including Schizophrenia[xxvi] and Bipolar Disorder[xxvii], also Dissociative Disorders[xxviii] and Somatic Symptom Disorder, previously known as Somatoform Disorder.[xxix] While not all childhood trauma leads to psychosis, and not all psychosis is trauma-related, trauma is also a well-documented potential risk factor for psychosis.[xxx]

Many people with complex trauma and mental health diagnoses experience a range of other challenges including substance abuse, eating disorders, self-harming behaviours, and suicidality.[xxxi] Any diagnosis or comorbid diagnosis may be a manifestation of Complex PTSD, or may be related to a coping mechanism (e.g. substance abuse) used to survive. With childhood trauma, comorbidity is the norm rather than the exception. Coexisting depression and anxiety are common, as is the diagnosis of personality disorder, particularly BPD. The developing minds of young children often respond protectively to extreme stress and the perception of threat through the mechanism of dissociation[xxxii] – that is psychological disconnection from the present moment; the `freeze' response – because children are literally unable to fight or flee.

Diagnosis – help or hindrance?

There was a rich discussion in both focus groups about the experience of diagnosis and its possible benefits and downsides for people living with complex trauma. There was a broad range of experiences and opinions. Some participants questioned which was more helpful - having a diagnosis or having one's story heard. Also important was whether clinicians engaged with people by asking about their story first or engaged with people as patients who have a diagnosis, or who need to be diagnosed.

For some of the participants a diagnosis helped alleviate their high level of shame and self-blame, a common characteristic of complex trauma. For these people, having their challenges named as complex trauma helped to provide a context and meaning for their challenges. The diagnosis also connected them to other people's experiences and helped reduce their feelings of alienation. This is because others could see them as a person who had gone through major struggles in their lives and survived.

For others, a diagnosis was a necessary label, but personally meaningless, only needed to access government support such as National Disability Insurance Scheme (NDIS) funding. For others who accessed Victims Services (NSW), having experienced a crime enabled them to access services rather than a diagnosis. Thus making the justice system, and sometimes the police, gatekeepers to services. Police therefore were required to believe a person's experience before they could gain access to counselling services. Participants considered this requirement unacceptable, given the emotional sensitivity of the issues.

One participant reflected there was little distinction between the diagnosis of BPD and that of Complex Post Traumatic Stress Disorder (CPTSD). For her, the critical question was whether she was asked, "What's wrong with you?" rather than "What happened to you?" This is the core underpinning of a trauma-informed approach, and could mean the difference between feeling vindicated and supported rather than stigmatised. The Power Threat Meaning Framework was also raised as providing a very helpful framework for understanding trauma. [xxxiii]

Some participants found it very important to engage with their mental health issues outside of a diagnostic framework, with the best way to understanding their problems being through a trauma lens. Many people observed the distinction between therapists and psychiatrists; some therapists were comfortable adopting a non-diagnostic framework; however, most psychiatrists engage with patients by diagnosing.

Sharing a trauma story

Another participant shared that a psychiatrist had once asked her what was wrong with her, to which she'd replied that she didn't really feel there was anything wrong with her, it was just that she had had a difficult life. This person identified that developing a life narrative, rather than receiving a diagnosis, had helped her to provide meaning to her current struggles.

For many participants, trying to find an appropriate diagnosis was a large part of their life story. For some people this was a journey through different diagnoses, different medications, and different clinicians. Many had struggled through unhelpful diagnoses before their challenges were finally understood in a way that was helpful for them. Many experiencing complex challenges had long journeys through the mental health system with frequent unhelpful side-tracks before finding adequate care and support:

> *"I think for me at all points of contact with health care professionals the hard thing is the restating of the trauma narrative and the impact that that has and that somehow that's necessary for care. The space that I've found safety is probably the GP that I've found, but even then I have to do a lot of work to be ok in that space because I take control of that interaction and lead it the ways that I need to lead it for it to be safe enough. She'll mess up and say stupid things, but I've learnt to be ok with that and I don't necessarily think that is a good thing."*

Stigma and shame

Some participants struggled with the stigma of a BPD diagnosis. One participant shared that although the BPD diagnosis initially made them feel good, the stigma associated with it subsequently left them struggling with it:

> *"…I remember when I first got labelled BPD and my counsellor gave me the DSM III it was at the time … I was like yes you know I'm not the only person, this is me, this is awesome, I'm not bad…so it had all that validation and then I discovered all the stigma around BPD and so then it went head over tail…"*

This participant reflected that despite advice to not let their diagnosis define them, it was hard when a diagnosis refers to your whole personality, and seems to be a moral judgement, rather than a subset of behaviours.

One participant reflected that a diagnosis of BPD excluded them from care rather than enabling it. Another participant shared that a BPD diagnosis effectively labelled them as demanding, attention seeking, exhausting and scary.

One participant, identifying as transgender and non-binary, shared that they avoided medical and psychological settings for fear of stigma, adding another layer of complexity to their trauma challenges. LGBTIQ people are at greater risk of abuse and violence than the wider community and hence also at greater risk of psychological trauma.[xxxiv] Some people will not access services if they fear the stigma of difference as well as diagnosis.

MENTAL HEALTH SYSTEM

Many mental health consumers with a lived experience of complex trauma struggle to find services which meet their needs. This arises from a lack of understanding around the basis of their distress, and a lack of training in, availability of and accessibility to, trauma-informed and trauma specific services. Trauma-informed services are services which are informed by the possibility of the lived experience of trauma in people's lives and their attendant sensitivities. Trauma specific services are clinical and support people to explore and heal from their trauma directly.

Many people continue to be re-traumatised within the mental health system for the above reasons as well as from overtly traumatising practices such as seclusion and chemical and physical restraint. Although reform means that seclusion and restraint are used less often, a lot of re-traumatisation occurs inadvertently and stems from a failure to attune to the experiences and vulnerabilities of trauma survivors.

> *"…inpatient spaces are not made for Complex PTSD. Like I think the medical system just in terms of mental health in general like I think the system isn't there to support people appropriately. I think it's a holding. It's not therapeutic at all. But I've never been able to get into the private system because of my suicidality and so the risk has always been too high and so I always have to go public and as soon as I'm in the public system there's no care and that's usually when my suicidality increases. But I'm unsafe to be at home because my partner can't keep me safe."*

The stigma and discrimination - which can include victim blaming - experienced by people in psychological distress are exacerbated for trauma survivors, who are often reluctant to seek help due to prior experiences of betrayal, lack of safety, shame and stigma, and a failure of services to respond to their needs. Frequent re-traumatisation can mean many survivors experience chronic failures in treatment and a lack of supportive responses which exacerbate their mental distress and contribute to a sense of hopelessness.

The mental health system often does not identify, acknowledge, or appropriately address the burden of complex trauma which is core to the complex needs of many consumers, including those who present with diverse diagnoses including comorbidity.

> *"For me in terms of solutions there needs to be something else we need to create something else or we need to like empower communities, or we need to like think of care in a more complex nuanced way than just locking people away and holding them until episodes calm down."*

LIVED EXPERIENCE OF SERVICES

> *"[My experiences] are across a range of time from being a teenager right up until still currently [adulthood] just finding that both of those contact points [GPs and police] are not safe."*

Police

Two different scenarios were explored by participants in the focus groups in which people experiencing mental distress may encounter the police force. The first is navigating the challenges of an ambulance accompanied by police arriving at a person's home when that person is experiencing a mental health crisis. The second is engaging with police to report the assault/s which underpin a person's trauma.

Participants did not have positive experiences of police arriving with ambulance services to their home. They described police initiating re-traumatising and distressing physical restraint measures rather than de-escalation strategies:

> *"…. I've also had a lot of interactions with the police over an extended period …. My last interaction with police was last year and my first was in 1997…… and not a lot has changed in that time. …. I know that for me it isn't safe. I recognise that for me I'm in a quite high risk from dying in a death by cop scenario because they come in so loud and so full on and with the strong reactions I have I can very well recognise how that can happen."*

It was felt that this reflected a lack of understanding about trauma and trauma triggers. In reporting crimes to the police, the need to engage with police (that is rather than a GP or other trusted person) in order to access support counselling such as from Victims Services was experienced as challenging. Despite sometimes ultimately receiving trauma-informed counselling, having to repeat a story to a range of different people was a common experience which was re-traumatising and felt unsafe.

Paramedics

In contrast to most experiences with the police, participants in general expressed more positive experiences with paramedics. Paramedics were often experienced as compassionate, although generally, not informed specifically about complex trauma. An exception to this was an experience shared by one participant, of a paramedic stating that it was wasting a paramedic's time calling an ambulance for an episode of self-harm. Another participant expressed surprise that paramedics were not better informed about trauma, given that they often receive training around the trauma risks in their own jobs.

Nurses

Participants shared experiences of their encounters with nurses in emergency department (ED) and inpatient settings. [xxxv] Again, a participant heard the view that seeking support with episodes of self-harm was wasting hospital time and resources. This person felt they were punished for self-referring rather than being involuntarily admitted and for trying to avert a deeper crisis. It was felt that the nurse's response related to the stigma of their BPD diagnosis and the assumptions surrounding it.
Another participant indicated that these sorts of negative comments from hospital staff had exacerbated feelings of self-disgust and contributed to struggles with suicidality. Sometimes small comments can evoke significant negative emotional reactions. Words matter and often add to a person's distress.

Another participant with lived experience of complex trauma as well as experience as a peer worker, reflected that nurses perceived people they had supported as a security problem rather than as people experiencing deep emotional distress. In one instance a person accompanied to the ED could not stop screaming. The staff did not try to support the person's distress, threatening instead that security would be called as other patients were being disturbed:

> *"I've found hospital staff to be not trauma informed. Being held down by six people to get a needle in your bum is not heaps helpful. And also then like being left in isolation and waking up on your own is not very safe. It's extremely unsafe because that's where my suicidality has always been the highest. Like in hospital situations. I would've thought that of all places, that would be the most trauma informed."*

Some people had also had challenging experiences with nurses in inpatient units. A common feeling was that inpatient settings overemphasise medical solutions and that nurses were not always able to listen compassionately to people's struggles. Several people said they would value the opportunity for more talk therapy in inpatient settings.

General Practitioners

Participants had mixed experiences of GPs. While an understanding and knowledgeable GP was valued, finding a sympathetic, let alone an informed GP, or one who was open to learning, took a long time. Often, participants suggested GPs needed to be coached about the impacts of trauma and complex trauma survivors' needs. Participants expressed being anxious about having to find a new GP on a journey through a system which does not recognise a person's need for a supportive GP:

> *"…even the good doctors that I work with now they initially weren't in a position of that sort of client centred mentality because it's not a part of their approach*

> *and even trying to start the conversation about navigating into other services is really hard…."*

Some people felt well supported by their GP. One participant had been supported through a crisis of suicidality by a GP who was willing to both learn from and support them. Another person had found a GP with psychotherapy training who had supported her to reengage positively with her emotions and who had not pathologised them as psychiatrists she had seen previously had.

However sometimes GP care appeared to be misplaced as well. One participant had been diagnosed with depression and anxiety by a family GP, who had failed to recognise that their trauma related to their difficult family environment. This person felt that this failure delayed their recovery and that they were viewed according to unhelpful frameworks. Others found that despite knowing about PTSD, many GPs did not know about trauma in its various complex forms.

People also discussed the role of GPs in supporting patients to navigate the health and other systems. Some participants found that GPs were not always best placed to help in this way or to assist in finding the most appropriate care and support.

Therapists

It was generally felt that the limited number of therapy sessions currently available under a mental health care plan (10 sessions)[1] [xxxvi] is not adequate for people living with complex trauma who often need access to long term talk therapy to thrive. One participant suggested that the recent increase in the number of therapy sessions for people with eating disorders would also be an appropriate model for people living with complex trauma, who often need long term therapeutic support. [xxxvii]

> *"One thing that I'd really like to see is that under Medicare, that people with Complex PTSD get access to more than ten psychology appointments per year and I know last year the Butterfly Foundation worked really hard to actually get a program up for people with diagnosed eating disorders umm to get umm forty sessions with a psychologist per year. And there is a very strong relationship between eating disorders and Complex PTSD. So I'm just thinking that umm people with Complex PTSD, their issues cannot be worked on sufficiently in ten sessions."*

Expert clinical opinion is of the view that: 'On average, this treatment is longer-term than that for less complex clinical presentations. For some clients, treatment may last for decades, whether provided continuously or episodically. For others, treatment may be quite delimited, but it rarely can be meaningful if completed in less than 10-20 sessions. Even therapeutic modalities that are designed to be completed

[1] Since the focus groups were held, the Australian Government has announced under its 2020-21 Budget, the doubling of subsidised psychological therapy sessions nationwide under the *MBS Better Access to Psychiatrists, Psychologists and General Practitioners* Initiative.

within 20-30 sessions may require more sessions or repetitions of 'cycles', or episodes, of the intervention. Obviously, goals and duration of treatment should be geared to the client's ability, motivation, and resources. When they are limited, interventions are directed toward safety, support, education, specific skills and, in some cases, psychosocial rehabilitation and case management'.[xxxviii] Some people may need treatment on and off over their lifetime.[xxxix]

Some people found that accessing Victims Services, and additional government funded sessions with therapists who understood complex trauma, supported their recovery. There was a feeling that a list of trauma-trained therapists would help meet baseline needs for people living with complex trauma, enabling access to appropriate support which was less emotionally and financially draining.

> *"I guess part of the challenge is trying to find a good therapist, so like my psychologist is awesome, but the challenge is trying to find a good one and it should not be that hard. … When I started searching for a new therapist I went through thirteen therapists just to find my current one. So I tend to refer to her as therapist take thirteen and there's like two years of trying and again massive re-traumatisation."*

Participants expressed challenges in finding a therapist who works in a way which is appropriate to their needs – one participant suggested 'speed dating' to identify therapists who might be appropriate to help them. This is because finding the right therapist with the right skill set can take many financially and emotionally expensive sessions. The search can involve a painful and triggering `retelling of the story' to therapists who are not necessarily experienced as trauma-informed despite self-identifying as such.

Experiences with different parts of the mental health services system

Participants who had spent time in inpatient units reported substantial differences in the therapeutic options available in inpatient public and private hospital systems, and financial accessibility to the private system.

One participant shared that when her partner could not support her through periods of suicidality she had to spend time in inpatient units. Her levels of suicidality excluded her from the private system, in which there was greater choice around therapeutic options. She also found that the kinds of non-medical talking therapies she wanted to access were not readily available in public inpatient settings.

Another participant said that accessing step up services could be challenging if you did not meet the criteria for public inpatient admissions and could not afford private health insurance – such a situation is inequitable. Participants felt there should be alternatives to current services in public inpatient units which are still funded by the public health system, but which can provide the levels of support needed for people struggling with suicidality and trauma.[xl]

TREATMENT

Non-traditional approaches

Many people experiencing mental distress related to complex trauma go to counselling or therapy. There are many different approaches to this and different approaches work for different people. They also need to be attuned to people's diverse background, cultures, and needs. However, it is widely recommended that effective complex trauma therapy should be `bottom up' *and* `top down'. This means approaches which engage the body as well as emotions, and the mind.[xli]

Complex trauma affects different aspects of a person and the connections and the way in which they work together. Counselling supports the person to re-integrate (reconnect) their emotions, sensations, awareness and thoughts.[xlii]Body-based approaches such as trauma-informed yoga and mindfulness can help the body and mind to reconnect.

A range of approaches such as psychodynamic, [xliii]somatic (body-based) work, [xliv]an understanding of trauma-based dissociation[xlv] and mindfulness and Eastern principles[xlvi] inform complex trauma counselling.

`Practice-based evidence' which in contrast to the more familiar `evidence-based practice', considers the experiences of both the client *and* the therapist have influenced treatment choices.[xlvii] `Common factors' research, which establishes that a combination of factors contribute to effective treatment, is also important. Some of these factors include the importance of what happens outside of the client-therapist relationship as well as within it. While complex trauma treatment needs to be relational - regardless of the modality/ies which are used – it also needs to foster skills such as self-soothing which are necessary for supporting safety, stabilisation, trauma processing, and fostering well-being.

A range of diverse treatment approaches are now available in addition to the more traditional approaches. 'Right-brain' oriented psychotherapies,[xlviii] which evolving clinical and research findings support, include art therapy,[xlix] sand play,[l] creative dance,[li] equine therapy, [lii]and drumming[liii]. Heart math, Heart Rate Variability (HRT)[liv] and neuro-feedback [lv]are also now widely used therapeutic tools. Energy psychology, [lvi]eye movement desensitisation and reprocessing (EMDR)[lvii], and clinical hypnotherapy[lviii] pursued from a trauma-informed frame can also be valuable and effective.

Clinical treatment

The majority of practitioners, in the field agree that a phased approach to treatment is recommended.[lix] It is important to note that these phases do not follow one another in a linear manner and that safety needs to be established time and again.

The three phases of `phased treatment' are:

- Safety and stabilisation.
- Trauma processing.

- Consolidation of the gains of treatment – re-integration.

The first phase (safety and stabilisation) is very important and is needed before any other work can proceed. People affected by complex trauma often find it difficult to regulate their levels of arousal, emotions and behaviour. They often also find it difficult to reflect (this is why `bottom up' approaches as well as `top down' cognition (thinking) approaches are important). Trauma is dysregulating and disrupts mental processes and concentration. Trying to change thoughts before learning how to self-regulate is often not only ineffective but can also re-traumatise people.

Most people with complex trauma, especially from early childhood can also dissociate often and this has treatment implications. Patients *`with significant dissociative symptoms...respond less well to standard exposure-based psychotherapy and better to treatments that assist them with self-stabilization as well'*.[lx]

In a group
Many complex trauma survivors find therapeutic groups beneficial. It is important to carefully screen participants so that the group matches the stage of treatment of each participant. It is also important that groups are facilitated by trauma-informed counsellors, and ideally co-facilitated. Such groups can foster safety, and a better understanding of the self, as well as reduce the sense of isolation and shame.

With other survivors
Peer (other survivors) support can also be very important. Peers can use their understanding of their own experiences to support others to feel safer, identify and build on their strengths, and increase a sense of hope and optimism for healing. Trauma-informed peer support helps create a shared understanding of trauma experiences, the different ways people cope, give and receive support, and recover. It fosters healing relationships, which negate the power and control of traditional services.[lxi] It is important for 'peers' to be secure in their own recovery including recognising and managing their triggers and trauma reactions.

Some people in the focus groups found the opportunity to share their own and hear other people's experiences a very positive and powerful experience. This suggests that more groups, as well as more trauma specific peer workers, could be a helpful support for many people struggling with the impacts of complex trauma.

Non-clinical supports
Consensus amongst participants in the focus groups was that non-clinical supports can often play a vital role in recovery journeys. These are outlined below.

- **Advocacy and Peer work**

One participant, a lived experience peer worker, expressed the powerful and therapeutic benefits of her role through opportunities to engage with other people with similar experiences. For this person, peer work together with a therapist's support had enabled her to move towards and sustain her recovery.[lxii]

Another participant found their mental health advocacy work a great support which also enabled her to find her own therapist. For many people being able to share their story publicly was a powerful contributor towards recovery, drawing them out of their isolation and loneliness.

It is well recognised that peer work and advocacy by people with lived experience can also provide hope and help to reduce the stigma around mental health issues. This in turn supports others to seek help.

- **More than therapy**

Many participants felt that funding support was needed for an extensive range of therapeutic activities beyond therapy sessions.

- **Opportunities to share with other people living with complex trauma**

Some participants said that they found that the opportunity to share their own and hear other people's experiences was very positive and powerful. This suggests that more groups, but also more trauma specific peer workers could be a helpful support for many people struggling with complex trauma.

- **Nature**

Many participants said they found that being able to engage with nature was a very positive part of moving towards and maintaining recovery.

- **Art, Writing and Music**

Creative self-expression was also important for many people, whether through writing, self-directed artistic work, or art therapy. One participant shared that they had found their art had changed over the course of their recovery. For this person, their recovery journey was also their artistic journey.

Another participant shared that they were learning a musical instrument which they had found to be very focussing and centring. This participant's therapist had even invited them to share some of the music they were discovering in a therapy session. Artistic self-expression was a bridge to others for this person, and a way of linking therapy to life outside the therapist's office.

- **Spirituality**

For some participants spirituality was an important component of the recovery journey. Spirituality is broad and can encompass a range of experiences. Without defining specifically what people found helpful, drawing on resources which held meaning for the person was the key factor.

The core message that came from this section of the focus groups is that it can be very helpful to understand complex trauma in ways that move outside a medically conceived understanding. This provides a further dimension to the question of diagnosis as well. The deep ambivalence many people felt about diagnosis was reflected in this search for non-medical ways to understand and modulate their experiences.

OPPORTUNITIES FOR IMPROVEMENT

This report promotes a better understanding of complex trauma for both providers and the sector more broadly, by drawing on the lived experience of people with complex trauma histories and the existing research and practice-based evidence. It has highlighted the importance of identifying and understanding the lived experience of trauma, particularly complex trauma underpinning mental distress and diagnosis. The stories of a group of people with lived experience, who participated in the project's focus groups, contributed to a deeper understanding of the need to reduce stigma and the challenges experienced in seeking and accessing support on their healing and recovery journeys through existing systems of care and treatment.

While this report addresses the public health challenge of complex trauma, we acknowledge that the findings of this report are limited by the small number of participants involved in the focus groups. Some opportunities for improvement have been identified based on the feedback from the focus groups as well as additional evidence from lived experience, research and practice. These include:

- The need for public health campaigns to raise awareness of the public health issue of complex trauma and to reduce stigma and discrimination.

- Strengthening appropriate education and training for the workforce by:

    - Translating knowledge from lived experience, clinical practice and research into training programs and curricula
    - Integration of complex trauma and trauma-informed courses into University, College and VET sector curricula.
    - Enhancing access to diverse complex trauma and trauma-informed professional development training programs nationally across sectors to be readily available.
    - Trauma-informed training for allied health, mental health practitioners, police, paramedics, emergency room clinicians and GPs.
    - Training for GPs to improve the system navigation supports they can provide to people living with trauma.

- Improving service delivery by:
    - Increasing the number of government-funded therapy/counselling sessions for people living with complex trauma including access for diverse populations.
    - Increasing access to trauma-informed therapists in government funded inpatient settings in multidisciplinary teams.
    - Increasing support for and access and dissemination of information to a broader range of therapies and healing approaches for people living with complex trauma.

- Integrating trauma specific peer workers in all service settings as members of multidisciplinary teams.

Both Blue Knot and BEING hope that this report will raise awareness and understanding about the reality of the lived experience of complex trauma to inform policy, practice and service changes. The challenges and achievements shared by consumers for this report suggest the need for additional inquiry and improvements in available supports for people living with complex trauma.

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