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CONFERENCE PAPER:

"ALL SOLDIERS HAVE NIGHTMARES"

(A quote from the character, Captain Nathan Algren, in the movie, "The Last Samurai")

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Introduction to Trauma

He is a transient, he lives in a tree. Trees don't come with hot and cold running water, no showers, or toothbrushes or washing machines, as you know. His appearance is dishevelled and quite pungent. As he walks by the restaurant goes seated on sidewalks in the fashion able Fremantle Café district he may see some one he knows. If he tries to join the party, the ladies present usually demand he leaves.

Based on the limited knowledge you have of him what are your feelings toward him? Where would you refer him?

He eats off the plates of others in the restaurant area of Fremantle. You leave it on your plate, "too full, could not eat another bite" he eats it, the leftovers.

What do you feel now, any different? Would you refer him any place different now?

He was traumatised as a child, lived with violent parents, suffered the usual sleep deprivation. Nutritional deprivation. The crucial points in childhood where there is a window of opportunity to stimulate the child to reasoning and academic excellence, were missed. No one in his knew about "that fancy book learning stuff". Nobody was sober enough to care, so he was never stimulated towards academics. He did life "tough". School was incidental in his life, he left as soon as he was old enough to figure out how.

What do you think of him now? Where would you refer him now?

His offences are minor, usually related to police moving him out of somewhere, when his presence annoyed one of the good people of the community. Resisting arrest, lying to police, assaulting an officer – that sort of stuff.

He gets \$400 and some change every fortnight on a pension. He gives \$250 of it every fortnight to Save the Children Fund as he cannot stand to think of a child going hungry. Food from other people's restaurant plates is fine for him, it does well by him, he would rather spend his food money on kids in far flung places.

What do you think of him now? Where would you refer him now?

The point is, what you think of him is irrelevant in terms of defining him. But your feelings and thoughts of him are extremely relevant if they blind you to the truth of who he is. Trauma can bend people, and you must bypass your own bias about that bending, or exhaustion from confronting that bending, and ask about trauma.

The word trauma conjures thoughts of "Bali, or September 11, or the Middle East". However, those perpetuating the trauma are seldom foreigners with political or religious intentions, but family members charged with caring for the victim.

Trauma is an overwhelming event or series of events that can result in the profound fragmentation of the mind and body, of relationships and families, of communities and even nations. This fragmentation can cause – PTSD, dissociation, other psychiatric disorders, physical illness and relationship breakdowns. Then this fragmentation spawns:

- re-traumatisation,
- intergenerational cycles of violence,
- maltreatment, and
- stigma.

Treatment Target:

- ✓ the current trauma responses, and
- ✓ to limit the cycle and its future impact.

Types of Trauma Care:

Critical incident Debriefings – one identified incident

In a Critical incident Guideline produced by Gary Byron, the then Director General, August 8, 1997 a critical incident was identified as “...*an situation or event, which causes an individual to experience unusually strong emotional reactions, as a result of that particular event or situation. The incident makes overwhelming demands on a person’s normal coping ability, and potentially may disrupt their ability to function at that time or later.*”

The following framed area is adapted from a paper presented by Michael Tunnecliffe, 11th December 2002 titles ‘Clinical Responses to the tragedy in Bali’

Professor Tony Taylor (Victoria university, NZ) suggests there are as many as 6 levels of victimisation, each having a set of needs to be addressed following a critical incident”

1. Primary victims – those directly involved on site
2. Those nearby or in the area
3. Those with psychological proximity (family and friends)
4. Responders and helpers
5. Those who know the family and friends
6. The wider community, unaffected but worried about their own future.

In order to treat each grouping the clinician needs to understand:

Victims have varying degrees of proximity to the event. Recovery is not a smooth process. Victims recover at a different pace, and are triggered by different events.

Avoid pathologising reactions-reactions of survivors, family and friends are going to be diverse and will in some cases have an impact on their ability to function normally for some time.

Normal people in abnormal circumstances behave abnormally, and that is normal.

Maintain support for front line medical service personnel. One of the important lessons learnt after Port Arthur was the need to keep up supportive assistance to the first responders. This was not done and compassionate, well-trained professionals left their professions.

After a critical incident it is helpful for the victims to:

- ✓ Receive appropriate education as to the event, and its possible impact.
- ✓ Know what to expect from himself and others.
- ✓ Practice affect expression and regulation.
- ✓ Re-instate himself in his stable world
- ✓ Understand when, and if, additional care is needed.

After witnessing the beating of one parent, or a violent argument, a drunken brawl, what happens all too often within the families we see? How many of the child witnesses are recognized as victims, or treated adequately?

With adequate intervention an individual will be mobilized and empowered to return to his own supportive network. He may not “get over” the incident but he will adjust and adapt as they restore themselves to their permanently adjusted environment. Without it, the effects of trauma remain.

Trauma reactions do not end when the incident fades from the headlines. Decades after Hitler’s Germany prison camp survivors can be triggered to panic at the sight of a German Shepherd or the sound of a particular accent. Families intergenerationally are impacted a world and even decades removed from the original event.

A report published by Warren A Harrison, May 1999 by Monash University Accident Research Centre presented that of those injured in vehicle accidents in Victoria in 1997 13% experienced Acute Anxiety Disorder, 15% a specific driving phobia, 30% PTSD and less than 14% a Major Depressive Disorder. This has profound implications for their future adjustment.

At the time of a trauma inducing incident:

Perceptual Distortions may be experienced in the areas of:

- Time
- Visual
- Auditory
- Emotional

At the time of crisis the traumatized become highly focused on the events around them. This focus enters a trance state in which conscious control is lessened. This state leads to perceptual distortion such as distortion of time (accident victims often report, “it was like time stood still, everything was in slow motion”), numbness even paralysis, the inability to scream or move, a sense of unreality, or of being in a bad movie that has no “off” button. Two people in the same trauma will recall very

different aspects of the trauma, the first may recall the victim's screams, the second may be totally unaware of that, focusing only on the grief demonstrated in the crowd. The verbalisations that occur, which are often abusive themselves: Such as, "its your fault...you are worthless" etc. take on the power of hypnotic suggestions, rendering negative consequences for the hearer.

On Scene Responses: Fight or Flight Mode

- Shock
- Nausea
- Crying
- Fainting
- Hyperventilation – breathing becomes shallow and rapid
- Trembling
- Urinary tract/Bowel release
- Heart racing
- Sweat glands operate at an increased rate
- Stomach stops digesting food
- Adrenalin increases accompanied by Cortisol
- Extremities become cold as blood flow is redirected
- The coagulative factor in the blood increases as the body readies itself for a wound.

Post-Critical Incident Stress Symptoms

- ✓ Nightmares
- ✓ Flashbacks
- ✓ Fear of insanity, or loss of emotional control
- ✓ Guilt, sorrow, remorse
- ✓ Depression
- ✓ Suicidal thoughts
- ✓ Heightened sense of danger
- ✓ Emotional numbing
- ✓ Emotional isolation/withdrawal
- ✓ Anger/hate toward subject
- ✓ Fear and anxiety about future situations
- ✓ Sleep disturbance
- ✓ Sexual disturbance
- ✓ Alienation, cynicism and distrust of "the agency" in particular, "the system" in general.
- ✓ Problems with authority figures – challenging and testing rules/regulations
- ✓ Memory impairment
- ✓ Loss of interest in work and activities
- ✓ Avoidance of activities that rouse memory of trauma
- ✓ Fantasies of retaliation/destruction
- ✓ Fatigue

Our coping strategies for normal life are overwhelmed by the crisis.

Specific areas of the brain are activated, producing strong fear reactions, the brain secretes hormones, and substances called opioids are manufactured, these produce a calming or numbing effect. **All of these processes take place automatically, there is no conscious control.**

Some of our clients live in such a chaotic world that it triggers these responses almost continuously. Take a minute to think what that would be like.

When faced with trauma we can expect three dynamics:

1. Automatic responses will occur
2. Conscious control is lessened
3. Responses will be under the control of unconscious processes, which may be referred to as instinctual. These are influenced by individual biochemistry, physiological and psychological influences at the time, and past learning

After the event individuals may be extremely critical of their responses. They may comment, "I am usually so good under pressure...I don't know what came over me...if only I had..." This aspect is particularly vital for effective treatment; the individual has to be educated to the fact that his/her responses were beyond his/her conscious control. Both the hero and the paralysed onlooker were at the mercy of their "instinctual" responses, neither was in control of their responses.

How does this relate to our work?

For some trauma sufferers the feeling of disconnection, depersonalisation can last hours to months. The mind and body try to heal the hurt, if not heal, encapsulate it and remove it from the present.

Trauma reactions involved sleeplessness, distrust of authority, agitation, unwanted recall of trauma inducing event/s, exaggerated startle reflect, irritability, guilt at surviving (being released), many an offender who has used alcohol or chemicals to adjust her/his life experience will seek what is known to work if s/he is confronted with such symptoms. Alcohol and drugs: increasing the likelihood of re-offence.

Many of our offenders live in Life long situational trauma – multiple incidents over the client's history

Dysfunctional families don't have members they hold hostages.

One of the dangers of our work is our over familiarity with the data. So many of the offenders have the same history,
same details,
different name and face.

We can become desensitised to the fact that the data we gather is not mere data but extremely important facts about the person under our supervision or care.

The (Western Australian) Sunday Times, April 11, 2004 p15 reported that *many burglars have a record of school failure, family conflict, poor parental involvement in schooling, and substance abuse.*

In the West Australian 8/9/01 is a brief article title “Fighting Blamed in Toddler Woes” by Yonnene Pearce.

“Domestic violence has the same impact on a child as war or abduction according to a Melbourne clinical psychologist. But researcher and educator in childhood trauma, Jennifer McIntosh said health professionals and the community were naïve about the impact of domestic violence on children, particularly infants and toddlers....International research had shown that from two months of age babies could form traumatic memories, and from two weeks they tried to shield themselves from conflict.

*Dr. McIntosh said children with prolonged exposure to domestic violence were four times more likely to develop problems such as depression, poor self esteem, hypertension **and aggression.**”*

Finkelhor’s 1984 model suggests that all abused children, develop maladaptive beliefs about trust, social stigma and power. Hordes of subsequent researchers have discovered that trust is such an issue with those who have been abused as children, and who have gone on to abuse others, that *“Building a therapeutic alliance based on trust between helper and helpee, therefore, may be the crux of successful treatment and lowered recidivism rates for male sex offenders”*. Of concern to us is the question **“How does the fact of mandated therapeutic intervention, and sharing of information from the therapeutic encounter with others involved in the offender’s sentencing or parole issues impact on that trust?”**

There are physiological issues at stake too. Annaclare van Dalen *“documented the connection between physical abuse and its impact on cognitive and intrapsychic functioning as well as the physiological impact on brain function and body chemistry.”*

Quoting Van der Kolk’s 1996 work, George Halasz writes “Van de Kolk suggested that in trauma the body keeps the score. The autobiographical memory of trauma is thought to be stored in the right brain’s orbitofrontal cortex.” (The Legacy of the Holocaust: Children and the Holocaust, “Can Trauma Be Transmitted Across the Generations?” p. 215)

This is extremely relevant for DoJ as it has been said that once the amygdala has been altered through trauma it remains altered, and body chemistry determines the presence of many mood/affect disorders, which are often present in those who commit crimes as adolescents or adults.

It has long been known that our muscles hold memories. However it may be more extensive than we realise.

In a recent documentary Brazilian authorities were at a loss to explain strange deaths and debilitation that was occurring, it was first reported in March 1997. People were

dying from massive haemorrhaging, and there appeared to be no known cause. Nobody suspected caterpillars. The caterpillars alone are irritants; en masse they can be lethal. Merely brushing them can release their venom, which causes the coagulative factor of the blood to drop from 100 to zero. Any site of historic physical trauma is particularly vulnerable. One woman was bleeding profusely through ear piercings, which had long since healed. A bruise, physical trauma, surgery, even though it may have healed decades ago and to the most careful observer, appears fully restored, becomes a target for excessive haemorrhaging.

As the cells replenish and replace themselves, apparently to a pre-morbid condition, they in fact pass down the memory of the trauma each and every time they are replaced. Some of our offenders have been brutally and physically abused, repeatedly, one wonders about the invisible scars and memories of abuse they carry with them.

Caterpillars are to the only creatures to be able to resurrect old traumas to the harm of the individual.

Ms van Dalen stated that juvenile offenders exhibit 3 prominent features:

- **drug involvement,**
- **a history of family violence, and**
- **intrinsic neurological and/or cognitive vulnerabilities** – each of which contributes to the potential for violence. They also have a shared history of family violence, either as a witness of extreme violence or as targets of brutality, which can affect the personality development of a child, and have long-term emotional effects.

Mel Levine, MD, in his book “A Mind at a Time”, wrote:

I participated in several research studies involving early adolescent juvenile delinquents. In these investigations we sought to uncover specific Neuro developmental dysfunctions, which were common among these kids. **We were struck by how many teenagers in serious trouble with the law had an expressive (neurologically based - mine) language dysfunction as one of the risk factors that led to their downward spiral.** In fact, it turns out that at two ages in particular, namely preschool and late adolescences language production problems are strongly associated with acting out, aggressive, and sometimes downright antisocial behaviours.” P 143

The question must be asked: Is the neurological impairment that results in language dysfunction a direct result of violence, neglect, or trauma? We know that for many of our offenders exposure to violence begins en utero as their mother’s are physically abused during pregnancy. Exposure to trauma can increase the development of vulnerability toward being both the victim and the perpetrator of violence.

Ms van Dalen advocates rehabilitation programs to focus on the traumas contributing to the antisocial behaviour, and for high-risk adolescents, not yet criminally involved to receive trauma intervention.

McMackin, Leien, Sattled, Krinsley and Riggs in 2003 wrote a chapter in the book titled, *Trauma and Juvenile Delinquency: Theory, Research and Interventions*, “*Most male offenders have been exposed to trauma. Many juvenile offenders have experienced both acute and chronic trauma. Trauma exposure among offenders is closely linked to their criminal behaviour, yet few protocols have been developed to treat posttraumatic sequelae in a delinquent population.*” As a result of their research four separate pilot groups were conducted in the Massachusetts Department of Youth Service secure residential facilities. The treatment included

- Trauma psycho education (including the relationship between the trauma and offending)
- therapeutic trauma exposure through discussion and expressive arts, and
- coping skill development.

A longitudinal sample of 509 juveniles confined to 48 correctional facilities in 20 states across the US discovered that *child maltreatment was associated with increased levels of depression and anxiety, which were implicated in the offending behaviour. This maltreatment included exposure to physical and sexual abuse.* (Child Maltreatment and Adjustment to Juvenile correctional Institutions, by Gover, MacKenzie and Layton – Criminal Justice and Behaviour, June 2003, Vol 30: 374-396)

The conclusion was that the results of this study provide empirical evidence that child maltreatment should be assessed when treating issues related to psychological adjustment within juvenile correctional environments.

There are only so many ways our dysfunction can be displayed. Therefore I am going to take one of the most commonly described situational trauma. **The alcoholic home.**

Janet Woititz wrote “**Adult Children of Alcoholics**”, on her web site she notes that her book was originally written with only children of alcoholics in mind. Since its first publication, we have learned that the material discussed applies to other types of dysfunctional homes as well.”

A child raised with one or more alcoholic parents, or in other dysfunctional situations will, as an adult, struggle with many dynamics. Claudia Black in her book, Changing Course, p 3, expressed it best when she claimed that the inhabitants of such a home are raised with the rule of

- Don’t Talk,
- Don’t Trust,
- Don’t feel:

The lack of anticipatory joy. If there is an event upcoming he will not become excited about it, as in childhood few of the promised parties, or celebrations eventuated. Without knowing it, he just does not believe it until he sees it. The upcoming event is not real until it arrives. This throws a damper on family expectations, it can even prevent others from having fun too. Christmas and birthdays are dreaded or overlooked, they never came to much, or if they did the drunk spoiled it for every one.

Never knowing the rules. The rules in dysfunctional homes change hourly. The challenge is to guess what the rule is and get it right, or else. One day he throws his shoes in the corner and its okay, the next he will be smacked across the room for it. He gets a “c” on a school exam and is screamed at and called every useless name his parents know, then the next he comes home having smashed up the car, and its okay. He never knows what is a big deal and what isn’t. ACOA’s often say, “life is like a party, every one knows what to bring, what to wear, I don’t, **I am always guessing**”. As a result as an adult he will explode over some minor infraction, and yet let a large problem slide right on by. They are always guessing what normal behaviour is.

He always apologizes, everything is his fault, his peers are often annoyed by his saying “I am sorry” for things he could not possibly control. A 10-year-old boy drew a picture of his mother, she was lying on a sofa, drunk, with cans and bottles scattered around her in the trashed room. When the therapist asked him what it meant he said “it means if I had been a better little boy my mum would not have had to drink”. Those raised in dysfunctional homes judge themselves without mercy.

He suffers trauma responses, he has often witnessed verbal and physical violence, laying in bed at night under the covers hearing the fight, desperately not wanting to hear it, desperately wanting to hear because silence might mean one of them is dead. Not knowing if he would kill her or she would kill him, or.....

Denial stalks the days and nights. If someone is acting abominably the rest of the family ignore it and act like it is not happening even if they are looking right at it. Its not alcoholism it’s a headache, or a migraine, or some other malady, never the real thing. I wasn’t hit last night, I fell down the stairs.

Darling Illustration.

Without realising it, they live a life of deception. This carries forward into adulthood and they can be seen to be lying by others who are aware of the reality.

As Claudia Black writes, in Changing Course, p. 12. *“To be raised with denial is to know the rule of silence.*

As children we learned that it was not okay to speak the truth, and, instead, we should pretend things were different than they were.

It may be that our perceptions were not validated, or we felt threatened about speaking up for fear of the consequences...

As upset, frightened or concerned as we were, we believed that we would jeopardize our well-being and betray those we loved if we spoke the truth.”

When Claudia Black and her research partner Brown were undergoing their initial research in the effects on children of living in an alcoholic home they discovered that often between the ages of 28-30 the adult child may unravel. Up till that time they may be a super over achiever, have everything, do everything, be on a roll. Then the wheels fall off.

One young man said his unravelling began as he was laying in bed at night listening to the tap drip. He became so angry. With himself! For not being able to fix it! They can be super responsible, or super irresponsible.

Adults raised in dysfunctional homes constantly seek approval and affirmation; they will do a \$40 hour job for \$20. They strive for the high A in the class. They often take themselves very seriously. They are people pleasers. They are terrified of abandonment, at the same time courting abandonment it because it is all they feel they “deserve”, or know how to handle.

Conversely, they often will do almost anything and put up with almost anything in order not to suffer the loss of a relationship, staying loyal when it is self-defeating to be so loyal. They will often choose insecure, volatile relationships because they matched their childhood relationship with alcoholic or dysfunctional parents.

Adults raised in dysfunctional homes find it difficult to delegate, anything, any body else ever said they would do for them, has been a failed project. They **learn not** to trust anyone’s word, and end up carrying the heavy end of the load – they insist on it.

Result: This diminishes other people’s self-confidence or abilities, they do less. The adult child then becomes resentful, not realising it is their insistence on the situation that caused others around them to under function. If as a parent they over function for their children, rewarding only dependent behaviour the results can be disastrous.

The web site for Adult Children of Alcoholics World Service Organization states: *“Even more self-defeating, we became addicted to excitement in all our affairs, preferring constant upset to workable solutions.”* Imagine the impact of that dynamic alone on one’s life, marriage, career, parenting.

In an alcoholic or dysfunctional home you can never win. If you have integrated with that dynamic you pass it on to others, neither your partner nor your offspring can win either, no one gets it right. This dynamic alone creates mayhem and de-stabilises the family unit, repeatedly.

The adult child of trauma, dysfunction, alcoholism can heal. They cannot relive or re-write the past, but they can recover from its pain – gradually. They can let down those defences that once helped them survive. They can learn new life skills, change their frame of reference, and function in a healthier manner, if they dare.

Dose-Response Relationship in trauma sufferers.

It has been widely held that the degree of trauma experienced equals the degree of PTSD symptoms experienced, this has been called “a dose-Response relationship” between traumatizing conditions and the severity of PTSD symptoms.

PTSD diagnosis according to the DSM-IV requires an **initial reaction** to the traumatic event. This initial reaction has been later associated with subsequent symptomatology. In their research Maercker, Beauducel and Schutzwahl presented in the Journal of Traumatic Stress, Vol 13, No 4, 2000, *propose that the initial reactions to the trauma explain a larger proportion of PTSD variance than do dose-response related measures.*

This would explain why one individual crumbles under exposure to a traumatizing event and another will seemingly shrug it off, the later symptomatology for the two will also reflect this difference.

The 1986 Horowitz model is supported with data showing that initial fear reactions moderated between event severity and later PTSD symptoms.

What this means for us on the ground at DOJ is that it is the client's response to the trauma that counts, not the severity of the trauma. And we are not going to know this unless we ask. Often they will not be aware of it, until we assist them.

In an article published in the Journal of Traumatic Stress, Vol 17, No2, April 2004 Jaycox, Ebener, Damesek and Becker researched whether or not trauma exposure and related symptoms interfered the recovery of adolescents entering substance abuse programs.

Of consequence to our work in their research is that:
...high rates of PTSD were detected among chemically dependent adolescents (24.3% for males and 45.3% for females)

Among adolescent substance users in treatment, females and those with traumatic stress symptoms reported higher levels of substance abuse, as well as physical and mental health problems.

Trauma exposure and related symptoms have the potential to affect substance abuse treatment.

Research on adults has shown that trauma experience and related symptoms of anxiety and depression interfere with clients' abilities to adhere to or benefit from drug treatment.

Some studies have pointed to poorer retention in treatment and others to increased likelihood of relapse.

There is a significant relationship between past life stressors, total trauma exposure, and problem behaviours. PTSD symptoms were associated with internalising behaviour problems but not with externalising problems.

These researchers concluded trauma exposure, life stress, and related symptoms of PTSD are a significant problem among those admitted to adolescent residential substance abuse treatment programs. The traumas reported are severe, and most reported exposure to more than one event. Among those exposed to trauma, 29% of the adolescents in the sample met the criterion for current PTSD.

In this complex sample of substance abusers, the researchers found that trauma exposure alone was related to an increase in externalising behaviour problems.

That does not mean the other 71% were not symptomatic, it just means they did not meet the DSM-IV criterion for diagnosis.

No discussion about trauma would be complete without addressing the concept of trauma being a causative factor in the high incidence of incarceration of our indigenous people. In 2001 it was estimated that Aboriginal, and Torres strait Islander people make up approximately 3% of the general Australian population, yet make up approximately 20% of the prison population. Noritta Morseu-Diop in a paper titled "You say you hear us, but are you really listening or are we just noise in the Distance? Which she resented at the Best practice Interventions in corrections for Indigenous People conference in Sydney in 2001, wrote:

*"There are many reasons for the high imprisonment rate of indigenous people...One cannot ignore the impact and process of colonisation and its devastating and intergenerational effect on the lives of Indigenous people throughout Australia today...(the) unresolved issues of trauma, loss and grief are in the centre of their lives and are **the cause** of the many other social issues and problems in the community. Whilst the many social issues/problems such as, family violence crime/imprisonment, alcohol and drug abuse, suicide, low self-esteem, ill-health, self harming, etc. are in the periphery and are the **symptoms**.*

One thing is evident, that the aboriginals who feel intrinsically tied to the land, feel egregiously wounded when that land, ergo an extension of themselves is misused, stolen, or made unavailable to them.

Dr. Russell D'Sousa a Melbourne psychiatrist who worked with many indigenous people in the Broken Hill as they travelled through crisis. Consequently he adapted his approach to more effectively serve them, it is a spiritually augmented CBT program consisting of 14 sessions over 10 weeks which focuses on the client's own belief system, and spirituality. He claims this program validates the client's beliefs and brings purpose and meaning to suffering which aids in the ability to cope. He sees the client's own spirituality as a copying aid.

Removal from one's culture, being overrun by another culture, living as it were a prisoner in one's own land, loss of one's one cultural identity are not experiences unique to our indigenous people. In fact a group of psychiatrists and doctors from across Europe went before the European Parliament in November 2003 to plead for assistance to treat immigrants. Immigrants who had been forced to flee their homeland for many reasons. Most have horror accounts of brutality, war, political upheaval, and extreme poverty. For most the trauma includes harrowing journeys, risky border crossings, organised by traffickers. Travel companions die en route; children are endangered in unroadworthy vehicles and unseaworthy vessels. Dr. Achategui of Spain instigated a program called SAPPPIR to attempt to de-traumatise these immigrants. He believes it is his duty to not only treat, but to advise the world of this cross-cultural phenomenon. (The West Australian, Saturday January 24, 2004, p 30)

Once the trauma symptomatology is relieved the client then has all of the usual relocation issues to manage. One of the difficulties with particularly the Bosnian

refugees is that so many of the “good” guys were made to do “bad” things. Their own generals forced them to shoot at the living shields, sometimes children, that the opposing forces used, in order to get to the enemy. So they come here and do not regroup and find an identity as they distrust each other. When they come to our attention as offenders we need to realise just how totally disenfranchised they are. They are in a strange land, they cannot speak or read the language, and they are too afraid or ashamed to connect with others from their own country of origin.

Trauma responses can be relayed inter-generationally, we know about the Adult Children of Alcoholics, the offspring of drunks who seek to break the cycle. Ann Smith wrote a book **The Grandchildren of Alcoholics** and some sneered. Her work is valid, of course the dysfunction is passed along behaviourally, cognitively, within the family myths and patterns of reactions down the generations. Helen Epstein wrote **The Children of the Holocaust**, to describe the consequence of being raised by parents interned in the Nazi concentration camps. In Europe, at the beginning of the 2nd world war, train loads of Jewish children were sent to safer places, such as the English countryside. These trains were called Kinder trains. After the war those parents, grandparents who survived and were well enough tried to find the children. Paperwork was non existent, tracking them was well nigh impossible. If, and when, they did locate them the children were no longer German speaking Western European Jews, they were Protestant, English speaking school children who did not want to go with their now unknown (to them) parents or grandparents, with whom they could not even communicate due to the language barrier.

The trauma of displacement, forced migration, invasion has been with us a long time, and it deserves renewed attention. If you are dealing with the children of such immigrants be aware that even though the accent is Australian the trauma is international and may well be a causative factor in the dysfunction in the home, and the subsequent offending.

FAMILY DANCE:

RIGID

ENMESHED

DISENGAGED

CHAOTIC

BLEND.

Addressing Trauma Reactions:

A Cognitive Approach

Working to enhance the offender's capacity for narrative intelligibility is vital as this leads to an integration of dissociated thoughts and emotional affect. Helping the offender to reframe the trauma and own it at both the cognitive and affective levels is essential.

Research has demonstrated that the way we think about a situation affects our emotional state, it determines the way we feel about the situation, it determines our felt level of stress, ability to focus on life's tasks, and even our general health.

It is important while bring the truth and reason to the client's analysis of a situation, that you do not devalue his self-explanation, even if it is simplistic. Build upon his beliefs; gradually shape them to the desired outcome.

An offender may say "My father left when I was 12, I had been in a bit of trouble at school, he and mum fought over me, I was the oldest kid, making life hard for them it was my fault."

- That offender's narrative of that life-changing event is key to his resolution of the issue. Challenging the myth he perpetuates that he was the causative factor in the divorce, writing it based on the truth, is key.
- He then needs to disown the inappropriate feeling of guilt and self blame, and
- own the sense of loss and abandonment, and
- the fact that there was nothing he could do to create or stop the event.

One way is to ask "would you let a 12 year old define you now? If a 12 year old tried to tell you what was or was not your responsibility in your parent's life what would you?" Most would kick a certain part of his anatomy. Then the question is "why are you letting the 12 year old (insert the offender's name here) define you now?"

An offender may minimize the way he thinks of his potential. His self-limiting cognitive patterns quickly convert to self-limiting behavioural patterns, often with dire consequences. Again, rewriting the narrative of his self-talk concerning his potential is essential.

The first way to end the wrongful narrative is to employ "**thought stopping techniques**" such as visualising "the stop sign", or using elastic bands to snap against the wrist.

The second way is the cognitive reframing method where negative, false beliefs and statements are replaced with positive, self-affirming statements. His merely saying positive things to himself will not change the basic self concept from negative to positive, but

- ✓ thinking clearly and accurately about the self or situation, and

- ✓ refusing to reinforce the error,
- ✓ restating the truth,
- ✓ attaching new emotions to the self narrative, and
- ✓ turning that into positive behaviour renders great potential for change.

De-catastrophise the thinking: After trauma the individual must prevent himself from allowing his thoughts to lead him to the worst possible conclusion, the smell of smoke does not always mean the house is burning down, an ambulance siren does not mean a fatal car crash, a yell from another room does not mean some one is being beaten. Such catastrophic thinking paralyzes the individual. The individual should tell himself the truth “all I know is I can smell smoke”, investigate calmly, and even if there is a fire continue to reassure himself with “I can take steps to manage this, I know what to do”.

These skills are acquired gradually, and take practice.

Emphasize and celebrate the healthy changes or adaptations the client has already made. This gives him a hook upon which to hang his confidence in his ability to overcome the next hurdle. Foster the recuperative abilities of the client.

An Integrative Approach:

Clinical application of attachment theory means replacing the insecure-attachment with a secure base for the self and object consistency. Multiple selves multiple voices can spring from trauma, violation and dissociation. Clinicians need to understand the contribution of mother-infant mutual influence to the origins of self and object representations.

Disorganized and disoriented attachments are formed in the presence of dissociative disorders. When trauma is present so often is dissociation.

I will refer to Dr. George Halasz from Monash Medical Centre again, the son of a German concentration camp survivor has studied the effect of maternal trauma on infants. He believes that massive trauma on an individual, say a mother, is passed on verbally and non verbally to her infant, shaping relationships and family dynamics to come.

He states that if the mother’s pain is too overwhelming or confusing to the infant he or she will detach, perhaps to the point of dissociation and psychological retreat. He believes that an infant can enter psychological isolation at the earliest levels of the mother child relationship. He believes that knowing the parent’s story releases ghosts in both the mother and child and makes a path for healing and reconnection in later years.

If there are other variables present in the home such as mal treatment, abuse, alcoholism, crime and drugs this disconnection can be one of the key factors that edge an individual towards a life of offending.

A young male aboriginal offender with over 150 offences to his name, many violent and brutal, at the age of 2 1/2 witnessed the savage rape of his mother and sister. He

became “blind”, he said darkness enveloped him and all he could hear were the screams, which distorted to sound like they were within him, mercifully they faded too. He remained unable to see until he was 7. He was transferred to the desert where tribal elders cared for him. Today he says it was a spiritual gift that the elders gave him in kindness to protect him from the reality around him. He will frame it within his own frame of reference. It is more likely that he dissociated deeply, could not bear to see what he was seeing, hear what he was hearing and in the words of Hugh Petersen, the former head of the Department of Psychology at Chapman University in Orange County, California was saved by “organ complicity” or a conversion reaction. Because it was couched in terms accepted by his own people, it cannot be psychiatrically labelled according to the DSM-IV

Re-education:

- ✓ The reconnection is accomplished by strengthening the offender’s capacity for reflective thought, which in turn,
- ✓ facilitates the organization and integration of error-correcting information.
- ✓ The offender needs to understand the link between early interpersonal trauma and later adjustment.
- ✓ The offender needs to apply affect recognition, and regulation.

To accomplish the clinician needs to employ motivational interviewing, self control training, trauma resolution, repetitive education. And the offender needs to be available, have a long enough order, be motivated and have the psychological sophistication to employ in the service of his/her own healing.

IT IS SLOW WORK: For the trauma survivor, the awakening of full awareness and sensation may seem too explosive to risk. It needs to be an unhurried process, based on mutual trust, in an emotionally safe and manageable environment. To push or manipulate the process is to further violate the traumatized and discourages client empowerment and choice.

Holistic Approach

Realising that depression, and PTSD are often co-morbid in trauma victims as is anxiety, although these are separate disorders they often result from trauma and need to be treated, often with medication.

Stress can result in wear and tear on the bones, connective tissue and joint cartilage which can then become diseased. That disease in and of itself which needs to be treated.

The body’s system that breaks down under stress is largely genetically determined, however to tell someone who now has resultant arthritis, or tissue damage due to a stomach ulcer, insomnia, tics, etc. that “it is stress” is not enough. The damage also has to be acknowledged and treated.

A Structured Approach

1. **Introduction:** Establish an environmentally safe atmosphere that encourages disclosure.

2. **Fact Phase:** This is a phase where you will be reflective. Ask for the replay of facts, with as much detail as they can recall and as you judge necessary to bring it alive for them. Do not assume that a couple or a family have the same recall of the event, or share the same fund of knowledge concerning it.
(Couple with suicide attempt)
3. **Feeling Phase:** This is the 2nd reflective stage. Encourage the expression of feelings, the conscious connecting of feelings with the event, this is a challenge when emotional numbing or dissociation has occurred. If one is blocked or scape goated focus on that one, drawing them out, modelling for the family, partner that none are to be left out of the experience, no matter how seemingly insignificant their particular role.
4. Repeat this as often as necessary with as many facts as necessary.
5. **Intervention/education Phase:** This is the phase where you will be most active. Re-educate, rework the scenario, assist the individual/family to adapt the narrative of the event to a healthy one, focusing on the strengths, “you survived...even though you were petrified you survived...you have learned from it.” Their subsequent feelings about the event and each other depends on how they analyse it, how they write it into their family narrative. You can assist here by actively bring your knowledge of trauma response to neutralise, normalise and educate.
6. **Closure:** Ask how they now feel about it, how they new think about it, rework their strengths corporately and individually.

Differential Trauma Assessment:

When dealing with trauma reactions an accurate diagnosis is essential for effective treatment.

Julian D. Ford and other serious researchers through the Department of Veteran’s Affairs National Centre for PTSD discuss a disorder known as Disorders of Extreme Stress Not Otherwise (DENOS) specified, as compared to PTSD.

Often these two conditions are co-morbid complaints. In a sample of military veterans seeking inpatient PTSD treatment 31% qualified for both conditions, 29% were diagnosed with PTSD, 27% classified as on DESNOS and 13% did not meet the criteria for either. DESNOS classification was associated with:

- a. Early childhood trauma and participation in war zone atrocities
- b. Extreme levels of intrusive trauma re-experiencing symptoms
- c. Impaired characterological functioning (object relations)
- d. Elevated risk of utilization of intensive psychiatric services.

The finding suggested that these two disorders can be co-morbid but remain distinctly different post trauma syndromes. The differences carry incredible implications for traumas.

To research this issue further visit:

trauma-pages.com/ford99.htm

Trauma related feelings evident in some kinds of offences:

- Intense fear,
- Helplessness,
- Horror
- Flash backs to the original trauma

can become triggers causing some offenders to re-offend. This highlights again the need for trauma response resolution treatment. These feelings can be present without a formal PTSD diagnosis. The healing process involves teaching the offender that the triggers indicating the trauma, also signal him/her to offending action. The coupling between the trigger and the offending behaviour has to be broken. Just because you feel afraid, helpless, horrified, and have flash backs to the original trauma, you do not have to offend!!!! You might be the only one who has ever said that to the offender.

Acute stress disorder:

Unlike with PTSD the stressor can be of any kind, not necessarily extreme or life threatening.

The **essential** feature is the development of characteristic anxiety, dissociative, and other **symptoms that occur within 1 month** of exposure to the extreme traumatic stressor. (DSM-IV, p. 429)

Either during, or after the event the individual has at least 3 of the symptoms:

- A subjective case of numbing,
- Detachment,
- Or absence of emotional responsiveness
- A reduction in the awareness of the surroundings
- Derealization,
- Depersonalisation,
- Dissociative amnesia

Following the trauma:

- The traumatic event is persistently re-experienced,
- The individual displays marked avoidance of stimuli that arouse recollections of the event
- Marked symptoms of anxiety, or increased arousal,

These symptoms must cause clinically significant distress and last at least 2 days, not persisting beyond 4 weeks.

Discussion: As a result of the trauma the individual develops dissociative symptoms, decreased emotional responsiveness, find it difficult to experience pleasure, feel guilty about pursuing general life. They have problems concentrating, feel detached from their bodies, experience the world as unreal, dreamlike, have problems recalling

events of the trauma. One symptoms from each of the symptom clusters of PTSD is required. (see DSM-IV p. 429-432)

Post-Traumatic Stress Disorder

The stressor must be extreme, eg life threatening. It can be experienced personally or witnessed. The person's response to the trauma must include:

- Intense fear
- Helplessness
- Horror, or
- In children – disorganised or agitated behaviour.

The characteristic symptoms include:

- Persistent re-experiencing the trauma
- Persistent avoidance of the stimuli associated with the trauma
- Numbing of general responsiveness
- Persistent symptoms of increased arousal

The full symptom picture must be present for more than 1 month

The disturbance must cause significant clinical distress or impairment, socially, occupationally, or in other areas of function.

Specific qualifiers are used as to the onset and duration of the symptoms:

Acute – less than 3 months

Chronic – symptoms persist over 3 months

Delayed Onset – at least 6 months have passed between the trauma and the onset of symptoms.

Application for treatment:

Incorrect diagnosis leads to incorrect treatment.

Our key role for the DoJ and the broader community is to assist offenders to end the offending cycle. Trauma as a criminogenic variable cannot be ignored.

The life stories of offenders can be glaringly familiar; some days it's like the same story, different name, different face.

Added to the historic trauma many offenders suffer,

- the trauma of being in “the system”, of the court experience, of witnessing or being victimised by prisoner on prisoner brutality in prison,
- recognition of the impact to their own life (years lost) and the lives of others of their offending behaviour, or
- the trauma of being removed from society
- the trauma of re-entry.

We are constantly learning from our clients.

“...we must continue to be sensitive to what our clients tell us about what they do, rather than to try to fit square pegs into round holes.”

(Offence Pathways in Sexual Offenders; Hudson, Ward, McCormack, University of Canterbury NZ, Journal of Interpersonal Violence, Vol 14, No. 8 August 1999, 779-798, 1999)

Knowledge that trauma has the potential to impact the client profoundly is imperative.

There has been an amazing increasing volume of work to examine the effects of domestic violence on children and delinquency and, much of the literature has been spread across disparate fields – sociology, criminology, psychology and social welfare. The departments rarely share knowledge or integrate their findings into a workable unit for the benefit of all. The problem has reached the proportion that surely such an integrated approach is warranted.

The needs mandate an integrated, sharing of knowledge across professional fields, and training as a must in this enlightened age regarding the effect of trauma on offenders and their potential to re-offend without skilled intervention.

The Clinician Trauma Compassion Fatigue

Secondary Trauma Stress and Vicarious Traumatization

“Secondary traumatic stress (STS, also “compassion fatigue”) and vicarious traumatization are conceptualised as reactions to the emotional demands on therapists and the social network members from exposure to trauma survivors’ terrifying, horrifying, and shocking images; strong chaotic affect; and intrusive traumatic memories.” (reviewed in Figley, 1995a; Pearlman, 1995; Sexton, 1999, Stamm, 1995 and Jenkins and Baird, 2002)

Jenkins and Bair presented a study in 2002 to examine the general distress and burnout suffered by sexual assault and domestic violence counsellors. The condition they were researching **STS** describes the sudden adverse reactions caregivers can have to trauma survivors. It is seen as an occupational hazard for those hearing accounts of trauma.

VT or **vicarious traumatization** is a dynamic suffered by therapists who help victims of violence, particularly sexual assault and incest survivors. Pearlman and Saakvitne (1995) define VT as the permanent “transformation in the inner experience of the therapist that comes about as a result of empathic engagement with client’s trauma material (Pearlman and Saakvitne, 1995, p. 31)

Disturbances in the professional’s cognitive frame of reference regarding:

- Identity
- World view
- Spirituality
- Affect

- Tolerance
- Fundamental psychological needs
- Deeply held beliefs about self and others
- Interpersonal; relationships
- Internal imagery
- Physical presence in the world

Verbal exposure to traumatic material theoretically changes the therapist's cognitive schema in 5 major areas:

- Trust
- Safety
- Control
- Esteem
- Intimacy

These effects may be profound and long lasting.

Burnout, for the purpose of the paper was seen to be a different dynamic, the symptoms included:

- Initial over involvement
- Emotional exhaustion that leads to withdrawal and progress into
- Depersonalisation of clients
- Poor service delivery
- Reduced job satisfaction
- Feelings of inadequacy
- Sense of failure
- Lowered self esteem

Professionals who work in institutions are more rather than in private practice are more at risk to burn out (Farber 1985).

Burnout has also been linked to chronic tedium in the workplace rather than exposure to specific kinds of client problems such as trauma (Schauben and Frazier, 1995)

Researchers dispute whether it is exposure to one particular client trauma, or an accumulation of various traumas over time that create VT.

“The present research suggests that STS and VT are experienced both similarly and somewhat differently by trauma therapists”

Compassion fatigue has been an empirically identified condition common to those who deal with the traumatised.

As professionals working with the traumatised we need to take care of ourselves:

Tick those you have in place:

- Effective supervision
- Limiting our exposure (not overbooking regardless of the need)
- Vital life outside the therapy hour

- ❑ Self observe – check your responses, take time off if you need to
- ❑ Listen to feed back from others who care about you
- ❑ Seek support within the institution, from colleagues
- ❑ Be aware of the signs of compassion fatigue, recognise that you cannot do everything for everyone, and that it is mandatory that you allow yourself to acknowledge that sometimes “it gets to you” and that’s okay.

Michael Tunnecliffe, quoting Gilliland and James (1997) suggests 6 key initiatives to recognise and manage “Compassion fatigue” and burn out.

- ❑ Maintain your education and training to review your perceptions about issues and clients you are working with.
- ❑ Be clear on your role and its parameters (no dual relationships)
- ❑ Be realistic about your goals when working with clients affected by trauma.
- ❑ Be prepared to talk through the issues which impact on you.
- ❑ Have a colleague who can provide you with technical support.
- ❑ Accept emotional support from family or friends.

Further Reading

Articles, available in Belmont office:

You Say You Hear Us, But Are You Really Listening or Are We Just a Noise In The Distance?” by Norima Morseu- Diop, Aboriginal and Torres Strait Islander Corporation for Legal Services, presented at seminar for the Australian Institute for Criminology, held in Sydney, 8-9 October 2001.

Secondary Traumatic Stress and Vicarious Trauma: a Validation Study, Sharon Rae Jenkins and Stephanie Baird, International Society for Traumatic Stress Studies, 2002

Trauma Exposure and Retention in Adolescent Substance Abuse Treatment, Jaycox, Edener, Damesek, Becker, International Society for Traumatic Stress Studies, 2004

Trauma Severity and initial reactions as Precipitating Factors for Posttraumatic Stress Symptoms and Chronic Dissociation in Former Political Prisoners, Maercker, Beauducel, Schutzwohl, International Society for Traumatic Studies, 2002

A number of abstracts compiled and in same folder identified as “Trauma Care”..

Books:

Black, Claudia; Changing Course, (regarding Adult children of alcoholics).

Levine, Mel; A Mind At A Time, Simon and Schuster, 2002

Rothschild, Babette; The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment

Terr, Lenore; Too Scared To Cry: Psychic Trauma in Childhood

Tunnecliffe, Lesley; Children Affected By Trauma

Tunnecliffe, Michael; Manage The Stress of Traumatic Incidents

Presentation on Stress designed for Power Point, written by Greg Bayne:
http://justnet/_files/safety_welfare/effective_coping_skills.pdf

psychematters.com