Communicating with people with Trauma Related Disorders

A resource prepared by the Intermediary Pilot Program

Background and Overview

About trauma

Trauma is a psychological response to a deeply disturbing or distressing event. Traumatic events may be one-off and experienced personally (e.g. a threatened or actual rape or serious physical assault) or witnessed (e.g. witnessing a death, serious accident or torture of another). Traumatic events can also include more prolonged experiences (e.g. sexual abuse, family violence, exposure to war, socio-political violence experienced by asylum seekers and refugees).

People who have experienced trauma respond and recover in a range of unique ways. Some will recover relatively quickly with the support of other people. Others may feel that their capacity to cope has been overwhelmed and struggle to come to terms with the trauma. These people may be at risk for developing a trauma related disorder.

Trauma-related disorders

The Diagnostic and Statistical Manual of Mental Disorders (DSM-V)[i] currently identifies the trauma-related disorders as Post-traumatic Stress Disorder (**PTSD**) and Acute Stress Disorder (**ASD**).

Symptoms associated with these disorders include intense, disturbing thoughts and feelings related to their traumatic experience that last long after the experience has ended. The person may relive the event through flashbacks or nightmares; they may feel sadness, fear or anger; and they may feel detached or estranged from other people. They may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch.

In PTSD, symptoms last for more than a month and often persist for months and sometimes years. In ASD, symptoms are contained to between 3 days - 1 month after the trauma. PTSD is the second most common mental health disorder, with 5-10 per cent of people experiencing PTSD during their lives. Women are twice as likely to report having PTSD than men. About a third of children or adolescents exposed to trauma are likely to develop PTSD.[ii]

Complex PTSD

In 2018 the World Health Organisation (WHO) published ICD-11[iii] identified **Complex PTSD (C-PTSD)** as a variant of PTSD. C-PTSD may develop following exposure to prolonged or repetitive events which are extremely threatening or horrific, typically interpersonal in nature, from which escape is difficult or perceived to be impossible (e.g. childhood sexual abuse, or prolonged domestic or other interpersonal violence). All diagnostic requirements for PTSD are met, as well as severe and persistent problems in affect regulation; beliefs about oneself as diminished, defeated or worthless; feelings of shame, guilt or failure related to the trauma; and difficulties in sustaining relationships and in feeling close to others.

There is some overlap between symptoms of C-PTSD and those of Borderline Personality Disorder (BPD) – namely difficulties with emotion regulation, negative self-concept, and interpersonal problems.[iv]

Using a trauma informed approach

Trauma-informed practice is a strengths-based framework which understands symptoms of trauma as a protective human response. It is founded on five guiding principles, to ensure that systems don't retraumatise people or contribute to their experience of powerlessness.[v] These include:

1) ensure physical and emotional safety in your interactions
2) establish trust through respect, transparency and consistency
3) offer the person choice where possible
4) collaborate and share power where possible
5) prioritise their empowerment and sense of self-efficacy.

VICTORIA State Government | Justice and Community Safety

Common Issues

Generally, people experiencing trauma-related disorders may experience a range of symptoms such as:

- re-living the traumatic event through distressing, unwanted memories and/or flashbacks. This is typically accompanied by acute anxiety and intense physical reactions e.g. racing heart, breathlessness, muscle tension, sweating, trembling, nausea or dizziness
- experiencing vivid nightmares about the traumatic event, resulting in disturbed sleep or sleep avoidance
- dissociating or 'blanking out' when faced with triggers or when overwhelmed. This may look like staring into space or dropping out of the conversation, and the person may not be aware of what is happening in their surrounds or what is being said
- avoiding reminders of the traumatic event, including activities, places, people, thoughts or feelings that bring back memories of the trauma
- being easily startled, and/or being constantly on the lookout for danger
- finding it difficult to relate to and feel close with others, difficulties with trust
- being more distractible and finding it difficult to concentrate and retain information despite efforts to do so
- overreacting to seemingly minor issues and struggling to manage feelings of anger and fear in appropriate ways. This can be perplexing for those engaging with the person.
- persistent feelings of shame relating to the trauma/abuse ('there must be something wrong with me'), guilt ('It is my fault this happened'), and helplessness
- feeling flat, numb and disconnected from the self and world around them
- may experience other mental health problems such as depression and anxiety or use drugs and alcohol as a way of managing symptoms.

Case Example: Mia

Mia is a 24-year-old female who lives independently and has a close network of friends and family. Mia experienced a violent rape by an ex-partner which she described as 'terrifying'.*

After recovering from physical injuries, Mia began to experience repeated flashbacks of the rape where she felt that she was reliving the experience. Mia also experienced distressing nightmares, and she reported staying up late into the night to avoid going to sleep. Mia reported that she would 'blank out' (dissociate) at work whilst serving customers and be unaware of what was happening around her. Mia became increasingly anxious and frightened to leave her house, and subsequently left her job and her studies.

Mia has felt unable to make a statement to police as the flashbacks are intolerable and she is fearful of attending the police station. Police requested advice to assist them to interview Mia.

Strategies that assisted Mia to make a statement to police included:

- *providing her with clear information about the process of reporting the incident to police, including who will be present, and what will happen on the day*
- *scheduling the interview at the time of day that Mia has identified is best for her, given her difficulties sleeping*
- *asking her to identify what physical and emotional signs might indicate that she is becoming increasingly distressed, potentially leading to episodes of dissociation*
- *identifying strategies that support Mia to regulate her emotions including visual reminders of when to ask for a break.*

*Name and details changed

General Strategies

The information below outlines general strategies that can be adopted by representatives of the court to enhance communication with people diagnosed with trauma-related disorders. These include:

- use a trauma-informed approach. Use a calm consistent manner, be transparent, offer choice where possible and always do what you say you are going to do. The person will be vigilant to signs that you are safe and able to be trusted.
- in the court, be clear about what is going to happen and why. Predictability reduces anxiety.
- offer choice where possible (e.g. offer the choice of taking a break if the witness appears distressed, give forewarning of any potentially traumatic material that is to be introduced to the witness, and maintain a calm, non-accusatory manner when putting the case.
- have a preliminary discussion about what would help the person to feel safe in further interactions. The capacity to accommodate these preferences will vary but may include – would the person prefer to speak with a female/male? Where would they feel comfortable to meet (home/police station/another neutral place)? Would they prefer to have a support person with them? Is there a preferred time of the day to meet when they function and communicate best (considering sleep issues and medication effects)? Are there particular triggers you should be aware of?
- in face to face meetings, the person will likely be scanning the environment for threats so be mindful of your body language – use relaxed facial expressions, adopt a relaxed posture and open stance (don't cross arms or face away), and make comfortable eye contact (some people with feel threatened by consistent eye contact).
- establish whether the person has strategies for managing flashbacks/dissociation/acute anxiety and encourage them to use those strategies as needed. Sensory tools (e.g. stress ball, weighted blanket) can assist with affect regulation. Let the person know that they can take a break whenever they need to.
- when asking questions remember that the person is likely to be highly anxious, distractible and potentially experiencing traumatic memories/flashbacks or dissociation. Use a slower rate of speech, use simple language, keep questions short, signpost when you are beginning, ending or returning to a particular topic and allow

Case Example: Nasim

Nasim is a 45-year-old male who was born in Iraq. He was a prisoner of war for four years during the Iraq-Iran war. Nasim witnessed his parents tortured and murdered and was separated from his siblings. Nasim arrived in Australia as a refugee when he was a teenager and was detained for 4 years in a detention centre. Nasim is now an itinerant worker and struggles to maintain employment and adequate housing. He reports having few social supports.*

Nasim presented at a community health centre stating that he had been assaulted by a member of his ex-partner's family. Nasim presented as on edge, distracted and quick to anger. Nasim reported that he sleeps for approximately 3 hours a night, and experiences horrific nightmares. Nasim also stated that he feels that he is worth nothing and is frequently suicidal.

Strategies that assisted Nasim give his evidence in the police interview included:

- *exploring whether Nasim has a support person from his own community that could attend with him*
- *considering the most appropriate location to conduct the interview, acknowledging that the police station may be an intimidating environment for Nasim*
- *exploring whether Nasim requires an interpreter and feels safe with an interpreter from his own community*
- *explaining the steps and process in reporting the crime to police, in terms that Nasim understands.*

*Name and details changed

additional processing time before expecting a response.

- monitor for loss of attention and dissociation ('zoning out'). Check in with how the person is coping, whether they need a break and prompt them to use their strategies. Grounding techniques can be helpful if the person is dissociative. They use the senses to assist a person to return to the present moment, (e.g tell me about 5 things you can see, 4 things you can hear, 3 things you can touch etc). You may need to repeat questions to ensure understanding.
- consider using visual aids to support communication and reduce the cognitive load e.g putting together a timeline of alleged events, or a visual reminder of who is who in Court. A visual reminder to use calming or grounding strategies might also be useful.
- monitor for signs of escalating anxiety/distress – for example increased distractibility, loss of eye contact, breathlessness, sweating, muscular tension; and offer breaks as needed. Encouraging the person to use their strategies and/or take slow, deep breaths with longer exhalation (e.g. breathe in for 4 counts and out for 5) if they appear overwhelmed may be helpful.

References

[i] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, fifth edition (DSM-V).* Arlington, VA: American Psychiatric Association.

[ii] Phoenix Australia. (2020). *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder.* Retrieved from https://www.phoenixaustralia.org/resources/ptsd-guidelines

[iii] World Health Organization. (2018). *International classification of diseases for mortality and morbidity statistics (11th Revision).* Retrieved from https://icd.who.int/browse11/l-m/en

[iv] Pai, A., Suris, A. M., & North, C. S. (2017). Posttraumatic stress disorder in the DSM-5: Controversy, change, and conceptual considerations. *Behavioral Sciences,7*(1), 7. https://doi.org/10.3390/bs7010007

[v] Kezelman, C. (2014). *Trauma informed practice.* Retrieved from https://mhaustralia.org/general/trauma-informed-practice