The Peregrine Centre Rural Mental Health Podcast

Episode 26. Miniseries: Working with trauma part 3

Speaker Key:

RS Rebecca Sng

AM Anna Maxwell

MG Maya Goldman

AG Al Griskaitis

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Intro Hello. I'm Dr Rebecca Sng, director of The Peregrine Centre. As we begin this episode of The Peregrine Rural Mental Health podcast, please join me in stopping to consider the land beneath your feet, wherever you might be listening from today. Let's take a moment together to acknowledge the traditional owners of that land. We pay our deepest respects to the elders of the past, those of the present, and the emerging elders of tomorrow. The Peregrine Rural Mental Health podcast is brought to you as part of our rural mental health partnership with New South Wales Health.

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RS Hello, everybody, and welcome to this episode of the Peregrine Rural Mental Health Podcast. Today is a pretty special episode. We're going to continue our series in Trauma, and we've got a panel of, let's say, experts who have come together to give us a bit of different perspective about how we can work with trauma. So we might start with introductions, if that's okay, Maybe. Anna, I'll start with you. If you can just tell the listeners who you are and a little bit about your career so far.

AM Thanks, Rebecca. So, my name is Anna Maxwell. I practice as a paediatric mental health social worker. My career, spanning 30 years, specialising in kids and families, adolescents, all working with adversity and trauma.

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Then, really, experiences in overseas, working with some awesome people, including Bruce Perry. And back in the day, Violet Oaklander. Lots of people in the States and the UK. And I'm very passionate about this area. So that's pretty much where I've been most of my career.

RS Thanks, Anna. And probably good to mention that Anna is joining us from Orange today. And so we might go to her partner in crime. Maya, do you want to introduce yourself.

MG My name is Maya Goldman. I'm an occupational therapist who has been working in the private practice paediatric world for the last seven years or so. I fell into the role of working with children and families who had adverse life experiences.

And over the last number of years, I really developed a greater interest in working

with young people who have lived through those traumatic experiences. Particularly, I had lived in Sydney, and when I moved out to the Central West about 3 years ago, that's when the real journey of working with young people and their families who've experienced trauma sort of began. And it's been a really exciting journey so far.

RS Perfect. Thanks, Maya. And last but not least, Al, do you want to introduce yourself?

AG Sure. Al Griskaitis. I'm a consultant psychiatrist. I'm based primarily down in Wollongong, and I do stuff online through thepsychcollective.com. My focus is a bit different to the other panellists. I work mostly with adult trauma, especially police and military. So a pretty different kettle of fish.

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RS Great. Thanks, Al. So, it's great to have a variety of perspectives on the panel today, and we'll be working our way through a few questions and maybe talking a little bit about a case vignette that you've all had a little read of beforehand.

But let me launch with this question, which is, I guess, a common question we're going to ask. When people say trauma, they often mean different things. Sometimes they mean a kind of one off experience. Sometimes, as Al said, they mean somebody who's worked on the… Let's say a front line worker or somebody who's been to war, but sometimes they also mean something like an abusive childhood or really difficult life experiences.

So, for you guys, what do you think is the difference between those kinds of trauma presentations? Maybe, Al, I'll start with you. What do you think is something that is noticeable in the difference between those presentations?

AG The problem with the term is it's very low resolution, and it's used to mean everything under the sun. So that's a problem. I think it's helpful to delineate childhood trauma, which I consider more of a developmental injury or something that affects developmental trajectory to adult trauma. So that's a useful distinction.

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And by that, I mean, I guess in some sense, with adult trauma, the proof is in the pudding. If someone ends up in a situation where they're now very emotional, very hypersensitive, jumping at shadows, hypervigilant, that kind of thing. Well, they've been traumatised by the fact that you can see it. And what traumatises one person may not traumatise another, depending on one's susceptibility. So the problem is, it's a complicated concept.

RS Yes. I think that's so true that that sense of hypervigilance or being on alert the whole time, head on a swivel, always obsessed with safety and security. I think that's a really important point to say. That is a sign that maybe somebody has had some kind of trauma, some kind of experience that overwhelmed them in some way.

AG Yes, I kind of think of it as they've entered into an alarm state. It's almost like…

It's good if you think about a tame bunny rabbit, you can pick them up and you can pat him, but a wild bunny rabbit will run a mile. And it's like a switch has been flicked in that direction.

RS Yes. What about you, Anna? Have you got other observations that you wanted to add to Al's?

AM Yes, I guess because we, Maya and I work predominantly with children, and so we predominantly see what Al was talking about, that developmental trauma. So that's where children have been overwhelmed with adverse experiences, which changes and alters the actual structure of the brain. And so it comes out in lots of different behaviours.

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And so lots of children that we see are kids in out-of-home care that have been removed, and it comes up in their behaviour and in lots of dysregulated emotions, and they get in lots of trouble at school. And so these are the kids that get labelled as being naughty, attention seeking.

And on top of that, we also see kids that also experience these one off incidences of trauma, like car accidents or environmental disasters like floods that we had out here some time ago, fires, that sort of stuff. So we also see that, that the biggest difference is, and what Al was saying, people can experience trauma and respond differently.

So, if you have a child that has had developmental trauma, and then on top of that, they then experience a pandemic, floods, a car accident, you've got multiple layers of different kinds of trauma, which makes it quite complex.

RS And that point about developmental trauma affecting the brain, or the kind of hardware in which you process life in the future. And, of course, often people who live in chaotic families are vulnerable to car accidents or premature death or death by suicide. Those kinds of things can layer on top of, as you say, this beginning. But also, you're trying to manage those with not very good hardware, and stuff that's not up to what you would expect of a child's age I suppose.

AM Yes, that's right.

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RS So, Maya, do you want to talk a little bit more about how trauma affects the brain? You know, what are the kinds of things that you see in your client or kids that you say that are really consequences of having this kind of repeated trauma?

MG Yes, absolutely. I guess, going off of what Anna's said, often I'll find I have a referral from someone, and it'll start with behaviours of concern. Child is hitting, kicking, big meltdowns, family don't know how to cope. Sleep is a really big one. So often I'll see families coming and saying their five year old or their seven year old, they're still co-sleeping, because there is absolutely no way that their child can sleep soundly. And that really results in carer burnout.

So I suppose, from the perspective of the referrals that I'm receiving, it's a lot of the surface. I guess, if you see the iceberg, a lot of what we are told initially, is

those surface level symptoms or presentations. And then using our little detective hats, hopefully we're able to find out a little bit more of those underlying puzzle pieces to figure out, well, really, what's going on for these people and this family. Which can sometimes be really tricky in terms of accessing that information.

RS Yes, I always think of that kind of holy trinity of a referral, where kids have an ADHD diagnosis, and ODD diagnosis, and an ASD diagnosis, and it's all… I mean, it may well be true for certain kids, but for a lot of kids, it's actually a consequence of trauma and this kind of obsession with safety and security.

MG Absolutely.

RS You mentioned, Maya, sleep. I know, Al, that's an interest of yours. Do you see those kind of disturbances in the adult population that you work with?

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AG Well, absolutely. So the issue with the hypervigilance is, it doesn't really stop. You don't really feel calm, and you've got unresolved trauma. So that whenever you've got a big problem, you've got a legal problem, say, you think about it, you can't not think about it, it bubbles up in your mind. And the same story with trauma, it bubbles up in your mind. So you're hyper aroused. You've got these problems on your mind, and they keep you awake.

So, consequently, sleep deprivation, mental fatigue, emotional fatigue. When a kid doesn't get a good night's sleep, they're quite difficult. Same for adults.

RS Yes. And I think that idea about not being able to file something away, that's important, isn't it? In all the kinds of trauma. That traumatic incident, I always think of it almost like a filing cabinet, where the file is sticking up. So you're trying to close the drawer, but it's always getting stuck at that particular memory.

AG I like that analogy a lot, because it's terrifying to even contemplate the trauma. And so it's very hard to address it. And usually, it requires quite a high resolution of really coming to grips with what happened. It's not just the events that happened. It's why was I susceptible to what happened as well, and what were the assumptions about the world that I had wrong? And they're very difficult things to face.

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RS That's a key point, isn't it? This idea that a traumatic incident often turns someone's world upside down or turns their assumptions on their head. I think the idea about a trauma treatment, I suppose, and there are different jobs that a treating practitioner might be doing. One of them is, of course, this re-experiencing of the traumatic incident to help process that memory, file that file away, and be able to close the drawer.

But, of course, there are other things that are happening, as well, as you say, Al. There's not just the bad thing that happened, but all the stuff around it. So, I guess it leads to my question about trauma informed practice. We see that term talked about a lot at the moment. What does that term mean to you guys? I guess,

Maya, maybe I'll start with you. What does trauma informed practice mean to you?

MG Well, I feel like trauma informed practice is really a way in which we approach how we interact with all of our clients. So in OT, we talk about therapeutic use of self, which is really how we use our whole body within a therapeutic setting. So it's how you greet the person, how you have a phone call with them, even how you might interact with them over an email exchange.

Really understanding that for a lot of these people, they have so much going on in their world. And coming across as kind is great, but coming across as compassionate and empathetic and being a shoulder that they can, if they're having a bad day, come to and talk to. You don't have to necessarily offer any kind of solution or suggestion, but letting them be heard. I think that's really one of the things that is so important.

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And those principles that I find I use every day in my therapeutic practice really help to create a sense of connection between yourself and the client And that can take a lot of time. But once you have that sort of connection, you can move really quite far in therapy. And so I think the idea of trauma informed practice is just about that. The whole way in which you approach your interactions with your clients and their families.

RS Yes, I think that's an important thing to highlight, that, in fact, trauma informed practice isn't just what takes place in the therapy room, per se, it's the whole surrounding thing. Anna, I know that you had mentioned that to me before. Do you want to add anything to what Maya said?

AM Yes, because one of the things, particularly working with children, is that we're not just working with the child. We have to work with their system. So we're working with parents or carers, schools, sometimes juvenile justice, sometimes child safety departments. So all of which often struggle with understanding how to support this child. And I guess we don't live in a bubble.

So in terms of trauma informed practice, I don't just see it as working or a philosophy or a value working with just the client. Although that's very important. But it's also keeping in mind that everybody that is working with these families may also have their own adverse experiences. We don't know what their past or journey is.

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So when I'm working with, for example, someone from a child protection organisation or the government department, I always keep in mind, I don't know what their day's been like, I don't know what their family life is like. I don't know how many clients or the complexity of their clients they may have. They may be completely burnt out, for all I know, I don't know.

So, any time I'm going to talk with, respond to, I'm always going to be doing it with an idea of, I'm going to treat you with compassion, curiosity, and respect. We might not agree, and we might be on very polar differences in what we think

would be beneficial for this child, family, whatever. But I am always, always going to be treating you with respect and curiosity. Because I don't know what's going on for individual people who are also a part, and a very important part of this child's, what we call, safety team or therapeutic web.

And so it goes just beyond a therapy or beyond how we work with an individual. And from my point of view, it must also extend to the systems and the colleagues that we work with as well.

RS And that's relevant to your work, isn't it, Al? When you're thinking about helpers, like maybe paramedics, who often face the challenges of trauma informed practice, or trauma informed care. But they themselves may well be experiencing trauma from kind of vicarious trauma of seeing lots of terrible things in the course of their job.

AG Look, they've got it really, really tough. Yes, I must say, I work with police, ambos, military, and paramedics. And the paramedics, because it's a compassionate vocation. So I think that does make them very prone to vicarious trauma, because the degree of empathy that they have. I think the caring professions are… My intuition is they're more subject to that kind of traumatisation because of that susceptibility.

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RS And when you talk about that kind of vicarious trauma, what sorts of signs do you see in the adults that you're working with that might suggest that somebody is struggling with vicarious trauma? Because I know they're sort of famous for not necessarily putting their hands up and saying, oh, you know what, I might need some therapy.

AG Yes. So we're talking with adult trauma here. It's sort of easy to conceptualise if you're in a life threatening event yourself, that activates the whole nervous system arousal pathway. Everyone kind of gets that. Whereas vicarious trauma, it's almost a little bit more mysterious. It's not me, it's that person over there who I don't even know, necessarily. So why am I so traumatised by it?

But we see this phenomenon often. I see it in police. They can deal with a lot of very difficult situations, to say the least, and that's fine until they become a father. And now they see these child victims, and all of a sudden it's like, oh my God, that could be my child, or that could be my whoever. And all of a sudden, it has all this resonance that it never had before, and they realise how susceptible their children were.

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And so that can extend out to children. It can extend out just to the innocent, if you like. Just depending on the degree to which you tend to empathise.

RS For sure. Okay. Well, we talked a little bit about this, but I'd like to just revisit the idea about brains and what happens to your brain after trauma. You said, Al, people are on alert all the time, and that, obviously, our brains are not built to be on the full state of alert 24/7. Obviously, there's sleep and those difficulties. But what is actually happening in the brain development of perhaps children, but

also adults who've experienced this kind of over time, chronic trauma?

AM I guess, from a developmental trauma point of view. So when we're taking histories and assessments, we even go right back to conception. So what was going on for the parents at conception?

Definitely what was going on for the parents, and particularly the mother in utero. What the birthing was like, what the experience of birthing was like. And then right through to any adverse experiences that might have happened to this child, particularly up to the age of three and a half, because we know that that's when the brain actually develops the fastest.

So we talk about windows of vulnerability, and you hear often parents go, oh, kids are so resilient. They are resilient, but they're also vulnerable at different times in their lives. And particularly up until they're about three and a half. The brain is on this amazing journey of, through both genetics and experiences of developing, but what we see, how they function, how people function in life, language, seeing, hearing, walking, talking, all that sort of stuff.

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But if they have adverse experiences early in life, the brain develops from what we call in a sequential pattern, so from the bottom up. From the brainstem, right up to the top, which is our uniquely human part of our brain, which is our cortex. So if there's any adversity that happens early on in life, even in utero, it affects the area of the brain that is being developed at that time of life.

So, for example, if mum was using drugs, alcohol, there was violence while the child was in utero. Then those sorts of chemicals and the experience of loud noises and maybe even being assaulted whilst being in utero, are going to have an impact on the brain stem. Because that is the time in which the brain stem is being developed the greatest is in utero.

And then when the child is born in the first two months of life, or, say, one year of life, when we've got language and… And Maya will be able to talk about this, too, in terms of the areas of the brain for movement and coordination and what we call interoception. So children learning about when they're hungry, when they need to go to the toilet, when they have pain, all that sort of stuff, that happens in the next part of life.

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And then, of course, we have the area of the brain, which is all about learning about relationships. And for developmental trauma, that is probably one of the most difficult areas when we work with children with developmental trauma. Because, as Maya was talking about, and I'm sure Al can also speak to this, Maya was talking about the therapeutic use of self.

So we use relationship to help children overcome and recover from trauma. But that is the thing that is scary. So scary for them the most, because it is relationships that hurt them. So we're in this really difficult position of the thing that they are afraid of the most, which is intimate relationships, is the thing that we use the most in terms of therapy and recovery. So it takes time.

And I think that's… If there's anything I want to get out there, it's about, it's not a 12 week process. It's not 12 sessions, it's not 30 sessions. This can take years, because we're trying to change neurological pathways and associations around what children have around people, versus having another experience of safe, connected, nurturing, responsive, attuned adults in their life.

RS It's this kind of Herculean task, isn't it, where your brain has grown up completely adapted to one way of living, which is… The reacting part of your brain is perfect and amazing, and the thinking part of your brain is less so. And then a complete renovation where you're maybe in a safe place now and then you have to open the doors and let people in. And it's incredibly threatening, as you say.

And when we say, oh, well, just face your fears and all that sort of stuff, it is really life and death to these kids, isn't it? And that's often why you say, as Maya said, that kicking, spitting the really wild animal reaction that Al was talking about, because it is life and death for those people. Yes.

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AM Yes. And one of the things that people find most difficult with children is that they feel the trauma in their bodies, and they feel the trauma in their emotions, but they don't necessarily have the skills to communicate that through language. And they definitely don't have the skills to be able to make sense of it in their thoughts.

And so we have to we really do, again, what Maya was saying, be detectives and piece all this stuff together to be able to understand their language around trauma, because it's not an adult language. It's a child language.

RS And I think that kind of idea about families and parents being really important, the healing process, when they're safe, that makes a lot of sense to people. But for you, Al, in your adult work, what role does relationships and human interaction play in adults recovering from occupational trauma?

AG Look a massive issue, a massive issue is the fact that most people with PTSD have very high sensitivity now. Specifically, they become high in neuroticism and irritability. So, you might have been a loving husband one day, and you get PTSD, and all of a sudden you're this just irritable bastard at home now. And everyone is walking on eggshells, and there's only so long people will put up with that if it's severe enough.

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So it's more about the calamity that can happen in relationships. So there are measures that can be taken. And, I mean, I usually prioritise this from my very first session with someone, because the relationships are always on the rocks by the time they get to me.

So I'll get them working on emotion regulation, strategies for irritability, perhaps some medication to dampen down the sensitivity. That usually happens very early on, because I want to rescue that relationship. Because when the relationships go, if they become estranged from family, it's a big problem. And there's often no coming back.

RS What Anna had said about the therapeutic relationship, is a relationship. There's something about what we're asking people to do when they come into therapy, which is forming a kind of intimate relationship. They tell us stuff that they wouldn't tell other people.

So, maybe I'll ask you, Maya, you mentioned before, there are certain ways in which you try and build that relationship. And I will ask all of you, because I think this is an incredibly important question. What strategies do you use when you're building that relationship, when you've got someone who's very gun shy about connecting with other people? I'll go to you, Maya.

MG I'm going to use an example that I had with a client yesterday, actually. This is a pretty stock standard case, where you have maybe a ten year old child who's in out-of-home care. And emotional regulation is what's on the referral. But the child is very closed off. So, working with a child who is very closed off can be really difficult, because they might protest, they might just say, no, I don't want to do that. Sit back, look at their phone, if they have a phone, that sort of thing.

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Yesterday, this young person came in and they looked exhausted, and I just named that for them. You look like you are going to fall asleep right now. So, being really observant to what's going on for that young person in that moment and acknowledging, you're tired. I didn't say, you need to be here at OT, and we need to be doing activities. I didn't say anything like that.

I just said, come on with me, we're going to go to the kitchen. I've got some bubbles. Filled up a bucket of bubbles with Dettol dish detergent. Grab the straw. And I said, we're making a bubble mountain today. And we sat at that table making bubble mountains for 35 minutes. It was the most engagement I've had from this young person in such a long time.

And you know what? Respiration, it's such a great tool. I mean, we talk about box breathing, five finger breathing, all of the different kinds of breathing, Right? But you know, what gets breathing going? Blowing bubbles.

So we sat there, and we blew bubbles. And by the 20 minute mark, she's going, you know what? I can do something else with these bubbles. And she's showing me these cool things that she's done in her bubble bath, where she's hanging bubbles off of her hand, and she's putting little… She's like, I can put little things inside of the bubbles, and I'm going, what? No way.

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And so, letting her be my teacher, letting her have some pride and share, and I'm respecting her. As Anna was saying, she walked out of that session awake. I know she felt good. She was highly regulated, because what we were using within our session were sensory based strategies. So, really focusing on that bottom pillar that holds our system together, our sensory system together, working on that regulation.

And that is… I sent her home, and I said, I really would love for you to show mum the bubbles that we made today. Can you do that? So coming into those sessions

and being down to earth about the reality of the tools and accessibility that these people have at their own disposal, a bucket, dish detergent, and a straw.

RS Thanks, Maya. What about you, Al? How do you make relationships with people who are scared of relationship?

AG Look, I guess I'd need to distinguish the sort of complex PTSD patients from the occupational trauma patients, because they're very different. In a way, the occupational trauma patients are a bit easier. They're sort of coming. They want help, they're in chaos. They need someone to help them untangled the chaos. And they're usually on board.

And especially if you make a commitment, look, I'm not going to… I'm not here to dig into every trauma memory on our first session. Let's just get to know each other a little bit. So often that puts people at ease. Now with the complex trauma. So these are the children who've been traumatised, they've now grown up and maybe incurred further trauma along the way. It's a long process, I find, to really establish the degree of trust.

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You might spend ten sessions before they actually even admit to… I mean, you know, blind Freddy can tell that there's been childhood sexual trauma or whatever that accounts for the situation. But they're not going to tell you until they're good and ready. And trust takes time, especially if you've been traumatised by your caregivers, then who the hell can you trust? So it's a much slower process with complex trauma.

RS What about you, Anna? What are your tips for people trying to make relationships with people who find it difficult?

AM I think it goes beyond, particularly when we're working with people where the trauma has been interpersonal. So we need to move away from this idea that that therapy is 40 to 50 minutes of talk therapy in a room, and clients or patients need to tell us what's happened. And we're the expert, and we tell them what strategies and what they need to do.

So I love what Maya was saying, in the practice that we have here, we've got a therapy dog. We do lots of cooking. We do lots of walking. We've got a beautiful park across the road from the clinic that we utilise. We've got gardens, we utilise every bit of space that we can possibly use, so we can slowly and gradually work with children.

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And so they experience this concept of an attuned adult, patient adult, one that works in parallel with them. And it's amazing. We talk, we play lots of card games and all sorts of things, and it's amazing what they talk about when they're regulated from a sensory point of view and doing something.

So we'll be in the park playing with the dog, and all of a sudden, they will start talking about, you'll get a little bit of a dose. And we talk about dosing and spacing, and you'll get a bit of a dose of what, I suppose, people might think of

therapy. They're talking about something really hard, and then they'll back off and then there'll be this big space.

And it's the experience of the clinician, of knowing when to lean into that and maybe extend just a little bit their tolerance of discomfort. But probably more importantly, when to move back, and then to allow them to reregulate and to use your central nervous system to calm them. So you're sharing your calm with them, to help them regulate their emotions and their behaviours.

But I think the other really important part is working with systemically, because a kid or any individual can't sustain therapeutic change by themselves. It needs to be a systemic approach. And I think that's from, particularly from a children's point of view, where… I think, Al, you were talking about when people have been betrayed by those that are supposed to care for them. The other thing that we see, and I'm sure you do see this in adult populations, is that they're also feel this sense of betrayal by the systems that they're in.

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So kids get moved around. We've seen kids that have been in 90 different placements in 13 years. So how the hell are you supposed to get safety and do therapy with a kid where the basic needs of just a stable home environment hasn't been met in their entire life? So we talk about trauma betrayal, which is systemic betrayal as well.

And that's, I'm sure Al can talk… That's a whole other podcast, really, that systemic betrayal. But, yes, it's just layer upon layer upon layer. But these just being with and dosing and spacing in terms of relationship is really important.

RS And it seems like there's a bit of a theme about control, that the client or the person coming to see you gets to be able to pull back when they need to pull back. And decide to maybe not sit in a room with a closed door, if that really triggers them. There's a lot of things that… I guess going through a trauma, one of the common things people talk about is feeling powerless, them not having any effect on what is happening, particularly young people and children, but also, I think, adults.

I wonder if there's a key concept there about trauma informed practice, which is about letting people who are coming into therapy have some sense of having control about their own story and their own courage. How much they want to take on today. What is it that they want to talk about? All those things that… Al, you talked about not going for the throat right at the first session and getting… Tell me all the terrible things that have happened to you.

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The other thing that strikes me in that story that you just told, Maya, it's this sense of being a person other than having the trauma. Of course, that's a very important part of why you're coming to work. But knowing the person as a person, as well as somebody who's experienced something very difficult, that seems to be a bit of theme about what everybody is talking about.

Okay. So let's get to the practical side of this podcast. If you had a resource that

you would really recommend to beginners. And I guess when I say beginners, I'm probably thinking about people who have reasonably good skills in mental health practice, but maybe aren't trauma specialists, and would like to know a little bit more about trauma. Whether that be developmental trauma, like Anna and Maya work with or Al, something like occupational trauma. Where would you start them? What's one resource that you really think would be very helpful?

AG Look, certainly for occupational trauma, there's practically nothing out there that's any good, which is why I've kind of developed a few things. So I've got some free videos on Psych Collective, which you can see on YouTube. And whenever people watch those, the feedback I always get is just, my God, why isn't this out there? So it's out there now.

And we've just finished putting together a little online course called Surviving Distress. And that essentially takes the lessons that we would teach in a three week inpatient admission on distress regulation skills, and condenses it into an online course that goes for about seven lessons or so. So that's about to come out again. That'll probably live on our website, thepsychcollective.com.

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RS Perfect. And we will link that on the Peregrine portal. So if you're listening to this podcast on the Peregrine portal, you can just go below the player. And what about you, Maya? What would you recommend?

MG Yes, well, it's a book by Theo Fleury and Kim Barthel called Conversations with a Rattlesnake. So Kim Barthel is an occupational therapist, and she is Canadian. He is a hockey player, ice hockey player, NHL star. And he experienced quite a lot of trauma when he was a young person. And so they work through the book in a conversation style. Basically, I think it's over two years of their therapeutic relationship, and it's put into a book, and it is beautifully done. It's super approachable.

And I just have so much respect for Kim Barthel. If there are other OTs out there who are looking to get into the trauma space, I would say, go, YouTube Kim. She is such a wizard. And that would be the other resource that I would suggest is Kim herself.

RS Great. Thanks, Maya. Okay. Final question before we talk about the vignette. What does recovery look like in trauma? What are some of the things that you've seen in the people that you've worked with which you think, well, yes, this is a sign that this person is recovered or got better after having come to see me and doing a lot of work with me? What are the things that you look for as signs of hope? Maybe, Al, I'll go to you.

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AG Thanks. If we just return to my analogy for a moment of… We start off in this tame bunny rabbit kind of mode, and then we end up in this terrified, wild looking bunny rabbit mode. A good recovery, I think, is not going back to tame bunny rabbit mode. You don't really see that. I mean, people are now unfortunately a lot wiser.

But you end up in maybe an aware bunny rabbit mode. So you're never blissfully ignorant, and you don't reassume your false assumptions. That doesn't tend to happen. Well, actually, maybe sometimes it does. And unfortunately, then people are prone to retraumatisation. So that is not necessarily a good thing if they do go back there. And I have seen that happen with bad consequences. But generally speaking, you want to end up in that sort of wise bunny, maybe.

RS Perfect. All right, thanks, Al. What about you, Maya? What does your recovery look like?

MG I think, having worked with a number of families. Seeing these families, again, we're going to talk about surface level presentation, having more stability. Having a relationship between the caregiver and the child, where the child genuinely feels safe and can approach the caregiver if they need to, or want to, without fear of being rejected.

I think the other thing that we see as OTs is a child living their life and participating effectively within their daily activities. So self-care tasks, they're participating at school, and they have friends at school, they're engaged, they want to go to the movies with their friends on the weekend. Those kinds of things.

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And then when you see teenagers, they're looking at the next step for themselves. So making plans for the future and being able to do that, because they have the cognitive capacity to do that.

RS Great. Anna. Anything to add to that?

AM I think both of those comments were great. I think just there's no cure to trauma. You don't get traumatised, go and get treatment, and then come out as you were. I think for me, and just going from what Al was saying, we've got kids here that at nine can say… Because we do lots of education around the brain and how wise their brain was and that it was really protective. But now that you're safe, your brain hasn't quite caught up to that yet. So you're still doing things that you used to do when you were feeling really scared.

And so we've got kids that can now have some insight around, oh, I flipped my lid, I got really scared, and I now know that I flipped my lid. Or they'll come and go, oh, you'll be so proud of me, Anna, I got really scared, but I did my breathing, and I went and talked to somebody, and I didn't hit that kid, and I didn't get expelled. So it's eventually being able to develop those skills and that awareness around their bodies and how their brains are working and to be able to manage it.

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And I've seen kids that have come in here, and you were talking right in the beginning about having multiple diagnoses. I mean, every kid we see would have four, five, six different kinds of diagnoses. And we work with the kids long term, and you see them being able to finish school. I've got one kid that when I first saw him, he was selectively mute. He's now doing business law at university.

They're able to have stability with their family of choice. They're starting to be future focussed and explore relationships. So being able to find a bit of joy in their life instead of their trauma constantly being in control of them.

RS Yes, that's a good point, isn't it? It's this idea about not completely having to make decisions based on safety and security for every single minute of every single day. All this choice or opportunity that you've described, opening up for people.

Okay. Before we finish, I wanted to talk a little bit about the vignette, which we're not going to read out to listeners today. If you're not familiar with the vignette, then we suggest you go and listen to the other two episodes in which we did roleplay this vignette. But we did talk about this family, which is a couple, stepdad and a mum, and a 16 year old kid called Kira.

So maybe I'll just ask for general impressions. I won't ask all of you, but maybe, Anna, I'll just go straight back to you. Your general impressions about this vignette, and what do you think are some of the tips for people who are seeing families like this?

00:46:33

AM Well, the thing that struck me, well, the theme that kept on coming through this vignette was around attachment disruptions for this young person. Earlier in life we had mum that was not coping very well, because her partner was away a lot, not really being able to accept a lot of help.

So my thought initially went to what was their attachment like and what was… For mum there might have been some undiagnosed post-natal depression. And then, of course, you've got that massive, complex grief and loss with the suicide of her father, and then the decline of mum. So, once again, this withdrawn disconnection and a theme of drugs and alcohol being used to numb.

So when I was reading it, I just kept on thinking, this is around attachments, relationships. And then, of course, 16. That's a difficult age for any kid and any parent. So, just the normal challenges that come with trying to raise an adolescent in this brave new world of social media and sorts of things. So, yes, I just kept from thinking, relationships, attachment, attachment, attachment, and adolescent developmental milestones. And that's just like, whew.

RS And you mentioned, Anna, something I'll go to you, Al, on, the use of drug and alcohol to avoid feelings. Is that something you see in the occupational trauma a fair bit?

00:48:08

AG Look, I think you see it everywhere, so I kind of have a bit of a double barrelled way of thinking about the use of substances. The obvious thing, it does numb the negative emotions. So if you've got a lot of negative emotion, you're absolutely freaking out. You've got no skills to throw at it. Well, alcohol will sort that out real quick for you.

But the other thing that alcohol will do, once you've had your two or three in

quick succession to take the edge off the negative emotion, is each sip will give you a little bit of positive emotion, which you're not otherwise getting anywhere else. So it's strongly reinforcing. So you sip, sip, or puff away, or whatever your substance of choice is.

So there's a double whammy effect with substance use, and it's very commonly used. And of course, that would be fine if there was no downside. But the downside is massive, because you end up in the withdrawal phase the next day, your sensitivity is through the roof. So you have a lot more negative emotion and a reduced proclivity to experience positive emotion naturally. So it's very reinforcing to continue its use. So that's what I see as the double whammy effect.

RS And that's such a good point, isn't it, that it's not… People don't do it because it's not fun. There's stuff about it that is solving a problem for people, but also, it's enjoyable. It tackles that centre of our brain that gives us pleasure and reward. And that's…

AG Yes. And if you can't get positive emotion in any other… I mean, they're starving for some positive emotion.

00:49:33

RS Yes, good point. Yes. And I guess, Anna, you alluded to a vicious cycle where the mother in this particular role play was saying, yes, I use drugs and alcohol. And then I started to feel bad about how I wasn't parenting very well. And that made me feel worse. And then, as you say, Al, maybe I'm not getting positive emotions about how good a parent I am, or how close I am with my child or whatever. So, Maya, what about you? Are there things that you would think about when you were working with a family like this?

MG Big time. I think this is a really interesting case. I don't know at what point necessarily they would be flagged to an OT. But when they are flagged to the OT, I think that really having the lens of what Anna was saying before in terms of the brain development side of things for this person, Kira. She's had so much developmental trauma that she's experienced, understanding that it's likely that her nervous system is not actually very good at regulating itself.

And understanding that really bottom up approach to working with a person with this presentation is probably what is needed. On the surface there are things that she was really great at in terms of motor milestones and that kind of thing. It doesn't seem like there is huge issues there that I would be having red flags about. But more from the perspective of regulating the nervous system and taking an approach of building that awareness, connection, regulation, and working with the young person around that.

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RS Yes, that's such a good point, isn't it? There's the talking therapies and the things to help people reflect and consider, and all those sorts of things. But there's also the body and the reactions that we learn in a traumatic kind of situation, or a situation where you don't feel 100% safe that are embedded in that kind of reacting part of your body.

MG Yes. And just in terms of how, for Kira, her mum wasn't coping great either. So the model that she had growing up isn't going to be necessarily what we hope for Kiera to follow in. And so helping her to learn different pathways, that's a real challenge. So being aware of that, I suppose, when working with this type of family is really important.

RS Yes, I think that's a great note to leave it on, isn't it? It's this idea that trauma treatment can take time. It's something that, really, you might need to be very patient about, because you're trying to rebuild neural pathways. You're trying to change how people attach to people, and the mechanism you're using to do that is relationship. And that's the one thing that people who are traumatised in relationship are scared of.

But also this kind of idea of cycles, as Al was referring to, maybe I'm using alcohol to manage my stuff, but then there's a cycle where it causes more problems in the long term.

Having said that, I think you've all defined situations in which you've seen people recover from trauma, and it struck me that it's a little bit like recovering from complicated grief. It's not suddenly that you'd never had that grief episode, or that somehow that person comes back to life. But actually, there's a kind of growing around it and incorporating that into a new way of being that's a kind of hopeful sign of recovery at that time.

00:54:02

I think we've run out of time, so I'm going to stop there. But thank you so much for everybody's input today. I think there was a lot of really helpful and dense, useful information there.

As usual, we will be putting some extra resources up on our website so people who are interested, please join us on the Peregrine portal. But for now, thank you to our guests, and we hope you join us in future episodes.

00:54:30

Outro I hope you found today's episode helpful. You'll find specially selected resources on this topic on our digital learning platform. To join the platform for free or to suggest questions or topics for further episodes, please visit our website theperegrinecentre.com.au.

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