HEALTH

# Refugee Trauma and Dissociation: Reintegrating Lost Parts of Oneself

*Refugees and asylum seekers experience betrayal trauma at a 'meta level', says author and social worker NAOMI HALPERN, who spoke about trauma dynamics and the therapeutic relationship boundaries at a Clinical Master Class at START TS. This is a summary of her address.*

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I will talk about the issues we come across when assisting complex-trauma clients, particularly relationship issues, which relate very strongly to attachment. As we know, relationships are the crucible for healing.

I will briefly cover the psychobiological impacts of trauma. I am sure that you are all very familiar with this subject. Then I will be looking at attachment, not just in terms of our clients' attachment styles, but also our own attachment styles, which ties in with issues of transference and countertransference.

Transference and countertransference are going to occur with any client who we work with, however these dynamics are far more complex and layered in the case of clients with a history of trauma or abuse. I will look at how we, as therapists, can very quickly and inadvertently find ourselves landing on Karpman's Triangle. I will point out some of the strategies that can get us onto the Triangle and how we can learn how to step off the Triangle as quickly as possible and get things back on an even keel.

So to start with, what is complex trauma? Complex trauma is the result of feeling threatened beyond our capacity to integrate, self-regulate and self-soothe in a given situation. So when people are overwhelmed by trauma and when trauma is persistent, which is the case for the clients we work with, it alters their capacity to self-regulate and to self-soothe.

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This has many other flow-on effects in terms of how clients are able to be present or not in the here and now and how they might understand and interpret experiences, in the counselling room with you as well as in the outside world.

So when we refer to child onset of complex developmental trauma, we are talking about children who have been exposed to very chronic, pervasive and cumulative trauma, it is not just a one-off trauma. One-off trauma can have enough repercussions in itself. However, the clients we work with are exposed to ongoing traumatic events and situations. Very often for these clients the foundation of their trauma experience is relational. It may be happening within the family. Even if the family is quite functional, if they have been exposed to terrible situations in their country of origin and their parents are overwhelmed and unable to cope with the circumstances, it will have flow-on effects on their children, which can result in insecure attachment, especially disorganised attachment.

What we know about complex trauma and its impact is that it has a strong influence on neurophysiology, psychophysiology and bio-psycho-social maturation and development, including attachment styles - a child's capacity to attach and attachment that they may develop.

If we look at adolescent or adult onset of complex trauma, what we find is people who have been trapped in abusive relationships, it might be family violence, domestic violence, intimate partner violence; prolonged captivity with isolation or torture. I am sure these are the experiences of some of the clients who you work with, those who have been exposed to ethnic cleansing, annihilation, those who have been caught up in prolonged war situations, in violence and civil unrest and of course, human trafficking, slavery and prostitution. What we often find is that a person is not only exposed to one type of trauma but there has been exposure to multiple types of trauma.

I will be speaking about dissociation in particular. Dissociation is associated with disorganised attachment and/or childhood abuse. Dissociative disorders can develop in the aftermath of trauma and can occur any time in the lifespan.

In my work I have specialised in adults abused as children often by paedophile rings. I am talking about organised sadistic abuse, but also about long-term childhood abuse situations and neglect. I often work with clients who have developed dissociative identity disorder as a consequence of the trauma they have experienced. You may be familiar with the book I co-wrote with Dr Colin Ross, *Trauma Model Therapy: A Treatment Approach for Trauma, Dissociation and Complex Comorbidity*.

In the latest *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* there are five forms of dissociation and some significant changes in the criteria. It is important to remember that clients who have experienced complex trauma may self-regulate with dissociation but do not necessarily have a dissociative disorder. So it is important that a differential diagnosis is carried out so we understand what a client's situation might be.

It is important to understand the structure of the brain and how trauma is processed by the brain and teach our clients about it. Psychoeducation helps clients to understand what they are experiencing and feeling, and to recognise they are not "mad".

Psychoeducation is such a key part of the work we do because it is through knowledge, education and empowerment that we transfer the power of healing back to the clients so they understand that they can learn to regain more control over their minds and achieve better functioning.

Psychoeducation is critical. We need to explain things in simple language. They need to learn about the function of the cerebral cortex and the frontal lobes as being the part of our brain where we think and analyse, it is where our capacity to conceptualise and reflect takes place.

When someone is traumatised, or when a traumatic experience is triggered, the frontal cortex goes offline and the limbic system, the middle part of the brain, is activated. This is where the non-verbal and emotional memory is stored and processed. So when you have a gut feeling that something is good, or something is not okay, but you cannot put your finger on it, that is the limbic system at work.

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The limbic system is where trauma memory is stored. External or internal triggers can activate the limbic system as well as memories. I remember a client of mine with cerebral palsy. One day he was at the Flinders Street station in Melbourne waiting for a train when a man walked past him wearing a particular type of cologne. When he smelt the cologne he was suddenly flooded with memories of the abuse inflicted on him by a family friend when he was a little boy.

He had no memory of the abuse before that trigger. That is what the limbic system does, it stores trauma memories in the unconscious. Down from the middle part of the brain is the brain stem, where all our instinctive responses are generated from. It is the part of the brain that regulates our breathing, heart rate, tells us if we are hungry, thirsty and, of course, this is also where the fight-flight, freeze and submit responses come from.

Our clients are not only dealing with one or two issues but many. It really brings home the overwhelming struggle that so many of our clients are dealing with on a daily basis, and it makes me wonder how some of our clients manage to get through life.

Our complex-trauma clients can display extreme behaviours. They can be too rigid and closed, too fixed and narrow in the way they present themselves, their perspectives and the way they navigate their world. They can also be very defensive, avoidant and overly closed when it comes to learning from the present. We find our clients are often continually trapped in the same situation over and over again, and it is as if they do not learn from experience but only respond with conditioned reactions.

On the other hand, they can also be too unstable and open to the influence of external experiences and perceptual distortions. Many times we have been surprised by our clients' reactions to things we say, how they understood or interpreted something.

Also, clients can be overly open to the influence of the past. They can be reflexive instead of reflective. They can be very impulsive and reactive and, of course, that can then lead to finding themselves in repeated situations that cause them harm and difficulty.

Trauma impacts on our clients in several different ways, including attachment styles. So if you have a child who has been exposed to traumatic experiences, you need to observe how he or she behaves, and see how that child, without the appropriate help and support, might respond in terms of adult attachment styles.

The Dismissive Attachment style in an adult will respond as if they do not need you. The client does not care if the therapist is on leave. According to them, everything is fine. The client is either shut down and disconnected, or shows the opposite reaction, preoccupied and anxious, the type who sticks to his or her therapist and is overwhelmed and traumatised when the therapist is away on leave, sick or has to cancel a session. Fears of abandonment and relection will be activated.

Attachment is a key part of the picture when we work with our clients. We like to think of ourselves as kind, compassionate, benign people who are there to do the right thing and help in the best way we can. But the client-therapist engagement is an unequal power relationship with an authority figure (the therapist) which will likely be reminiscent of a situation where

our client was abused or traumatised in the past.

We like to think we create a safe, private space for our clients to open up to us, but for the traumatised client therapy may feel secretive as it is conducted with the doors closed. They may fear that once the door is closed that they cannot get out if something goes wrong. So how we construct the room is important, such as where we invite our clients to sit. When I am giving a presentation I use my hands a lot. But when I am with a client I sit with my hands on my lap and barely move them at all because I noticed that any hand movement was observed by my clients and I realised it was very stressful and traumatic for them.

The message we are conveying to our clients is: "trust me". "For you to get better you need to trust me, you need to let me in enough so we can form that crucial therapeutic relationship where the work will be done." But it is a one-way street, isn't it? We invite them to enter into a trusting relationship where the power is all on one side. We invite our clients to tell us everything about themselves, but we do not disclose anything about who we are or what our experiences are, quite appropriately, but nevertheless it is an unnatural relationship and reminiscent of past relationships and experiences where there was an unequal power balance.

And we tell clients that our role is to bring them a step closer to those aspects of their lives that they might want to forget or stay away from. So because of that fact alone, at some level, we are going to be experienced by our clients as the perpetrator. So we need to be aware of post-traumatic transference, unmet attachment needs, the expectation that they are going to be betrayed by us and of re-enactments which will arise in the context of therapy and in the relationship with the therapist too.

Then, on top of all those transference issues, we may also have culture, language, gender and ethnicity factors that may make the therapeutic relationship difficult to navigate. Clients will test us in lots of different ways to gauge how safe we are.

So arriving late for therapy, going over time, non-attendance, non-engagement in the therapeutic process and excessive calls or emails between sessions can be part of testing the boundaries. We need to be clear and consistent with boundaries. One of the things I learned early on is that it is better to be firm about your boundaries early on and once you get to know a client you can loosen them a bit, rather than have looser boundaries at the beginning and then try to reign them in.

Then other symptoms and behaviours emerge – flashbacks, self-harm, suicidality, depression, and overt or passive aggression which are very difficult behaviours and experiences for our clients obviously, but also for us to manage.

It is likely that you will not have only one trauma client but many. So you are dealing with these behaviours many times a day with different clients, and that is where our post-traumatic transference comes in to play. We need to be aware of our attachment needs, vicarious trauma and history of abuse, if we have one, because all these issues will impact on the relationship with the client, in addition to any culture, language, gender and ethnicity factors I mentioned earlier.

The two types of countertransference responses that we need to be mindful of is Type I: enmeshment, rescuing and boundary violation behaviour, trying to love our clients back to health and being this nice, kind, generous person who is there to give and give.

Or the Type II person being counter-phobic, avoidant, experiencing a numbed response to our clients' stories, not having an appropriate empathic engagement with our clients. It is most important that we understand our own attachment style. It is not enough to understand our clients' attachment style, we need to understand our own and look at how the clients' and our own attachment style interact. Most of the case consultations I give see client and therapist in some kind of an impasse. Attachment issues are often the piece that is getting all caught up.

If we are not cognisant of attachment dynamics we will find ourselves stepping on the Triangle very quickly. We might go into rescuer mode and if we are in rescuer mode, what does it look like? Well we might go over time or we might have excessive out-of-hours contact with our clients. We might be the victim in the relationship and by that I mean accepting unreasonable behaviour from clients.

Now of course there's going to be a certain degree of unreasonable behaviour that is grist for the mill and we expect and accept that, but we need to know where the line is and when it is being crossed, or we could be the perpetrator. We could get angry or judgemental about our clients or emotionally withdraw from them.

It is important to understand the Triangle dynamics. No matter what our clients do, it is our responsibility to stay off the Triangle. If we find ourselves inadvertently stepping onto it, which is very easy to do, we must find ways to quickly get back on track and step off the Triangle. A therapeutic misadventure in the transferential relationship can lead to the re-victimisation of the client and the vicarious trauma of the therapist.

We are not always going to be able to avoid those situations. I want to highlight a case. I had the most distressing experience in 2009. At that stage I had been practising for 21 years and I had a client commit suicide. It was out of the blue, unexpected and, as you can imagine, it was absolutely traumatic. It happened a couple of weeks before Christmas, and we know that can be a very vulnerable time for our clients, they will often decompensate around holiday times because their family issues will be activated and they know we are going to be away.

I had a female client with dissociative identity disorder who I had been working with for about three years at that time. Every time I went on leave, and particularly if it was Christmas, she told me what an awful therapist I was as I knew that this is the worst time of the year for her. I had been through this with her many times and we had always worked through it and discussed how she was going to stay safe and who would be her back-up therapist and her contacts. I had done it so many times. But having just lost a client I was absolutely distressed and I could feel very quickly that my anxiety was rising and I could see her reacting to that. In the end I just snapped - I'll call her Jane. I said: "Jane, if you don't feel as though you can keep yourself safe then really you're going to leave me no other choice but to call the Crisis Assessment Team". She looked at me absolutely horrified and I thought, "Oh my God Naomi, what have you just said and done? You've really blown it now."

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So I looked at her and I said, "The bottom line is, if you kill yourself I can't keep on working with you". Luckily she had a very good sense of humour and we repaired very quickly and moved on. But these are the kind of situations we can very easily find ourselves in and we need to find a way to navigate ourselves and our clients through those issues.

We need to look after ourselves first, because if we are not taking care of ourselves that is when we will find ourselves in vulnerable and risky situations with clients. So making sure we are being nurtured and rested; that we have good supervision; if we have got a trauma history and a client triggers our history, that we go back into therapy; that we do professional development; all these sorts of things are about taking care of ourselves first. It will not stop us from finding ourselves in situations where we get on the Triangle with a client, but it will minimise it and it will enable us to recognise it much quicker and get things back on track, rather than the situation spiralling out of control.

I mentioned at the beginning the importance of psychoeducation and stabilisation and this is the crux of the work with our clients. Many clients will not get beyond this stage. It took me a long time to accept that some will not progress beyond phase one, but it is better than where they were at before.

So focusing and getting phase-one work under the client's belt is going to minimise those risky situations, because it is when we are either pushing our clients, or they are pushing themselves that we get into those risky situations on the Triangle. We are aiming to work within the window of tolerance. We want those arrows to be a little bit peeking over the lines. So we stretch our clients a little bit beyond their comfort zone, but not so that they either shoot off into a hyperaroused state and go into fight or flight, or they shut down and go into freeze and submit.

In terms of staying off the Triangle I do not want to frighten you into thinking: "I've got to be so concerned about not harming my client that I'm not going to try new things and experiment". We need to be careful that we are not walking on eggshells and not prepared to try new things. We need to also stretch ourselves in terms of being open to different strategies, new things that might work with one client but will not necessarily work with another. As Einstein famously said, "Anyone who has never made mistakes has never tried anything new." I do not know about you, but I have found that if I make a mistake, if I stuff up, as I have done many times over the years, and I acknowledge it and I apologise, our clients are often very forgiving. Obviously we want to make as few mistakes as possible, but do not be frightened of making a mistake, otherwise that will inhibit you, you will not be authentic.

Finally, thank you for your commitment to assisting your clients and for making a difference to those who are suffering, because it is really hard work and it does take its toll on us. When you have worked with trauma you are changed forever. Once the veils are lifted and you know what is going on out there you cannot put them back. And that is a big price we pay, so it is important we acknowledge each other in the work we do. So I would like to extend my thanks to you. ℟