

# BLUE KNOT FOUNDATION FACT SHEET FOR GENERAL PRACTITIONERS UNDERSTANDING COMPLEX TRAUMA

- 1 Trauma stems from the overwhelming of coping capacity in light of precipitating event/s. If not resolved, it has a range of negative impacts on physical and emotional health. Trauma can be both 'single incident' (posttraumatic stress disorder; PTSD) and *cumulative, underlying and interpersonally generated* ('complex').
- 2 Complex trauma is more prevalent, and more comprehensive in its effects, than single-incident PTSD (Courtois & Ford, 2009; van der Kolk, 2009). The majority of people who access the mental health and community service sectors have complex trauma histories (Bloom, 2011; Jennings, 2004).
- 3 Strong longitudinal and epidemiological data (ACE Study, 1998; 2010) suggests that *on a daily basis and often unknowingly*, general practitioners see a number of patients who experience the effects of complex trauma. People with diverse presentations, high comorbidity, and/or unspecified pain (i.e. 'medically unexplained symptoms'; MUS) can receive discrete diagnoses based on presenting symptoms, which means that the underlying trauma remains unrecognised and thus untreated.
- 4 Extensive research has established the relationship between overwhelming childhood experiences and emotional **and** physical health problems in adulthood. *Childhood coping mechanisms become risk factors for adult ill health if overwhelming childhood stress is not resolved* (ACE Study, 1998; 2010). Coping mechanisms which were initially adaptive and protective (where 'more trauma requires more adaptation'; Fisher, 2013) negatively impact health over time.
- 5 Childhood trauma is complex trauma of which *child abuse* in all its forms (i.e. sexual, emotional, physical and neglect) is an insidious variety. But childhood experiences *do not need to be abusive to be traumatic* (Hesse, Main et al, 2003). For example, care-givers with unresolved trauma histories may be unable to meet the emotional needs of their children. Unresolved trauma has life-long impacts and affects the next generation as well (ibid).
- 6 Early life trauma, occurring during formative brain development, is particularly damaging. It affects *development of the self per se* and a range of functions including the ability to metabolise stress and vital capacities associated with survival (Courtois & Ford, 2009; Schore; 2003). Unresolved trauma radically restricts the capacity to respond flexibly to daily demands and life challenges, impairs physical and mental functioning, and leads to diverse and often 'puzzling' symptoms.
- 7 Practices to assist health and treat injury, which are thus regarded as benign, can also create trauma (eg the phenomenon of 'medical trauma'). Many routine medical procedures and surgeries are experienced as traumatic *even when their outcomes are assessed as successful*. This especially, but not exclusively, relates to procedures involving immobilisation and anaesthesia, and especially but not exclusively with respect to children (Levine, 2010).
- 8 Studies show that hospitalised children ('many of them being treated for injuries requiring immobilisation') develop symptoms similar to those of returning soldiers (Levine, 2010). Children admitted to hospital due to injury are at high risk for development of posttraumatic stress, even when the injury is relatively minor (Sanders et al, 2005): '*[T]here is still inadequate attention to preventing undue fear in people who must undergo painful procedures or general anaesthesia*' (Levine, 2010:63).
- 9 Practice which is 'trauma informed' is as attentive to *the way in which* a service/procedure is administered as to *what* the service/procedure comprises. Care with respect to the *context* of treatment considerably reduces the likelihood of (re)traumatisation.



National Centre of Excellence  
for Complex Trauma

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- 10** Core principles of trauma-informed practice are *safety, trustworthiness, choice, collaboration and empowerment*. Active *listening to*, and *validation of*, patient experience, and warmth of manner coupled with professionalism and medical expertise, create a context in which patient history, self-reports and disclosures can be conveyed. *Attentiveness to context and manner of relating* may seem to 'take time' which GPs can ill afford. But it can actually *save time* by facilitating a context conducive to eliciting valuable patient information, which may be otherwise unavailable and which may assist in informing treatment decisions.
- 11** Hyper and hypoarousal can be trauma responses. The dissociative (hypo) response of 'emotional shutdown' is frequently mistaken for, and misdiagnosed as, depression (Rothschild, 2011). Patients exhibiting either/both hyper and hypoarousal are at the upper limits of their coping capacity. Gentle non-pharmacological assistance to attain/recover emotional self-regulatory ability (e.g. grounding and soothing exercises and resources) is indicated. Autonomic stabilisation should be recovered prior to administration of any non-essential medical procedure, and in cases of emergency, prior to administration of anesthesia where possible.
- 12** Medication does not treat trauma directly, and where indicated, is best used in conjunction with psychotherapy. When severe emotional dysregulation inhibits a patient's capacity to participate in counselling and/or psychotherapy, medication can help stabilise the patient until self-regulatory capacity is established. It needs to be noted, however, that in inhibiting experience of emotion, medication can impede access to feelings which need to be processed; medication alone is not a treatment of choice for trauma.
- 13** If trauma is not resolved people cannot 'move on' ('the time honoured expression 'time heals all wounds' simply does not apply to trauma'; Levine, 2010:88). This is why it is imperative that its effects are recognised, understood, and appropriately treated.
- 14** Complex traumatic stress requires a different treatment path than single-incident PTSD (Courtois & Ford, 2009; van der Kolk, 2003). Prior to release of the nationally and internationally endorsed Blue Knot Foundation Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery [www.blueknot.org.au/guidelines](http://www.blueknot.org.au/guidelines) trauma guidelines related to single-incident PTSD which are inadequate to address complex traumatic stress ('There is more to trauma than PTSD'; Shapiro, 2010). Blue Knot Foundation's *Practice Guidelines for the Treatment of Complex Trauma & Trauma Informed Care and Service Delivery*, have been officially recognised as an Accepted Clinical Resource by The Royal Australian College of General Practitioners.
- 15** It is possible to recover from trauma. Neuroscientific research establishes that the structure and function of the brain can change throughout life (*neuroplasticity*) and clinical findings show that even severe early life trauma can be resolved (Siegel, 2003; 2010). Resolution of parental trauma also has beneficial effects on children, and intercepts transmission of trauma to the next generation (*ibid*). Research shows that optimism about recovery from trauma is warranted, and such optimism should be communicated to patients. You can learn more by attending one of Blue Knot Foundation's professional development opportunities for GPs. To find out more, go to [www.blueknot.org.au/training](http://www.blueknot.org.au/training)

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