Exploring patterns of relationship between family constellation factors and trauma symptomatisation.

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Overview

- Background to the study – literature: trauma, family constellation, systemic understandings of constellation and trauma
- Aims of study and research questions 1 & 2
- CYMHS Research context
- Method (including a diversionary discussion)
- Investigation of existing trauma work in family therapy
- Limitations of study
Background context: Trauma

Trauma has been described in a range of ways:

- Simple and complex trauma or type 1 and type 2
- Simple or type 1 trauma results from a single traumatic event
- Complex or type 2 trauma results from repeated trauma events or severe and protracted trauma experiences (James & MacKinnon, 2012; McDermott, 2004)

Trauma impacts the brain development of children (Cook et al., 2005; Spates, Samarweera, Plaisier, Souza & Otusi, 2007)

Heavy trauma generates defensive operations i.e. aggression, denial, sleep disturbance, self-anaesthesia and dissociation (Briere & Lanktree, 2012; Spates et al., 2007; Stein & Kendall, 2004)
Trauma responses can be grouped as: hyperarousal, avoidance and numbing, and re-experiencing (Blake, Weathers, Nagy, Kaloupek, Gusman, Charney & Keane, 1995; Bryant, Moulds & Guthrie, 2000; Tarren-Sweeney, 2013)

Trauma diagnoses may include: depression, generalised anxiety, panic attacks, borderline personality disorder (paediatric BPD), eating disorder, ADHD, ADD etc. (Lejonclou, Nilsson & Holmkvist, 2014; Watson, Gallagher, Dougall, Porter, Moncrieff, Ferrier & Young, 2014)

Ethnocultural-specific symptoms i.e. visions, nervous attack, spirit possession (Cook et al., 2005)

Family therapy conceptualisations are non-pathologising: “trauma symptoms are a unique set of interactive coping symptomisations that may have long term developmental impact” (MacKinnon, 2012)
Trauma during infancy and childhood significantly impacts development and function by interrupting developmental continuity… *Shapes the architecture of the brain* (Arsenault, Cannon, Fisher, Polanczyk, Moffit & Caspi, 2011; Powell, Cooper, Hoffman & Marvin, 2014)

Traumatic stress precipitates a chemical imbalance causing: *dysfunctions of learning, memory, behaviour and emotions, and negative personality effects*. (Spates et al., 2007)

Systemic approaches position family as central in addressing trauma:

- *often whole family is impacted by trauma/vicarious trauma*

- *attachment relationships crucial to addressing some traumas*

(Foote, 1999; Hanney & Kozlowska, 2002)
Family structure plays an important role in level of family function (Ahrons, 2006; Amato, 2010; Kelly, 2007)

Link between parental separation (and quality of co-parenting relationship) and:
- adjustment difficulties,
- Mental and physical health concerns,
- Low scores on emotional, behavioural, social and academic outcomes (Ahrons, 2006; Amato, 2010; Kelly, 2007; Irving, Benjamin & Troche, 1984)

Family constellation disruption:
- May be traumatising for children,
- May disrupt important family lifecycle stages,
- Often involves loss of broader supportive family systems
Background context: Family therapy - constellation and trauma

- Limited Literature in this area

- Would different family constellation affect the family’s and the children’s recovery from trauma?

- If family constellation change are somewhat link to children’s trauma experience, would such information improve the family therapist’s accuracy to choose the right treatment target?
Focus of study and research aims

- Gap in the literature this study will investigate: *Many factors are not well understood regarding the impact of family constellation-related factors and young people’s experiences of trauma.*

- To identify whether intact family constellations coincide with lower levels of trauma symptomisation for children than do family constellations that are mobile, changing or fluid; and

- To determine implications from a file audit examination for family therapy practice that addresses trauma.
Research questions.

1. Do intact families, where biological parents and their biological, under 16 year old children live together, exhibit different levels of trauma symptoms to children and youth from families that are non-intact?

2. What implications can be drawn from findings of the first research question for the best practice of family therapy that addresses trauma?
Setting up research in the CYMHS context.

- Research & Ethic approval processes
  - Team level
  - ACU level
  - Service Division
  - Health Service
  - Statewide level

- Seek assistance from the research support unit as early as possible

- Study the application protocol

- Be patient & endure
Research question 1: Method

- Mixed method file audit investigation and analysis (CYMHS database, Consumer Integrated Mental Health Application [CIMHA])
- Phenomena of interest: client age and gender; family constellation; number of children at home/not at home; family mental illness; age of child at time of parental separation; number of constellation changes over time; number of therapy sessions; CGAS rating; ICD10 diagnoses; number of trauma symptoms
- File audit sampling procedures for CYMHS data incorporating Logan City and Bayside regions
- Exclusion criteria: clients with no experiences of trauma; clients with a disability; clients living in out of home care (kinship care included)
Research question 1: Method (continued)

- Sample: \( n = 64 \)

- CYMHS clients who had been exposed to potentially traumatising experiences

<table>
<thead>
<tr>
<th>Intact ( n = 32 )</th>
<th>Non-intact ( n = 32 )</th>
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</thead>
<tbody>
<tr>
<td><strong>Female ( n = 16 )</strong></td>
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<tr>
<td>Early Childhood (3-5 years) ( n = 4 )</td>
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<td>Middle Childhood (6-11 years) ( n = 4 )</td>
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<td>Pubescence (12-14 years) ( n = 4 )</td>
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<td>Adolescence (15-18 years) ( n = 4 )</td>
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Research question 1: Exploratory trauma symptom measure

- Categories were derived from empirical measures:
  - Acute Stress Disorder Scale (Bryant, Moulds & Guthrie, 2000)
  - Clinician-Administered PTSD Scale for DSM IV (Blake et al., 1995)
  - Assessment Checklist for Children (Tarren-Sweeney, 2013)
  - Assessment Checklist for Adolescents (Tarren-Sweeney, 2013)
Research question 1: Exploratory trauma symptom measure

Three symptom categories/17 items

- Re-experiencing symptoms (3 items):
  - dreams, nightmares and/or hallucinations;
  - physiological or psychological distress at exposure to cues;
  - intrusive memories and flashbacks

- Avoidance and numbing (5 items):
  - avoidance of specific activities and/or diminished interest in activities;
  - detachment, estrangement, dissociation, numbness, dazed, unable to recall aspects of trauma;
  - future hopelessness/sense of foreshortened future, suicidal thoughts and behaviours;
  - restricted affect, withdrawn, affectionless, non-communicative
Hyperarousal, emotional and behavioural dysregulation (9 items):

- difficulty falling or staying asleep;
- irritability, outbursts of anger;
- impulsivity, and/or major behavioural/emotional changes from premorbid state;
- hypervigilance, wariness or hyperalertness (including separation anxiety);
- automatic physiological responsiveness (sweating, trembling, difficulty breathing, racing heart) and or physiological complaints (headache, stomachache, nausea, panic attacks);
- difficulty concentrating;
- violent, aggressive;
- secretive, suspicious, mistrusting;
- maladaptive self-soothing behaviours including sexualised and eating disordered behaviour and hyperchondriacal symptoms
A brief diversionary discussion:
Trauma events v. trauma experiences

- Trauma is generally defined by the experience it induces in the individual... the “traumatised” or the “survivors of trauma”

- Physiologically: stress and distress lead to a universal set of personally nuanced physiological responses involving the:
  - Autonomic nervous system, and
  - Limbic system (Codrington, 2010).

- Yet trauma definitions refer more clearly to trauma as a response to a traumatic event or events
DSMV & ICD10 trauma definitions

ICD10 diagnosis for Post Traumatic Stress Disorder (PTSD)

- “Criterion A: The person has been exposed to a traumatic event…
- Criterion B: The traumatic event is persistently reexperienced…”

ICD10 diagnosis for Adjustment Disorder (AD)

- “The disorder is caused by psychosocial stress of a not unusual extent. Symptoms occur within one month.” (presumably of the psychosocial stress event(s))

DSMV diagnosis for PTSD: the first criterion has 4 components:

- Directly experiencing the traumatic event(s)
- Witnessing, in person, the event(s) as it occurred to others
- Learning that the traumatic event(s) occurred to a close family member or friend
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)”

Acute Stress Reaction and AD are described in DSMV as responses to stressful life event(s)
A brief diversionary discussion: Trauma events v. trauma experiences

There is a needed definitional shift of focus from EVENTS as causing trauma to an emphasis on an individual’s EXPERIENCE, that we may define as traumatised, as reflected in our psychological trauma measures.

Systemic perspective: individuals’ and families narratives and internal processes influence:
- impact of trauma,
- resilience to trauma, and
- symptomising responses to trauma.
Research question 1: Method – Data Analysis

Intact and non-intact family cohort data will be analysed using SPSS 22 (2012) for identifiable patterns, using nonparametric testing:

- Chi square
- Fisher’s exact test
- Crosstabulation
- Frequency exploration.

Phenomena of interest, compared for both intact or non-intact family status AND number of trauma symptoms:

- *Number of children living in clients’ family home/s and number of children not living in client’s family home/s*
- *Family members with a mental illness: immediate family or extended family or a combination of both*
- *Age of client at time of first family separation*
- *Number of therapeutic sessions attended*
Research question 2
Method: Literature survey

- Implications from findings of file audit investigation, set against contemporary family therapy literature for trauma presentations

- Of interest:
  - therapeutic practice that supports low levels of trauma symptoms, and
  - therapeutic practice that affirms supportive family structures.
Research question 2: Implications for practice - trauma work in family therapy

- Central systemic approaches to trauma therapy:
  1. Attachment theory-based approaches
  2. Narrative/dialogical approaches
  3. Other interventions i.e. Bowen and social constructionist approaches

- Most approaches have a skills training or physiological regulation component to support symptom management i.e. components of DBT, mindfulness, grounding, anchoring, Radical Exposure Tapping, Emotional Freedom Technique and Eye Movement Desensitisation & Reprocessing (Greenland, 2010; Greenwald, 2005; Linehan, 1993; Rothschild, 2010; MacKinnon, 2014)
Implications for practice:
Trauma work in family therapy – Attachment theory-based approaches

Attachment theory-based approaches:

- View child’s primary attachment system as crucial to trauma healing
- Utilise strength of primary attachment relationships to promote safety, symptom management and trauma resolution
- i.e. creating illustrated storybooks in family therapy (Hanney & Kozlowska, 2002); Theraplay (Jernberg & Booth, 2001); Family Attachment Narrative Therapy (FANT) (Lacher, Nichols & May, 2005); Dyadic Developmental Therapy (DDP) (Hughes, 2005); and Attachment Based Family Therapy (ABFT) (Diamond et al., 2014).
Implications for trauma work in family therapy: Narrative/dialogical approaches

- Narrative and dialogical approaches focus on:
  - the development of alternative or secondary or subordinate storylines to the dominant trauma narrative, or
  - the generation of a dialogically processed trauma picture, often involving genograms, trauma timelines and lists.
  - i.e. *Subordinate or secondary storylines* (Yuen, 2007; White, 2005); *Story writing with the chronically ill* (Penn, 2001); *Interventions utilising genograms and trauma timelines* (Figley & Kisler, 2013; James & MacKinnon, 2012; Jordan, 2006)
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<th>Implications for trauma work in family therapy: Other interventions</th>
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<td>Several efficacious approaches incorporate meaning-making process and system-value processing, informed by:</td>
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<td>➢ Bowen ideas</td>
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<td>➢ social constructionist ideas</td>
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<td>i.e. <em>Multidimensional Family Therapy</em> (Liddle, 2013); <em>Ceremony-based approaches to group trauma therapy</em> (Lubin &amp; Johnson, 2015)</td>
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Implications for trauma work in family therapy: Family mental illness and resilience

For family therapy work with traumatised children, families often have a complex of mental illness across family members that need to be addressed when working systemically.

Promoting families’ resilience is important for helping families:

- recognise strengths they have developed in their life struggles,
- become empowered to recover, and
- learn from adversity and integrate experiences (Schaaf, 2012; Ungar, 2013; Walsh 2003; Walsh, 1996).
Limitations of study

- Research question may have potential errors in findings:
  - client case managers and other involved clinicians under-reporting, over-reporting or inaccurately reporting
  - researcher error in translating phenomena documented in cases into codable data
  - variabilities of reporting in files.

- While variability or inaccuracy in file data may be unavoidable researcher error in translating phenomena into coded data this will be reduced through the process of expert panel validation.
Limitations of study (continued)

- Other limitations include issues of generalisability of study findings to standard Australian populations, since:
  - all clients to be investigated have a trauma history and have experienced mental health problems significant enough to warrant support from CYMHS,
  - this study uses a small sample size
  - a limited demographic is represented by the cohort
  - a nuanced ethnic, racial, cultural, religious and SES grouping is represented by the study population
Limitations of study (continued)

Due to the categorical nature of data, nonparametric test analysis will be undertaken. A larger sample and continuous data would enable parametric testing which may yield more statistically powerful results.

Limitations relating to research question two involve the likely outcome that it will provide an incomplete survey of family therapy trauma research.
References


