blue knot foundation

National Centre of Excellence for Complex Trauma

Welcome to the Winter edition of Blue Knot Review, an electronic journal chronicling recent developments and new perspectives around complex trauma and trauma-informed practice.

What is Dissociation and Why do we Need to Know about It?

Recent editions of Blue Knot Review introduced the just released Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation (2020). These guidelines are different from, but also complement, the updated Practice Guidelines for Clinical Treatment of Complex Trauma (2019). Both sets of guidelines, and also others, are available for free download and/or purchase here.

This month we provide a dot point summary of the first chapter of the new
Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation (2020). As the introduction to these guidelines' notes, dissociation is transdiagnostic and correlated with a range of adverse and often severe health impacts (Loewenstein, 2018: 229). Dissociative disorders are so common that therapists need to know how to recognise and treat them (`their prevalence is such that they cannot be left to a few specialists'; Schwarz, Corrigan et al, 2017: 227).

Yet dissociative symptoms are often misdiagnosed or not accounted for at all. This is because many mental health professionals `do not know what dissociation looks like or how to assess for it' (Danylchuk & Connors, 2017: 39). The following dot point summary is of the content of the first chapter of the new Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation (2020). In subsequent editions of Blue Knot Review, we will present content summaries of the remaining two chapters of these guidelines.

Content summary of Chapter 1 of Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation, 2020:

- The importance of dissociation is increasingly but insufficiently recognised within and outside the field of mental health.

- While often associated with disorder, dissociation can be expressed in many forms (`healthy and adaptive, pathological and self-protective...' Bromberg, 2001: 310); `it makes a vast difference how and in what context dissociation is used' (Goldman, 2016:98).

- Neuroimaging reveals that dissociation `is accompanied by altered activation of brain structures… involved in regulating awareness of bodily states, arousal and emotions' (Brand, 2012).

- Dissociation can be understood in several ways – as a lack of integration of the mind and mental states, as an altered state of consciousness, as a defence mechanism and structure, and as a normative process (`even in the most well-functioning individual, normal personality structure is shaped by dissociation'; Bromberg, 2001).

- When dissociation is persistent it is often, although not always, trauma-related. Persistent inability to connect, access, and move between different registers of functioning impedes health and well-being. If severe, unrecognised and untreated, it can erode quality of life and pose serious health risks.

- Repression occurs when `single or a few memories, perceptions, affects, thoughts, and/or images are thought to become relatively unavailable to full conscious awareness' (Loewenstein, 1996). Dissociation, in contrast, relates not only to content but also to state of mind. When trauma-related, it is often associated with distinct gaps and deletions in continuous memory for life history and/or experience. This is much less common in repression, where `the material that is unavailable is so limited in scope' (Loewenstein, ibid: 311).

- The motive for repression is avoidance of conflict. In dissociation, however, internal conflict is not experienced because the experience which would give rise to it is not formulated: `It is not that [conflict] is `moved' to a hidden location in the mind…it is simply not allowed to come into being' (Stern, 2010: 92).

- Repression relates to experience which was pre-formulated and unpleasant while dissociation relates to experience which was unformulated because it was unbearable (`not me'; Sullivan, 1953 in Howell, 2005; `[r]epression is always something that one does, but dissociation can happen to one'; Howell, ibid: 199).

- The pioneer of understanding of trauma-related dissociation was Pierre Janet (1859-1947) whose ideas prefigure contemporary views of it.

- Integration, coherence, and self-continuity are not innate but rather result from developmental and relational experience (`Constructing a mental self-continuity of consciousness, memory and identity is a task, not a given'; Spiegel, 2018:4).

- Links between mental states are fostered by interpersonal connections. States are the building blocks of consciousness and behaviour, and self, identity and well-being depend on linkage between self-states (Howell, 2005, ref. Putnam, 1992, 1997).

- In the normal course of events and development, `we are usually able to integrate our ongoing interaction…with

our social surroundings into a coherent sense of self' (Steinberg & Schnall, 2001, 2003:103). `Good enough' care-giving allows internalisation of positive relational interactions and healthy socialisation in which ruptures are repaired and the capacity to self-regulate is acquired. But developmental trajectories can be disrupted by deficient primary care-giving.

- Impediments to linkage of self-states can occur in various ways. Research shows that `[t]he best predictor of adult dissociation is emotionally unresponsive parenting' (Lyons-Ruth et al, 2006, in Chefetz, 2015: 89).

- The process by which development and socialisation of self occurs via the mechanism of dissociation is akin to Bowlby's account of `defensive exclusion' (Bowlby, 1981; 2006). What threatens the care-giving relationship is `defensively excluded'- i.e. dissociated – in the interests of preserving the primary attachment. For some people, most obviously in contexts of trauma, the need to dissociate (`defensively exclude') is extreme.

- Chronic dissociation in childhood comes at great cost. This is because the coping strategy that permits continued attachment to care-givers impedes the ability to attach securely later on: `The drastic means an individual finds to protect his sense of stability, self-continuity, and psychological integrity, compromises his later ability to grow and to be fully related to others' (Bromberg, 2001:6).

- It is possible for childhood trauma and other developmental deficits to be resolved and for secure attachment to be achieved (Siegel, 2003).

- When generated by stress that is overwhelming (i.e. trauma) the ability to move flexibly between self-states is impeded substantially (`the person surrenders self-state coherence to protect self-continuity'; Bromberg, 2011:68). The capacity to access thoughts, feelings, and important registers of functioning is limited or lost (Chu, 2011:41).

- Dissociative disorders are frequently correlated with a history of trauma (Spiegel, 2018:4) and inclusion of the dissociative subtype of PTSD in DSM-5 is significant.

- Studies show that dissociation features in many disorders: `dissociation may accompany almost every psychiatric disorder and operate as a confounding factor in general psychiatry' (Sar, 2014:171).

- The significance of dissociation as a transdiagnostic presence and its correlation with suicide attempts and non-suicidal self-injury (Calati, Bensassi et al, 2017) has implications for diagnosis, health risk, and effective treatment/s. It also has implications for treatment response per se (Price, Kearns et al. 2014).

- A continuum model of dissociation, while not subscribed to by all, has a number of benefits. When conceptualised as a continuum, and as a normal psychological capacity and process which can become problematic in particular circumstances (e.g. unresolved trauma, in which the dissociative response was initially protective) we can begin to understand the contexts which contribute to maladaptive coping and ways of managing stress which can become dysfunctional.

- One description of problematic dissociation - and its progression to disorder - is `a healthy defense gone wrong' (Steinberg & Schnall, ibid: 8) is helpful.

- Dissociation can be regarded as an inherent capacity of the mind, whereby `mind' comprises self-states which are variously linked. Primary care-giving relationships in childhood are initially and powerfully formative in shaping the degree to which the interplay between self-states is flexible and adaptive but maladaptive impacts are potentially amenable to being resolved.

- Well-being derives from the interplay of associative and dissociative processes; we cannot notice and pay attention to everything and dissociation can be normal and healthy (Chefetz, 2015). But dissociation can also serve defensive as well as benign and `everyday' purposes.

- The greater the need to defend against overwhelming experience, the greater the need for dissociation and increased potential for compromised psychological functioning.

- An understanding of dissociation in its various forms, both clinical and non-clinical, needs to be integrated into the public domain in general and within and across health sectors and services in particular.

References

Bowlby, J. (2006) *A Secure Base* New York: Routledge.

Brand, B.L. (2012) `What We Know and What We Need to Learn About the Treatment of Dissociative Disorders', *Journal of Trauma & Dissociation*, 13:4, 387-396.

Bromberg, P. M. [1998] (2001) *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation* New York: Psychology Press.

Calati, R., Bensassi, I. & Courtet, P. (2017) `The Link between Dissociation and both Suicide Attempts and Non-Suicidal Self-Injury: Meta-analyses', *Psychiatry Research* (Vol 251), pp. 103–114. https://doi.org/10.1016/j.psychres.2017.01.035

Chefetz, R. (2015) *Intensive Psychotherapy for Persistent Dissociative Processes: The Fear of Feeling Real* New York: Norton.

Chu, J. A. (2011) *Rebuilding Shattered Lives: Treating Complex PTSD and Dissociative Disorders*, 2nd edit. New Jersey: John Wiley and Sons.

Danylchuk, L.S. & Connors, K.J. (2017) *Treating Complex Trauma and Dissociation: A Practical Guide to Navigating Therapeutic Challenges* New York: Routledge.

Howell, E. (2005) *The Dissociative Mind* New York: Routledge.

Howell, E. & Itzkowitz, S. (2016) *The Dissociative Mind in Psychoanalysis: Understanding and Working with Trauma* New York: Routledge.

Loewenstein, R.J. (2018) `Dissociation Debates: everything you know is wrong', *Dialogues in Clinical Neuroscience* (20, 3), pp.229-242. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6296396/

Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation (2020) Blue Knot Foundation https://www.blueknot.org.au/resources/Publications/Practice-Guidelines

Price, M., Kearns, M. et al. (2014) `Emergency Department Predictors of Posttraumatic Stress Reduction for Trauma-Exposed Individuals With or Without an Early Intervention', *Journal of Clinical Psychology* (82, 2), pp.336-341.

Sar, V. (2014) `The Many Faces of Dissociation: Opportunities for Innovative Research in Psychiatry', *Clinical Psychopharmacology and Neuroscience*, 12, 3, pp.171-179.

Schwarz, L., Corrigan, F. et al (2017) *The Comprehensive Resource Model: Effective therapeutic techniques for the healing of complex trauma* New York: Routledge.

Spiegel, D. (2018) `Integrating Dissociation', *American Journal of Psychiatry*, 175:1, pp.4-5.

Steinberg, M. & Schnall, M. (2001) *The Stranger in the Mirror Dissociation, The Hidden Epidemic* New York: HarperCollins.

Stern, D. (2010) *Partners in Thought: Working with Unformulated Experience, Dissociation, and Enactment* New York: Routledge.

A Lived Experience Journey

If you tweak the tail of the tiger, you'd better know where you are running to.

Blue Knot would like to thank the author of the following article for so generously sharing the challenges of finding practitioners who have experience and expertise in supporting people with experiences of complex trauma and dissociation. The author's experience attests to the importance of practitioners being dissociation- as well as trauma-informed. As the lead article indicates we will be including summaries of all 3 chapters in our new Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation (2020) to assist in this process.

** Trigger Warning: This article may contain content that could disturb some readers. You may choose not to read it. If you do read this story and reading it causes you distress and you need support, please call the Blue Knot Helpline on 1300 657 380 (9am-5pm AEST, 7 days).*

In 2004, when I was 51, working as a rehabilitation consultant I found interpersonal difficulties with clients a

source of shame and embarrassment. I wanted to "improve" myself and also get to the bottom of "what was wrong with me" as this had been a long- term issue. I sought help from a GP who referred me to a Psychologist (not clinical) who was in his 70s but had a good reputation for helping people, despite being at the end of his career. I told him of a background trauma that had sporadically surfaced throughout my life and recent severe anxiety.

After several months I said I would leave now and he said, "well this is what therapy is all about". So despite not knowing what he meant I continued to see him until I noticed a "relationship" with him emerging within my body, heart and mind. This concerned me greatly as I thought it was forbidden. He continued to encourage me toward emotional expression. He recorded cassette tapes of the Relaxation Response which I dutifully listened to at night before going to sleep. This is how he got deep into my emotional brain.

I noticed myself responding to a person who showed affection and concern for me, but I was terrified. He took little notice of my alarmed state despite me asking why he was not responding to my terror. Attempts to bring me out of myself (my words) were initiated with physical contact, coming toward me on his chair to hold my arm. (I can only assume he did this as a way to change my flat affect).

The physical contact continued despite being clearly dangerous and brought about the full exposure for the first time of the traumatic physical incident as a very young child. I knew I was in serious trouble emotionally and psychologically. I became alarmed at the development of PTSD resulting in the dramatic unfolding of images, sensations, and awareness of what had been deeply buried for 50 years. I thought he would talk it through with me, giving me a current perspective. He did not engage or ask me what was going on. Each weekly session, I began to freeze before sessions, vomiting on one occasion. I arrived and left his room in a chronic state of distress and ran through the car park back to work. I was physically, emotionally and psychologically unravelling to my core.

My whole sense of time vanished as did what little sense of myself and my world I had before seeing him. I kept saying to my husband "Please tell me I'm here". I was working as a consultant and bleeding trauma all over any interpersonal contact. How could I have known I had

developed dissociation as a default self-state. I was unaware that I was unaware. I just thought I had a background of emotional abuse. My mother had always scapegoated me and made her problems my fault. My father a drinker and emotionally abusive.

However this had replayed the original traumas of both a very early physical incident and disorganised attachment including long term maternal neglect and persecution.
I realised I had been completely unaware of this emotional need before. I had suppressed the “need to feel” all my life. I couldn’t let the opportunity go to experience it because it presented the potential to make me whole for the first time in my life and solve all my problems. But I was losing promising opportunities every session.

I was trying to keep all this as close to my chest as possible because I was so ashamed of needing this connection and genuinely didn’t realise it was allowed in a professional setting. I had grabbed a copy of Peter Levine “Waking the Tiger” from a massage therapist’s shelf and thus began my journey of trying to find out what was going on.
I was trapped by needing him to engage with me but being frozen when he continued physical contact and demands in a way I felt compelled to oblige. Looking back I realise I was in that terrible conflict of needing care from the perpetrator. How familiar this was.

I became catatonic in the car when driving home at excessive speeds. When home I would fall on the floor and be startled by family members walking into the room. Comfort and connection were very hard to find, as my husband was frightened by my state. I was distraught with grief. I felt so ashamed of needing that connection, I couldn’t tell anyone. I continued in a acutely distressed emotional and psychological state for 2 and a half years when he retired.

The classic environment ensued for the maintenance of long term Complex PTSD. As complex PTSD developed, I became emotionless in my presentation. In 2006, The Psychiatrist I was referred to, was understanding of the trauma but not aware of the mental unfolding happening before her eyes as I walked through the door. The dramatic initiation and continuing development of neuroplastic pathways was apparently not evident despite me saying it was happening. Such a total collapse had required me to spend most of the time on big cushions on

her floor over the 2 years I consulted her. She bought “The Haunted Self” 2006 by Van der Hart, Nijenhuis and Steele and showed me as if I was able to utilise the knowledge inside the book. When she finally said “What am I going to do with you?”, I felt rejected and amazed by the lack of response given my severe symptoms. I was not aware of where I sat on the continuum of consciousness. I had to take a year of leave from work, to try and sort myself out. I used books to help me understand. Judith Herman’s Trauma and Recovery was a lifesaver.

In 2008 still feeling overwhelmed, I consulted a Clinical Psychologist this time with a focus on mindfulness and body scan techniques. I thought to myself that this will work because the trauma is in my body. This relationship lasted 4 years during which time I became seriously suicidal. I pleaded with him to talk about what I was experiencing. How could he not be curious about what was happening to me as I walked through the door using all my strength to remain upright. His treatment tool was mindfulness meditation which was limited in meeting my needs. I said to him, “can’t you see”? I was desperate for emotional and psychological recognition and contact. It became so critical he engage with me, that I had to stop myself from running in front of the cars outside his office. By 2012, it was incredibly difficult to leave when I continued in such an emotionally distraught state. But it felt right somehow because I was not getting what I needed.

During this time in 2010 my father died and then in 2012 my brother died. My eldest son got married in 2011. I had been hoping to be well for these major family events. In late 2012 I saw a male Psychiatrist who made an assessment after a few sessions without asking questions and said to me. “There is no one in this city/state who can help you”!!! Crikey, how to make someone feel abandoned. Now I was in more trouble, despite all my strength to keep myself going, I could not believe my ears. As I slinked out through the door he quietly said “oh come back and see me if you need to”!!!

I was having to find my own way toward the next mental health professional who may or may not be able to help me. Unfortunately I was not aware of the Blue Knot Foundation. My husband and I had couple counselling which did not meet my needs. I felt ashamed when she referred to my “my broken brain”. I took this personally

and as an outrageous comment in the circumstances. I told her so, to no avail.

By 2015 I presented to a female Psychiatrist who specialised in complex trauma and had a good reputation. The receptionist said “You’ll be right now”. I had my fingers and toes crossed. At least I still had hope. At my first appointment I was emotionally distraught. There was no initial “interview” as such which concerned me. I knew from experience she was not going to help me without an extensive getting to know me approach. A deep investigation into my history was required. I said I needed help with both the primary and secondary trauma, but this was not taken seriously enough. Although the role of the “non verbal” aspect was recognised I felt I was having to role reverse and look after her. This was a familiar emotional setting for me.

During 2016 my youngest son was married and my mother died. During these crucial family events, I was embarrassed by the emotional limbo I was in while still far from being well.

We worked together toward what I thought was a common goal of healing the original trauma, but I realised she was expecting me to engage with her!! My brain wasn’t able to do it for me or her.

In 2019, after 4 years with this therapist and 15 years since the original exposure, I could tell I was emerging from dissociation but not sure how far I had to go. She suddenly commented “How excruciating-why didn’t you say”. I kept my amazement under wraps and tentatively replied “I have been saying”. I couldn’t believe it. What did she think I had I been doing if I wasn’t trying my heart out to connect while enduring untold suffering. I felt totally let down, with the best opportunity lost, after thousands of $ and all my blood sweat and tears.

About this time I read Norman Doidge “The Brain That Changes Itself” 2010. It became clear to me since 2004 my mental-emotional neuroplasticity was developing toward the present moment, desperately seeking “a person”! I now understand that in 2004 I presented with a dissociative personality structure. I of course could not have realised it was actually all of me that was cut off. I was just a very good survivor. I was dependent on the treaters to diagnose accurately as the developmental trauma occurred when I was very young.

Given I told all the practitioners over 15 years about the previous lack of full awareness of the childhood trauma, I thought the role of dissociation was obvious, that they would be putting dissociation front and centre while working toward helping me into a coherent place in the present where I would at last be allowed to feel. As of March 2020, I now feel free that I am functioning without consulting any mental health professional. Despite not being dissociated, the original trauma remains untreated.

- Anonymous

Understanding Trauma as a System of Psycho-Social Harm: Contributions from the Australian Royal Commission into Child Sex Abuse

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This article examines how particular understandings of trauma as a systemic form of psychosocial harm framed the establishment of the Australian Royal Commission into Institutional Responses to Child Sexual Abuse, informed its successful investigatory process, and shaped its recommendations and outcomes. In so doing, the Royal Commission makes an important contribution to the field of trauma studies, which has been characterized by

contested histories and is subject to continuing debate in clinical and academic research. For much of the twentieth century, trauma and its impacts have been typically articulated through a bio-medical discourse of individual harm and health outcomes. We argue that the establishment of the Royal Commission reflected an expanded understanding of trauma, constitutive of moral, political and psychological arenas as evidenced in its methodology, conceptual approach and treatment of survivor testimony. We also argue that the institutionalization of an historically situated and politically engaged approach to trauma within the Royal Commission itself was effective in contesting narrow psychological or juridical concepts of harm by developing approaches to trauma as a system of harm with complex impacts on families, communities and indeed the nation. We evaluate the implications and consequences of this shift in the work of the Royal Commission, with particular attention to the development of an interdisciplinary relational approach to the study of trauma as a key principle in the emergence of a trauma-informed culture.
Read more here ...

Reliving Trauma: The Bushfire Crisis has Mentally Scarred Many Australians

Amy Sarcevic

In summer 2019, Bianca fled her home on the first sight of a catastrophic fire warning on her mobile phone, which — still to this day — she never leaves out of sight.

Resisting the fight element of her fight-or flight state, Bianca, mother of two young children, had no choice but to take shelter in nearby Sydney for the days that followed. Meanwhile, her neighbours stayed and fought huge behemoths of flames, surrounding their once leafy Blue Mountains suburb. Returning to her neighbourhood — a charred landscape — Bianca (a prolific writer on the subject of mental health) knew it was wise to keep an eye on her unfolding psychological and physical symptoms. Read more here ...

Training and Organisational Services

The Training and Services Team will be focused on planning to return to face to face training in the coming months. We know the community are eager to see our upcoming calendar and we hope to be able to share very soon. It will be offered in line with government restrictions so may look a little different for now, but all the details will be in our upcoming calendar.

Consultations on organisational training are still occurring and one of the team would be happy to speak further about what we can provide for you and your teams. We offer packages of training and supervision to integrate both theory and practice. This supports teams to unpack key themes in a safe and meaningful way to take back to the workplace.

Supervision both group and individual, are open and the team are still taking enquiries and bookings. If you want to organise your supervision before the end of the financial year we are taking pre-payment.

Make sure to keep up to date with any new developments on our website. Enquiries can be directed to training@blueknot.org.au

National Counselling and Referral Service (NCRS) – expanded purpose

The National Counselling and Referral Service is now not only supporting people affected by the Disability Royal Commission. It is a key trauma-informed support for people with disability, family members, carers, advocates and workers who have experienced or witnessed abuse, neglect, violence and exploitation during these difficult times. Anyone who wishes to access this support does not need to make a submission or have any prior involvement with the Disability Royal Commission.

If you are living with disability (or are a family member of or caring for a person with disability) and

- have experienced abuse, neglect, violence or exploitation
- are currently experiencing abuse, neglect, violence or exploitation
- are distressed or anxious about coronavirus
- are affected by the Disability Royal Commission

You can call the National Counselling and Referral Service on 1800 421 468.

This service operates from:

• 9am-6pm AEST/AEDT Mon-Fri and
• 9am-5pm AEST/AEDT Sat, Sun and public holidays.

Who the service is for:

- people with disabilities who have experienced violence, abuse, neglect and exploitation anywhere
- parents, guardians, other family members of a person with disability
- carers of a person with disability
- advocates for people with disability
- service providers or agencies working with people with disability
- employers or colleagues of a person with a disability

What the service provides:

- professional short-term counselling and support
- a gateway to frontline counselling services
- supported transfers to and from the Royal Commission, advocacy and legal support services
- information and referrals about other useful services
- information about trauma and distress and why people can feel overwhelmed

How to contact the National Counselling and Referral Service (NCRS) supporting the Disability Royal Commission

There are a number of different ways you can contact NCRS depending on your accessibility needs, and the type of service you require.

Telephone: Contact **1800 421 468** or **02 6146 1468** to speak with one of our counsellors for short term counselling support and referrals.

Video Conference (VC): VC is available to people who have restrictions around their ability to contact our counsellors via telephone. Please contact us first by email at to ncrscounsellors@blueknot.org.au You can call us yourself or with a support person on **1800 421 468** AEST to discuss accessing this service. This service is available for a single session with a focus on linking you with local and ongoing supports.

Webchat (WC): Webchat is available for people who require support, information or referrals. Webchat is

found at the bottom right of the screen our website. It is not a counselling service. Please refer to the Webchat Terms and Conditions for further information should you choose to use this service.

SMS: SMS is available to people who have been in contact with us by phone or webchat and can be used to provide people with information or referrals. SMS contact **0451 266 601**. It is not available for counselling support.

N.B. This is a separate service from the Blue Knot Helpline which provides counselling, support, information to people with experiences of childhood trauma and for support around applications to the National Redress Scheme.

If in crisis, in need of immediate support or concerned for your safety:
Call Lifeline on **13 11 14**. If you are currently experiencing any form of violence or abuse, or are concerned for your safety, call 000.

What you can expect when you call the National Counselling and Referral Service:

- Our counsellors are here to listen and support you
- Everyone's experience of trauma is different, and everyone has different needs
- Counsellors will provide support in your call based on your needs
- Counsellors can refer you to longer term supports for ongoing counselling
- If you need an advocate, counsellors can refer you to an advocacy service
- Counsellors can also provide information about trauma and its impacts
- We try to answer each call when it rings and usually do
- Sometimes we won't be able to answer straight away and you will be on hold until the next counsellor becomes available
- If you cannot wait on hold you are welcome to email our counselling team or have a support person email requesting that we call you back and we will do so as soon as possible

Accessibility

If you find it difficult to hear or speak you can contact us through the National Relay Service (NRS). Please phone

133 677.

If you find if challenging to use the telephone, you can contact the National Counselling and Referral Service supporting the Disability Royal Commission using video conferencing. To do so please connect with us first via email at ncrscounsellors@blueknot.org.au or by calling us yourself or with a support person on **1800 421 468** AEST to discuss accessing this service.

If you require support in another language you can use the Translating and Interpreting Service (TIS National) free of charge by:

- Calling the National Counselling and Referral Service and asking for an interpreter. The counsellor will make the arrangements, or
- Calling TIS on **131 450** and asking to be connected to National Counselling and Referral Service on **1800 421 468**.

Around a quarter of Australian adults have experienced childhood trauma, abuse or neglect.

Your support will ensure live-giving Survivor Workshops can continue.

Around a quarter of Australian adults have experienced childhood trauma, abuse, or neglect.

This trauma often feels like it has no end—it steals precious time and creates needless pain. For people living through it, their family and friends, experiencing this firsthand is very distressing.

This is why Blue Knot has created Survivor Workshops.

We wanted to create a pathway for survivors of trauma to learn more about trauma and begin the vital process of healing.

These workshops are offered free to survivors; they have proven to be incredibly affirming. So much so, that we cannot keep up with high demand.

Because of this, we must ask you for your urgent support. Will you please donate today so that these important Survivor Workshops can continue?

We realise that this year has already been very difficult. We have witnessed the devastation of bushfires, followed by floods. And now, we continue to reel from the impact of the coronavirus as it rewrites our social norms.

This has had a direct impact on our ability to provide face-to-face delivery of our Survivor Workshops. We have had to postpone these—yet the sensitive nature of our Survivor Workshops means that they cannot be delivered remotely and a backlog has been building.

We have seen how effective and utterly life changing these workshops are—and we desperately need to ensure that we are able to continue providing them.

In order to help the people turning to us today, we need to raise $60,000 by June 30.
Your donation will help us get closer to this life changing goal.

The Survivor Workshops raise awareness about survivors' strengths and resilience, the role of coping strategies, how the brain responds to stress, and most importantly, research which shows that recovery is possible.

• You can help a mother find peace with motherhood.
• You can help a father overcome the pain of abuse.

This is the gift you can give to the survivors of trauma reaching out for help at this most critical moment.

You can help. Please send your life-giving gift today.

Donate Now

Blue Knot Review is an electronic journal chronicling recent developments and new perspectives around complex trauma and trauma-informed practice. Contact newsletter@blueknot.org.au for feedback or to contribute. Click here to subscribe or forward this email to anyone who may be interested

The Blue Knot and Redress Helpline and has established a referral database of mental health practitioners, doctors, service providers and support groups to provide referral options to callers of our Helpline. If you are a trauma-informed health professional you can apply to be included on this referral database here.

Blue Knot Foundation
www.blueknot.org.au | admin@blueknot.org.au | 02 8920 3611
Blue Knot Helpline 1300 657 380 - 7 days - 9am-5pm AEST/ADST