

**Autumn 2022**

# **Blue Knot Review**



[professionals.blueknot.org.au](https://professionals.blueknot.org.au)

 **blueknot**  
empowering recovery from complex trauma

**Welcome to the Autumn Edition of Blue Knot Review. This quarterly journal focuses on the practical application of key concepts, and developments and perspectives about complex trauma and the continuum of trauma-informed practice**

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## Research Highlight

### **Barriers to accessing and continuing mental health treatment among individuals with dissociative symptoms (Bethany Brand; et al)**

The highlighted research this quarter is the new publication by Bethany Brand PhD et al. The journal article identifies the barriers to accessing and continuing mental health treatment among individuals with dissociative symptoms. This research further supports the need for increased understanding of the dissociative spectrum. Brand et al states:

Dissociative disorders (DDs) are characterized by interruptions of identity, thought, memory, emotion, perception, and consciousness (American Psychiatric Association [APA], 2013). DDs are empirically associated with a history of trauma (Dalenberg et al., 2012). While it is often thought these disorders are rare, studies show the prevalence of DDs ranges from 4% to 38% in inpatient, outpatient, and general populations (García, Rico, & Agráz, 2006; Gast, Rodewald, Nickel, & Emrich, 2001; Şar, Akyüs, & Doğan, 2007). Individuals with DDs experience impaired global functioning and are at high risk of engaging in dangerous behaviours such as self-harm and suicidal acts (Mueller-Pfeiffer et al., 2012; Nester, Boi, Brand, & Schielke, 2022; Nester, Brand, Schielke, & Kumar, 2022; Webermann, Myrick, Taylor, Chasson, & Brand, 2016).

However, only 28–48% of these individuals receive mental health treatment, and of those that receive treatment, as few as 25% rate the treatment as appropriate to their needs (Leonard, Brann, & Tiller, 2005; Şar et al., 2007). Studies show individuals with DDs who do not receive dissociation-specific treatment experience high rates of disability, frequent hospitalizations, and poor quality of life (Leonard et al., 2005). These negative consequences, coupled with the low rate of treatment utilization, highlight the need for understanding and mitigating the barriers to treatment for dissociative individuals.



The study aims to identify barriers to accessing and continuing mental health treatment among individuals with trauma-related dissociation. The authors made the following hypotheses:

1. The majority of dissociative individuals would experience barriers to accessing mental health treatment.
2. The majority of dissociative individuals would experience barriers to continuing mental health treatment.
3. A subset of the dissociative individuals would experience barriers related to their dissociative symptoms.



To read the full article find the link and citation below:

M. Shae Nester, Sarah L. Hawkins & Bethany L. Brand (2022) Barriers to accessing and continuing mental health treatment among individuals with dissociative symptoms, *European Journal of Psychotraumatology*, 13:1, DOI: 10.1080/20008198.2022.2031594

# Education and Training

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## Introduction to Dissociation

**'Put simply, dissociation can be regarded as an inherent capacity of the mind, where `mind' is comprised of various self-states which are linked and moved between flexibly or inflexibly depending on the nature of the relationships we have. While primary care-giving relationships in childhood are initially and powerfully formative, their impacts are amenable to reworking later in life.'** (Siegel, 2003)

Many mental health practitioners have not received or had access to training regarding complex trauma and dissociation. This means that they might not notice dissociation, especially when it is mild. Blue Knot developed a new training program to support professionals who are providing trauma specific services support them to attune to the presence of dissociation.

This training will cover the concept of dissociation building understanding of the continuum of dissociative experiences. It considers the understanding of complex trauma-related dissociation and its impacts on the mind and body. It will also explore structural dissociation and working with dissociation with the three phased approach. Finally, it will generate discussion about attuning to dissociation in the therapy setting.

This training is for those who are working with clients in a therapeutic setting. Attendance at the Three Phased Approach training is recommended as foundation for grounding in the material. If you would like to attend this training follow the link to our website:

<https://professionals.blueknot.org.au/professional-development-training/training-programs/introduction-to-dissociation/>



# Toolbox

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## Dissociation and how to identify dissociative experiences when working with clients.



Dissociation varies in type and intensity and operates along a continuum. It can occur in everyday forms such as daydreaming, but it also operates in more severe forms, with the most severe form being Dissociative Identity Disorder (DID). DID stems from traumatic overwhelm in early childhood, before the self is developed, in which states have never been connected, remain disconnected, and in which multiple states can be generated. Dissociation occurs beyond conscious awareness and control. It can also be triggered after the precipitating trauma by seemingly minor cues which serve as reminders of the prior experience of overwhelm.

If a client is dissociated, they cannot receive the 'here and now' input because they are not engaged in the present moment. As clients with experiences of complex trauma may have contrasting dissociated self-states great care needs to be taken as even mundane words and phrases may be received and responded to differently depending on the states/part. Thus, all practitioners need to be aware of trauma-related dissociation, for which sensitive, attuned and trauma-informed responses are needed to establish safety and stabilisation.

**“The most important distinction... to make is between mild dissociative experiences that are normal experiences that range from moderate to severe” (Steinberg,2003:33)**

## **Attune to the possibility of dissociation from first contact**

“The fact is that people with dissociative disorders present with subjective experiences that are normal, but which for a clinician can easily be discounted as a person being quirky, inattentive...or having a constitutionally bad memory.” This underlies the need for training to identify dissociative symptoms, because even chronic forms may be undetected, and clinicians routinely miss any signs of...milder forms of dissociation in the clients they see. (Cheftz)

## **Recognise the limits of a ‘whole person’ approach when working with dissociative clients**

Dissociative clients may have diverse, trauma generated, and unintegrated internal states which have varying degrees of consciousness for one another, This challenges the extent to which these clients experience themselves as a whole person. It also challenges the extent to which therapists can experience them this way as well.

## **Attune to the relationship between dissociation and shame**

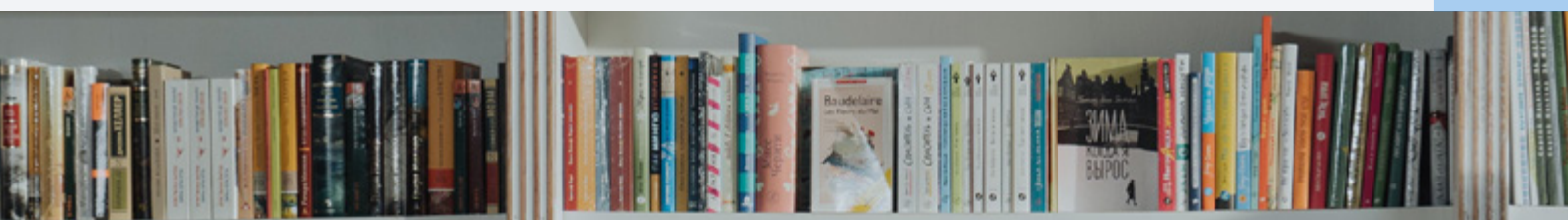
“Shame is a great instigator, maintenance and enhancer of dissociation” (Kluft)

## **Orient to parts language and work**

Orienting to working with ‘parts’ is helpful for working both with structurally dissociated clients (ie: whose early life trauma generated divisions of the personality) and clients for whom internal diversity is less severe and not chronic. This is because it represents a natural extension of client work more generally.

These are just a few examples from the Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation. The guidelines provide further information on ways to identify and treat dissociation as well as the research that underpins it. They can be purchased or downloaded from our website.

<https://professionals.blueknot.org.au/resources/publications/clinical-guidelines/>



# Toolbox

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## Exploring Vicarious Resilience

“Vicarious resilience is defined as positive modifications in a therapist’s way of thinking and behaving as a result of their empathetic engagement with the service users’ traumatic experiences (Hernández-Wolfe et al., 2007).

Vicarious trauma and vicarious resilience are both seen as natural and normal processes that can develop, sometimes simultaneously in any worker or therapist that works with people who have experienced trauma.

Engstrom, Hernandez & Gangsei (2008) identified some ways Vicarious Resilience can be seen and expressed:

- **Reflection on people’s capacity to heal with sense of amazement and pride**
- **Reassessment of how the worker views their own life concerns - there is a direct positive shift in perspectives on the world and their own lives**
- **A strong commitment and belief in the concept of hope**
- **Development of the ability to deal with own frustrations**
- **Greater ability to use ‘self’ in relationships with people they support**
- **More appreciative of the freedom in their own life and take things less for granted**
- **Reframe to see the strengths in a given experience that previously may have been viewed as negative**

Some of the ways of developing and maintaining vicarious resilience focus on the capacity for empathy and compassion:

- **The nature and extent of the clinician’s connection with their client’s growth, resilience, and pain**
- **Empathic attunement with their client**
- **Kindness**
- **Core empathic capacities (i.e., tolerance, resistance, endurance, capacity)**



Hernandez et al (2010) identified that as worker/therapist using reflective questions in supervision or when journaling can support building capacity for vicarious resilience:

- What challenges have you witnessed your clients overcoming in the therapeutic process?
- What did your client inspire in you that you want to nurture and expand?
- Do you have any thoughts about how your perception of yourself may have been changed by your clients' resilience?
- Do you feel that your general outlook on the world has changed in some way?
- Can you identify any impact in your own views about spirituality?
- Have you had any thoughts about how your views on trauma work may have been positively impacted by your clients' resilience?
- Have any thoughts about how the ways you take care of yourself have been impacted by your clients' resilience?



Further reading available in the article:

P. Hernandez, D. Engstrom and D. Gangsei (2010) Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. *Journal of Systemic Therapies*, Vol. 29, No. 1, 2010, pp. 67–83

# Working with Dissociation on the Phone

**'Dissociation is mostly not about dissociative disorders. It is about how a mind struggles to cope with the intolerable and unbearable' (Chefet, 2015: 23).**

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

## Recognising when a caller dissociates on the phone

It can be hard to recognise when a person is dissociating especially over the phone. You might notice that the caller:

- uses a different tone of voice
- completely loses their train of thought
- switches to a different self-state that sounds completely different
- spaces out
- has significant lapses in memory
- loses time
- feels disconnected from themselves
- pause and sound detached

## Recognising when a caller dissociates on the phone

### Support the caller to ground themselves so they can connect back into the here and now

When a caller dissociates, support them to come back into the present, to recognise when they are present, and what it feels like, if possible. Different strategies can help ground them e.g. ask the caller to listen for three sounds and name them. Sound can be a safe bridge back into the present.



## Support the caller to come back into their body

Survivors often dissociate from their body. Simple body awareness exercises can help ground them. Ask the caller to push their feet down into the floor and to notice where they feel this movement. This is a safe way to reconnect with the body, and for the caller to notice when they are also connected with you.

- Gently observe to the caller that they may have spaced out: “Seems like you may have spaced out. Can you tell me when you went?”
- Try to get the caller to talk about their surroundings: “Are you able to tell me where you are? What colour is the room?”
- Build your own awareness of when you dissociate and notice how it feels.

To read more find our Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation on our website at

<https://professionals.blueknot.org.au/resources/publications/clinical-guidelines/>



## Resources – Book Review

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### **Understanding Dissociative Identity Disorder – A Guidebook for Survivors and Practitioners**

This accessible guidebook has been created to be used alongside the picture book, *Our House: Making Sense of Dissociative Identity Disorder*, as a broad introduction to childhood trauma and its legacies, with a focus on dissociation and DID.

This clear and easy-to-read resource offers an insight into trauma, its continuing effects and the continuum of dissociation. Practical exercises and opportunities for reflective discussion are included throughout to encourage personal engagement either individually or through treatment. Written with clinical accuracy, warmth and compassion, it will expand the reader's knowledge of DID and deepen the understanding, application and usefulness of the picture book.

<https://www.routledge.com/Understanding-Dissociative-Identity-Disorder-A-Guidebook-for-Survivors/Schofield/p/book/9780367708191>

### **Our House – Making Sense of Dissociative Identity Disorder**

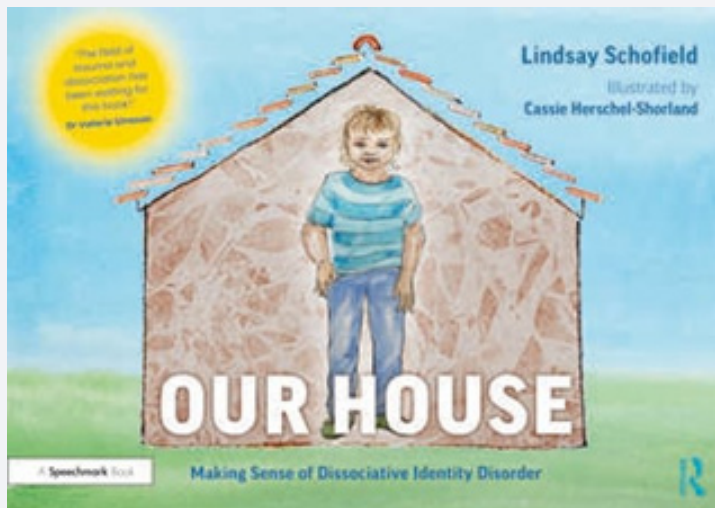
*Our House* tells the story of a child who has experienced something that children should never have to experience. It introduces the reader to the people who arrived to help them cope with the bad things, in the house that they all share.

Accompanied by beautiful and gentle illustrations, the story takes a non-threatening approach to demystify dissociative identity disorder, using the metaphor of a house to explain what it is and how it develops. *Our House* can be read by individuals, or used as a treatment tool to stimulate discussion, and is suitable for all ages. It includes additional guidance which explains the metaphor in depth, as well as advice regarding dissociative disorders and signposts to further help for both individuals and professionals.

Bringing clarity to a complex issue, this is an invaluable resource for survivors of trauma and for those who support them, counsellors, psychologists, social care workers and other professionals, as well as family and friends. An accompanying guidebook is also available, offering further information, resources and activities, and page-by-page insights into illustrations from the picture book. Both books can be purchased as a set.

<https://www.routledge.com/Our-House-Making-Sense-of-Dissociative-Identity-Disorder/Schofield/p/book/9780367708238>

**A discount is available till June by using this code: FLA22 when you purchase either or both publications.**



I am delighted to welcome such an accessible resource to help demystify the frequently denied and sensationalised condition of DID. The pictures and simple text of the everyday can be readily understood and will go a long way to helping those struggling with a DID diagnosis or its effects, and those supporting them.

Dr Cathy Kezelman AM,  
President  
Blue Knot Foundation –  
National Centre of Excellence  
for Complex Trauma; lived  
experience

## Resources – Podcast

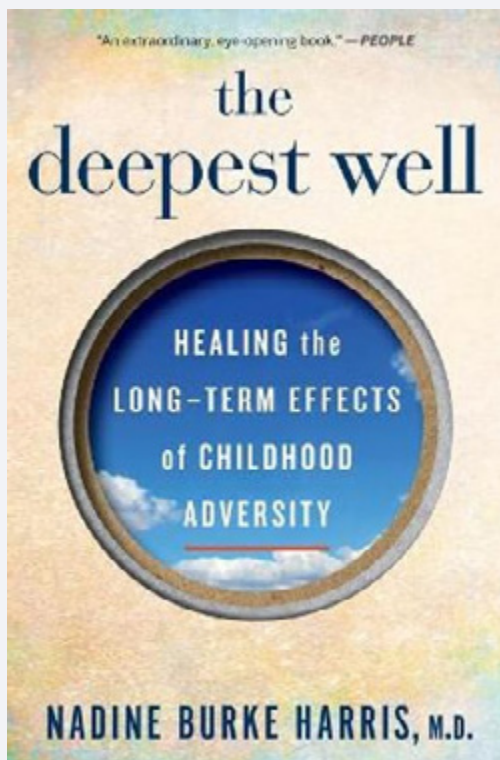
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### **Book Club: Navigating Childhood Trauma with ‘The Deepest Well’ – Why is it important to understand more about the possible effects of childhood adversity?**

Host Dr Johanna Lynch; a GP, enlists her trusted friend and colleague, Dr Cathy Kezelman AM, President, Blue Knot Foundation to unpack the popular book – ‘The Deepest Well: Healing the Long Term Effects of Childhood Adversity’ (2019) – by renowned pediatrician, Nadine Burke Harris.

Hear from Johanna and Cathy as they dive into ‘The Deepest Well’ revealing crucial insights into the ‘unseen epidemic’ of childhood adversity. Listeners will gain an understanding of the urgency and scale of this issue for clinicians; the role of awareness in medical funding and policy; and most importantly, the wealth of evidence backing Burke Harris’ key message that, in both the immediate aftermath and cumulatively following experiences of childhood adversity, the question is not ‘whether’ but rather ‘to what degree’ trauma takes its toll on us, our bodies, our health, and our lives.

<https://www.mhpn.org.au/podcasts/Book-Club-Episode/Navigating-Childhood-Trauma>



Dr. Nadine Burke Harris was already known as a crusading physician delivering targeted care to vulnerable children. But it was Diego, a boy who had stopped growing after a sexual assault, who galvanized her journey to uncover the connections between toxic stress and lifelong illnesses.

The stunning news of Burke Harris’s research is just how deeply our bodies can be imprinted by ACEs adverse childhood experiences like abuse, neglect, parental addiction, mental illness, and divorce. Childhood adversity changes our biological systems and lasts a lifetime. For anyone who has faced a difficult childhood, or who cares about the millions of children who do, the fascinating scientific insight and innovative, acclaimed health interventions in The Deepest Well represent vitally important hope for preventing lifelong illness for those we love and for generations to come.

# Resource: Managing Stress and Anxiety using Mandalas

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**'A mandala is the psychological expression of the totality of the self'**

**Carl Jung**

The word mandala comes from Sanskrit, and it means "sacred circle." The Mandala is also known as a circle or 'container of the essence' and is believed to represent wholeness, health, connection, unity, harmony and the cycle of life.

Mandalas were first used in therapy by Carl Jung, who found that the act of drawing mandalas had a calming effect on patients while at the same time facilitating psychic integration.

Mandala drawing was viewed as a creative means of traumatic disclosure that would symbolically organise and integrate emotions and experiences, while serving the same function as writing a narrative. In Henderson's 2007 study, a significant improvement in PTSD symptom severity via mandalas was found.

Mandala colouring requires both hemispheres of the brain to remain focused, to enable the areas of the brain work in a balanced way. Intricate designs of mandalas stimulate the brain to aesthetically choose the colour. Colouring mandalas help activate both analytical and creative parts of the brain, increase problem-solving skills, refine cognitive skills and foster inner strength.

Mandalas are also used for meditation. Some practices involve tracing the lines of a mandala with one's eyes, creating a high level of concentration and sense of present-moment-awareness.



Creating mandalas can be helpful for centering, meditation, emotional expression and self-soothing. The structure of the circle provides a sense of containment to help decrease anxiety. The use of fine repetitive movements enables the person to stay focused on the activity leading to 'being in the present moment'. This results in positive physiological changes and a relaxation effect within the body.

Colouring within mandalas, is a tool you can use to support regulation when stressed and to create space for quiet reflection. This video provides a demonstration of art as a meditative practice and further information about the process of creating a mandala.

<https://professionals.blueknot.org.au/resources/videos/>

<https://mondaymandala.com/m>





## Events

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### Film release – **When the Camera Stopped Rolling**

This powerful feature documentary portrays the triumph of love and creativity over the pain of complex traumatic disruption. When the Camera Stopped Rolling documents the trailblazing mother-daughter filmmaking team of Lili Fraser and Jane Castle and the intergenerational trauma that was its shadow. Narrated by Jane with unflinching honesty and set against stunning visuals, the film is testament to the power of image and language to make meaning of what has defied meaning.

Balancing meticulous archival research with gripping narrative, the filmmaker interweaves both characters' struggles and triumphs with clarity and compassion. Intimate yet universally relatable, When the Camera Stopped Rolling is testament to the potential for post-traumatic growth and reconnection. It provides a portal through which audiences can explore their own healing journeys and opens up new space for dialogue. As such, it is a valuable tool for professional psychotherapists and is bound to stimulate a deeper exchange around the impacts of, and therapeutic strategies to address, complex trauma.

# WHEN THE CAMERA STOPPED ROLLING



The film addresses multiple traumas across the generations: the broken bonds of attachment; domestic and family violence; childhood neglect; dissociation and fragmentation; the impacts of addiction; the systemic violence of societal gendered discrimination; the loss of connection through dementia and mental illness and the brutal trauma of sudden and violent death.

Despite these potentially weighty subjects, the film captures the potential for their transformation through what is ultimately a form of creative, narrative exploration. While *When the Camera Stopped Roll* can be seen as an act of transcendent sublimation it can also be studied as a real-world artefact of the filmmaker's own, courageous recovery process.

The film's main character, Lillas Fraser, was one of Australia's pioneer filmmakers who trailblazed her way through the glass ceiling to make over 40 films and unwittingly inspired the next generation of feminist filmmakers. But like most pioneers, Lillas's drive towards self-actualisation was fuelled by a complicated personal history, the impacts of which began to intensify over time.

Using the rich textures of her mother's and her own deep cinematographic archive, Jane chronicles their journeys through trauma towards healing. For Lillas, this began with her dramatic escape from her violent marriage and was followed by sobriety and her discovery of the nascent feminist filmmaking community of the 1970s. Her impulse towards self-reflection was actualised in her most personal film, *Women of the Iron Frontier*, made in her mid-50s; a thoughtful reflection on her previous films and a critical milestone in her recovery. Interweaving her mother's journey with her own experience of intergenerational trauma, Jane takes the audience on a brave exploration of her own struggle for internal survival within the challenges of disrupted attachment and family violence which played out in her troubled relationship with her mother.

What provides inspiration amidst what might otherwise be a bleak trauma-landscape is the gentle yet stunningly beautiful re-imprinting of these experiences, which demonstrates that resilience, and even repair, can be found in the darkest of places.

The powerful use of both visual and poetic metaphor throughout the film enables audiences to journey into depths that lie beyond language and in doing so enables an experience of the disparate elements of love and destruction that are so often inextricably intermingled. As a deeply visual and aural sensory experience in itself, the film also captures the visceral affect that is so often experienced in the psychotherapeutic relationship.

Practitioners in the fields of psychotherapy, psychoanalysis and psychiatry may also find resonance in the poignant portrayal of the therapy journey that both Jane and Liliás explore at various and intersecting times in the film. At play is the hidden, non-intrusive presence of the therapist, the very antithesis of the hostile disturbance of the original traumatic experience. Ultimately, the film is a tribute to the redemptive power of the presence of the non-intrusive but connected other.



## **WHEN THE CAMERA STOPPED ROLLING is screening in cinemas across Australia from APRIL 2022**

Jane Castle, the daughter of trailblazing Australian filmmaker, Liliás Fraser, tells the epic tale of her mother's extraordinary life, her career and their challenging relationship.

Tickets available now:

<https://whenthecamerastoppedrolling.film/#watch>

# Blue Knot Referral Database

## Seeking trauma-informed practitioners to join us

Every day the Blue Knot Helpline and Redress Support Service receives phone calls and emails from adult survivors of complex trauma from all over Australia. Many are seeking assistance to find a trauma informed counsellor, GP or psychiatrist in their area.

Through the work we do at Blue Knot with survivors of complex trauma, we are aware of the barriers often faced in connecting with suitable, trauma-informed support. To support survivors in their recovery journey, we are committed to providing the most appropriate referrals to health professionals who are trained and experienced in working with complex trauma.

We currently require more health professionals to join the database to meet this need, particularly in regional and remote areas of Australia.



## **What is the Blue Knot Health Professionals Database?**

The Blue Knot Foundation manages a Referral Database of health practitioners and organisations with experience in supporting adult survivors of childhood trauma, and in particular in working with adults who have experienced childhood abuse and neglect.

When a Blue Knot Helpline and Redress Support Service caller requests a referral to a health professional in their local area, our counsellors identify service providers from this database and provide contact details. The caller then makes direct contact with the individual Health Professional or practice.

## **What are the criteria for joining and how do I apply?**

Basic requirements for joining the Health Professional Database as a practitioner are a minimum of three years' experience in complex trauma work with adult survivors of childhood abuse and neglect, and current registration with a recognised professional body.

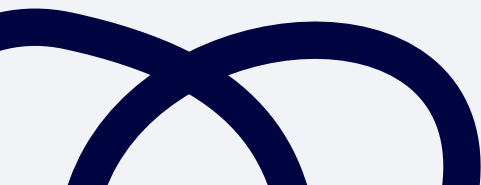
Details about additional supporting documentation required is available in the online application forms. You can submit your application and supporting documents directly through the Blue Knot Professionals website at the link below, applications will be responded to within one week.

Blue Knot will soon be advertising for trauma-informed General Practitioner's, Please note if you are a Fellow or member of the Australian Society of Psychological Medicine (ASPM) your application can be fast tracked through the approval process.

<https://professionals.blueknot.org.au/contact-us/join-us/apply-to-blue-knot-referral-database/>

There are no fees for applying for listing on the Blue Knot Referral Database. If you have general inquiries about the Health Professionals database or the application process, please email

[referraldatabase@blueknot.org.au](mailto:referraldatabase@blueknot.org.au)



# Join us as a Professional Member

## Would you like to become a professional member?

As a professional member you will join our professional community, a committed network of practitioners and people supporting others with experiences of complex trauma to recover.

As a professional member you will receive a 10% discount on our professional development training, a copy of our quarterly journal Blue Knot Review and regular updates regarding any new information or tools.

<https://professionals.blueknot.org.au/contact-us/join-us/join-our-professional-community/>



[professionals.blueknot.org.au](https://professionals.blueknot.org.au)

