Trauma, Trauma and More Trauma: CAT and Trauma in Learning Disability

Julie Lloyd

In the Reformulation series reporting on CAT CPD, Julie Lloyd describes the CAT, ID & Trauma Conference - offered by the CAT LD Special Interest Group, 30th November 2018.

When we picked 'trauma' as the theme for our fifth conference, there were so many angles for us to explore. Not only do we have people's individual traumatic experiences (which are more frequent when having a learning disability), not only are there families who suffer when confronted by their child's degree of disability and not only are there staff who can get traumatised through dealing with challenging behaviour. There is also the trauma induced by frequent rejection from a society which finds adults with learning disabilities aversive. So, no shortage of topics.

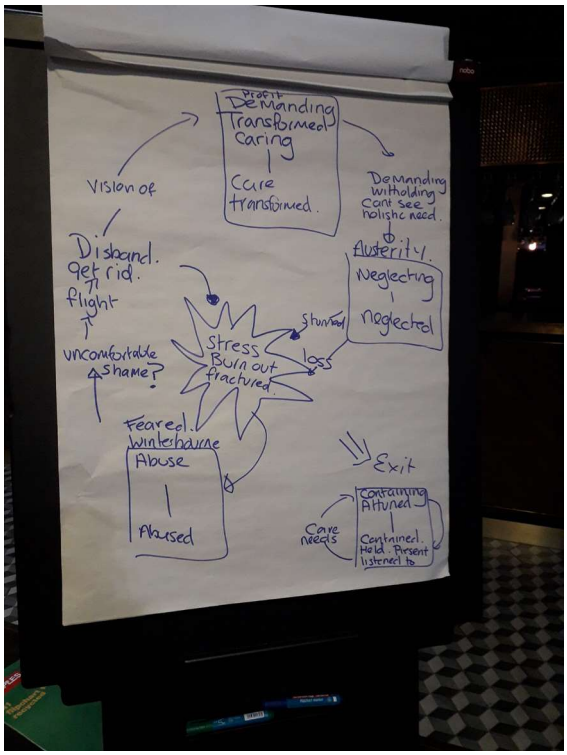
81 people attended. Throughout the conference in addition to speakers, we had people mapping live to show how it could be done, crossings out and all. David Wilberforce linked all the presentations together.

Lucy Morris opened with Phil Clayton mapping offering a CAT case study describing CAT for a person with LD and relational trauma. As is so often the situation in learning disability work, the client was referred by other people. This adds to the relational complexity, so mapping was used early on and throughout therapy to describe a gradual building of their relationship. This was not a therapy that could be rushed but went at the client's speed so it was about 18 months before the client could talk about traumatic experiences.

Using relational pictures led to the client commenting on how they felt "really real". When the Reformulation letter was done after 2 years of work, the client said they felt understood and heard. It was very difficult to find exits from the client's sense that they didn't deserve care, but thinking about trauma means exits included how we keep people safe and how we need a way of stopping additional trauma. Lucy felt a sense of relief when, together with her client, they found exists regarding learning how to be with other people and trying out a new role: Respecting – respected.

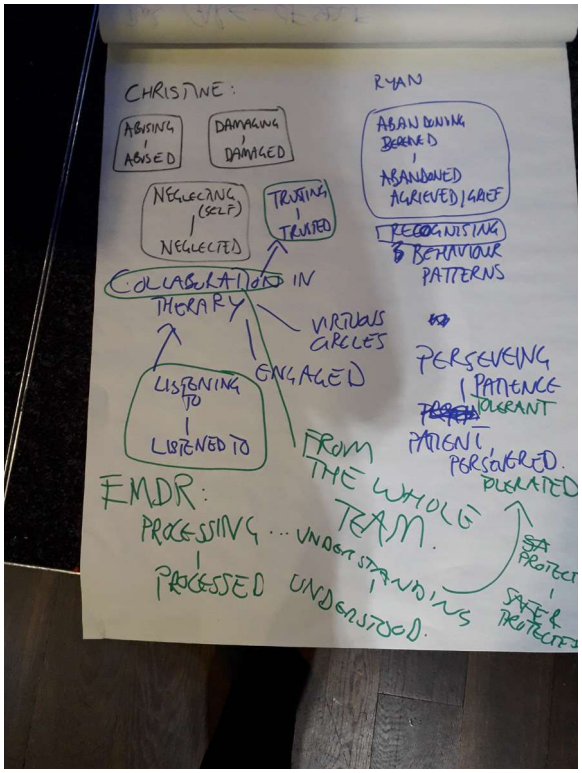
Lucy also facilitated staff reflective practice meetings to help the team understand the relational patterns between them and the client, and at one of the meetings the client themselves shared the reformulation to help staff help him. Lucy noticed that afterwards the team nursing notes about him were written more compassionately; there were less incidents and those that did happen were approached in a more productive and understanding manner. Now Lucy is developing a healthier map with the client and talking about the ending. Phil's mapping for this at the conference involved not only paper but also using objects of reference (e.g., wooden bricks in a box) as well as words. Phil built a wall from bricks; then taking away some, got the conference to see what this felt like to them when making 'more trust' and 'making eye contact' and 'being okay with being vulnerable', within the context of 'timing and pace' and 'developing space' and 'putting a brick back if too scary'. The conference noted that it was easier to take a brick from the top of the wall than the bottom (early experiences are harder to take bricks from as the wall might fall down), sharing taking bricks down, respecting the wall as it is, and noting that the therapist can own their own bricks in the wall.

Graham Simpson-Adkins presented on the ACE measure (Adverse



Childhood Experiences), with Beth Greenhill mapping. He discussed how power is used when people are asked about trauma. Data, available from the neuro-typical population, shows how half the UK population experience 1 trauma in childhood. However, trauma increases exponentially with the more ACEs people have; For example, if a person has had 1 trauma, then 87% of that population have a second, and then 50% have 4 or more. Furthermore, the higher the number, the more likely ACEs include abuse, neglect, and household dysfunction. In Learning Disabilities, (LD), little is known about ACEs. We do know that trauma is much higher in LD e.g., 2-3 times higher rates (or up to 10 times higher in some LD populations) and we also know that the greater the impact of the disability, the higher the amount of sexual abuse. Often victims in learning disability services are described as having challenging behaviour i.e., behaviour that is easily mistaken as just an inevitable part of Learning Disability. But in LD services, how often do we ask about ACEs?

This returns us, however, to the issue of power. Graham asked should we ask, or should we set up services in a trauma informed way anyway? In learning disability services fewer people tell, they don't often voluntarily disclose, and if they do disclose it tends to be much later. Although healthy disclosure allows post-traumatic growth, what is it like to be asked by someone much more powerful than you when you have not chosen to disclose? Often people feel they have to tell if they are asked (which propels them onto an emotional roller-coaster). Service users can experience undue pressure to conform to what the professional wants and fear perceived consequences if they don't. Their decision to disclose appears to be influence by disproportionate power in which people acquiesce as felt obliged to answer. This hands power to the professional to act on their judgement. A professional gains advantage when they acquire knowledge of another person's information, so survivors often withhold some information. Graham ended by asking what would an ACE framework in LD look like and in particular in relation to CAT?



Nancy Sheppard, with Phyllis Annesley mapping, described working with parents of children with disability. Nancy described linking behavioural work with attachment and Reciprocal Role issues as people can get stuck following Positive Behavioural Support programmes otherwise. (Positive Behavioural Support is the mainstay of approaches to managing challenging behaviour). Nancy gave a case example where parent had lots of her own ACEs and how powerful naming the Reciprocal Roles (RR) was. Nancy used Alison Jenaway's (2007) developmental model of RR and the parents' role to help the baby develop a middle ground of loving but with boundaries and limits; good enough care. However, children with learning disabilities are frequently less responsive to their care givers and do not initiate interactions. Their signals may be harder to interpret which often results in a lack of mutual pleasure in Mother – Child interactions. Nancy described how as a result, parents may be overly stimulating or more remote. Parents may fear they have caused the disability (blaming – blamed) which undermines achieving secure attachment. The parents own attachment patterns and RR will also input on their capacity to manage the child's feelings in order to reach a middle ground. Nancy described several further cases including one in depth with the map; by looking at the parent's own stuff the aim is to help them to be better parents. She commented that it is unusual to be allowed to work with parents in their own right and she knows that in many LD teams this isn't possible.

Phyllis (with Nancy mapping) described how when working in learning disabilities and High Secure hospital the work is about 'trauma, trauma and more trauma'. She described understanding the patient's presentation via CAT and using CAT in a wider setting. She discussed looking at CAT within the wider therapeutic structure and on how all her work is informed by her awareness of their zone of proximal development (ZPD). Phyllis illustrated how one of the clients made her own map, whereas for 3 years previously she would not speak to any psychologists. Phyliss quoted the client saying, "Even at times when I pushed you away, you never gave up on me". Phyllis has developed what she calls a 4Ps programme for staff about pain, pulls, patterns and professional response, which uses CAT ideas.

We moved on to explore how systems can be traumatised. Phil Clayton, Lianne Franks and Lily Lewis with Jo Varela mapping used the CAT model of trauma in Ryle's (1997) 3 levels of processing and Multiple Self States Model.

Level 1 = limited RR repertoire, state shifts, harmful work environments and staff and/or organisational cliques

Level 2 = inflexible and inconsistent relating

Level 3 = useful self-reflection.

They then considered how these levels of functions and state shifts appear within the NHS and Social Services under austerity. There are staff shortages, neglect, burn out, etc., and knowledge is lost (so there is a meta-procedure reduction). It is a neglecting system with a disappearing workforce that is deconstructed. Phil et al draw out what a good enough system's values would look like. Lianne gave an example of a forensic Learning Disability ward. There was a huge disconnect between management and the ward; feeling all at sea, with an aim about just getting through the day as well as a wish to make things better. Was the system traumatising staff and patients? It seemed to be. Overwhelming 20-point action lists were drawn up by management. Lianne used Maslow's (1943) hierarchy of needs around safety and performance to reformulate. She described how CAT is useful to understand traumatised systems at the micro and macro levels. To move towards recognition, she offered reflective practice, supervision and meetings with management. Revision was achieved via using CAT maps to create 'exits' for services and ensure the political agendas were relational and trauma informed.

The conference ended by exploring the trauma of death presented by Emily Handley-Cole and Kieron Beard (with Julie Lloyd mapping). People with learning disabilities are seen as less valuable and their early death (occurring prematurely on average 23 years men and 29 women) is often considered inevitable. Services often hold that reviewing deaths is something to be avoided, as such review brings feelings of failure, blame and being useless, which often leads to concealing and imposing silence and censorship. Emily and Kieron described how the way forward from this withholding is to search for healthier approaches to deal with death through a lively dialogue. Hence the founding of the Mortality Review in which Emily works.

This was a very powerful conference in which difficult topics were aired using CAT's approach to describe some of the traumas embedded within working in the learning disability field. If you would like to know any more about the CAT LD group, see on the ACAT web site.

Julie Lloyd is a clinical psychologist, CAT practitioner and supervisor. At the time of this conference she worked in a community team for people with learning disabilities for Surrey and Borders NHS and in a psychiatric intensive care unit for Southern Health, NHS. (By the time this article was published she retired from the NHS and from chairing the CAT special interest group for people working in learning disability services). She co-edited Cognitive Analytic Therapy for People with Intellectual Disabilities and their Carers, and Cognitive Analytic Therapy and the Politics of Mental Health.

References

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Trauma Workshop - London

12th September 2019

Location: Abbey Centre, Westminster, London

Current Thinking regarding Trauma – some possible implications for CAT. Led by Annie Nehmad and members of the CAT and Embodied Mind Special Interest Group.

The neuroscience of the last few decades is shedding light on what happens in the brain, body and mind during and after trauma. We will consider the neurobiology of Trauma, focusing especially on Porges's Poly Vagal Theory, and the work of van der Kolk. CAT was for many years ahead of the game in relation to the treatment of Trauma and dissociation, but we now need to take on board new findings and new practices, to enrich what we already do, and the CAT model itself.

www.acat.me.uk/event/1035/

#ACATTrauma0919