Psychological Approaches to Dealing with Trauma

Dr Noreen Tehrani
Chair: Crisis, Disaster & Trauma Section
British Psychological Society
www.noreentehrani.com







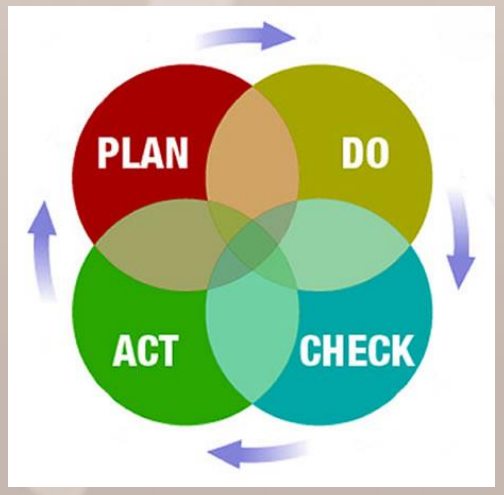

What kind of events are traumatic?

- Major Disasters:
  - Terrorist attacks, Major fires, Aircraft crashes, Train crashes
  - Floods, Earthquakes, War, Famine, Epidemics
- Secondary or Vicarious Trauma:
  - Online Child Abuse, Supporting victims, Counselling/Therapy, Accident investigation, teaching, Social work…..
- Every Day Trauma:
  - Accidents, suicides, robbery, rape, domestic violence, attacks, car crashes…

Organisational or Personal?

- Where a trauma occurs in an organisation there is a duty of care
- Health and Safety at Work Act (1999)

  Every employer shall ensure that his employees are provided with such health surveillance as is appropriate having regard to the risks to their health and safety which are identified by the assessment.
- Control Cycle
  - Plan – Develop Policy, Systems, Procedures, Training, Support
  - Identify – Individuals & Groups at Risk
  - Check – Psychological Screening/Surveillance
  - Monitor – Information, benchmarking



Intentional or Accidental (Act of God)

- Trauma is increased if the source of the trauma was perceived as an intentional or personal act.
  - A terrorist attack
  - An armed robbery
  - Rape and domestic violence
- Some traumatic events come to be regarded as intentional
  - Drunk driver road death
  - Rail crash due to faulty rails
  - Flammable cladding on high rise flats
  - Flooding
- Need to deal with the attributions of the victim of trauma
  - Anger can get in the way of recovery

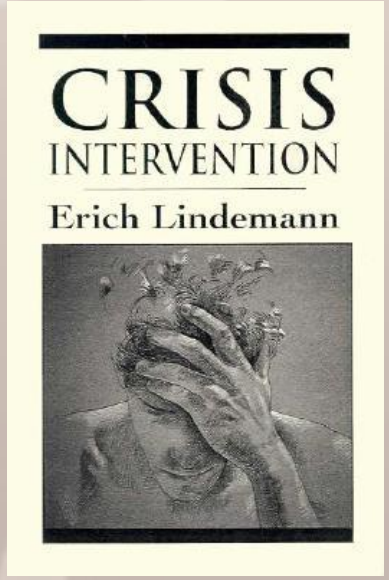
Civilian and Military Disasters

On November 28th 1942, a fire occurred at the Cocoanut Grove Night Club in Boston. 492 people died. The Cocoanut Grove was originally a speakeasy—an illegal bar during alcohol Prohibition. The club had a licensed capacity of 500 people, and on the night of the fire there were about 1000 people in the building. All of the above contributed to the tragedy.

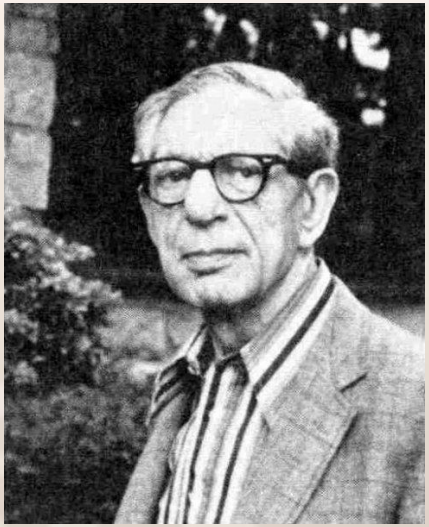
The term shell shock was coined by a British physician during the First World War. It has become synonymous with PTSD. Originally the diagnosis only applied where soldiers survived an explosion apparently unharmed, yet soon after showed symptoms of spinal or nerve damage.

Erich Lindermann 1900-1974

- Studied 101 victims of the Coconut Grove fire
- Regarded the responses of the people as an acute form of grief rather than trauma
- Did not explore the impact of exposure to the fire
- His focus was the loss of relationships
- Survivors are in a state of crisis when the face an obstacle to important life goals A period of disorganisation ensues, a period of upset, during which many abortive attempts at solution are made
- Interventions were person centred – increasing resilience

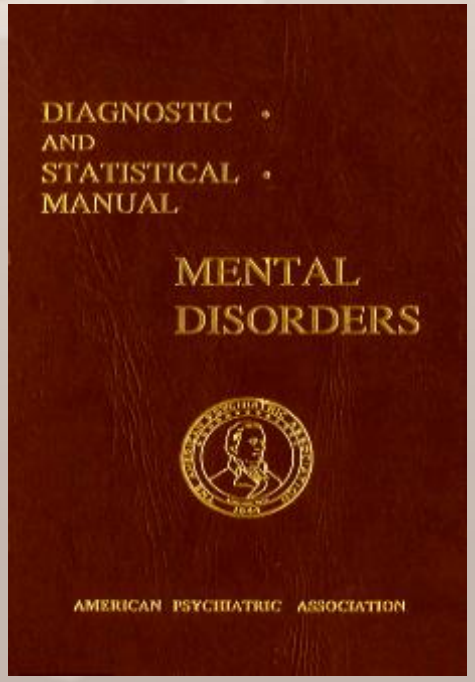


Abram Kardiner 1891-1941



- Trained by Freud
- Anthropologist
- Observed First World War veterans and re-interpreted their symptoms in his book the “Traumatic Neurosis of War”
- Symptoms of psychoneurosis
  - Startle and irritability
  - Outbursts of aggression
  - Fixation on the trauma
  - Constriction to functioning
  - Atypical dreams

  DSM1 – Gross Stress Reaction (1952)



Two models of trauma support

- Lindermann
- Dealing with ongoing traumatising situations
  - Resilience focussed approaches
  - Resilience building groups, psychological first aid
  - Appropriate for compassion fatigue and burnout

- Kardiner
- Dealing with a traumatic incident
  - Trauma focussed approaches
  - Initial safety, soothing and support
  - Demobilising, defusing and debriefing
  - Appropriate for primary and secondary trauma

Psychological First Aid (Hobfoll et al 2007)

Safety needs
- Remove or reducing exposure to harm
- Provide food, water, shelter & medical assistance
- Repeat simple and accurate information

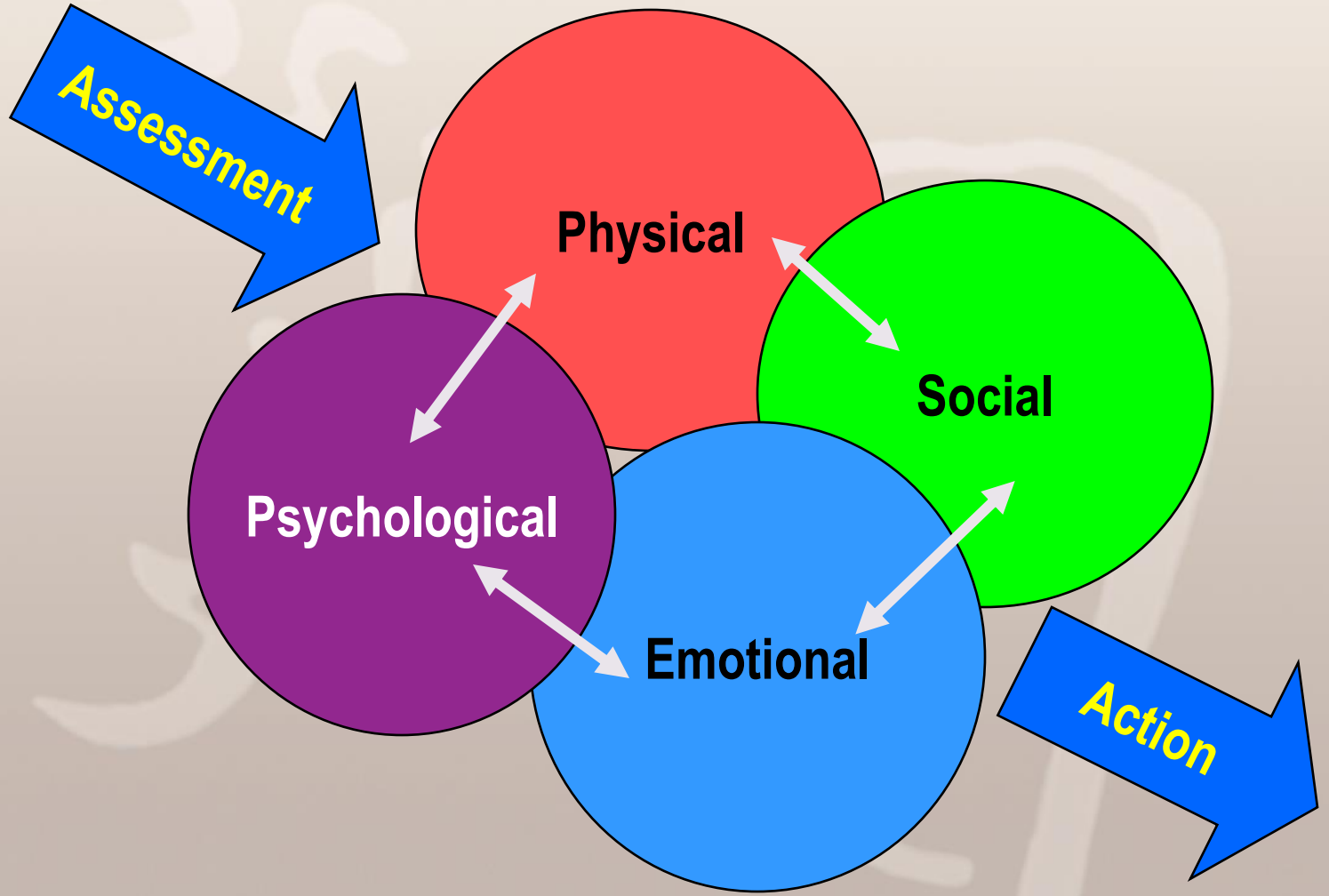
Calm
- Stabilize emotions
- Reduce stressful situations, sights and sounds
- Listen to stories
- Offer accurate information about the disaster or trauma and the relief efforts
- Provide information on stress and coping.

Connectedness
- Help people contact friends and loved ones
- Keep children with parents or other close relatives whenever possible
- Respect cultural norms
- Link people with available services

Self efficacy
- Engage people in meeting their own needs
- Assist with decision making

Hope and expectation of recovery
- Convey expectancy that people will recover
- Reassure people that their feelings are common

Crisis Management Demobilising and Defusing (CISM)



Worker Risks– Assessing the Risks to the Workforce

Assess the risks to the workers posed by the incident – these may have an impact on the organisation

Physical	Likelihood Frequent 5 4 3 2 1 Rare Impact Severe 5 4
Social	Likelihood Frequent 5 4 3 2 1 Rare Impact Severe 5 4 3
Emotional	Likelihood Frequent 5 4 3 2 1 Rare Impact Severe 5 4 3 2
Psychological	Likelihood Frequent 5 4 3 2 1 Rare Impact Severe 5 4 3 2

Signed:

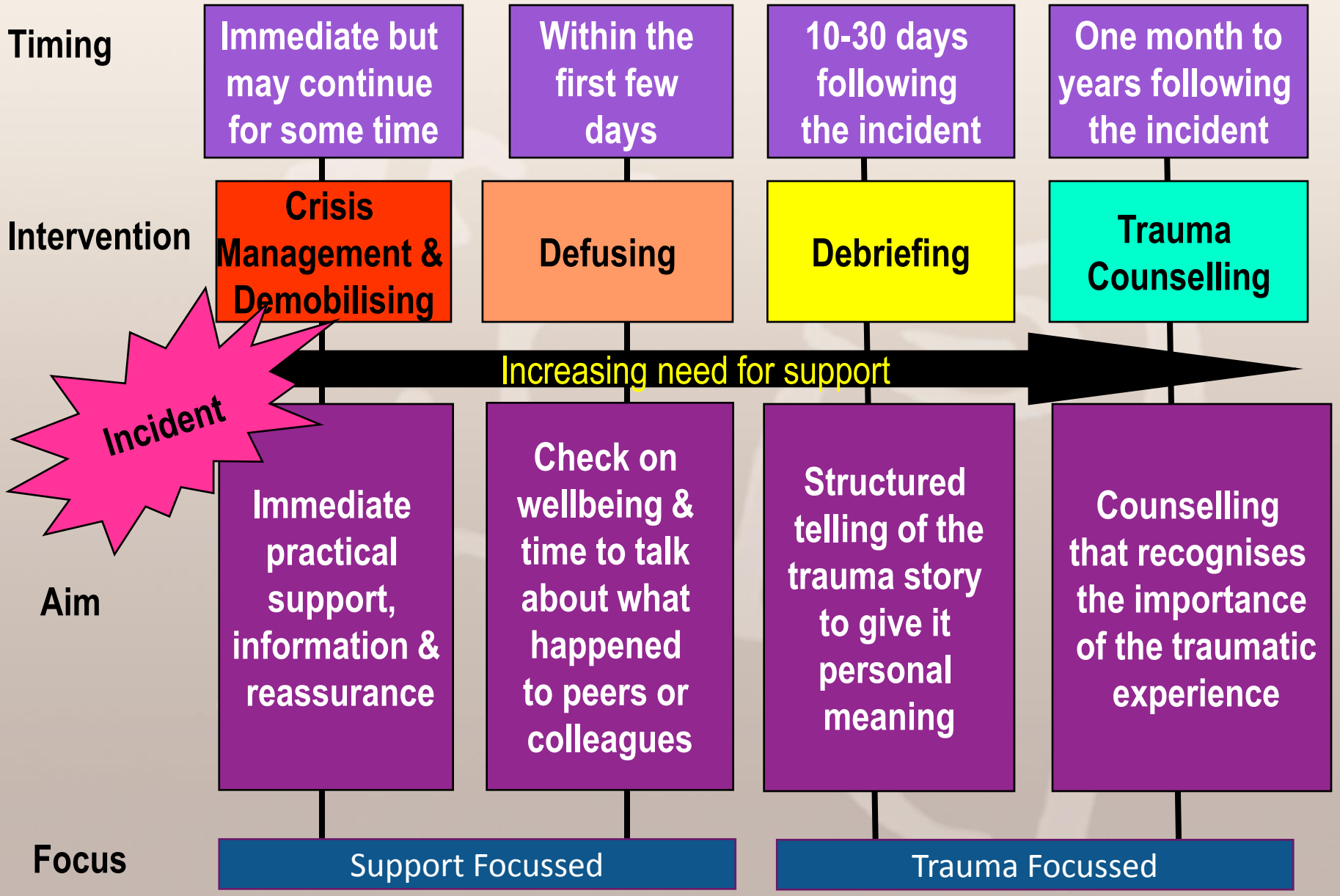
Demobilisation Checklist

Incident **Date** /

Introduction (manager) Have you	Described why you have brought everyone toge
	Explain that the session will last 10 minutes?
	Give an update on injured colleagues or othe
	Recognised the efforts of those involved?
Information (HR/Security) Have you	Explained that not everyone responds in after a traumatic incident?
	Normalised the stress responses?
	Described the normal responses to traumatic events?
	Given simple advice on taking ca
	Handed out Traumatic Stress in
	Provided information on the and debriefing?
	Arranged a time for defusi
Closing (Manager) Have you	Offered on-going suppor
	Summarised what you
	Checked fitness to c
	Arranged transpor
Recording	Completed the D
Self-Protection (Manager/HR/Security) Have you	Checked own f
	Given yours
	Told HR wh

Group Defusing Checklist

Introduction (manager) Have you	Briefly acknowledge what has happened	
	Explained that defusing is part of the trauma programme	
	Will take around half an hour	
	Confidentiality/Voluntary	
	Benefits of taking part	
The Story Have you	Say what you know	
	When did you become aware that there was a problem?	
	Establish the order in which things happened	
	Style of session: • Conversational • Accept silence • Summarise and paraphrase regularly • Turn negatives into positives • Hold boundaries • Allow everyone speak for themselves • At end summarise the whole story	
Check out reactions	Physical: Sleeping, Eating, Tense, Tired	
	Social: Relationships, Support, Contact	
	Emotional: Responses, Moods, Reactions	
	Psychological: Flashbacks, Nightmares, Panic	
Education/ Support	Talked about how to reduce impact Talked about extra support Hand out leaflets	
Recording	Complete record of defusing	
Self-Protection	Checked own feelings/thinking?	
	Taken some personal recovery time?	
	Told HR what has happened?	


Timing
Immediate but may continue for some time
Within the first few days
10-30 days following the incident
One month to years following the incident
Intervention
Crisis Management & Demobilising
Defusing
Debriefing
Trauma Counselling
Incident
Increasing need for support
Aim
Immediate practical support, information & reassurance
Check on wellbeing & time to talk about what happened to peers or colleagues
Structured telling of the trauma story to give it personal meaning
Counselling that recognises the importance of the traumatic experience
Focus
Support Focussed
Trauma Focussed

Criteria for Developing PTSD (DSM5)

- Exposure to actual or threatened death, serious injury or sexual violence in one of the following ways:
  - Direct experience
  - Witness in person of events that happen to others
  - Learning that a traumatic event has happened to a close family member or friend
  - Experiencing repeated or extreme exposure to aversive details of the traumatic event

    e.g. first responders, police officers (and others) exposed to details of child abuse – must be work related
- Symptoms must last at least a month

Symptoms of PTSD

(DSM 5)

Re-experience (1 or more)

- Intrusive memories
- Distressing dreams
- Flashbacks or feeling that the trauma is reoccurring
- Intense distress when exposed to cues
- Marked physiological responses to cues

Hyperarousal (2 or more)

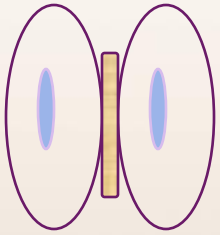
- Irritability/anger
- Reckless and self destructive behaviour
- Hyper-vigilance
- Exaggerated startle
- Problems with concentration
- Sleeping difficulties

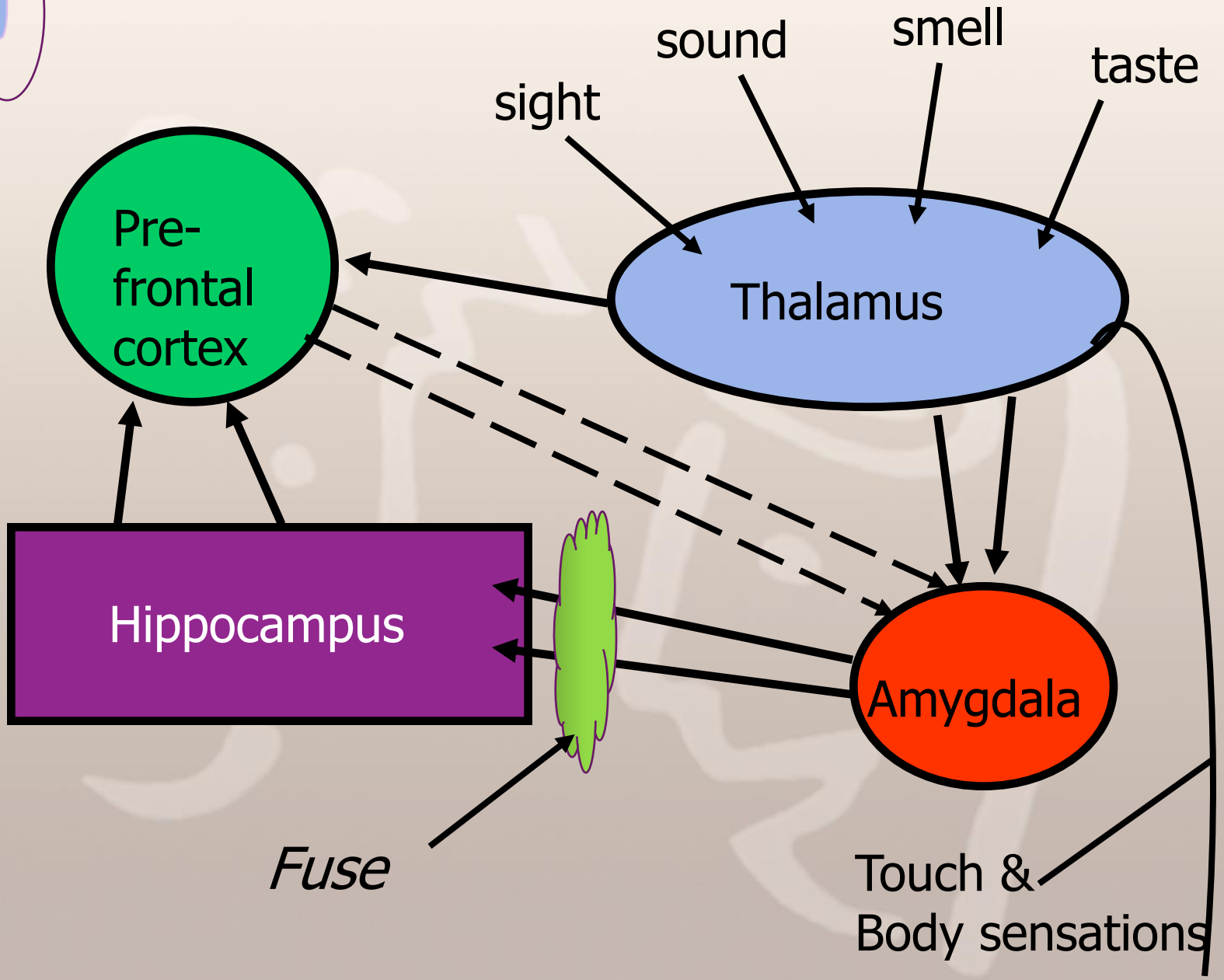
More Symptoms of PTSD
(DSM 5)

Negative thinking/mood (2 or more)

- Inability to remember parts of trauma
- Negative beliefs or expectations
- Distorted thinking including blaming of self or others
- Persistent negative affect and lack of positive emotions
- Lack of interest in future
- Feelings of detachment
- Inability to feel positive emotions

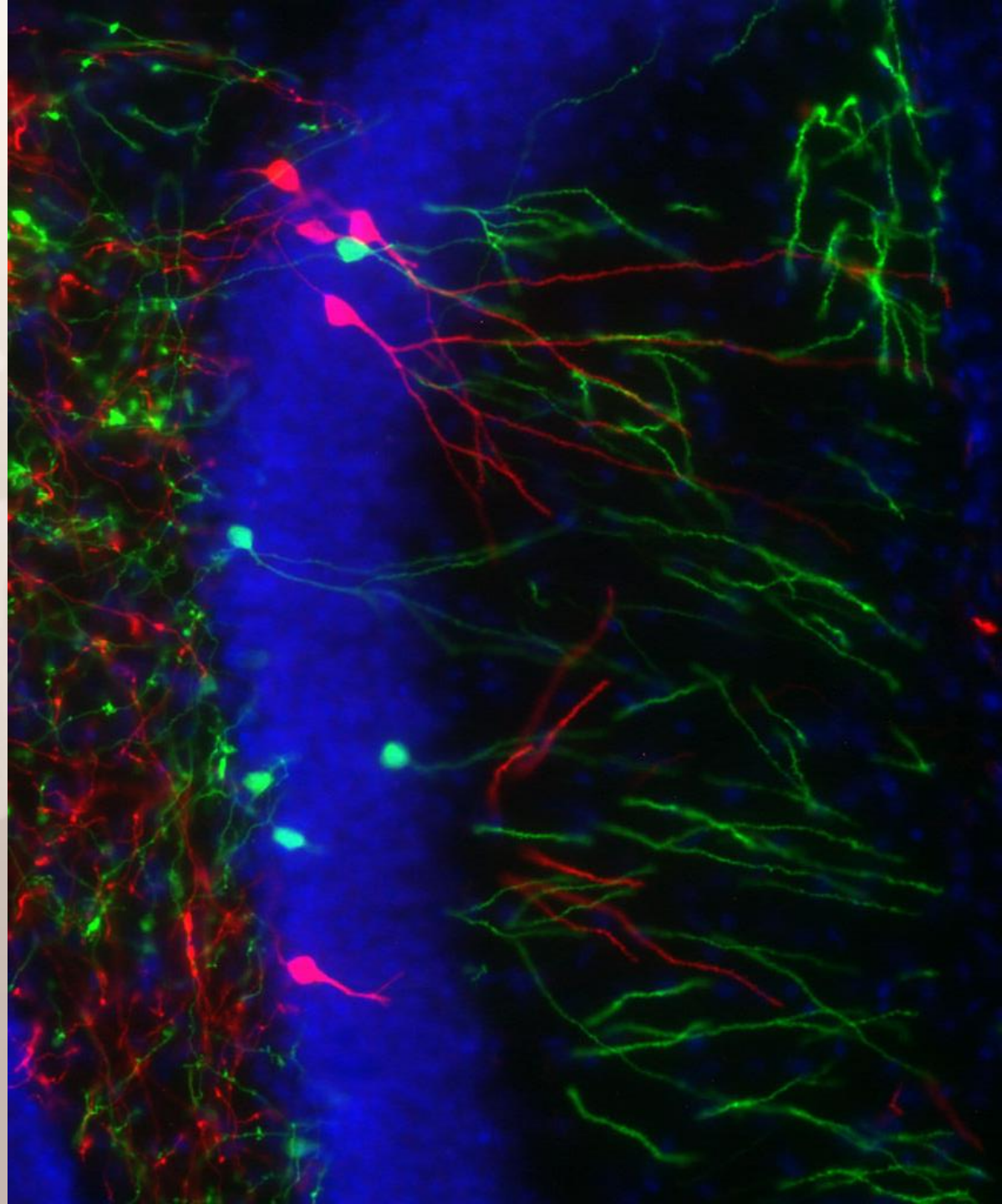
- Avoidance (1 or more)
  - Avoidance of distressing memories, thoughts or feelings about trauma
  - Avoidance of reminders e.g. People, places, objects that cause distress




sight
sound
smell
taste
Pre-
frontal
cortex
Thalamus
Hippocampus
Amygdala
Fuse
Touch &
Body sensations

Blowing the fuse

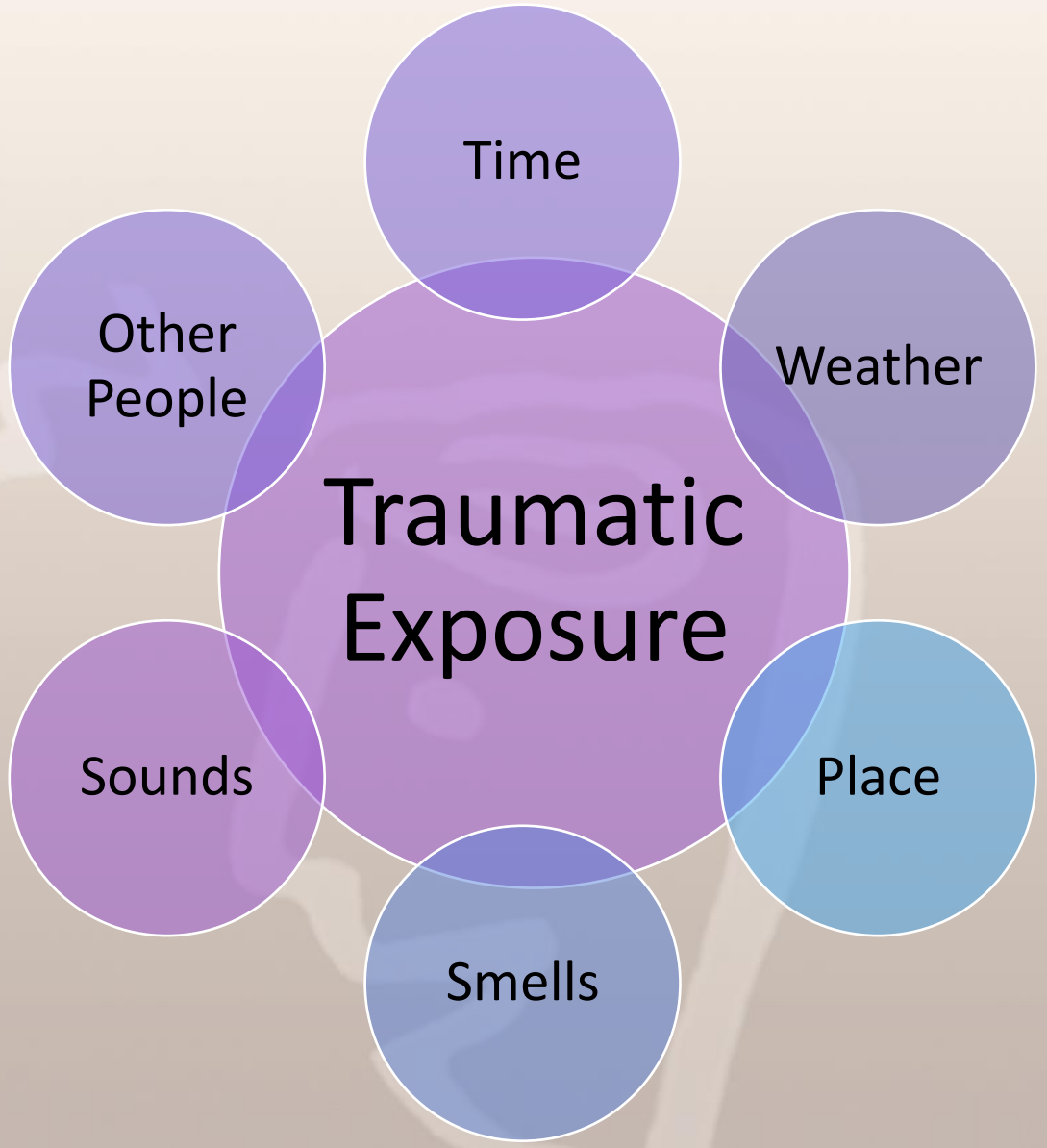
- Dis-regulation of arousal system
- Inability to find the words
- Poor memory
- Re-experience
- Dissociation



Amygdala Memories

- Do not fade
- Outside awareness
- Are unstable
- Communicate in dreams, flashbacks and physical responses
- Can lie dormant for long periods of time
- Not intelligent
- Are linked to body memories

Everything connected with the trauma is filed with the trauma and can cause flashbacks



Moving sensory memories out of the Amygdala
(without blowing the fuse)

- Teach relaxation and self-soothing
- Focus on facts and physical sensations
- Identify what happened
- Start at a safe place
- Take a small chunk of the story at a time
- Paraphrase, reflect and summarise
- End at a safe place

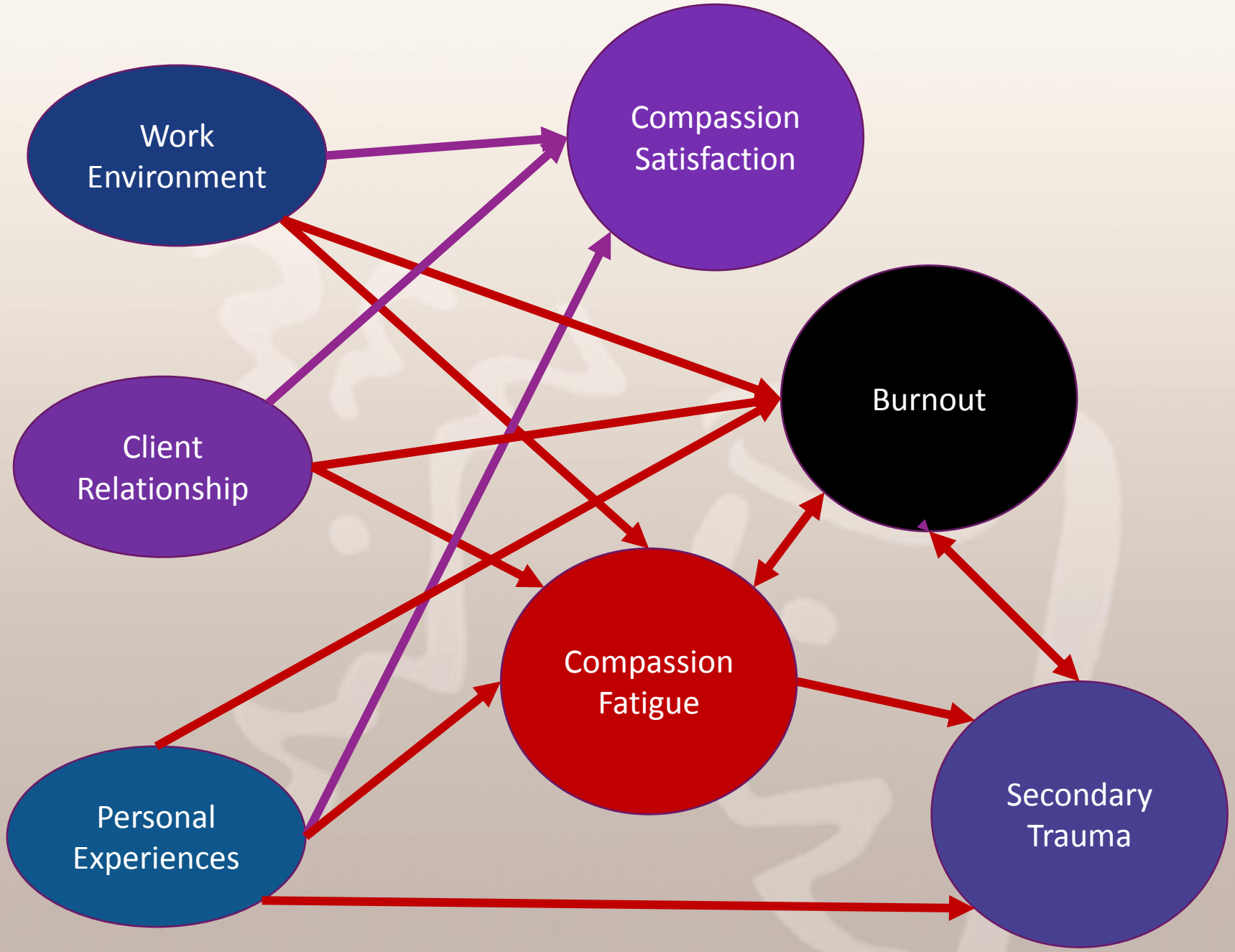
The Debriefing Controversy

- Difficulties caused by NICE guidance
- There is no reliable evidence that debriefing is harmful
- Debriefing is highly valued by participants
- There is no reliable evidence on any of the early interventions are effective
- A debriefing-like process is a key element of TF-CBT
- Research is proposed by BPS/College of Policing to identify the elements of early interventions which are helpful and where more research is required

Secondary Trauma, Compassion Fatigue and Burnout

Professional Quality of Life (Stamm, 2010)

- Compassion Satisfaction
  - The pleasure derived from being able to do your work well
- Compassion Fatigue
  - Emotional exhaustion from dealing with angry, distressed or upset clients
- Burnout
  - Emotional exhaustion, depersonalisation, loss of self esteem
- Secondary Trauma
  - Experiencing the same kinds of trauma symptoms as experienced by clients


Work Environment
Compassion Satisfaction
Client Relationship
Burnout
Compassion Fatigue
Personal Experiences
Secondary Trauma

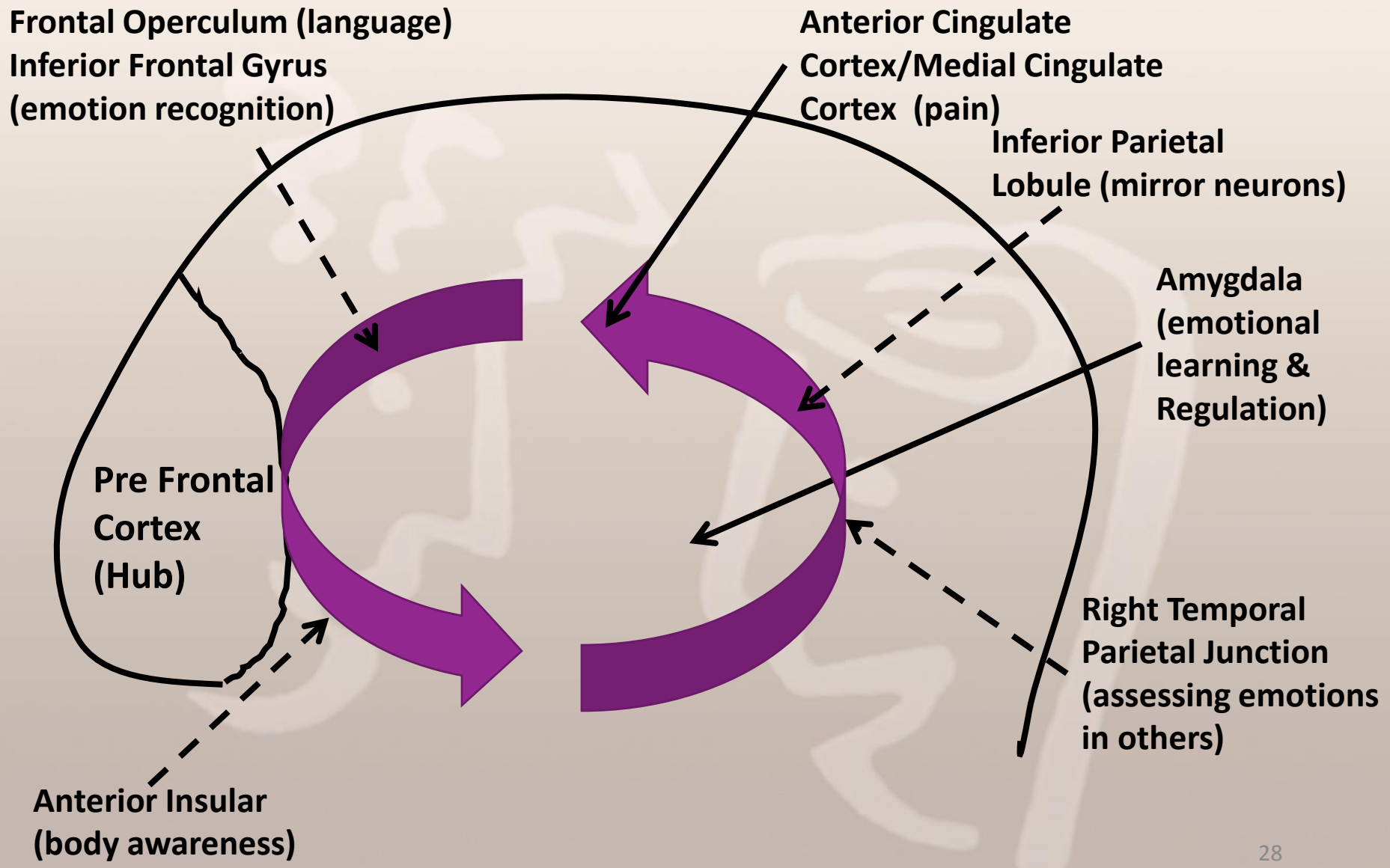
Compassion Fatigue

- Found in professionals engaged in providing care for people who are highly distressed, angry or emotionally demanding
- More common in carers with high levels of emotional empathy
- Associated with symptoms of generalised depression, emotional exhaustion, detachment and lack of enthusiasm for things that were once enjoyed

Cognitive and Emotional Empathy

- Empathy is fundamental to successful human relationships
- Two levels
  - Cognitive empathy – the ability to identify with the perspective of another person and infer their mental state (Baron-Cohen et al 2004)
  - Emotional empathy – the observer recognises the emotional experience of another and responds to that state (Eisenberg & Miller, 1987)
- People with high levels of emotional empathy are more prone to burnout, compassion fatigue and secondary traumatic stress (Figley, 1995)

Empathy Circuit (after Baron Cohen)



Secondary/ Vicarious Trauma

- Exposure to traumatic images, stories or materials can create secondary or vicarious trauma
  - Visual Images
  - Auditory reports
  - Written accounts
  - Artefacts
- People can be traumatised by their ability to imagine a traumatic event

Neuronal Pathways in the Brain

What influences Secondary Trauma developing?

- Imagination – being able to visualise the situation
- Empathy – understanding how the victim would feel
- Sensitivity – being of a sensitive personality
- Familiarity – recognising something familiar
- Exhaustion – reduction of personal resilience and hardiness

Signs of secondary trauma

- Re-experience
  - Unable to switch off from the work
  - Dreams, flashbacks of events experienced by others
  - Over-reactions to work related issues
  - Re-enacting aspects of victim behaviour
- Arousal
  - Unreasonable irritability or anger focussed at family, colleagues or situations
  - Self destructive behaviour
  - Jumpy, inability to sleep or relax
  - Poor concentration leading to increased numbers of accidents or errors

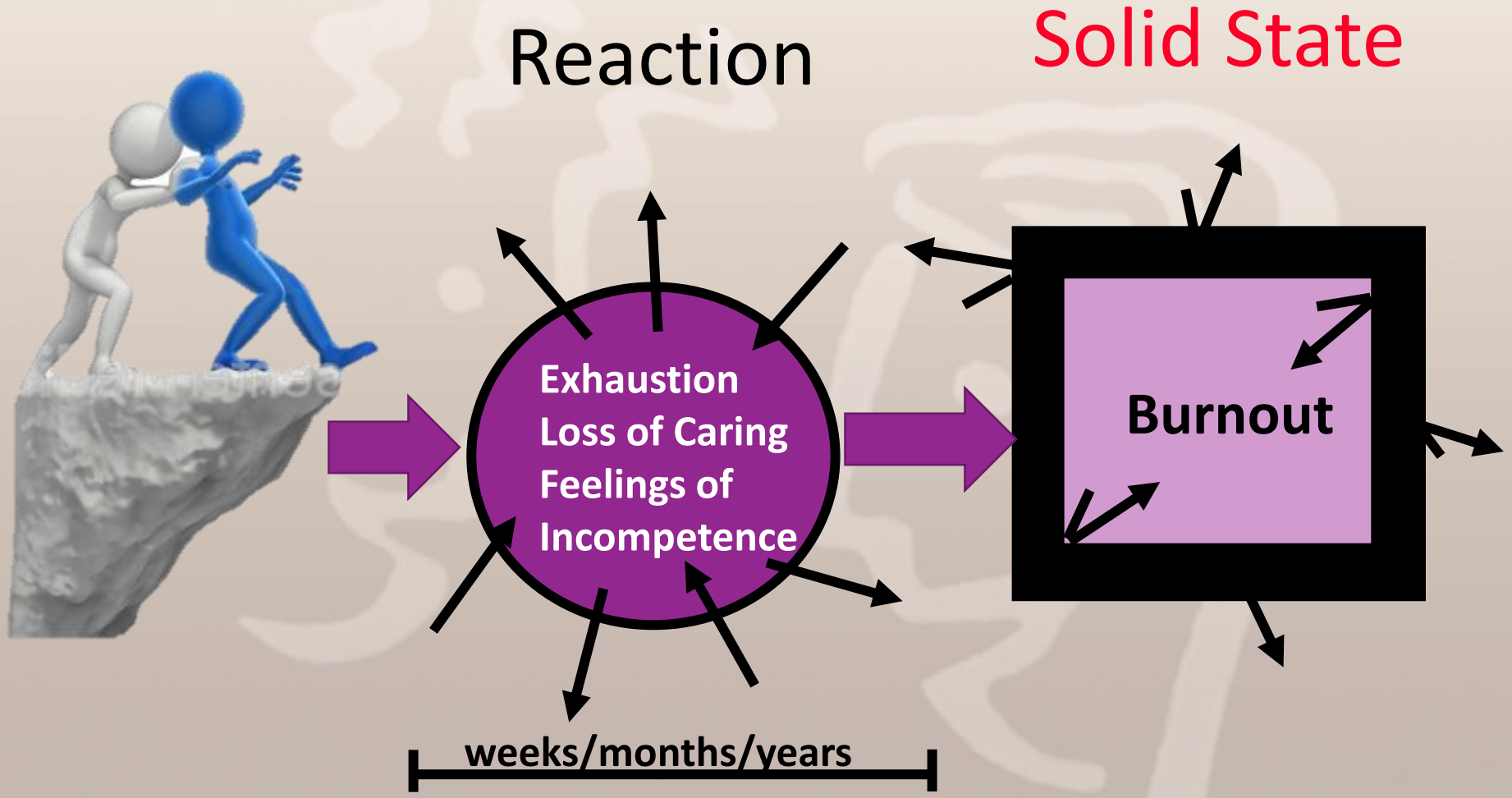
More signs of secondary trauma

- Negative Cognitions
  - Negative self beliefs e.g. “I’m incompetent” “The world is bad” “No one can be trusted”
  - Lack of interest in things you used to enjoy
  - Negative outlook on life leading to unreasonable fears, beliefs and attitudes
  - Feelings of isolation from family, friends
  - Emotional numbing and difficulty in showing sensitivity or positive emotions
- Avoidance
  - Putting off doing work or dealing with demanding cases
  - Not looking too deeply
  - Avoiding questions which might lead to upsetting responses
  - Blocking out or forgetting the most distressing areas

Burnout

- **Pre-condition**
  - Involvement in activities requiring extensive contact with people creating a high level of demands in tense situations
- **Symptoms**
  - **Emotional Exhaustion:** Physical fatigue, emotionality, sleeping difficulties, loss of sense of humour
  - **Depersonalisation:** Inability to care about others, isolation, lack of identification, seeing others as sub-human
  - **Feelings of incompetence:** Loss of ambition/drive, no sense of future, feelings of being hopeless or helpless

Burnout

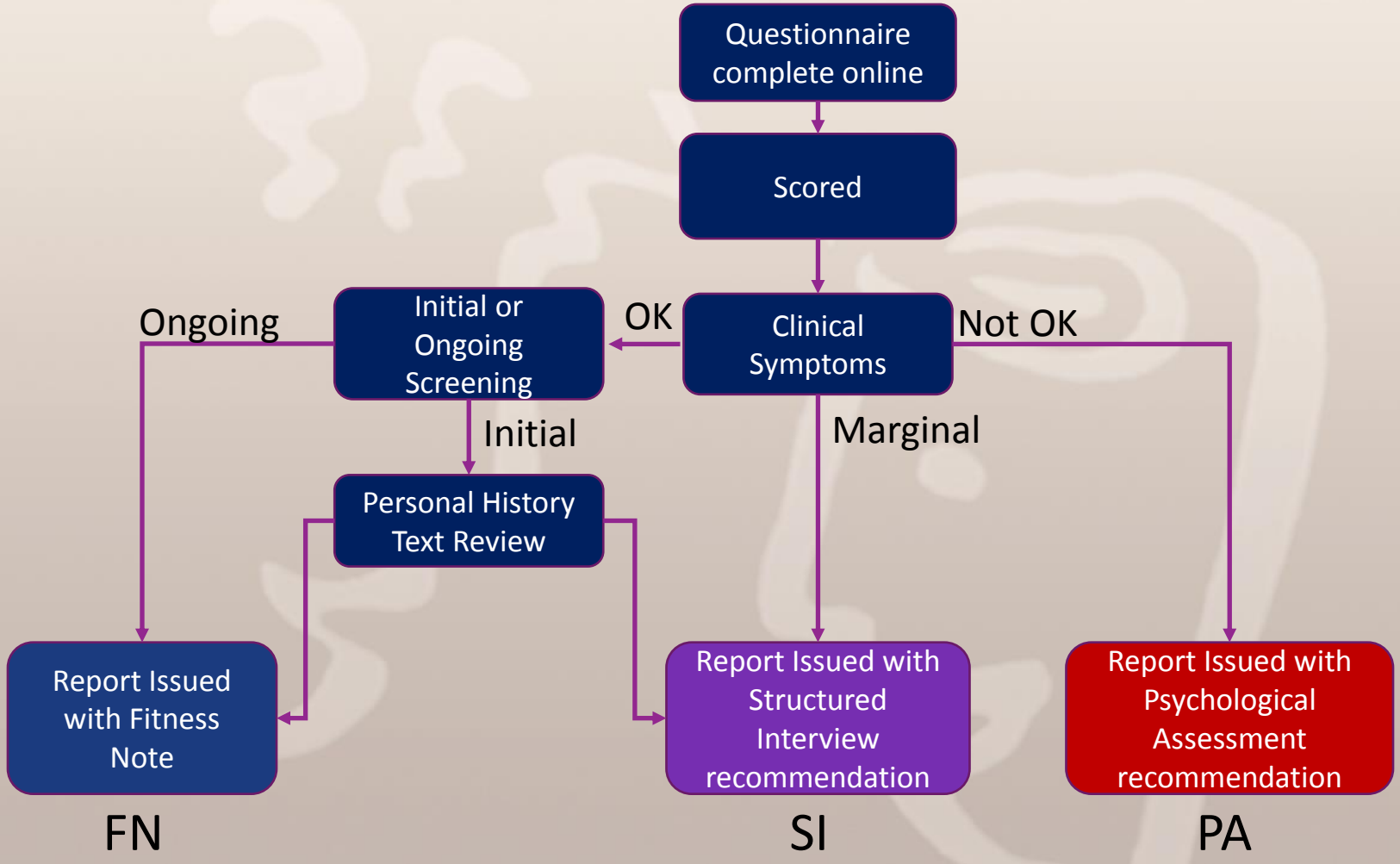

Reaction
Solid State
Exhaustion
Loss of Caring
Feelings of
Incompetence
Burnout
weeks/months/years

What should organisations be doing?

Wellbeing Approach to Trauma

Level	Organisation Focus	Employee Focus
Primary	**Culture:** Respectful, emotionally intelligent, caring and supportive **Structure:** Engaged leadership, self-reliant teams **Communications:** Honest, open & two way **Trauma Informed:** Recognition of responsibility to manage/reduce trauma, benchmarking of screening information	**Policies & Procedures to support the Organisational Focus:** **Risk Assessment** Role, Situational & Personal **Screening & Surveillance** High risk roles and vulnerable groups **Recovery & Rehabilitation** Programmes of support for employees
Secondary	**Supervisor:** Training in leadership, crisis management, supervision, conflict management **Teams:** Induction training, stress and trauma resilience and team building	**Supervisor:** Team surveys, discussions, wellbeing forums, rehabilitation planning, coaching using wellbeing materials **Teams:** Engagement in health promotion materials, team resilience building groups.
Tertiary	**OH assessments & advice:** fitness for work, rehabilitation, redeployment, medical retirement, referrals for treatment. **OH interventions:** Referral screening and support, trauma support programme,	**OH support for supervisors, officers & staff** **Supervisor:** Information, guidance & support in handling employee issues **Teams: P**hysical and psychological advice, health surveillance, wellbeing support, trauma and wellbeing counselling & coaching

On-Line Surveillance for High Risk Roles



Comparisons between different groups

Clinical Symptom	On-line Child Abuse (n=557)	Child Abuse (n=843)	Family Liaison Officers (n=304)	Human-itarians (n=238)	Youth Safeguarding (n=217)	General Public
Anxiety	18%	28%	24%	36%	11%	3.5%
Depression	24%	29%	28%	41%	15%	8-12%
PTSD	8%	13%	7%	19%	5%	3%
Burnout	19%	23%	22%	39%	16%	NA
Secondary Trauma	14%	21%	20%	38%	11%	NA

Heat Map of Workability showing Mean and % above threshold scores

Workability	Primary Trauma		Compassion Fatigue		Anxiety		Depression	
	mean	%	mean	%	mean	%	mean	%
Poor	41.7	43%	16.3	43%	6.4	86%	4.2	64%
Fair	37.5	28%	16.2	53%	5.3	66%	3.8	69%
Good	29.7	14%	10.7	24%	3.1	31%	2.2	35%
Very Good	25.5	9%	8.8	14%	1.9	15%	1.3	18%
Excellent	16.9	6%	6.7	6%	1.3	11%	0.9	13%

What should psychologists be doing?

Training
(CDT guide)

- Trauma Informed
  - Part of graduate level training for all psychologists
- Trauma Skilled
  - Post graduate and qualified trauma counsellors who provide counselling services using evidence based interventions
- Trauma Expert
  - PhD status for trauma work. HCPC members with a track record of working with trauma survivors including those with special needs

Evaluate Interventions

- Lack of research into trauma interventions
- CDT Section's Project into Early Interventions
- Which trauma therapy works best?
- Need for real world research
- CDT practitioner's ethics committee

Take care of themselves

- Supervision
- Reflective practice
- Exercise
- Hobbies
- Healthy diet

Thank you

Noreen.tehrani@noreentehrani.com

www.noreentehrani.com