traumaclinic
counselling

From trauma debriefing to trauma support: A South African model for early intervention following trauma.

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Course outcomes:

When you have completed this course you will have an understanding of:

- The difference between trauma debriefing and trauma support.
- The controversy surrounding debriefing.
- The importance of prevention.
- The South African development model for early intervention following trauma.
- The three stage process of trauma support used at the traumaClinic.
- Guidelines for the traumaClinic trauma support process.

CONTENTS

From trauma debriefing to trauma support: A South African model for early intervention following trauma.

A note on the learning and teaching approach

This course is built on the principles of supported open learning pioneered by the UK Open University and developed by South African Institute for Distance Education (SAIDE) and The SACHED Trust. Course participants (Students) are asked to do all the tasks as they appear in the text in order to take full value from the course. There are three kinds of tasks:

Fact check – to memorise key knowledge items

Reflection and analysis – to take time to actively engage with the ideas in the course

Assignments – a chance for an extended written task to consolidate your knowledge and express your views.

OVERVIEW

traumaClinic is a national network of practitioners based in South Africa providing consultation, assessment and intervention for individuals, families, organisations and, communities affected by traumatic events, mainly criminal violence, work related trauma and motor vehicle accidents. During the past ten years a model of trauma support has been developed at traumaClinic based on practical experience in the particularly South African environment where criminal violence is common.

The terms ‘trauma counselling’ and ‘trauma debriefing’ are in common usage in the public domain. The most commonly used early response model has been critical incident stress debriefing (CISD). However, the questions raised by a number of studies over the last ten years concerning this popular model, have forced traumaClinic to review and rethink the approach to recently traumatised individuals. This presentation provides an overview of the trauma support model that has evolved in response: a rationale, summary and case studies.

1 THE PSYCHOLOGICAL DEBRIEFING CONTROVERSY.

Early psychological intervention for those affected by traumatic events has long been associated with the term “debriefing”. The emphasis on debriefing arose from the search for ways to prevent the development of PTSD in trauma victims. It was widely believed that a focused intervention that engaged individuals emotionally with the trauma they had experienced, served to protect them from psychological problems in the future.

“Debriefing” is a military term referring to interviews in which critical incidents are examined by those involved in them and those in authority. These kinds of interventions have been widely used, for example by the police in Britain for at least 30 years (Dunning, 1999).

The term “psychological debriefing” (PD) is particularly attractive in the context of the military and emergency services such as the police, fire fighters and ambulance services as it

suggests that the intervention is not a form of counselling (i.e. a quasi-medical intervention), but a normal extension of institutional culture (Litz et al, 2002). However the term now has very wide currency. As Bisson, McFarlane and Rose (2000, p. 39) observe, “forms of debriefing have become the most written about, widely practised and well-recognised forms of early psychological intervention following trauma.” It was widely believed that if victims could have at least one debriefing session in which they could talk about and express some of the feelings evoked by the event, their long term adjustment would be improved and they would be at less risk for developing PTSD.

1.1 Debriefing: Criticism and disillusionment

However, approximately ten years ago, critical papers began to appear warning that debriefing could be harmful. Rather than being beneficial, it was claimed, it could actually increase the risk of chronic PTSD. Even where it was not harmful, there was little evidence that it was beneficial in the sense of serving a preventative purpose.

Bisson et al (2000) and Rose, Bisson, & Wessely (2001) in their Cochrane Review summarised the results of randomized controlled trials published in 1996 and 1997. In two of these, one with motor vehicle accident (MVA) survivors, and one with women who had miscarried, there was no evidence that debriefing was better than no debriefing. In another trial with burn survivors, debriefing was associated with worse outcome, and significantly, the outcome was worse the longer the debriefing session took. In only one study, of debriefing for those affected by a hurricane, was there any evidence of benefit, and in that case the debriefing took place 6 months later, not in the immediate aftermath.

Several less well controlled studies failed to find a positive effect of debriefing in comparison to a non-debriefed group. One study found that fire fighters who were debriefed were less likely to develop an acute stress reaction, but they were more at risk for delayed PTSD. Road accident victims who received debriefing were worse off three years later than those who had not been debriefed in terms of general psychiatric symptoms as well as in their overall level of functioning (Mayou, Ehlers, and Hobbs, 2000).

Litz et al (2002) calculated effects sizes for the more rigorous studies and concluded that debriefing resulted in “slightly worse PTSD scores at follow-up”. However, the effect sizes were too small for it to be concluded (that) PD was either “detrimental or helpful” (p. 116). They recommended against “the indiscriminate use of single-session psychological debriefing” and suggested that attention should be given to identifying and assisting “only those individuals who are not likely to recover over time on their own” (p. 118).

Fact check

Question 1

Debriefing was developed to prevent the development of PTSD? True/False

Question 2

As little as one debriefing session could lessen the risk for developing PTSD after a traumatic event? True/False

Question 3

It was widely believed that a focused intervention that engaged individuals emotionally with the trauma they had experienced, served to protect them from ……in the future.

Question 4

For how many years has debriefing been used? …….

Question 5

What is the alternative therapy to debriefing? Give one example of a more recent intervention that has been scientifically proven to be more affective?

Reflection and analysis

Debriefing is a controversial issue. In the space provided write three pros and three cons of debriefing.

Pros	**Cons**

1.2 Debriefing: Confusion of terms

The above research challenged many of the assumptions held by therapists offering crisis intervention to traumatized individuals. Some responded to the findings with incredulity and even denial, but in others it caused a backlash with the term “debriefing” becoming synonymous with doing harm. It was concluded that qualitative feedback from many participants who found it valuable, was misleading with respect to its actual impact. It was suggested that the fact that most trauma survivors do not go on to develop chronic PTSD, may have generated “a spurious sense of efficacy regarding the preventative value of psychological debriefing” (Bisson, et al, 2000).

Like most frontline organizations that offer support in the aftermath of trauma, we at traumaClinic had worked on the assumption that it was important to provide debriefing style interventions where possible, as a means of preventing the development of future mental health problems. In light of these research findings, we began to re-evaluate our procedures for crisis intervention. As we examined the literature closely, we recognized that it was important to clarify the meaning of terms and to separate out several different issues that might otherwise be confused.

Mitchell and Everly (1995, p. 271) describe Critical Incident Stress Debriefing (CISD) which has been in use for twenty years and is the prototype of debriefing interventions. It is a structured seven phase “structured group meeting or discussion” usually lasting 2-3 hours in which affected individuals are given the opportunity to discuss their thoughts and emotions about that event in a controlled, structured and rational manner. They also get the opportunity to see that they are not alone in their reactions.

The process has “both psychological and educational elements, but it should not be considered psychotherapy” (p.270). After, the facilitators have been introduced to the group, participants are asked to describe what happened “on a cognitive level” (i.e. intense display of emotion is not encouraged at this point). Next they are asked for their most prominent thoughts about it and this is likely to evoke “some leakage of emotion into the discussion” (p. 272). The fourth phase focuses on questions like “What was the worst thing about the situation for you personally?” (p. 272) and is “the most emotionally powerful.”

Following this there is a shift back from “emotionally laden content ... to more cognitively oriented material” by focusing on descriptions of specific symptoms that individuals have been experiencing. This is used as a springboard for psycho-education about likely stress reactions, suggestions for practical coping strategies and advice on a range of practical issues such as “diet, exercise, rest, talking to one’s family, [and] working with supervisors” on appropriate changes in response to what has happened. There is a final re-entry phase in which further questions are answered and concerns clarified.

Although originally designed for emergency services personnel, CSID has been used widely with victims in many contexts including schools, industrial settings and natural disasters. When first introduced, CISD was not a stand-alone intervention, but part of a “comprehensive intervention system [that] consists of multiple crisis intervention components which functionally span the entire temporal spectrum of a crisis” (Everly and Mitchell, 2000, p. 213). Unfortunately, the term CISD was used to refer to the specific group intervention as well as to the overall package. This was rectified with the introduction of the term Critical Incident Stress Management (CISM) for the overall programme.

There are large similarities between CISM and other comprehensive approaches to be referred to later. In interpreting the data that has created the debriefing controversy, it is important to recognize that the confusion about the meaning of CSID is part of a general tendency to use terms like counselling and debriefing quite loosely. CISD was not designed to be a stand-alone intervention or an individual intervention. One of its goals is to promote social support among group members. However, none of the studies that found negative effects of debriefing used the Mitchell and Everly protocol and several of them used single individual sessions of one hour in duration (e.g. Mayou, Ehlers, & Hobbs, 2000). Such interventions would be likely to activate intense emotions without contributing to social support, and Everly and Mitchell (2000) warn that “clinicians should use caution implementing a group crisis intervention protocol with individuals singularly” (p.213).

The confusion in the field can be seen from the fact that the Academy of Cognitive Therapy (2005) guidelines for professionals involved in responding to those affected by traumatic events include the recommendation “Helpers are advised not to include psychological interventions at this early phase.” It is not easy to determine where practical support leaves

off and psychological interventions begin, but hopefully, the writer is not warning us against offering empathic listening, giving information to normalize symptoms, or attempting to correct exaggerated negative cognitive appraisals.

Offering emotional support and helping (assisting) individuals to share difficult feelings is experienced as helpful by many people. The literature suggests that it may be insufficient to prevent the development of problems in the future when offered in the format of a one-off session. However, protection is provided by an ongoing support system of trusted individuals with whom one can share on an ongoing basis. For this reason, it is best to give priority to encouraging individuals to draw on and consolidate their existing social supports.

Gist, Woodall and Magenheimer (1999) warn of the danger of promoting what they call "trauma tourism", where well-meaning people travel to the site of disasters with the intention of offering debriefing style interventions. This creates the misleading impression that all individuals need specialist counselling offered by outsiders. Nevertheless, there are many individuals who are vulnerable because they lack social support, and experience relief when trauma workers facilitate having some form of sharing with other affected people, especially if they are work colleagues or family members.

While more research is needed to clarify these points, contemporary practice is to ensure that "psychological interventions" take their place as part of a comprehensive range of interventions designed to address problems at all levels, and that one-off emotionally intensive interventions are avoided.

Fact check

Question 1

Most trauma survivors go on to develop chronic PTSD True/False

Question 2

"Structured group meeting or discussion" usually lasting 2-3 hours in which individuals are given the opportunity to discuss their …… and
……about that event in a controlled, structured and rational manner.

Question 3

What is one of the goals for CISD?

Question 4

Why is it important to encourage individuals to draw on and consolidate their existing social supports?

Question 5

What is trauma tourism?

Reflection and analysis

Describe the steps in Critical Incident Stress Debriefing (CISD).

1.3 Debriefing in South Africa

The idea that an intensive single session could be of therapeutic value has been very influential in South Africa. Straker and Moosa's (1994) work with those traumatized by government political repression and brutality, emphasised the value of providing the opportunity for those affected, to talk and express what they were feeling. Although they did not specifically recommend a single session, they pointed out that in the unstable political and social conditions counsellors could not count on seeing these individuals more than once. The single session assessment and intervention developed by Pynoos & Eth (1986) was and still is widely used with children although nowadays it is usually part of a series of interventions (Leibowitz-Levy, 2005, this issue).

In South Africa, the term 'debriefing' has been used rather flexibly to refer to a range of interventions. Peeke, Moletsane, Tshivhula and Keel (1998) describe a 'trauma debriefing' intervention offered to employees (mostly women) in a financial institution following an armed robbery by four black men one Saturday morning. No one was injured, but everyone had been held hostage at gunpoint while robbers forced employees to open the safe. When staff returned on Monday they did not feel safe, fearing the robbers were still inside or might

return. However, there was pressure on employees to get back to work. The human resources manager had been trained in crisis intervention and had identified at risk individuals who, because of other recent losses, might need individual attention, and made arrangements for them. The intervention included three group debriefing sessions. The first was difficult to conduct because several women were in extreme distress and “cried and ran in and out of the session” (p. 24). The counsellor divided the group into two and dealt with those who were coping least first, and elicited those who were coping to support those who were not. Many white employees had developed a generalized fear of, and anger towards, all black people. This made it difficult to relate to their black colleagues. This issue was constructively addressed. In a later session employees felt empowered by the fact that managers were also undergoing emotional strain, and managers felt supported by the way in which the crisis intervention staff assisted with immediate decisions. Another problem was that staff who (were) not on duty at the time of the robbery became resentful of the attention given to the others and intolerant of their distress. The final session focused on re-empowerment and “the managers were able to reclaim their positions of leadership, which added to a sense of containment.”

It can be seen how this ‘debriefing’ intervention involved a range of pragmatic as well as psychological components.

Assignment:

Question 1

In a brief essay, explain the pragmatic as well as psychological components of this ‘debriefing’ intervention.

1.4 Disability and compensation: The importance of prevention

Despite the emphasis on resilience, there is continuing concern about PTSD among emergency services personnel. This is not only motivated by the need to protect the health and effective functioning of employees, but also by the cost to organizations of disability or compensation payouts on the basis of PTSD (Edwards, Van Wyk, Sakasa and Bates, 2005). Mitchell (1999) describes how, following the 1989 Hillsborough Football stadium disaster that happened in the United Kingdom in which 93 spectators died, there were several such disability claims from policemen. This led to an investigation into how the response to trauma was handled in the police in the United Kingdom, and she found an absence of systematic infrastructure. Some units had trained peer debriefers who were experienced as providing a valuable service, while others provided little or no psychological support. Since debriefing in groups can heighten interpersonal tensions "one-to-one counselling is common, and there is evidence that individuals may fare better using this modality" (p. 261). There were reports of "informal or natural debriefing" (p. 257) in which peers spontaneously discussed traumatic events among themselves, but nothing like this occurred in nearly 40% of incidents described by respondents.

PTSD has also emerged as a significant problem in the South African Police Service (SAPS), where, since 1994, when the first democratic government was elected, there has been a dramatic increase in disability claims on the basis of chronic PTSD. There is evidence that this is at least in part due to organizational changes in the police, where a politically driven process of transformation has resulted in many of those in the police before 1994 experiencing lower job satisfaction and lack of institutional support, both significant factors in promoting resilience.

For example, in the Eastern Cape, there was an outcry as the SAPS attempted to force officers who had been on long term sick leave, to go back to work. 110 officers were involved who had been "certified ill by doctors - most suffering from post-traumatic stress" (Mathewson, 2004, p.1). This may be an example of the way in which granting sick leave

after trauma increases the incidence of avoidance behaviour leading to absenteeism and staff turnover. Another factor, however, may be the attractiveness of PTSD as a route to medical boarding, since SAPS authorities accused many of the claimants of malingering, as they had been transferred to other centres and did not want to move. This conflict was exacerbated by the fact that the institutional culture did not provide support for the emotional processing of traumatic events. Many emergency workers and police officers to whom debriefing was offered, regarded it as a waste of time.

Kopel and Friedman (1997, 1999) found that police appear to deal with exposure to traumatic events by distancing themselves from the unpleasant experience and avoiding dwelling on it. For some individuals this avoidance, rather than being dysfunctional, seems to be an effective means of coping, but it is likely to increase the risk of at least some individuals developing PTSD and to render them unable to benefit from interventions that could resolve it.

Fact check

Question 1

Give an advantage of one-to-one counselling after a traumatic event has occurred.

Question 2

What is natural debriefing?

Question 3

Granting sick leave after trauma may increase the incidences of …….. behaviour leading to absenteeism and staff turnover.

Question 4

What defense mechanism do police appear to use to deal with exposure to traumatic events?

Question 5

Why could using the above defense mechanism lead to PTSD?

1.5 Individual intervention in the prevention of PTSD

The practice of pushing people to confront distressing memories has been called into question in the context of one-off crisis intervention session, but in current psychological treatments for PTSD the conscious exposure to traumatic memories in central to the reprocessing of trauma memory. Evidence has been accumulating (that the) risk of PTSD can be reduced significantly by a structured series of as few as five sessions of cognitive-behaviour therapy (CBT) that includes emotionally intense exposure sessions.

Foa, Hearst-Ikeda and Perry (1995) offered female assault victims four two-hour sessions of a CBT intervention that included relaxation training, information about the importance of facing the painful memories, a session of guided reliving, recommendations to relive the situation at home on several occasions, and cognitive restructuring. In most cases the intervention began within two weeks of the assault. Two months post-assault only 10% of the subjects met criteria for PTSD, as compared to 70% in a matched group who received repeated assessments. Six months post-assault, the difference between the groups was considerably less, but the CBT group had a significantly lower level of re-experiencing symptoms and was significantly less depressed.

The same positive effects of CBT have been shown in four randomized controlled trials from Bryant's group. Bryant, Harvey, Dang, Sackville, and Basten, (1998), and Bryant, Sackville, Dang, Moulds, & Guthrie (1999) offered 5 sessions of CBT or supportive counselling (SC) to MVA survivors with acute stress disorder. CBT markedly reduced incidence of PTSD: six months later less than 20% of those who received CBT had PTSD, as compared to two thirds of the SC group. Bryant, Moulds, Guthrie, and Nixon (2003) offered 5 sessions of CBT or SC to trauma survivors with mild traumatic brain injury and ASD within two weeks of the traumatic event. 58% of the SC group still had PTSD post-treatment and at 6 month follow-up. In the CBT group the figures were 8% and 17% respectively.

Bryant, Moulds, Guthrie, and Nixon (2005) offered trauma survivors with ASD six sessions of SC, CBT or CBT with hypnosis (CBTH). The latter group received a hypnotic induction before exposure sessions that included the suggestion that they enter into the events fully and "experience as much affective and sensory detail as possible" (p. 335). At 6 months follow-up, 59% of the SC group met criteria for PTSD as opposed to 21% in the CBT group

and 22% in the CBTH. There was little difference between CBT and CBTH, except that the latter group showed a greater drop in re-experiencing symptoms

While treatment that started two weeks after a trauma can be regarded as an early intervention that has a significant preventative effect for the development of later PTSD, the same can unfortunately not be said for interventions using elements of exposure in the immediate phase, that is, the first few days following a traumatic experience. In fact, until such time as we know more definitely which techniques really do make a difference within the first few days in terms of prevention, it is wise to avoid elements of re-exposure at such an early stage, particularly as a one-size-fits-all.

1.6 Lessons from the debriefing controversy

The debriefing controversy began with scepticism on the part of critics about the value of interventions that promoted emotional processing fuelled by studies which showed that in certain contexts such interventions could be harmful. Although there is no doubt that many benefit from being able to share their feelings with peers or a counsellor, it became clear that interventions that intensify negative emotions may be counterproductive at a time when psychological recovery is best supported by reducing emotional intensity and focussing on practical adjustment (Litz et al, 2002). In the immediate aftermath it is important to focus on creating a sense of safety, both practically and interpersonally, a goal that may be undermined by pushing for emotional expression. The more emotionally charged phases of the Mitchell and Everly structure may therefore be contraindicated, even though it is likely that only a small of individuals are at risk of sustaining damage through the procedure.

Several cautions are therefore in order when offering crisis intervention following traumatic events. First, it is not appropriate to assume that all individuals need specialist help in the form of group of individual counselling. The literature on vulnerability and resilience reviewed by Edwards , Sakasa & Van Wyk (2005) highlights the wide range of individual differences in response to traumatic events and the resourcefulness and resilience that characterize a significant proportion of affected people. Second, while group meetings can enhance group cohesiveness and strengthen social support, they can also lead to alienation and conflict because not all those affected may be ready to become vulnerable or are comfortable seeing others doing so (Mitchell, 1999). Third, a focus on the horror of the trauma and its negative impact can create the expectancy that psychopathology is a common consequence of trauma and therefore render individuals more vulnerable to becoming or remaining symptomatic (Herbert & Sageman, 2004).

These cautions can be observed within a comprehensive approach to trauma intervention which balances the salutogenic, resilience enhancing, perspective, with the recognition that emotional processing is part of normal recovery for most people and that it can often be fostered within existing social support networks. When using individual or group interventions that invite expression of feelings and facing the emotional impact of what has happened, the risk of harm can probably be mitigated by being alert to individual differences, screening out vulnerable individuals, and maintaining a clear salutogenic perspective that focuses on each individual's capacity to find and build resilience (Dunning, 1999).

Fact check

Question 1

List some of the CBT interventions that were used during the female victims (discussed in

Question 2

Question 3

At this stage one does not know which techniques really do make a difference within the first few days in terms of prevention, it is however wise to avoid…

Question 4

Give one advantage and one disadvantage of group meetings for trauma victims.

Advantage:
Disadvantage:

Question 5

When using individual or group interventions that invite expression of feelings and facing the emotional impact of what has happened, the risk of harm can probably be mitigated by

Reflection and analysis

Give your own impression on debriefing referring to the information above.

2 THE TRAUMACLINIC EARLY TRAUMA SUPPORT MODEL.

At traumaClinic we have ‘gone back to the drawing board’ and re-evaluated and reformulated our practice in light of the above research as well as our considerable experience on the ground over the past 15 years working with more than three thousand individuals who have been exposed to potentially traumatizing experiences. Our approach to early intervention is flexible, pragmatic, problem-oriented, phased and multifaceted, and accords with guidelines emerging internationally as described in the recent literature.

2.1 Broad spectrum multi-component interventions: International models

Salzer and Bickman (1999) draw attention to the host of practical matters that need to be addressed in the immediate aftermath of a traumatizing event and the need for immediate priority to be given to stabilising the situation, ensuring that affected individuals have the basic necessities of life such as food and shelter, and creating a situation of safety where there are no further threats to life and property. Alongside this, interventions are needed to strengthen and build social support by helping individuals to work together to address the

various effects of the trauma, and to help members to talk about what has happened in a manner that enables them to find direction, solve practical problems and return to constructive everyday activity. In addition it is important to identify vulnerable individuals, especially those who may not have access to helping resources, and offer them active assistance.

Everly and Mitchell's (2000) CISM is a set of multiple interventions that can be drawn on as appropriate as a crisis unfolds. In addition to the CSID group meeting, the approach includes stress inoculation training for emergency services personnel in preparation for traumatic incidents, assessment and referral for individual intervention, consultations with management in organizational settings, or with disaster response teams and other emergency services personnel, support for pastoral intervention from religious leaders and within religious institutions, group crisis meetings with organizations or families.

Macy et al (2004) describe a comprehensive approach called "posttraumatic stress management" (PTSM) developed by the Community Services Program in Boston, USA, which also provides an infrastructure for dealing with disasters and traumatic incidents. They emphasise that all significant role-players need to be involved in a process of assessment and planning of a range of interventions to meet the needs of all those affected. In the case of natural disasters and traumas that affect a considerable number of people, liaison with community leaders is essential as it is they who will play major roles in organizing, motivating and giving constructive direction to community members.

For example, an intervention following a school bus accident in which four children died, included identifying specific groups of affected individuals and providing support and "resiliency based psychological coping groups" for each of them, identifying those in need of individual counselling, providing support at funeral rituals and the memorial service, facilitating classrooms discussions, and running "meetings with school administrators to help them assume leadership roles over time"(p. 221). A range of psychotherapy interventions are incorporated including psycho-education, expressive techniques, exposure methods, mindfulness training, and coping skills enhancement and resource building. Some interventions are similar to CSID, however, "rather than focusing primarily on disturbing or negative elements of the traumatic event, we take great care to build a sense of safety and stability at the beginning of our group sessions. We then focus on phenomena that elicit the expression of, and that promote, the resiliency of the group members and of the community as a whole" (p. 221).

Fact check

Question 1

The traumaClinic's approach to early intervention is flexible, pragmatic, problem-oriented, phased and multifaceted. What does pragmatic mean?

Question 2

After a traumatic event interventions are needed to:

Question 3

“Posttraumatic stress management” (PTSM) developed by the Community Services Program in Boston, USA, emphasise that all significant role-players need to be involved in a process of assessment and planning of a range of interventions to meet the needs of all those affected. Who could those “significant role-players” possibly be?

Question 4

Why is it essential to liase with community leaders?

Question 5

Interventions are similar to CSID, however, “rather than focusing primarily on disturbing or negative elements of the traumatic event, they take great care to build a sense of safety and stability at the beginning of our group sessions. How could you, as a therapist, create a sense of safety and stability with your client?

2.2 TraumaClinic trauma support: A three-stage process

Because addressing individual emotional distress and supporting the emotional processing of what has happened is only one aspect of intervention, we refer to our work at traumaClinic as “trauma support” rather than “trauma debriefing” or “trauma counselling.”

The focus is on assessment and early identification of areas where intervention is needed. There is no predefined procedure or prescription. A variety of possible interventions is available, mostly familiar components of trauma crisis intervention. Interventions are selected in response to what is found in the initial and ongoing assessment process and, in keeping with the emphasis of Gist and Woodall (1999, p. 217) on the importance of promoting resilience, ensuring that they supplement and reinforce resilient responses of individuals and organisations, and do not supplant or replace natural contacts and supports that promote autonomy and resilience, with artificial structures that may reinforce vulnerability and encourage reliance on inappropriate, ineffective, or ill-timed strategies of coping and resolution.

A typical trauma support process will unfold in three stages. In Stage 1, which will occur in the first few hours or up to two days following the incident, the focus is on providing direction and guidance in practical ways, structuring solutions to immediate problems (most importantly the need for safety and protection), assessing and, if necessary, bolstering individuals’ levels of social support, and responding empathically to the range of distressing emotions felt by the victims. These activities continue in Stage 2, which occurs after a few days and may last for two weeks, but, in addition, counselling or psychotherapy, or other intervention strategies, are offered to those individuals who have been assessed to be at risk. Finally, in Stage 3, two to four weeks after the incident, we follow-up, re-assess whether further interventions are needed at the individual or organizational level, and encourage organizations and individuals to consolidate their capacity for support in a resilient manner.

Within these broad stages, we attend to several parallel objectives in a manner designed to support, facilitate and optimise the processes which have been shown to contribute to

normal recovery from trauma, and which occur naturally in the families and social networks of affected individuals.

- Our trauma support staff act first as consultants or managers in the aftermath to trauma, rather than as counsellors.
- They do not expect to deal exclusively with victims, and they give attention to other important role players including work supervisors, work colleagues and family members.
- We recognize that different victims require different forms of help, and that different forms of help are appropriate at different times for the same individual.
- We also attend to the traditional aim of trauma debriefing, namely to prevent the subsequent development of PTSD and other related disorders by focusing on early identification of factors that might complicate or hamper recovery, and, where appropriate, offer individual or group counselling or therapy.

First, we incorporate strategies for normalizing psychological responses to trauma, explicitly through psycho-education, and implicitly in responding to people's experiences in an accepting manner. In the face of evidence that many individuals incorrectly misattribute these kinds of symptoms as evidence of character weakness, moral turpitude or impending insanity, the offering of corrective information can have a stabilizing effect. We provide an informational page entitled "Useful information for trauma victims" which lists common symptoms (physical, emotional, behavioural and cognitive) of an acute stress reaction. They are described as "the typical after-shock of a horrible event – they are normal reactions to an abnormal experience" and readers are told that this reaction will likely "diminish after a few days and in most cases life will return to normal after approximately three to four weeks." The information sheet also includes guidelines for self-management such as "structure your time – keep occupied", "Reach out to others; ask for support – do not try to be 'strong'", "do not make any big life decisions for a while", and "Be careful of drugs, alcohol and medication to make things easier". These accord with similar guidelines put out after the 2001 9/11 attacks in New York and Washington (Academy of Cognitive Therapy, 2002) and after the London bombings in July 2005 (Traumatic Stress Clinic, 2005) and support a balance between carrying on with life constructively and expressing and sharing one's emotional distress with supportive friends or colleagues in a manner that promotes reflection and processing of the implications of what has happened. They are also in line with the approach of Gist et al (1999, p. 287):

"People are resilient; friends are important; conversation helps; time is a great healer; look out for others while you look out for yourself."

Second, we give a great deal of attention to social support, by identifying individuals who are vulnerable to isolation, and strengthening existing social support within peer groups or the family. We also work to prevent the families and peers of affected individuals from undermining the recovery process. The best professional assistance is often neutralised by input from the significant persons in the world of the trauma victim, such as spouses, managers, friends and colleagues who can exert much more impact, constructive or destructive, than those offering professional help.

Third, we try to identify distressed individuals who might not recover normally because of factors that are complicating or obstructing the normal recovery, and to address these complicating factors through individual counselling or psychotherapy or interventions in the family or workplace.

Fourth, we discourage measures that might encourage victims from moving into a sick role. There is little evidence that rest alone is a major factor in recovery. Although medication can play a helpful role (Foa, Davidson, Frances and Ross, 1999), its provision can undermine the individual's sense of efficacy in being able to rely on their own resources. This could account for the findings of Gelpin, Bonne, Peri, Brandes & Shalev (1996) who compared 13 survivors of terrorist attacks and work accidents treated with benzodiazepines, with a matched control group who were not given medication. At one month and six month follow-up the benzodiazepine group was not more improved than the controls (nine still met criteria for PTSD compared to three of the controls). Thus we do not usually recommend the use of medication, particularly benzodiazepines.

Similarly we advise against sick leave, particularly in work related trauma, unless a person has been physically injured. Our experience has shown that leave of absence often creates problems with readjustment to work, and tend to lead to further absenteeism. For example, when a correctional services employee escaped unhurt after his car was rocked, overturned and burnt by a mob while driving in a township, we did not recommend he be given sick leave as he

was coping well. Management still offered it to him, but he did not take it and was found to be still coping well at follow-up. A number of his colleagues who had experienced similar trauma previously, and who had been given sick leave afterwards, had still not returned to work months later.

Finally, we ensure that our traumaClinic personnel monitor their own capacity to work in trauma situations and take steps to protect them against burnout. In a study of lay trauma counsellors working with another South African organization, Ortlepp and Friedman (2001, 2002) found a relationship between SOC and stress related to trauma work. They also found that the trauma counsellors obtained a great deal of satisfaction from their involvement in trauma work, and the guidelines which limited the amount of consultation and counselling had been effective in protecting against burnout since scores on a scale that measured this were generally low. The traumaClinic recommendation is that counsellors should share their experiences with their peers informally or as part of peer supervision, and with other persons in their primary support system, just as it is recommended to trauma victims themselves.

Fact check

Question 1

The traumaClinic does not recognize that different victims require different forms of help

True/False

Question 2

During trauma support, at the traumaClinic, trained psychologist may focus on early identification of factors that might complicate or hamper recovery? True/False

Question 3

Explain what it entails to normalizing psychological responses to trauma?

Question 4

At the traumaClinic, a traumatized client is given an information sheet which includes guidelines for self-management such:

Question 5

In the guidelines, the traumaClinic advises against sick leave, particularly in work related trauma, unless a person has been physically injured. Their experience has shown that leave of absence often creates

Reflection and analysis

Explain the three-stage process of trauma support used at the traumaClinic.

2.3 TraumaClinic in Action: Case Studies

Here are a few case examples which illustrate aspects of our approach.

2.3.1 Case study 1:

The Grassy Park petrol station murders: In June 2002, six pump attendants on the night shift were shot dead at a petrol station in Grassy Park near Retreat on the Cape Flats. The members of the day shift arrived in the morning to find them dead. In many cases those who found them had family ties to, or were friends of the dead men. Intervention involved a series of contacts with the survivors who were seen immediately and then one week, 3 weeks and 6 months after the murders. Formal counselling or debriefing was not possible because of language problems, but the owners and management were advised in how to provide practical support to the survivors in a number of ways. They paid to have the bodies transported to the respective homes for the funerals and they provided practical support for the rituals that followed, for example, giving time for them to attend the funerals. With a view to optimising social support they were advised to arrange alternative living arrangements for those who were living alone or had no family support to turn to. Management was also advised on strategies to assist employees in overcoming the expected resistance to, and fear of returning to work, for instance by arranging safe transport to work and rearranging work hours. With this intervention, all the survivors recovered within a few weeks and none developed PTSD, even though they received no formal counselling.

2.3.2 Case study 2:

Absenteeism following an armed robbery: The positive response of management at the petrol station can be contrasted with what happened at a bottle store that was the target of an armed robbery before closing time on a Saturday night. The store manager was off duty and unavailable and the staff phoned the regional manager who simply instructed them to close up and go home. traumaClinic was called in the following Tuesday because many staff were resisting coming to work. The Regional Manager had not visited the store and the seven staff members felt that management were not looking after them. They could not regain a sense of safety in their place of work and their fear was compounded by resentment against management and a pre-existing low morale. The store manager, caught in the middle between the reasonable needs of staff and the lack of interest on the part of Regional Management, became critical of the employees. Staff were offered individual and group sessions to assist them in regaining a sense of control and confidence, but absenteeism remained a problem. Staff turnover was high and two of the original seven members were eventually boarded on the grounds of stress.

2.3.3 Cases 3 & 4:

The role of family members in supporting or undermining an intervention is shown by what happened after another armed robbery at a jewellery store in 2001 during which three staff were held at gunpoint. Management were advised on improved security and responded positively and the affected staff each had individual sessions that focussed on establishing a sense of safety and overcoming behavioural avoidance. One of the three became symptomatic and a probable significant factor was the response of her husband who, instead of being encouraging, said, "I don't want you to go back there, it's a dangerous place." She remained extremely fearful at her work place and eventually had to be transferred to a position in the head office. She was fortunate in that another position was available.

In another case the husband's response also seemed to be a factor contributing to the maintenance of his wife's symptoms. She was accosted in her kitchen by a man wielding a knife. When she screamed he ran away. Nothing was taken and she was unharmed. At first she seemed to recover well, but a few days later she snapped at her domestic worker who had been with the family for many years, a close confident, asking her, "Where were you when the attacker appeared?" Affronted, the worker resigned and left. As she became more symptomatic, her husband accused her of being dramatic and giving in to exaggerated fears. She was given four sessions of cognitive behaviour therapy and a number of conjoint marital sessions in which she expressed the wish that they install higher fences and remove hedges to improve visibility as a means of providing for more security in the home. He believed she was overreacting and would not agree to her suggestions. The eventual outcome of this case is not known, but it does show how important it can be for recovery for victims to feel understood and have their concerns validated by those close to them (Herman, 2001).

3 CONCLUSIONS

The controversy resulting from the evaluation of certain specific 'debriefing' interventions has resulted in a careful re-evaluation of the principles of trauma intervention, internationally and in South Africa. In line with the recommendations from current research, traumaClinic's approach aims to find the balance between fostering resilience and offering specialist interventions that address intense distress, including those that treat PTSD.

As in most areas of psychological intervention in South Africa, there is a need for more research. It would be particularly valuable to follow the example of Macy et al (2004) by writing case studies of specific interventions as a basis for a comprehensive programme evaluation.

4 REVIEW

In this course, you have read about the following topics. Check whether you feel you understand each section by ticking the relevant box. If you feel you need to do more work in the area, re-read the section and do the tasks again.

THE PSYCHOLOGICAL DEBRIEFING CONTROVERSY ( )

DEBRIEFING: CRITICISM AND DISILLUSIONMENT ( )

DEBRIEFING: CONFUSION OF TERMS ( )

DEBRIEFING IN SOUTH AFRICA ( )

DISABILITY AND COMPENSATION: THE IMPORTANCE OF PREVENTION ( )

INDIVIDUAL INTERVENTION IN THE PREVENTION OF PTSD ( )

LESSONS FROM THE DEBRIEFING CONTROVERSY ( )

THE TRAUMACLINIC EARLY TRAUMA SUPPORT MODEL ( )

BROAD SPECTRUM MULTI-COMPONENT INTERVENTIONS: INTERNATIONAL MODELS ( )

TRAUMACLINIC TRAUMA SUPPORT: A THREE STAGE PROCESS ( )

TRAUMACLINIC IN ACTION: CASE EXAMPLES ( )

Though you may feel now that you have mastered all the sections, it is worth trying an objective practice test before you undertake the multi-choice assessment. Write your responses to the following questions and check the answers in the key on the next page.

Question 1

There was a definite turn in the profession of psychology away from old fashioned 'debriefing'. What marked this turning point?

Question 2

Summarise the three stages of the traumaClinic trauma support model and discuss why this model is being used as opposed to earlier debriefing models.

Key:

Cochrane Review by Rose, Bisson, & Wesseley (2001)

Stage One: This takes place anytime from a few hours to two days after the incident. Practical solutions are sought for immediate problems, especially surrounding issues of safety. Social support systems need to be put into place and emotions surrounding the trauma need to be empathically listened to.

Stage Two: This stage flows from stage one and lasts for up to two weeks. In this stage at risk individuals that need counselling, in one form or another, are identified.

Stage Three: Two to four weeks after the incident the situation is re-assessed, plans are devised for those individuals and organizations that need further input. Individuals and organizations are encouraged to identify and draw on their own resources to cope.

Self-assessment questions

Summary

- The learning outcomes for the course are:
- To know the difference between trauma debriefing and trauma support.
- To understand the controversy surrounding debriefing.
- To know the importance of prevention.
- Understand the South African development model for early intervention following trauma.
- List and explain the three stage process of trauma support used at the traumaClinic.
- Know the guidelines for the traumaClinic trauma support process.

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