traumaclinic
counselling

UPDATE ON EARLY INTERVENTION FOLLOWING TRAUMA:

Facilitation of trauma recovery. Debriefing? Counselling? Or trauma support?

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Course outcomes:

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

- Discuss current approaches to prevention of negative impact of trauma.
- Describe features, pros and cons of Critical Incident Stress Debriefing (and its derivative CISM), Psychological First Aid, and Cognitive Behavioural Therapy in relation to trauma management.
- Describe guidelines for early intervention in the context of watchful waiting.
- Describe guidelines for the traumaClinic trauma support process.

Update on early Intervention following trauma

PREVENTION OF NEGATIVE EFFECTS FROM TRAUMA: EARLY INTERVENTION, DEBRIEFING, COUNSELLING OR TRAUMA SUPPORT?

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 task:

1. ***Fact check*** – to memorise key knowledge items.

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

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

CONTENTS

OVERVIEW

Given the wide-ranging and disabling impact of traumatic experiences, especially those traumas that stem from human neglect, maliciousness, and violence, it is understandable that prevention has been one of the focal points of activity, practice and research in the field of trauma. The title of the 2007 convention of the International Society for Traumatic Stress Studies (ISTSS) was “Preventing Trauma and its Effects: A Collaborative Agenda for Scientists, Practitioners, Advocates, and Policy Makers”, an attempt to bring all the relevant disciplines and international experts together to establish consensus about the state of the science. This conference was most helpful in separating myth from fact and to provide guidelines for further research and service delivery in the prevention of the debilitating effects that trauma can have.

In terms of early intervention, the goals of prevention are clear: to provide evidence-based interventions and strategies for those persons who are most vulnerable, in order to prevent chronic posttraumatic mental health problems and impairments of functioning. However, early intervention is a daunting challenge for researchers, decision makers, and care providers. The sobering reality is that the need for efficacious and effective care that is appropriate to differing cultures, and in line with available resources, far outweighs available scientific knowledge. Rigorous clinical trials are rare and the ecological validity of intervention studies is typically very low (Litz, 2008). It is, however, reassuring that prevention and early intervention are in the forefront of all the relevant scientific disciplines and we are rapidly generating very useful knowledge, as well as consensus about approaches in the practical care of trauma survivors.

It is conceptually helpful to divide the period immediately following a traumatic experience into two intervals: the immediate phase (the first 48 hours) and the acute phase(a few weeks later). In the scientific community there is more or less consensus that in the immediate phase any one-size-fits-all intervention is not only not feasible, but for most trauma survivors unnecessary. For others it may be too early and intrusive, while for some it may be too little.

One model for all, such as CISD (see section 1), contradicts the available research on risk and resilience, which has made it quite clear that initial distress and impairment following trauma is not necessarily abnormal and the large majority of trauma survivors draw on their own coping ability, support and personal resource to recover and adapt. Furthermore, in the immediate phase it is not likely that survivors would actually have the need for professional assistance, because they usually have other competing needs that are more important, such as the need for safety, medical help, and other more primary needs.

Consequently caregivers are advised, in the immediate context, not to be prescriptive, but be flexible, accepting, and respectful of the varied human responses to trauma and the varied contexts in which trauma happens. Immediate interventions should focus on helping individuals to regain connection with their social support sources, validation and safety, provide information about when and how professional help should be sought (Litz, 2008).

In the public sphere, and even in the professional sphere, there is much confusion of terms in this area. Terms such as trauma debriefing, defusing, trauma counselling, crisis intervention are being used interchangeably with little understanding of what the terms actually mean. Some clarification is called for.

Fact check 1

Question 1

What are the two phases following a traumatic experience?

1. _____ phase

2. _____ phase

Question 2

What are their timescales?

1.
2.

Question 3

What common terms are used for interventions after traumatic experience?

Reflection and analysis

In a few sentences, describe your ideas of the important points to bear in mind when undertaking these interventions.

1 CRITICAL INCIDENT STRESS DEBRIEFING (CISD)

In the immediate aftermath of trauma the model that has traditionally been most frequently used is Critical Incident Stress Debriefing, a model devised by Mitchell (1983) specifically for emergency and other workers (police, ambulance, emergency room, military personnel) who are regularly exposed to potentially traumatic experiences in the course of their work. The process is applied in a group setting soon after a particular incident and it usually lasts several hours in one sitting, where every participant is given an opportunity to recount and re-examine/reprocess their particular experience of the incident. The process consists of a prescribed seven steps (more or less) and is usually highly charged emotionally. Various modifications have been made, but essentially it remains a stepped model of intervention.

1.1 [1]THE SEVEN STEPS OF CISD

1. Introduction phase, an orientation to the process.

2. Fact phase, participants recount the facts and their actions during the event.

3. Thought phase, group members are asked to remember their thoughts during the incident.

4. Reaction phase, members talk about the worst part of the experience and express their feelings.

5. Symptom phase, members are asked to review their own physical, emotional, behavioural and cognitive reactions during the event and after.

6. Teaching phase, normalisation of these reactions and providing information about coping strategies.

7. Relating phase that closes the meeting and provides a summary of issues and recommendations.

Prior to 2002 CISD was the preferred model internationally in the immediate aftermath of trauma, in groups and individually. However, it is a highly prescriptive approach and a blanket procedure that is usually applied to everyone that has been exposed to a potentially

[1] Mitchell, 1983

traumatic event. In other words it will include the majority of individuals who are most likely to recover with the help of their own natural and systemic resources.

Furthermore, the evidence is that CISD does not actually benefit those individuals who really need the help, those who are most likely to develop later problems. A number of studies, including a number of meta-analysis, have demonstrated that CISD has no preventative effect, and some cases actually do worse (Rose, Bisson and Wessely, 1999, 2002); (Adler, et al., 2008). Due of this lack of evidence to support its usefulness, CISD is no longer supported by professional bodies such as the International Society for Traumatic Stress Studies, and the interagency standing committee of the United Nations. Other bodies, such as National Institute for Health and Clinical Excellence in the UK, have gone further and actually issued strict advisories against the use of CISD in the National Health System, because of its potentially damaging effect (NICE, 2005).

However, CISD and CISM (a later version of the seven step model) remain appealing to caregivers and are still widely used in spite of the consensus of the scientific community. It is appealing because it is logical and uncomplicated, it is easy to learn and it can be applied by persons with little academic expertise. However, it is questionable whether it actually serves the needs of trauma survivors or the needs of service providers (Litz, 2008).

It has been argued the weakness in CISD is that it is a single session intervention and that more sessions may be more effective. A number of studies of multi-session interventions have shown results similar to single session interventions. In a Dutch study, comparing multiple sessions to a no treatment control condition with motor vehicle accident victims, found no difference between the intervention and the non-intervention group. Interestingly, this study also found that 90% of the intervention group found the help they received satisfactory to very satisfactory, even though no objective benefit was demonstrated (Brom, Kleber, & Hoffman, 1993).

Fact check 2:

Question 1

Number the stages of CISD in the correct order.

____ Relating phase

____ Symptom phase

____ Thought phase

____ Introduction phase

____ Reaction phase

____ Fact phase

____ Teaching phase

Question 2

What are the advantages and drawbacks of CISD?

Advantages

Drawbacks

Reflection and analysis

In a few sentences, describe your view of CISD. Would you use it? Why or why not? What issues about it concern you?

2 WATCHFUL WAITING

In response to the negative findings regarding debriefing the international scientific community has been inclined towards a hands-off, non-interventionist approach during the immediate phase. The focus has shifted from active intervention during the immediate phase following trauma, to assessment and early identification of those trauma survivors who are most likely to develop PTSD or other problems, with a view to initiating early treatment during the acute phase of recovery (NICE, 2005). An example of this approach is the National Health System approach to victims of the 2005 London tube bombings. No counselling or debriefing was offered, but affected persons were followed up by post and assessed at various times during the three-year period following the bombings. As soon as it was evident that they had discernable symptoms of distress (PTSD, depression, anxiety or somatic complaints) they were referred for treatment, as early as three months after the event (Brewin, Scragg, Robertson, Thompson, D'Ardenne, & Ehlers, 2008).

This approach, also called “watchful waiting”, has necessitated the development of reliable assessment instruments that can be used for the early identification of persons with ASD or other problems. A number of instruments have been developed over recent years that have proven to be useful (See Chapter 13).

However, Bisson makes a valid point: From fear that we may be doing something wrong or may be doing too much, we may be doing too little (Bisson, 2007). Similarly, following a study of CISD provided to US peacekeepers that showed that CISD had minimal effect, Adler and others (2008) concluded that it may be tempting to suggest that there be no formal interventions in the immediate phase following potentially traumatising events, because most people are not at risk for posttraumatic distress, but it would be inappropriate to abandon the human, social, and informational needs of persons exposed to serious trauma.

3 RECOMMENDED GUIDELINES FOR EARLY INTERVENTION

Given the current evidence base, it is important to remember that the usual reaction following a traumatic event is a normal one that leads to recovery (see Chapter 4). We should not interrupt this process, but instead of doing nothing Bisson and colleagues (2009) make five recommendations for early trauma interventions, during the immediate and acute phase:

Shortly after a traumatic event, it is important that persons affected by the trauma should be provided with practical, pragmatic psychological support in an empathic manner. Affected individuals should be provided with information about possible reactions; with coping strategies / what they can do to help themselves; with accessing support from those around them, particularly family and community; and how, where, and when to access further help, if necessary.

Early trauma support should be appropriate, and should be based on an accurate and current assessment of needs. Because people cope with stress in different ways no formal, blanket intervention should be applied for all persons exposed to the trauma. The use of

trauma support should be voluntary except in cases where the trauma victim is so severely impaired by the event that their own safety or the safety of others is threatened.

Interventions should be culturally sensitive, developmentally appropriate, and related to the local formulation and narrative of the problems, and ways of coping.

Lack of distress and rapid recovery may not be a desired outcome, because ethnic, political, cultural and economic factors may shape differing goals for functioning. Providers should be sensitive to the particular motivations of each survivor.

As far as possible early intervention providers should constantly strive to evaluate the effectiveness of their procedures in ameliorating specific outcomes, and the need to revise interventions.

A group of 20 internationally recognised experts in the field of early intervention, recently defined five empirically supported intervention principles to guide and inform intervention and prevention efforts in the immediate and acute phases following mass trauma (Hobfoll, Bell, Bryant, Brymer, Friedman, & al., 2007)(cf Chapter 3 for a more detailed description):

- Promote sense of safety.
- Promote calming.
- Promote sense of self-efficacy and collective efficacy.
- Promote connectedness.
- Promote hope.

Litz and Maguen (2007) make a valid point that early intervention is not necessarily only about prevention of PTSD and other trauma related disorders. They propose a number of other goals, no less valid or useful, to guide early intervention:

- Helping people to decrease, manage, or eliminate functional incapacities caused by trauma.
- Promoting and training individuals or groups to use positive coping strategies and healthy behaviours.
- Encouraging and assisting individuals or groups to develop, nurture, and take advantage of comforting, positive, and caring social supports.
- Targeting complicated bereavement or traumatic grief for special attention.
- Helping individuals cope with subsequent threat.

Fact check 3:

Question 1

Trauma counselling is always voluntary? True/False

Question 2

The same intervention should be applied to all clients that have suffered from a traumatic event? True/False

Question 3

Intervention should be revised and changed if there is a need? True/False

Question 4

There are five empirically supported intervention principles to guide and inform intervention and prevention efforts in the immediate and acute phases following mass trauma. One of them is to promote a sense of self-efficacy. In your own words, what does this mean?

Question 5

Affected individuals should be provided with information about possible reactions. What are these possible reactions?

Reflection and analysis

Interventions should be culturally sensitive. What is meant by this? Can you give an example?

4 PSYCHOLOGICAL FIRST AID

One model of early intervention that has gained credence and support, particularly during the past decade, a model that incorporates of the above recommendations and guidelines, is Psychological First Aid (PFA) first described by Raphael in 1977. Developed largely to cope with the aftermath of large-scale disasters, PFA is a flexible conversational approach that provides comfort, support, connectedness, information, and fosters coping in the immediate interval. Most often, in the aftermath of a traumatic event individuals and groups are unable to draw on their normal individual and community resources for recovery, because of the

personal shock, confusion, disorganisation, disconnection, and breakdown of social support systems that usually follow traumatic events. PFA addresses these issues in the immediate aftermath with a non-intrusive, non-prescriptive, but formalised care that addresses human and practical needs first and foremost. It is not sufficient as a secondary prevention strategy, but by reducing anguish, arousal, distress and disconnection, and by enhancing coping and control, the risk of complications is diminished, and the likelihood of follow-through to secondary prevention and treatment is enhanced.

Although this model has been widely adopted and applied, no empirical evidence of its efficacy has been published as yet.

4.1 [2]Psychological First Aid Core Actions

4.1.1 Contact and engagement

Goal: To respond to contacts initiated by survivors, or to initiate contacts in a non-intrusive, compassionate, and helpful manner.

4.1.2 Safety and comfort

Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfort.

4.1.3 Stabilisation (if needed)

Goal: To calm and orient emotionally overwhelmed or disoriented survivors.

4.1.4 Information gathering: Current needs and concerns

Goal: To identify immediate needs and concerns, gather additional information, and tailor additional PFA interventions.

4.1.5 Practical assistance

Goal: To offer practical help to survivors in addressing immediate needs and concerns.

4.1.6 Connection with social supports

Goal: To help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, and community helping resources.

4.1.7 Information on coping

Goal: To provide information about stress reactions and coping to reduce distress and promote adaptive functioning.

4.1.8 Linkage with collaborative services.

Goal: To link survivors with available services needed at the time or in the future.

Fact check 4:

Question 1

PFA is a flexible _____ approach that provides _____,

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[2] Brymer et al., 2006

_____, _____, _____, and fosters coping in the immediate interval.

Question 2

Psychological First Aid (PFA) diminishes complications? True/False

Question 3

PFA is an intrusive form of therapy? True/False

Question 4

The PFA was developed to deal with very traumatic experiences? True/False

Question 5

In the PFA actions, what is the goal for safety and comfort?

Reflection and analysis

The goal of connection with social supports is to help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, and community health resources. Why, in your opinion, is this important?

5 TRAUMA SUPPORT: OPTIMISING TRAUMA RECOVERY ENVIRONMENT

At traumaClinic in Cape Town, South Africa, we have developed a model for early intervention by re-evaluating and reformulating our experience of 15 years with individuals and groups across a wide spectrum of the South African population in the light of research as it is emerging (Van Wyk, & Edwards, 2005). The approach as it has evolved is not prescriptive, but flexible, pragmatic, problem-oriented, phased and multifaceted, similar to 'post-traumatic stress management' as developed in the Community Services Programme in Boston, USA (Macy, Behar, Paulson, Delman, Schmid, & Smith, 2004).

Addressing individual emotional distress and supporting the emotional processing of what has happened, as it is typically done in debriefing and conventional counselling, is only one aspect of intervention. The focus is much more on activating resources in the victim's world, instead of focussing on the pathological (Edwards, Sakasa, & Van Wyk, 2005). For these reasons we refer to our work at traumaClinic as "trauma support" rather than "trauma debriefing" or "trauma counselling".

There is no predefined procedure or prescription, but importance is placed on the early identification of areas where intervention is needed, or possible areas where problems could develop, such as avoidance patterns, destructive anger or overwhelming arousal. A variety of possible interventions is available in response, mostly familiar components of trauma crisis intervention. Interventions are selected in response to what is found in the initial and ongoing assessment process, and the overall importance of promoting resilience, in keeping with the emphasis of Gist and Woodall (1999, p. 217) on ensuring that any interventions "supplement and reinforce resilient responses of individuals and organizations" and do not "[supplant or replace] natural contacts and supports that promote autonomy and resilience, with artificial structures that instead 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. In addition, selected individuals are offered counselling or psychotherapy. Finally, in Stage 3, two to four weeks after the incident, we follow-up and reassess 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. They also 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. We do this 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. We do this; 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, family, 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 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 who were treated with benzodiazepines with a matched control group who were not given medication. At one month and six-month followup, 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. 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. Some of his colleagues, after going through similar

experiences, were given a month's sick leave that was extended for even longer when they found it difficult to return to work. However, we do encourage management to give leave to attend to practical matters, such as giving evidence to the police or arranging or attending a funeral.

Finally, we ensure that our TraumaClinic personnel monitor their own capacity to work in trauma situations and take steps to protect themselves against burnout. In a study of lay trauma counsellors working with another South African organization, Ortlepp and Friedman (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 5:

Question 1

1) What does trauma support mean?

Question 2

Part of trauma support is promoting resilience. What does this mean?

Question 3

A typical trauma support process will unfold in three stages. Briefly describe the three stages.

Question 4

During counselling medication can play a helpful role, but why is it not always recommended?

Question 5

What is burnout and how can it be prevented in trauma work?

Reflection and analysis

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. Think of your primary support system; write them down with a brief explanation why you think you could rely on them.

TraumaClinic in action: Case studies

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

Case 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 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, they arranged transport to and from work for the survivors for the next few days, they provided practical support for the rituals that followed, for example, giving time for them to attend the funerals, and supporting those who lived alone in finding somewhere else for them to stay for a while or someone to stay with them. Management were advised on strategies for assisting their staff in readjusting to the work situation and not develop resistance and avoidance. With this intervention, all the survivors recovered within a few weeks and none developed PTSD, even though they received no formal counselling.

Case 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 next 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.

Cases 3 and 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.” Eventually she had to be transferred to a job in the head office. 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 and screamed. He ran away and nothing was taken. 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, 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 followed by some 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. Her husband believed she was overreacting, was not sympathetic, 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, 1996).

Assignment:

Given the varying experiences shown in the case studies and TraumaClinic recommendations, write guidelines for practitioners dealing with cases like those above. Write up to 500 words.

6 EARLY COGNITIVE-BEHAVIOURAL THERAPY

CBT has been used in various forms and settings as an early intervention procedure, sometimes as early as two weeks after a traumatic event. The techniques used generally mirror CBT techniques that have been found to be effective in overcoming PTSD symptoms. Techniques shared by the various early CBT therapies are the following: Psycho-education regarding trauma, stress management, cognitive restructuring and some form of memory reprocessing. The most common forms of CBT are cognitive therapy and exposure therapy.

The core strategies of cognitive therapy are to:

provide experiential opportunities for patients to monitor, examine critically, and to change the way they think about various trauma-related challenges, to modify beliefs about the meaning and implications of the trauma.

In addition virtually all cognitive therapies include an element of exposure, such as confrontation with difficult situations, or writing about the trauma(Hollon, Stewart, &Strunk, 2006).

Exposure therapy (Bryant and Harvey, 2000; Bryant, Moulds, & Nixon, 2003) focuses more on repeated and prolonged exposures to trauma related stimuli, in the person's imagination and in the real situation.

Evidence for the efficacy of CBT in preventing chronic PTSD is unequivocally strong among certain trauma survivors (motor vehicle and industrial accidents), but less clear-cut for traumatic events that involve interpersonal violence, such as assault and sexual assault (Foa et al., 2009)

Reflection and analysis

How would you use exposure therapy to help a trauma client who was held up at gunpoint in her own home?

Assignment:

Read one of the references in this section and comment on its implications for the use of CBT in managing trauma. Write up to 500 words.

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.

CRITICAL INCIDENT STRESS DEBRIEFING (CISD)	( )
WATCHFUL WAITING	( )

RECOMMENDED GUIDELINES FOR EARLY INTERVENTION	( )
PSYCHOLOGICAL FIRST AID	( )
TRAUMA SUPPORT: OPTIMISING TRAUMA RECOVERY ENVIRONMENT	( )
TraumaClinic in action: Case examples	( )
EARLY COGNITIVE-BEHAVIOURAL THERAPY	( )

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.

Self-assessment questions

Question 1

Put CISD or PFA (Psychological First Aid) in the blanks:

____Relating

____Safety and comfort

____Information gathering

____Symptom

____Contact and engagement

____Thought

____Stabilisation

____Current needs and concerns

____Introduction

____Reaction

____Connection with social supports

____Fact

____Practical assistance

____Teaching

____Linkage with collaborative services

____Information on coping

Question 2

Which terms are NOT commonly used in trauma management?

trauma debriefing, external expression, defusing, trauma counselling, post-trauma actualisation, crisis intervention, dependency share technique, re-engagement therapy etc for sections 1 to 6.

Key:

1. CISD/PFA.

CISD Relating

PFA Safety and comfort

PFA Information gathering

CISD Symptom

PFA Contact and engagement

CISD Thought

PFA Stabilisation

PFA Current needs and concerns

CISD Introduction

CISD Reaction

PFA Connection with social supports

CISD Fact

PFA Practical assistance

CISD Teaching

PFA Linkage with collaborative services

PFA Information on coping

2. Which terms are NOT commonly used in trauma management?

trauma debriefing, external expression, defusing, trauma counselling, post-trauma actualisation, crisis intervention, dependency share technique, re-engagement therapy

Summary

The learning outcomes for the course are:

- Discuss current approaches to prevention of negative impact of trauma.
- Describe features, pros and cons of Critical Incident Stress Debriefing (and its derivative CISM), Psychological First Aid, and Cognitive Behavioural Therapy in relation to trauma management.

- Describe guidelines for early intervention in the context of watchful waiting.
- Describe guidelines for the traumaClinic trauma support process.

7 REFERENCES

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