Unwinding The Mind--Re-Positioning Management of Critical Incident Stress, Post Traumatic Stress, and Prolonged Duress Stress

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Abstract

Given estimates that 1 percent of our communities suffer from Post Traumatic Stress (Scott & Stradling, 1998) we need to continue to improve management of trauma. There are conflicting findings over the effectiveness of managed interventions (Hytten & Hasle, 1989; Silove, 1992; Brom, Kleber & Hofman,1993; Wilson & Raphael, 1993). Some reasons for equivocal findings may include how "trauma" events are perceived by those encountering such events (McFarlane, 1988) or presence of a family history of psychiatric disorders (Davidson, Swartz, & Storck, 1985; McFarlane, 1988).

Most approaches to managing Post Traumatic or Prolonged Duress Stress use cognitive behaviour models (Scott & Stradling, 1998). These try to help sufferers process the traumatic experience and deal with the fears engendered by recall of the trauma (Foa & Kozak, 1986). Sufferers are taught biofeedback strategies to regain some physiological management over their response to the situation. When these approaches fail, thought disruptive approaches such as eye movement desensitization (Shapiro, 1989) are suggested.

This paper suggests that those managing stress continue to refine their strategies. Some refinements include repositioning conceptual understanding of what may mentally happen after a traumatic event and ensuring that people have basic personal management skills to cope with flashbacks and intrusive thoughts.

1. Introduction

Recent studies indicate a conflict of findings over the effectiveness of stress management interventions (Silove, 1992; Brom, Kleber & Hofman, 1993; Wilson & Raphael, 1993). Brom, Kleber, & Hofman (1993), for example, find no significant differences between treatment groups. However, as with many studies, the interventions were made one month after the trauma event rather than the 24- to 72-hour period generally recommended in Critical Incident Stress Debriefing

[CISD] approaches. Consolidation of beliefs about the traumatic event and about how well people are coping (or cannot cope) with their emotions and recollections of that situation are likely to be entrenched by this time. As a consequence, people are likely to have re-adjusted (reporting consequent minimal effects) or de-stressed themselves before any measures have taken place. On the other hand, Hytten & Hasle (1989) found that high levels of competence and access to debriefing were favourable factors in coping with stress.

Some explanation for equivocal findings may come also from how "trauma" situations are perceived by those encountering such situations. McFarlane (1988) notes that some people may find such events a stimulating personal challenge. Moran & Colless (1995) find that a successful emergency response may provide very positive feelings in terms of accomplishment, pride, and job satisfaction.

Given that one estimate of the frequency of Post Traumatic Stress Disorder [PTSD] is 1 percent of a community population (Scott & Stradling, 1998), there is a need to continue to seek effective stress management. Coping mechanisms tend to be palliative--the use of alcohol or time off work, for example--rather than active--such as directly confronting emotions and perceptions of the experience (Lazarus, 1966). Consequently, counselling needs to focus on active management.

2. Repositioning Management of Crisis Impact or Trauma

In general, stress can be sorted into three stages:

- acute stress (symptoms last up to three months after the event),
- chronic stress (symptoms are present beyond three months),
- delayed onset (symptoms begin to appear six months after the event).

The period in which stress shifts from acute to chronic (three to six months) may reflect an underlying shift from difficulties coping with stress to developing PTSD.

2.1 Repositioning Management of Acute Stress

People are affected in some form through any encounter with a crisis situation. They may encounter aftershock, guilt, feelings of anger, and even a need to blame someone for what has happened to them. One emerging issue is that people are increasingly anxious (and even feel guilty) about how they feel and behave after an event relative to community or stereotype expectations. Those handling people from trauma situations need to carefully monitor what they say to these clients--suggesting how they may be feeling may heighten feelings of guilt or concern over having feelings that differ from what has been described to them.

Most sufferers find natural ways in which they reduce stress--exercise, talking it

over with family or friends, or just sleeping. Others use medication (anti-depressants, sleeping pills) or alcohol as a means of distancing the feelings of stress pressure and judgement. In general, many recover from stress and trauma in a period from between a couple of days to a couple of years. The degree of stress impact depends on the severity and length of exposure to a "trauma" situation. Other factors may include:

- *The amount of training and experience held by those in contact with the trauma situation.* High skill levels and familiarity through experience tend to reduce the impacts of stress. On the other hand, familiarity and ability to cope may be offset by cumulative stress that leads to burnout and Prolonged Duress Stress Disorder [PDSD].

- *The objectivity allowed by the situation.* Low threat and "clinical" crisis situations appear less threatening, whereas situations that are close-and-personal or have scarce resources can be overwhelming.

- *How a person views themselves in relationship to the world.* Perceived high self-efficacy may indicate resilience against stress effects. On the other hand, an already stressed person is more vulnerable to new stress impacts.

- *The psychological composition of the person, including their underlying personality, how they cope with stress, and any history of mental illness.* Substance abusers, for example, tend to adopt a palliative (Lazarus, 1966) approach that is unlikely to do more than temporarily block out stress and defer dealing with the psychological impacts involved. Davidson, Swartz, and Storck (1985) surveyed Vietnam war veterans in the United States who were diagnosed as having PTSD and determined that 66 percent had evidence of psychiatric disorders in their families. Similarly, McFarlane (1988) found that around 55 percent of traumatized emergency service workers had some form of psychiatric disorder in their family history.

Immediate management often takes the form of informal (peer or family sourced) or formal (counsellor sourced) activities.

Informal. Many people use informal assistance to "debrief" or de-stress the perceptions of an encounter with a stressful event. This usually takes the form of repeated periods of telling and re-telling "the story of what happened," often reliving intense emotion.

Informal counsellors need to understand a few important principles to increase their effectiveness. Two key principles are to:

1. *Listen no matter how many times to the story, and,*

2. *Avoid over-reaction to the intensity of the emotions.*

Even professional (formal) counsellors can get trapped into feeling a need to

move on when a client wants to re-tell "their story." Listeners need to bear in mind, however, that each repetition of the story helps the teller to adjust and accept (re-normalize their experience). Each re-telling can offer new information about the event or increase the teller's awareness of their feelings and choices they made during the event, helping them understand and absorb the experience.

As "their story" is re-told, tellers can become quite emotional. Those listening need to allow such feelings to emerge and be expressed while communicating to the teller the presence of a non-judging and empathic listener. Untrained counsellors (and even trained counsellors) can become uncomfortable with the emotional displays. They may feel an urge to intervene with a placating "there, there" approach or tell the sufferer to "grow up" or "stop making a fuss" (these urges can increase with each telling of the story and associated emotional upset).

Failure to listen to retold stories and to accept emotional reactions tends to further isolate the sufferer from outlets for communication and feelings of belonging. This may lead to more internalization and repression of the emotions and to a greater sense of ME versus the REST OF YOU--neither of which is helpful in terms of dealing with the beliefs or feelings involved.

Formal. Some form of crisis counselling that involves more professionally skilled personnel or at least trained peer workers may be offered. One approach is Critical Incident Stress Debriefing [CISD] (Mitchell, 1983; Mitchell, 1988; Mitchell & Dyregrov, 1993). "Debriefing" describes a process that facilitates the unpacking and normalization of stresses and perceptions gained from an incident. The approach can include respondents or victims or bystanders and may be offered in four ways--on-site, defusing, formal CISD, and follow-up CISD.

On site debriefing is offered soon after an event (from within hours to four days) and is done to help participants sort and sift through their thoughts and feelings while the associated stimuli from the site are present. Part of this process involves reducing distorted "perspectives" through linking the stimuli with the consequent feelings and thoughts. Similarly, facilitators seek to place actions, thoughts, feelings, and events within the context of a bigger picture. This helps participants normalize their experiences and hold less powerful reactions to subsequent recollections and intrusive thoughts.

Defusing is done within a group, usually in a fairly informal setting. Each person within the group tells their personal "war stories" and thus releases emotional and cognitive insights within a more understanding environment. The effectiveness of this defusing depends on the amount of trust the members of the group have for each other and the facilitator. Generally, the facilitator is a senior and experienced person. There are a number of problems with defusing, including:

- New members to a group are less likely to participate or may filter their expressions of thoughts and feelings.

- The presence of group members who are responsible for performance and promotion evaluations tends to restrict the expression of thoughts and feelings by other members.

- Defusing activities may get linked to increases in substance abuse.

- Defuser groups can generate an Us Versus Them mentality.

Those facilitating defusing processes need to allow space and time for repeated stories and emotional release to emerge and be cathartically experienced.

Formal Debriefing is best undertaken by trained mental health professionals. The process usually involves seven stages:

1. an introduction stage in which the process is explained and rules of participation are developed,

2. re-creation of the " facts" of the event (where participants were and what each participant saw-heard-smelled-touched-did),

3. describing first thoughts and impressions (on encountering the situation),

4. describing consequent feelings and reactions,

5. an assessment of the event that encourages a more "normal" and adjusted perception of the experience of the event,

6. some education in stress response indicators and stress management, and,

7. re-entry to likely demands of the outside world.

Generally this session involves small groups seated around a table in a quiet room. The facilitators seat themselves as far from the door as possible to allow participants to feel they can easily and quietly leave the room. Participants may feel their morale and emotional states fall when reliving their own experiences and listening to the experiences of the other participants. Morale and emotional states improve as participants uncover three important "facts." These are:

1. Feeling hurt and angry is acceptable.
2. They are not alone in their experiences (as they find common ground in perceptions and feelings).

3. Their post-event feelings of separateness and estrangement from the world around them are normal and expected, given their experiences of the situation.

Follow-Up Debriefing begins at least two days (48 hours) after an event, and is used either to work with those previously not debriefed or as a post-debrief process for those needing further help. While the process is very much the same

as that undertaken in Formal Debriefing, greater effort is needed to transform rationalized fact to real fact, as participants have had time to interpret and filter the original stimuli of the actual event.

Repositioning. Handled by trained and empathic counsellors, CISD can be effective. Facilitators need to have patience and empathy, and nudge rather than control stages of the process. Too often, untrained personnel or those with professional qualifications rather than crisis counselling experience are rushed in to deal with "victims." While there will be many effective counsellors in health related professions such as nursing and social work and even non-counselling psychology, formal debriefings may require a higher set of skills and training. As a side issue, care needs to be taken with those with good intentions who provide informal counselling to bystanders at major incidents. The quality of informal help offered at the JF Kennedy Airport (New York) after the TWA800 crash was such that it induced stress rather than allayed it in a number of cases.

In many cases people undergoing CISD will report quite positive feelings shortly after their counselling session. Too often, however, contact with the real world can trigger flashbacks, intrusive thoughts, and negative feelings. Without appropriate self-management skills, these people are likely to decrease their belief in their ability to manage and cope. They often try to stop or avoid the intrusive thoughts. These actions diminish effective management of the stress involved, and counsellors and facilitators need to coach the affected individuals in managing intrusive thoughts and in self-relaxation. Three useful "tools" that help self-management are:

1. *Provide a visual image that helps sufferers relate to their situation*. One effective analogy equates a stressed person's situation to that of a deep sea diver who has gone too deep or stayed under water too long. Notice the similarity of intensity and pressure (depth) and duration (too long) with the situation of the stressed person. Facilitators then point out that just as the diver needs to stage her or his way back to normal sea-level conditions, allowing the lungs and blood to re-normalize, so the stressed person needs to "stage" their way back through their experiences to regain normal life. This image is quite dramatic yet effective with most people, and they gain a degree of comfort and re-assurance from it.

2. *Provide a simple means of coping with intrusive thoughts*. Many suffering from intrusive thoughts and flashbacks try to ignore or stop them. This creates anticipatory tension that not only increases disturbance but also promotes increased avoidance behaviour, reducing ability to concentrate and sleep. Without effective management, sufferers try to reduce their risk of having such thoughts and flashbacks, beginning to fear anticipation of the thoughts and flashbacks. When instructing people in relaxation or meditation, trainers usually tell their students to welcome the thoughts, inspect them for any need to act, and then let the thoughts float away if there is no need to act. Scott & Stradling (1998) use the image of an unknown train rushing through a railway

station to represent an intrusive thought. They then suggest that the client was unlikely to jump into the path of the train to try to stop it. Rather than resist the intrusive thought or flashback, they suggest the client sets a time later in the day in which he or she will give the thought full attention and time.

3. *Provide more training in monitoring and using the physiology of the body.* Counsellors and facilitators need to ensure that their clients gain sufficient skill in using simple biofeedback techniques to help calm and relax themselves from upset states. These techniques may be a simple stopper such as PBR (Pause-Breathe-Relax) in which the user pauses, breathes in, then breathes out saying silently "relax" (see Heath, 1998) or a more complicated approach involving controlled breathing and some form of body monitoring.

Counsellors need to remember that distressed people need reassurance. As Mitchell stresses in his workshops and seminars, counsellors need to tell their clients that they will get better, no matter how they feel now or in the future. This needs practice and sensitive delivery, otherwise the message tends to be received as a platitude and become disregarded. One interesting point is that when clients emphasize "when" in their refrain of "when will I get over this" and do so with a flat voice or despairing tone, they may be indicating entrenched or chronic stress that may signal the onset of Post Traumatic Stress disorder.

2.2 Repositioning Management of Chronic or Delayed Onset Stress

Those who remain stressed by a situation for more than three months are diagnosed as chronic stress sufferers. Some experiencing an onset of stress after at least six months are diagnosed as suffering delayed stress. Both situations can lead to PTSD or PDSD. While PTSD stems from ineffective management of stress from a traumatic single experience, PDSD stems from the cumulative effects of a number of less intense stress situations (Ravin & Boal, 1989). While the set of lesser PDSD stress experiences (typically three or four) may mask each other and may complicate management approaches, the symptomologies and lifestyle interference for both are very similar.

People experiencing PTSD (and PDSD) may experience:

- Recurrent intrusive thoughts about the event or moments from that event.
- Recurrent distressing dreams replaying and even worsening the event.
- Severe distress or severe physiological reactions to stimuli that trigger recall or associations relating to the crisis.
- Persistent avoidance behaviour associated with encountering stimuli linked with recollections of the crisis.
- Ongoing and distracting attempts to avoid thoughts, feelings, or talking about the crisis and their experiences of that crisis.

- Loss of memories about the crisis and experiences associated with it.
- Diminished response to the outside world (*psychic numbing* or *emotional amnesia).*
- Reduced (or terminated) participation in or enjoyment of pre-crisis activities and pre-crisis beliefs.
- Feelings of emotional detachment or foreshortened existence.
- A significant reduction in emotional interactions with those close to the sufferer.

Further specific details can be found in the **Diagnostic and Statistical Manual of Mental Disorders**--DSM-IV.

Just how endemic PTSD / PDSD is remains speculative. Scott & Stradling (1998) state that around one percent of a community may be impaired by these disorders. Parker (1977) assessed victims of cyclone Tracy (Darwin, Australia) and found that while one week after their evacuation from Darwin around 58 percent could be classed as psychiatric cases, this figure only fell to 41 percent twelve weeks (three months) later. Patrick & Patrick (1981) found a similar figure for cyclone victims in Sri Lanka, where 70 percent were psychologically disturbed one week after the event and 46 percent remained so after four weeks.

One apparent cause for continued dysfunctionality and the subsequent onset of PTSD or PDSD emerges when traumatized people feel they have no support. Scott & Stradling (1998) suggest that stress will be maintained when sufferers perceive they have limited or no support, continue to avoid any situational or memory reminder of the crisis, and perceive limited or no opportunity to share their feelings. These authors point out that as the onset of PTSD and PDSD is likely to reduce any search for problem resolution or effective coping skills, sufferers can reduce interactions with others, and thus perceive decreased support and reduced opportunities to share their feelings.

In general, some form of Cognitive Behaviour Therapy (CBT) is used to help those with PTSD / PDSD to change unrealistic negative thoughts into more realistic, positive, and problem-resolving behaviours (Scott & Stradling, 1998). CBT uses outcome measurement, structured counselling sessions (including a consensually agreed agenda), and homework assignments. Therapists tend to be directive and problem-solving, usually by getting the client to provide their own answers to questions posed by the counsellor. Many of these questions aim to draw out answers that show inconsistencies and illogical beliefs and perceptions held by the client. Clients are also trained in physiological management of stress. They are encouraged to undertake experiments involving small increments to check out their constraining fears and beliefs, with a caution that they may experience two steps forward and one step back. The idea is to get the client to see

their beliefs and rule sets as being postulations and hypotheses rather than proscriptions and mandatory commands requiring submission.

In particular, CBT works to counter cognitive biases. These include "all or nothing" thinking, overgeneralizations, negative mindsets, magnification, minimization, automatic discounting, conclusion jumping, emotional reasoning, "should " and "ought to" statements, and personalization. In turn, clients are then rehearsed in solving their problems, moving through five phases: problem definition, brainstorming options and solutions, assessing advantages and disadvantages of the options and solutions, selecting and implementing a solution, and reviewing outcomes (including coping efforts).

Most methods used when CBT appears to fail resort to interfering with the client's embedded negative story. Shapiro (1989), for example, outlines a procedure based on eye movement. The procedure has the client visualizing their trauma while the counsellor rhythmically moves a finger (held 30 to 35 centimeters from the client's face) rapidly across the visual field around twice per second. Clients then measure their perceived stress levels (SUDs--subjective units of disturbance) and this continues until SUDs are rated at around 0 to 3 out of 10. Clients verbalize any changes to their images during the procedure, and can report feeling tired and lightheaded after the procedure. Clients with conditions such as epilepsy or those with eye defects should not undergo this treatment.

Repositioning. Scott & Stradling (1998) find that the changes in symptomology over the first three months suggest that trauma- and stress-induced beliefs are being formed in this period. Belief transformation may even be more rapid than this--possibly between one and seven days. The changes in symptomology reported by the authors may, in fact, reflect an entrenchment of those beliefs through confirmatory processes. In other words, the "I am useless" belief arises within the first week, and the "See! That proves I am useless" confirmatory process is then used. As a consequence, cognitive restructuring tools may need to be used far earlier in treatment, possibly inside a week from the traumatizing event.

One of the real strengths of CBT is the challenging of illogical beliefs and perceptions. When clients are coached into critical consideration of their beliefs, rules, and avoidance behaviours they develop skills that can be used in future circumstances. Another strength can be found in the careful and cautious retraining of the client to control their physiological reactions and the focus on small incremental experiential exercises or homework activities.

Emphasis in CBT, however, tends to remain focused on reducing the size of, or desensitizing, the negative associations held by clients--for example, lowering SUDs levels. More attention could be placed on re-attaching positive value to stimuli that otherwise trigger negative emotion, as can be seen in approaches like Neuro-Linguistic Programming. Without a revitalization of positive experiences (or attached positive frames of reference), clients will simply adopt smaller

negative or neutral positions, rather than positively valued positions.

Long-term stress management needs to provide greater visibility to the processes involved by using compelling yet simple imagery to represent the process involved. Few people realize that PTSD and PDSD situations involve two layers of problems. The inner or core layer is the unprocessed data (sensory impressions, cognitive interpretations, and emotional reactions) of the trauma experience that the brain wishes to process and file away. The outer layer is developed through the desire to avoid the pain believed to be attached to the unprocessed memories. People who avoid confronting what are (or what are expected to be) painful memories become sensitized to these avoidance behaviours or apprehension states and then try to avoid those as well. Counsellors and managers may need to work within this two-tiered, and thus two-stage, process, dealing with the "fears" and with the "unprocessed data."

In simple and powerful terms, PTSD or PDSD sufferers who ask "when will this be over?" or "when will it finish?" or "how much more suffering must I endure?" need to uncover or discover that healing can happen once they stop avoiding their fears. The real answer is something like "it will begin to end when you are ready to let it end, and will end when you allow your brain to process and interpret the data surrounding your experience."

3. Conclusion

Management of stress and trauma remains a significant activity within society. Setting aside the costs in lost work output and in the use of social service resources, those suffering from stress can disrupt and damage themselves, those working and living nearby, and the community at large. Those suffering PTSD or PDSD who also have psychotic disorders may even initiate domestic and spree violence.

Management of stress and trauma can be improved by providing greater explanation about what is mentally happening, even if only on conceptual and analogical terms. Facilitators and counsellors can help provide the models and skills needed to increase the self-sufficiency of clients in handling stressful situations, flashbacks, and intrusive thoughts. Clients need to learn to acknowledge and process intrusive thoughts at a convenient later date rather than resist or avoid such intrusions. Overall, current management emphasizes reduction of negative feelings and negative behaviours. Contemporary management needs to consider the possibilities of replacing these negative feelings or values with positive feelings or values, thus promoting greater self-efficacy.

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