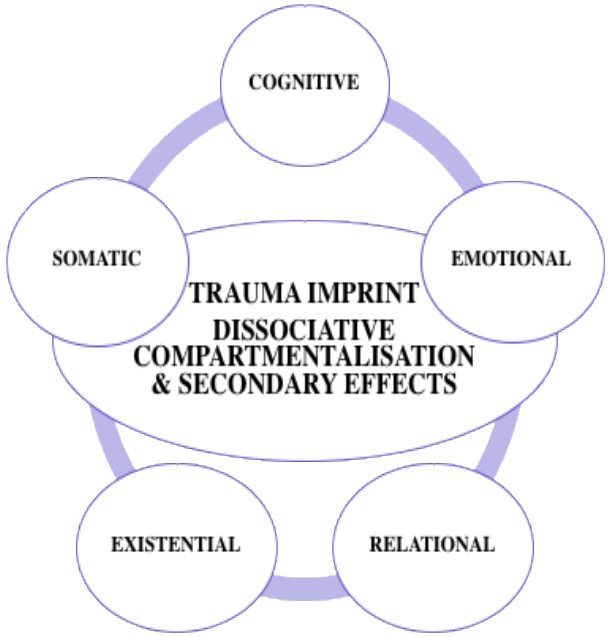
NEGOTIATING THE ENDURING TRAUMA IMPRINT IN CRITICAL INCIDENTS



OVERVIEW

- Here today, not as an expert in responding to Critical Incidents, but as a clinician experienced in working with enduring acute and developmental traumas as they present in the Consulting Room.
- On 20th June, 2017, 6 days after the Grenfell Tower Disaster, I attended the scene to offer therapeutic support.
- What I hope to do in this presentation today is weave together the two strands of knowledge of trauma with appropriate ways of responding to the traumatic suffering which can result as a consequence of being involved in a Critical Incident.
- The objective being: not to offer a fully fleshed out model of responding to Critical Incident Trauma but to gestate thinking about what any models in the future can integrate.

THE TRAUMA IMPRINT ➞
ENDURING EFFECTS ➞
ALL LEVELS OF HUMAN EXPERIENCING

KNOWLEDGE OF THE TRAUMA IMPRINT

THEORY

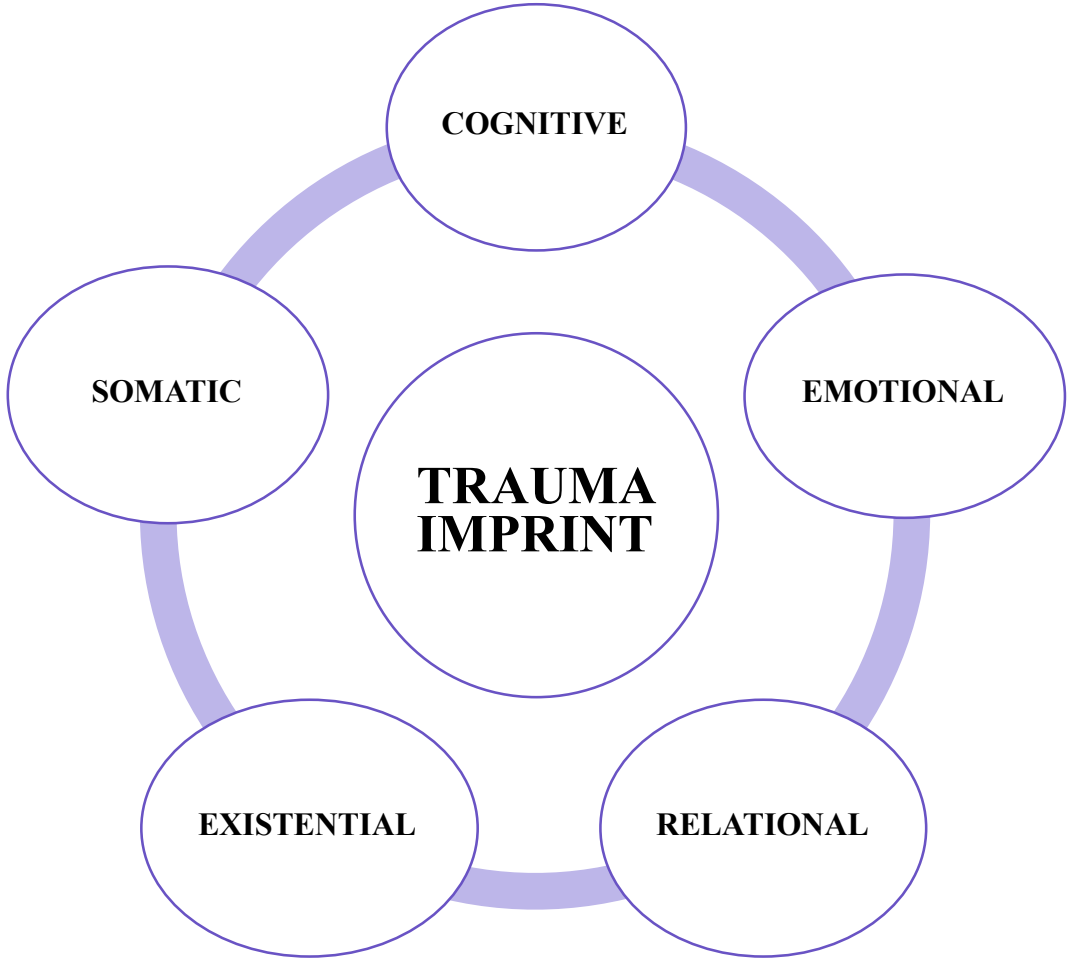
Cozolino, L. (2010), Erskine, R.G. (2015), Levine, P.A. (1997, 2010), Van Der Kolk, B. (2014).

RESEARCH

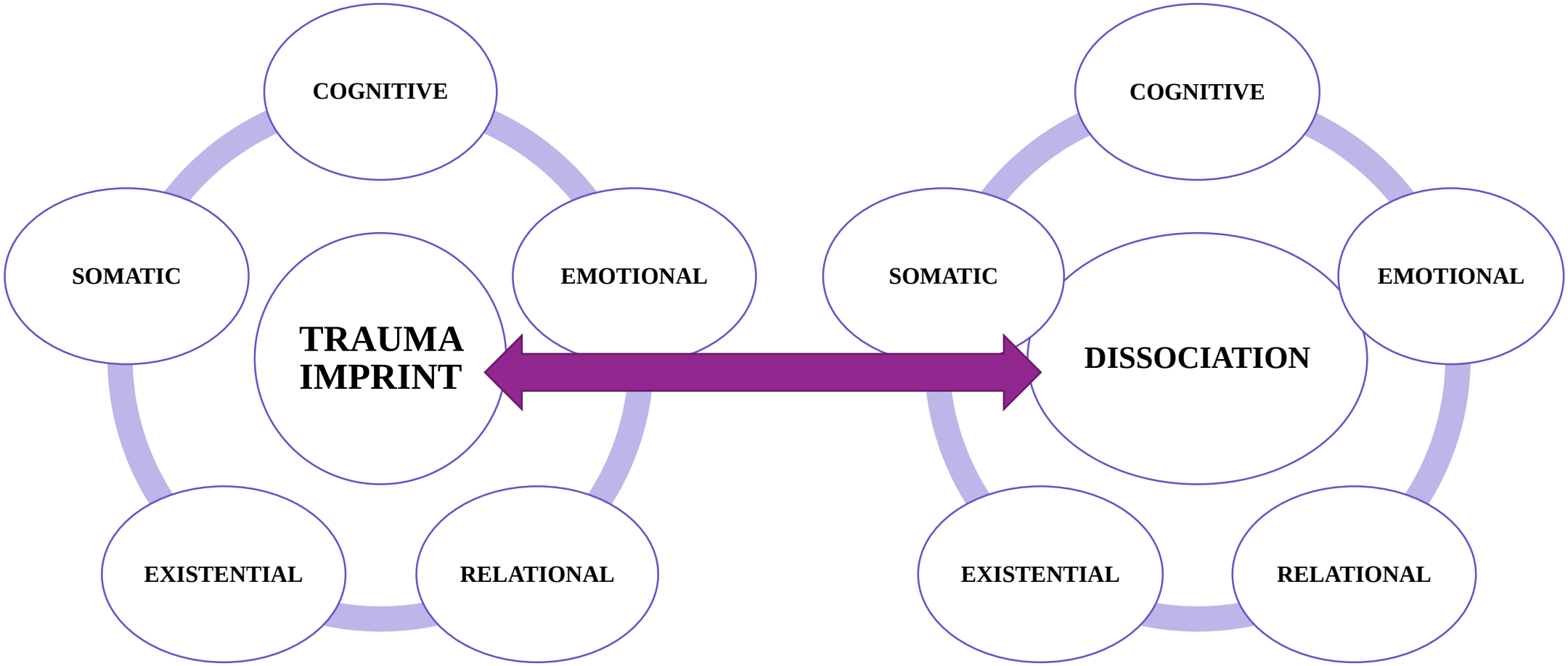
Bados et al (2008), Liotti, G. (2004), McTighe, A.J. (2017), Nilsson, S. et al (2015), Smith S.L. et al (2016).

CLINICAL CASE STUDIES

Fisher, J. (2017), Rothschild, B. (2000, 2003), Totton, N. (2015), Yellin, J. & White, K. (2012), Kalsched, D. (2013).



WE ALSO KNOW THAT THE USE OF PROTECTIVE DISSOCIATIVE MECHANISMS EMBEDS AND EXACERBATES THE TRAUMA IMPRINT



DISSOCIATION & THE TRAUMA IMPRINT

- Memory puts normal, everyday experiences into the past – these memories are filed away and can be recalled at will. But due to the avoidant, protective mechanisms of dissociation the memories (cognitive, emotional and somatic) are not fully processed by the mind before they are stored. They are ‘split off’ out of processing awareness. Some memories remain but often the most painful ones are separated from conscious experience.
- Rothschild (2000,p.13) says that, “The most severe consequences of trauma result from dissociation” because although the traumas are hidden away/unconsciously repressed/ compartmentalised, their dense effects are encoded throughout the system at psycho-emotional and psycho-physiological levels and are capable of being triggered by everyday events and sensations. The trauma never ends.
- Layers of secondary defences (such as interpersonal withdrawal, somatisation of mental and emotional disturbance, and the creation of negative self thoughts) are recruited in and are interwoven around the original traumatic experience as an additional protective, but partial, solution. Causing enduring dysfunction.
- The Trauma Imprint endures if the original ‘memories’ and the secondary mechanisms are not fully processed.

IMPRINTED/DISSOCIATED ‘MEMORIES’

MEMORY CHANNELS	MEMORIES
Cognitive Imprinted/Dissociated Memories	“How, when, where?” Recall of specific mental details and overall narrative of the event.
Emotional Imprinted/Dissociated Memories	State Dependent emotions experienced during the event, fear, emotional overwhelm.
Somatic Imprinted/Dissociated Memories	Pain, loss of function in limbs, freeze response, visual disturbances, headache, sense of touch.
Physiological Imprinted/Dissociated Memories	Elevated heart rate, panic throughout the system, breathlessness, holding of breath, dizziness.
Visual Imprinted/Dissociated Memories	Images of destruction, perpetrators, dead loved ones, weapons, mutilation, collapsing buildings, fire.
Auditory Imprinted/Dissociated Memories	The sounds of screaming, the screeching of brakes, the crash of metal, gunshots being fired.
Olfactory Imprinted/Dissociated Memories	The smell of smoke, melting plastic, gun smoke, blood, death, bodily fluids, aftershave, perfume.

WHY DOES ALL THIS HAPPEN?

Because the Human Being cannot immediately and directly metabolise the cataclysmic horror and terror of what they are experiencing.

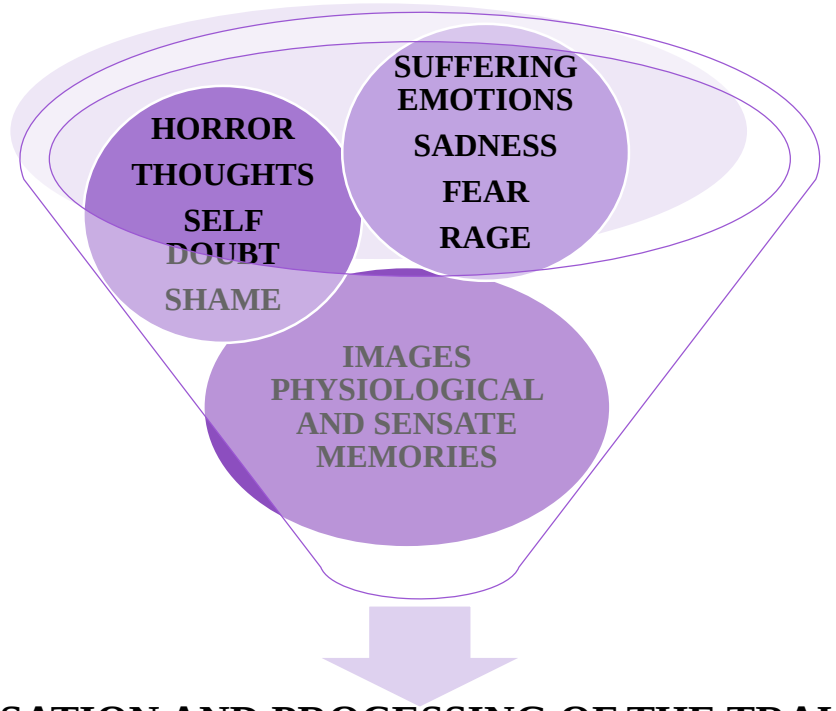
Occurs throughout all levels of their system:

- Cognitive/Mind/Thoughts
  - "***The mind can't know***"
- Emotional/Feelings
  - "***Too frightening/distressing to feel***"
- Relational/Otherness
  - ***"I am completely alone in this suffering"***
- Existential/Meaning Making
  - ***"I have no framework to understand what I am witnessing"***
- Somatic/Physiological/Sensorial (Visual, Auditory, Olfactory)
  - "***Immediate, unconscious, physiological protective responses***"

ASSISTANCE TO METABOLISE/PROCESS THE SUBJECTIVE DISTRESS CREATED VIA THEIR INVOLVEMENT IN ACUTE/CRITICAL INCIDENT TRAUMA?

Engagement with trauma sufferers should begin in the initial aftermath of the traumatic event.

72% of self referred individuals (within 1 month) post 9/11 assessed as having either symptoms of PTSD, Acute Stress Disorder or Adjustment Disorder. 610 people with 5,438 reported symptoms.

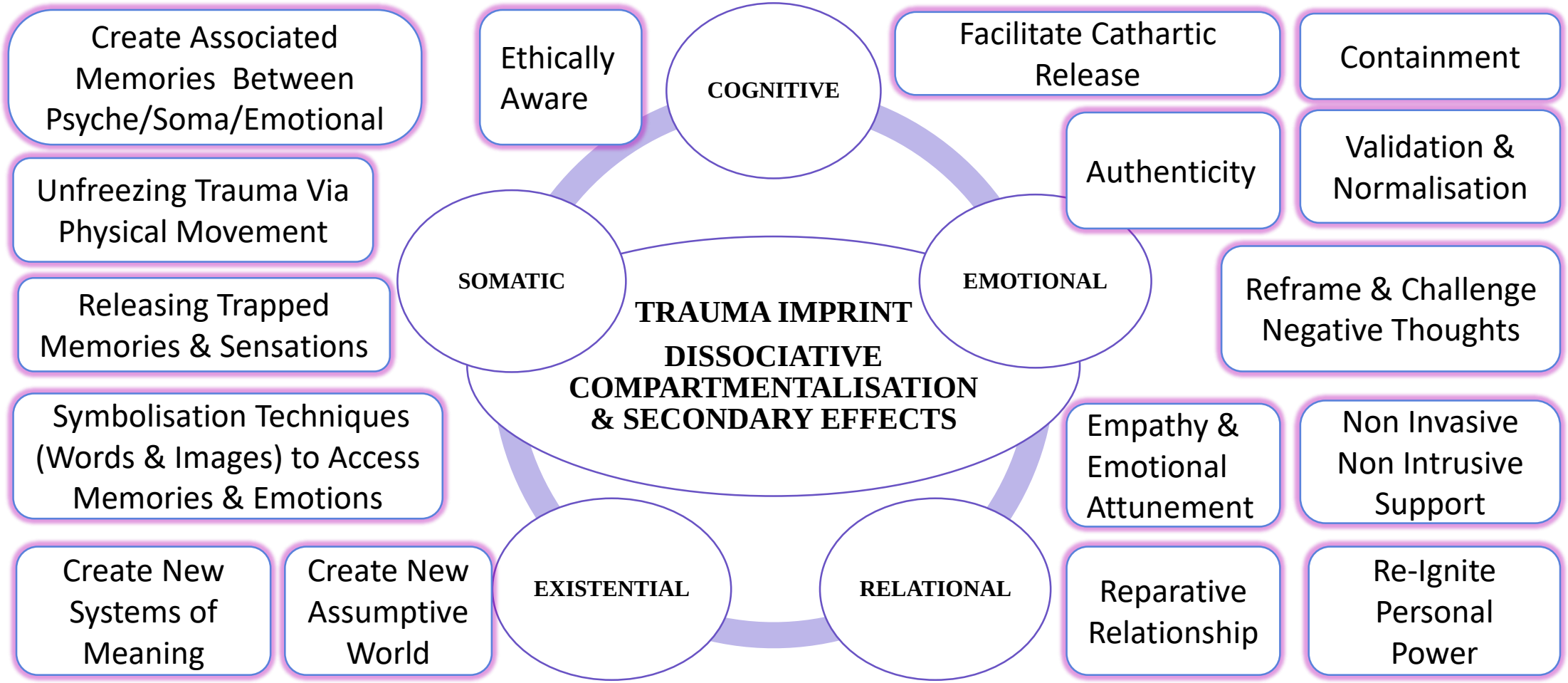


DSMV-5 Criterion for PTSD not met until 6 months post traumatic event but they indicate onset of symptoms can begin immediately.

MINIMISING OR REMOVING THE ENDURING NATURE OF THE TRAUMA IMPRINT

METABOLISATION AND PROCESSING OF THE TRAUMATIC EFFECTS THROUGHOUT ALL LEVELS OF HUMAN EXPERIENCING: COGNITIVE, EMOTIONAL, RELATIONAL, EXISTENTIAL, SOMATIC

EXAMPLES OF INTERVENTIONS USED IN CLINICAL PRACTICE TO METABOLISE AND PROCESS THE TRAUMA IMPRINT/DISSOCIATIVE SYMPTOMS

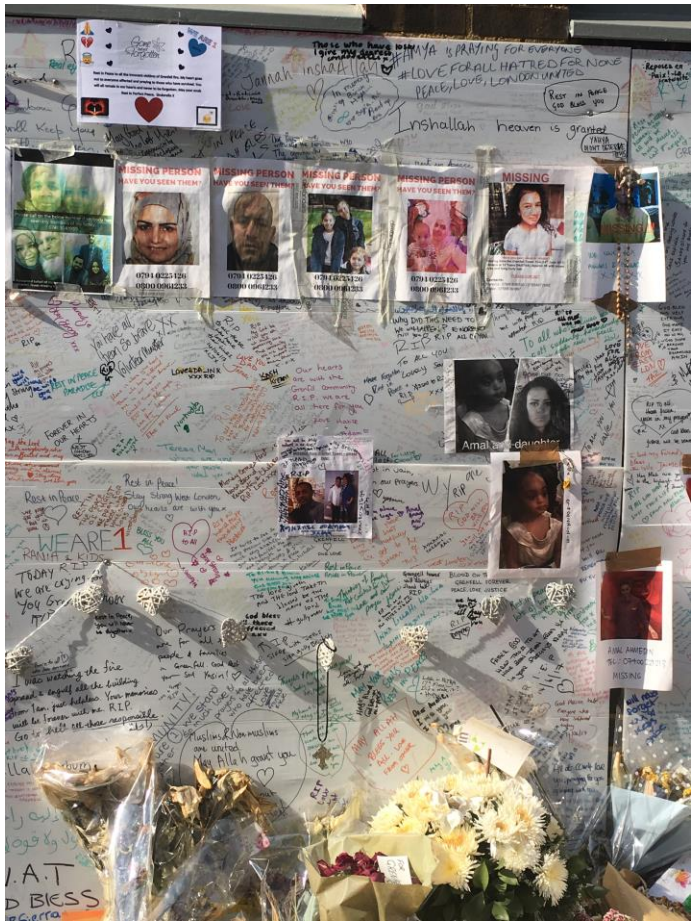


EXAMPLES FROM GRENFELL AND KEY CLINICAL CONSIDERATIONS

Recognise the capacity of the human spirit to self heal

Resilience

Ability to process and metabolise their own suffering



- **Reliance on the community of which they were a part** – positive self/object relationships.
- **Negotiating fight/flight/freeze responses** - by direct involvement with others, attending to various images by bearing witness to the various scenes at the base of the tower and ‘Unfreezing’ by perpetually congregating and walking from venue to venue.
- **Use of symbolisation to associate thoughts with feelings, emotions with behaviours** – use of ritual via the creation of memorials, expressing feelings in words on cards and letters to victims, leaving meaning laden objects and photos at sites around the base of the tower.
- **Emotional catharsis** – release of grief and rage, accessing emotional vulnerability.
- **Self empowerment** – victims removing identification tags to dis-identify with victimhood, refusing to wear donated ‘rags’ and seeking financial support to buy what they needed.
- **Reclaiming of personal power** – recruitment of media, marches, banners, YouTube videos, Facebook pages.
- **Creation of new meaning systems to hold and contain the event** - taxi driver finding a way to mentally structure and create a framework in his mind to process the horrors of what had taken place here by linking the land with John Reginald Christie (the serial killer of 10 Rillington Place fame). To him this was an un-Godly place.

Authenticity	Containment	Empathy	Ethics

EXAMPLES FROM GRENFELL AND KEY CLINICALCONSIDERATIONS

- Significant ‘use of self’ – **authenticity**, capacity for emotional **containment** of self and others, emotional resilience, expression of genuine thoughts and emotions.
- Take a real ‘self’ out of the clinical space and into the community – go to where need is perceived. Example of “walking with” and young man at the tube station.
- **Empathic** attunement/emotional mindfulness and entering of a reparative relationship (albeit brief). Examples of being ‘used’ in a variety of contexts.
- Therapeutic presence and ‘bearing witness’ to the experiential needs of the ‘other’.
- Heightened awareness of **ethical** considerations – non-invasive, non-intrusive support. Example of lady running the support centre at the church.

EXAMPLES FROM GRENFELL AND KEY CLINICAL CONSIDERATIONS

Validation | **Normalisation** | **Cathartic Release** | **Reframing Negative Thoughts**

- **Validation** and **normalisation** of emotional states.
- Working to assist **cathartic release** when required. Example of mother telling me about her child clinging fearfully to her since the fire.
- **Reframing** and supportively challenging **negative thoughts**: guilt, blame, self doubt and shame. Example of working with firefighters. The ‘Hidden Victims’ as researched by Fullerton et al (1992).

Symbolisation

Assumptive World

EXAMPLES FROM GRENFELL AND KEY CLINICAL CONSIDERATIONS

- Use of **Symbolisation** Techniques is very powerful and assists people to access all realms of experience via words and images. Example of assisting the man to write poetry, process emotions, express rage.
- Creation of new **Assumptive World.** Normal for people to experience a world before and after the event. The need to create a new assumptive world, a new sense of the future. Example of men sitting on the step, "*Things will never be the same again… This can never happen again… Things can only get better after this*". The formulation of hope at the bottom of Pandora's box.

REFERENCES AND BIBLIOGRAPHY

- Bados, A., Toribio, L., & Garcia-Grau, E. (2008). Traumatic Events and Tonic Immobility. *The Spanish Journal of Psychology*, Vol 11, No.2, PP.516-521. Downloaded from: https://www.ncbi.nlm.nih.gov/pubmed/18988436
- Benwell, M. (2016). *Rillington Place: What John Christie's Residential Burial Ground Looks Like Now*. Downloaded from: http://www.independent.co.uk/news/uk/crime/rillington-place-bbc-john-christie-serial-killer-visiting-the-home-where-he-killed-adaptation-a7035831.html
- Bonnano, G. A. (2004). Loss, Trauma and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Adversive Events? *American Psychologist*, Vol.59, No.1.pp.20-28. Downloaded from: https://www.tc.columbia.edu/faculty/gab38/faculty-profile/files/americanPsychologist.pdf
- Cooper, M. (2008). *Essential Research Findings In Counselling & Psychotherapy*. London: Sage Publications.
- Cozolino, L. (2010). *The Neuroscience of Psychotherapy: Healing the Social Brain* (2nd edition). New York: W.W.Norton.
- Davis, J.A. (2013). Critical Incident Stress Debriefing From a Traumatic Event. *Psychology Today*. Downloaded from: https://www.psychologytoday.com/blog/crimes-and-misdemeanors/201302/critical-incident-stress-debriefing-traumatic-event
- Erikson, E. H. (1950). *Childhood and Society*. New York: Norton.
- Erskine, R.G. (2015). *Relational Patterns, Therapeutic Presence: Concepts and Practice of Integrative Psychotherapy*. London: Karnac.
- Fisher, J. (2017). *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation*. New York: Routledge.
- Forneris, C.A., et al (2013). Interventions to Prevent Post-Traumatic Stress Disorder: A Systematic Review. *American Journal of Preventative Medicine*, 2013, 44(6):635-650. Downloaded from: https://www.ncbi.nlm.nih.gov/pubmed/23683982
- Fullerton, C.S., McCarroll, J.E., Ursano, R.J., & Wright, K.M. (1992). Psychological Responses of Rescue Workers: Fire Fighters & Trauma. *American Journal of Orthopsychiatry*, 62(3), July 1992. Downloaded from: https://www.ncbi.nlm.nih.gov/pubmed/1497102

REFERENCES AND BIBLIOGRAPHY

- Gartlehner, G. et al. (2013). Interventions for the Prevention of Posttraumatic Stress Disorder (PTSD) in Adults After Exposure to Psychological Trauma. *Agency for Healthcare Research and Quality*. Downloaded from: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0055866/
- Kalshed, D. (2013). *Trauma and the Soul: A Psycho-Spiritual Approach to Human Development and its Interruption*. New York: Routledge.
- Katz, C.L. (2017). *BMJ Best Practice: Mental Health Response to Disasters and Other Critical Incidents*. Downloaded from: http://bestpractice.bmj.com/topics/en-gb/1065
- Kellogg, S. (2015). *Transformational Chairwork: Using Psychotherapeutic Dialogues in Clinical Practice*. London: Rowman & Littlefield.
- Levine, P.A. (1997). *Waking the Tiger: Healing Trauma*. USA: North Atlantic Books.
- Levine, P.A. (2010). *In An Unspoken Voice: How the Body Releases Trauma and Restores Goodness*. USA: North Atlantic Books.
- Liotti, G. (2004). Trauma, Dissociation and Disorganised Attachment: Three Strands of a Single Braid. *Psychotherapy: Theory, Research, Practice, Training*. Vol.41.pp. 472-486, 2004. Downloaded from: https://rvtsmidt.no/wpcontent/uploads/2014/03/Liotti_Trauma_Attachment-2.pdf
- Maslovaric, G., Zambon, V., Balbo, M., Fernandez, I., & Piola, P. (2013). Acute Post Traumatic Stress Reactions in Children Survivors of a Large Road Traffic Accident: Epidemiological Analysis and Eye Movement Desensitization and Reprocessing Treatment. *Journal of Trauma Treatment*, 2013, S4. Downloaded from: https://www.omicsonline.org/open-access/acute-posttraumatic-stress-reactions-in-children-survivors-of-a-large-road-traffic-accident-2167-1222.1000S4-001.php?aid=21041
- McTighe, A.J. (2017**).** Evidence-Based Practices, Ethical Considerations, and Advocacy Efforts to Reduce Mental Health Stigma in Veterans with Post-Traumatic Stress Disorder. *Journal of Trauma & Treatment*,2017, Vol.6. Issue 5. Downloaded from: https://www.omicsonline.org/open-access/evidencebased-practices-ethical-considerations-and-advocacy-efforts-to-reduce-mental-health-stigma-in-veterans-with-posttraumatic-2167-1222-1000398-95908.html

REFERENCES AND BIBLIOGRAPHY

- Mitchell, J.T. (ND). *Critical Incident Stress Debriefing* (CISD). Downloaded from: http://www.info-trauma.org/flash/media-f/mitchellCriticalIncidentStressDebriefing.pdf
- Nilsson S Hyllengren P., Ohlsson A., Kallenberg K., Waaler G., et al. (2015). Leadership and Moral Stress: Individual Reaction Patterns Among First Responders in Acute Situations that Involve Moral Stressors. *Journal of Trauma and Treatment*,2015, S4: 025. doi:10.4172/2167-1222.S4-025. Downloaded from: https://www.omicsonline.org/open-access/leadership-and-moral-stress-individual-reaction-patterns-among-first-responders-in-acute-situations-that-involve-moral-stressors-2167-1222-S4-025.pdf
- Pandya, A. et al (2010). Services Provided by Volunteer Psychiatrists after 9/11 at the New York City Family Assistance Centre: September 12 – November 20, 2001. *Journal of Psychiatric Practice*, 2010, May; 16(3):193-199. Downloaded from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3086595/
- Rothschild, B. (2000). *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment*. New York: W.W Norton & Co.
- Rothschild, B. (2003). *The Body Remembers Casebook: Unifying methods and models in the treatment of trauma and PTSD.* New York: W.W Norton & Co.
- Rothschild, B. (2006). *Help for the helper: the psychophysiology of compassion fatigue and vicarious trauma*. New York: W.W Norton & Co.
- Smith, S.L et al (2016). The National Trauma Research Repository: Ushering in a New ERA of Trauma Research. *SHOCK*, 2016, Vol.46, Supplement 1, pp.37-41. Downloaded from: https://www.researchgate.net/publication/307514091_The_National_Trauma_Research_Repository_Ushering_in_a_New_ERA_of_trauma_research_Commentary
- Shaw, D. (2014). *Traumatic Narcissism: Relational Systems of Subjugation*. New York: Routledge.
- Shedler, J. (2017). Selling Bad Therapy to Trauma Victims. Psychology Today. Downloaded from: https://www.psychologytoday.com/blog/psychologically-minded/201711/selling-bad-therapy-trauma-victims

REFERENCES AND BIBLIOGRAPHY

- Shengold, L. (1989). *Soul Murder: The Effects of Childhood Abuse and Deprivation*. New York: Fawcett Columbine.
- Totton, N. (2015). *Embodied Relating: The Ground of Psychotherapy*. UK: Karnac Books.
- Ursano, R.J., Fullerton, C.S., Weisaeth, L., & Raphael, B. (2017). *The Handbook of Disaster Psychiatry* (2nd ed). UK: Cambridge University Press.
- Van Der Kolk, B. (2014). *The Body Keeps The Score: Mind, Brain and Body in the Transformation of Trauma*. London: Allen Lane (Penguin Books).
- Tunnecliffe, M. (2007). *A Life In Crisis: 27 Lessons From Acute Trauma Counselling Work*. Western Australia: Bayside Books.
- US Department of Veteran Affairs. (2017). *PTSD and DSM-5*. Downloaded from: https://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp
- Wachtel, P.L. (2008). *Relational Theory and the Practice of Psychotherapy*. New York: The Guilford Press.
- Wilkinson, M. (2006). *Coming Into Mind: The Mind-Brain Relationship*. UK: Routledge.
- Yellin, J. & White, K. (2012). *Shattered States: Disorganized Attachment and Its Repair*. London: Karnac Books.

APPENDED ADDITIONAL RESOURCES

COGNITIVE EFFECTS

- Obsessive fantasies, nightmares and paranoia associated with the fear of it happening again
- Intrusive images and flashbacks, with the images being experienced throughout the system as if they are happening now
- Negative internal dialogue: self blame and criticism
- Self doubt, feelings of worthlessness, shame and guilt
- Loss of a sense of personal power/self efficacy
- Does not feel ‘normal’
- Nowhere to run, trapped within an experience which is difficult to manage

EMOTIONAL EFFECTS

- Can range from intense sadness and grief responses to intense anger, rage, hatred and resentment
- Fear and anxiety due to the lack of control during and after the event
- Does not feel safe
- Hopelessness
- Despair
- Lack of capacity to contain emotions
- Fluctuating experiences of polarised emotions, for example - rapid shifts between sadness and rage

APPENDED ADDITIONAL RESOURCES

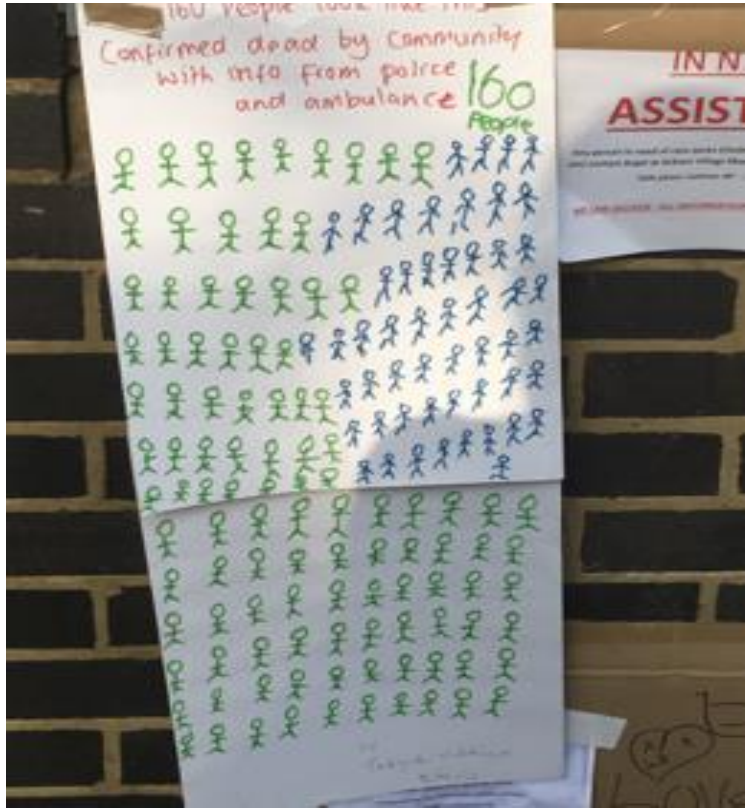
RELATIONAL EFFECTS

- Reduction in the capacity to relate partly due to the incapacity to relate to themselves fully at internal levels
- Isolation and social withdrawal/avoidance of social situations
- Internal abandonment
- Loneliness
- A sense of feeling different from other people because of what they have experienced, the inability to fully express it, and/or because they feel unheard, misunderstood or invalidated

SOMATIC EFFECTS

- Hyperarousal in the system to include elevated heart rate, high levels of stress hormones (cortisol and adrenalin)
- Rapid increase in physical states of arousal (on edge)
- Easily ‘flooded’
- Nervous anxiety
- Hyperarousal suppresses the function of the hippocampus, evaporating the ability to think properly and apply logic and reason
- Sleeping too much
- Not able to sleep
- Exhaustion and depletion of energy
- Physical Illnesses – somatisation of psychological effects/conversion of symptoms

APPENDED ADDITIONAL RESOURCES



EXISTENTIAL EFFECTS

- A sense of a “before the event” and an “after the event” – Their sense of their life as lived changes
- Disruption and confusion in sense of identity/self concept due to intrusive self chastising thoughts “I should have ran” becomes “I am a person who did not run”, “I am strong” becomes “I am weak”
- Self punishing thoughts, internal victimisation and an internal dialogue of self doubt and shame negatively transforms the “Who am I” within the self
- Split off parts of self/identity can be in conflict with one another
- A sense of betrayal and injustice, the pointlessness of life, life has no inherent meaning or purpose
- Loss of a religious and/or spiritual framework, “What kind of God would allow that to happen?”