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Reducing the Effects of Trauma

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Abstract What is offered here is a practical tool within the Australian Social Work context for understanding and reducing the effects of trauma on individuals following a threat to their personal safety as the result of a crime We have identified within our Social Work experiences of working with people affected by a traumatic event that what is of benefit to these people and what helps them work through their individual trauma experience is a tiered approach of intervention which reduces the psychological effect of trauma. Through some professional development focussed on the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Mental Health and linking theory to practice we have been working towards an adaptive practice model which we can utilize within our Social Work roles (Australian Centre for Posttraumatic Mental Health, 2013). It ties together a stepped care approach by the Australian Centre for Posttraumatic Mental Health (2013) and practical strategies for working with people who have experienced trauma. We have also reflected on how this knowledge and practice model has been effective in working with people affected by trauma from our own practice experience.

Keywords Trauma, Practice, PTSD, Social Work, Psychological Recovery

Introduction

Briere and Scott (2006, p.17) states that 'trauma can alter the very meaning we give to our lives, and can produce feelings and experiences that are not easily categorized in diagnostic manuals'. As Social Work practitioners, with over ten years of experience of working with people who have experienced a trauma, it has been common to hear them say they think they need to sit down and talk about their experience with a trauma specialist. From a practice perspective there is definitely merit for talking about a trauma to help start addressing the mental health needs of the person. Nevertheless, in practice and what the Australian Centre for Posttraumatic Mental Health (2013) outline as effective is offering a stepped approach of psychological intervention, starting out with offering Psychological First Aid (PFA), developing tools for Psychological Recovery, and then working through the Trauma Memories with a trauma specialist.

In practice, questioning the details about a trauma can be daunting and a Social Work practitioner may feel under skilled and under resourced to deal with trauma memories or conscious that a person who has experienced a trauma may be re-traumatised by having to retell their story. For most it is safer to leave the details of the trauma and pad around it, sorting out the safety and practical side to make the person's current environment manageable and referring out the trauma issues to someone more experienced. This is in no way a practice flaw; this approach is often dictated by skill base, funding, program guidelines and resources. Working with a cornucopia of people presenting with different trauma experiences, as Social Work practitioners we realized there needed to be something more tangible to help and support a person who had experienced a trauma in general.

We have actively been working into our practice a model to help people who have experienced a traumatic event. This aligns with the stepped care approach outlined by the Australian Centre for Posttraumatic Mental Health (2013). We have been able to do this through knowledge gained by attending some specific training on the management of post-traumatic mental health. Co-author Karen Martin reflects:

> 'The therapy and intervention previously applied in my practice focussed on cognitive behavior therapy and solution focussed approaches, however a few of my client's have reported in the past that although aspects of the therapy was helpful it wasn't getting to the root of the trauma. I felt I was unable to assist the client to sustain psychological wellness, the clients were reporting ongoing physiological and psychological symptoms which were not getting better. As a therapist I felt like I needed to understand the effects of trauma and its treatment. Having training

specifically on the management of trauma and psychological treatment of Post Traumatic Stress Disorder helped to ground my practice.'

Having the trauma management knowledge has helped reinforce our practice style utilizing a three tier approach based on the stepped care model of psychological interventions recommended in the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (Australian Centre for Posttraumatic Mental Health, 2013).

Tier 1 - Immediate Help – Psychological First Aid

As recognized in trauma response literature there is merit to getting some help immediately. Best practice of trauma intervention identifies that early access to supportive services and seamless service delivery enhances recovery (Herman, 1992). Renowned trauma therapy specialists such as John Briere and Catherine Scott (2006), Babette Rothschild (2000), Leah Giarratano (2004) and the Australian Centre for Posttraumatic Mental Health (2013) work on the foundation that any psychological intervention can reduce the potential of long-term psychological impact.

There are different tiers of support which help in reducing long-term psychological effects of trauma. Herman (1992, p.159) emphasises that 'the first task of recovery is to establish the survivors safety, this task takes precedence over all others for no other therapeutic work can possibly succeed if safety has not been adequately secured'. This is why in the aftermath of a traumatic experience people benefit from Psychological First Aid, this is Tier 1. The Australian Centre for Posttraumatic Mental Health (2013, p. 69) states that Psychological First Aid (PFA) 'seeks to reduce distress and attend to basic needs following a potential traumatic event by providing simple interventions such as comfort, information, support and practice assistance'. It works best within the first few days or weeks of an event. 'The primary goal of PFA is to enhance an individual's natural resilience and coping ability in the face of trauma' (Australian Centre for Posttraumatic Mental Health, 2013, p.69).

The basis of Psychological First Aid is simple and informal with the goal to get some form of normality and sense of safety and security in one's current situation. The aim is to normalize and validate a person's reaction or response to a trauma, to put structures in place to reduce stress and associated reactions. It is based on the premise of *Maslow's Hierarchy of Needs* where a person requires basic survival and safety needs before they are able to deal with issues that are having an emotional and social impact on them (McLeod, 2007).No specialist training is required to provide this support.

In general by following the practice standards set out by the Australian Association of Social Workers (2013) practitioners are completing this at the forefront of their practice. They are gauging the person's needs and endeavoring to apply principles of safety, calming, connectedness, self-efficacy and hope. Practical ways to meet these principles may be linking a person with temporary accommodation or a place that offers a sense of safety or security and ensuring they have some emotional and physical resources to get them through the initial time period. Checking in with a person, having debriefing sessions or ensuring effective family and social supports are available so a person experiences some connectedness.

Tier 2 - Lessening the Impact – Tools for Psychological Recovery

Most people who have experienced a traumatic event are not familiar with how trauma affects them, they often have trouble understanding what is happening to them. Briere and Scott (2006) emphasise that a critical element for assisting survivors of acute trauma is to provide psycho-education; this includes information about self-care, provided within weeks and months following the trauma.

'The essential part of therapy should always be to enlighten the patient as to the nature and meaning of symptoms' (Herman, 1992, p. 135). This is when a person who has experienced a trauma would benefit from understanding and working on skills to psychologically recover, ensuring their mental health needs are met. Tier 2 is about recognising the effect of trauma triggers and reducing activation.

In this intervention the aim is to try and dampen the detrimental psychological impact of what is referred to as'conditioned memory' or 'conditioned emotional response' within the limbic system of the brain (Rothschild, 2000; Briere & Scott, 2006).

Tier 2 intervention is more formal and requires more contact with the person affected by trauma. It is provided within weeks or months of a trauma. It aims to prevent long-term trauma effects, associated emotional reactions and behaviours. It helps to develop management skills to address symptoms of post-traumatic stress or other mental health manifestations that exist when affected by trauma such as depression, guilt, anger, and drug use or avoidance behaviours.

Levine (2010, p.76) states that a practitioners intervention with a person who has experienced a trauma is to 'help navigate the labyrinth of trauma by helping them find their way home to their bodily sensations and capacity to self soothe'.

In practice, tools to lessen the impact and lean towards psychological recovery includes: information gathering around needs, problem-solving to reduce stress, activity scheduling to reduce stress and emotional impact, managing reactions to minimise distress, challenging negative behaviours, and helping to develop healthy connections to prevent social withdrawal. Also having tools such as

mindfulness techniques and starting gradual exposual therapy help lessen the impact. Having an understanding on how our brain processes trauma is beneficial in working on strategies to reduce stress and reactions. Co-author Leeanne Rule reflects that,

> 'when sharing common trauma reactions and the way the body and brain react to such trauma, people are relieved that they are not alone, they express that they thought they were going mad and that no-one understood'.

In the brain the limbic system primary has the function of being responsible for our emotional responses and how we form memories (Rothschild, 2011). When a person who has experienced a trauma repeatedly adopts a behaviour based on a traumatic memory this has potential of refuelling this trauma-formed belief and becoming immersed in memory hence *conditioned emotional response*. From our readings work by Briere and Scott (2006) give good applicable knowledge of the how trauma affects the limbic system of the brain, in particular the role of the Hippocampus and Amygdala.

This applicable knowledge has helped when working with people who have experienced a trauma as it is important to provide a simple understanding of how the brain interprets and processes the traumatic event as the person will find it easier to remember the link between being triggered, reacting and processing.

The brain when affected by trauma reacts in three main areas the Neo-cortex, the Amygdala, and the Hippocampus. The Neo-cortex, or the brain's filing system, consists of explicit memory, which is based on cognitive, fact and verbal constructs of narrative (Rothschild, 2000).Memories are stored here and we recall these when we need to make sense of a narrative or experience. Explicit memory stops working during trauma.

The role of the Amygdala, or the fear centre of the brain, is to remember the feeling related with an event but not the facts (Rothschild, 2000). The Amygdala controls our alarm system when we sense danger; it controls the activation of the stress hormones which activate our alarm system sending us into fight or flight. The Amygdala is the driver of implicit memory; this is an involuntary memory and automatically happens. It is based on our five senses: smell, sight, taste, hear and touch. Trauma memory is stored here. When the Amygdala alarm systemis activated signals are not sent to the Neo-cortex, therefore cannot assess the threat, manage emotion, plan responses or control our impulses.

The Hippocampus role is to remember facts but not emotions; it records and connects (Rothschild, 2000). It has three main functions:

1. To put experiences into context;
2. To recall our memories; and
3. To integrate our experience by cognitive mapping.

When we experience a traumatic event the Amygdala produces a high level of stress hormones that suppresses the function of the Hippocampus. It is like the Hippocampus cannot put the pieces together because there is no memory reference point. The trauma is in the implicit memory and the context is in the explicit memory. As a result activation occurs – an automatic fight/flight response. In other words, there is a glitch in the system, it is like an electrical wire has a cut in it and it is not connected properly. Our memory is not integrated, so the alarm system flickers on and off, with each trigger, we get a false alarm, which activate us and the brain thinks we are in danger and sends us into fight/flight. After a traumatic event, when no longer in danger, the Hippocampus returns to normal functioning.

For example a person experiences a traumatic assault in which the offender was wearing a blue shirt. During the assault the Amygdala produces increased amount of stress hormones that suppress the function of the Hippocampus and it stops working: not experiencing the event. When this happens the Neo-cortex is not informed as to the context of the blue shirt. Rothschild (2000) captures this through the explanation that the Hippocampus returns to its normal functioning once the traumatic event is over however with the emotional trauma response based in the implicit memory and the story (cognitive) based in the explicit memory it is unable to perform its functions. Rothschild (2000) further explains that the implicit memory is not linked to the explicit memory: it cannot put it into context; it cannot recall it and it cannot integrate the two memories (cognitive mapping).

In the above example, if this person some days after the traumatic event comes into contact with a person wearing a blue shirt and describe physiological reactions such as a panic attack, we know this is a flight response to their alarm system. The blue shirt triggers the Amygdala into activation and it senses danger, sending off a false alarm, the body responds by preparing the person for flight. Their body signs are heart racing, sweat, shaking and feeling nauseated. Their overall response is to flee and once they leave the situation the alarm shuts off and their physiological reactions return to normal. As a Social Work practitioner you are aiming to work with the person experiencing these reactions to reduce the length and severity of these physiological reactions. In reality it does not mean that they are in any danger but the *conditioned emotional response* is to panic due to seeing a blue shirt. As the Hippocampus was suppressed during the traumatic event it only recalls part of a fragmented memory and it is as if they are back in the trauma. By physically fleeing the situation this is reinforcing to the brain that there must have been a danger, so next time they see a blue shirt the same process will occur. The *conditioned emotional response* to the blue shirt memory is refuelled and the brain learns to react in a fearful way.

The question arises, how do we deal with this situation better? We need to process, we need to stay in the moment and re-train the brain that there is no danger in seeing a blue shirt. In order to do this the person would be encouraged to stay in the situation or stay with the memory for as long as they can each time the trigger occurred through exposure therapy work. The Neo-cortex needs to come in and inform the Amygdala through the Hippocampus that there is no danger. By using mindfulness techniques such as controlled

breathing, this assists us to have the ability to pay attention to the present moment rather than the trauma memory. The brain can eventually integrate the two memories and become aware that it is not a dangerous situation. Having mindfulness techniques provides the grounding to engage in gradual exposure therapy. Exposure therapy works on the premise of habituation, that 'if people can be kept in contact with the anxiety-provoking stimulus for long enough, their anxiety will inevitable reduce' (Australian Centre for Posttraumatic Mental Health, 2013, p.71). Exposure therapy aims to re-engage the limbic system to function more effectively. When people avoid memories or processing experiences relating to a traumatic event they fail to replace the memory with positive cognition, they need to challenge this memory and re-engage with the emotional responses (Amygdala) and shift the memory into explicit storage in the Neo-cortex.

Tier 3 - Breaking Down the Trauma Memories

The final tier, Tier 3, is focussed on breaking down the trauma memories and making meaning of it. At this level people are experiencing symptoms of post-traumatic stress, they are avoiding talking about their experience, having flashbacks, reliving the experience, and having intrusive thoughts or associated behaviours that are having a detrimental impact on their day to day lives (American Psychiatric Association, 2013).

Briere and Scott (2006,p. 180) state 'that excessive avoidance of trauma triggers and memories, although entirely understandable, potentially interferes with psychological recovery by undercutting the normal process of exposure, activation and processing'.

In this tier we focus on the activation of the trauma network. This is where a working knowledge and experience in trauma management by the worker is essential. As a Social Worker having training in management of post traumatic mental health would give a basis for practice and assist the traumatised person. This is where a person who has experienced a trauma is ready to work through their trauma memories and make meaning of it. It is important that the person is given the opportunity to process the trauma. The interventions which we have applied in our practice model align with the recommendations for psychological interventions for Acute Stress Disorder and Post Traumatic Stress Disorder by the Australian Centre for Posttraumatic Mental Health (2013, pp.69-72).These interventions include Brief psychotherapy, Imagery rehearsal, Mindfulness-based therapies, Narrative exposure therapy, and Trauma-focussed cognitive behavioural therapy which can incorporate exposure therapy and cognitive processing therapy.

What has also helped from a practitioner perspective is to have an understanding of the 'two-worlds model' of Post Traumatic Stress Disorder when assisting the person who has experienced a trauma to process thoughts and memories. The 'two-worlds model' by Giarratano (2004,p. 107)explores the *Weltanshauung*or world view when working with trauma. This is based on the premise that what we believe, or the way we see things will ultimately determine how we think and act.

This incorporates feelings of safety and security and any events that challenge or contradict this maybe perceived as threatening or stressful (Giarratano, 2004).Giarratano (2004) coins the analogy of Trauma World rules versus Now World rules. Using this analogy as a psychoeducation tool helps to explain how traumatisation can alter the way that people think about the world. It explains that having experienced a trauma 'is like living in two worlds simultaneously' (Giarratano, 2004,p. 107). Giarratano (2004) points out that the Trauma World is where trauma formed memories and thoughts are very real and distressing whereas the Now World is where one interacts in the current day.

When explaining this, symptoms such as triggers, thoughts and images of the trauma pulls the person back into the 'Trauma World'. This affects the person's engagement in the 'Now World' as they have limited concentration, processing capacity or interest in the now. 'The aim of therapy is to assist the client to live in the Now World' (Giarratano, 2004, p. 107). Through therapy we discuss and explore how the rules of each world differ and that they are not transferrable and that the Trauma World rules do not make sense in the Now World (Giarratano, 2004, p.108).

Co-author Karen Martin reflects on the use of this analogy in her therapeutic practice,

> 'This analogy has been used to shift clients into the healing process. As a result of the trauma the client develops rules within the trauma world which are not easily applied or make sense to the now world. For example, a parent with a child who is late home from school as a result of an attempted kidnapping has learnt in the trauma world that 'late means kidnapped'. The parent then applies this to the now world and it impacts on their daily functioning, thought processing and physiological reactions as it does not make sense. Through therapy work it is about cognitively challenging the trauma formed rule 'late means kidnapped' and identifying that it is not transferable to the now world.'

Conclusion

Working with people who have experienced a trauma can be challenging but as Social Work practitioners we have found working through these tiers with people we are offering a more holistic and empowered approach that they feel more supported, and have a better understanding of their physiological and psychological reactions to triggers so they

can put strategies in place to lessen the impact. Without some trauma focussed intervention they may go on fuelling the memories and impacting on their everyday lives.

What we have seen as benefits of using this adaptive practice model is reflected below. Co-author Karen Martin expresses:

> 'With working in this developed practice model I have observed that people who have experienced a trauma are able to move towards psychological wellness in a positive way, and gain more insight into the impact of trauma in their life. This model provides them with practical tools and strategies to lessen the impact. It is my experience that once a person has an understanding of psychological and physiological impacts it empowers them to believe that they can recover from the traumatic experience. As a practitioner I feel this model has provided me with the skills and knowledge to effectively work and nurture change for people who have lived through a traumatic experience'.

Co-author Leeanne Rule reflects:

> 'From some feedback, clients have said that it has been helpful to have an opportunity to share their story and that they have a better understanding of the physical and emotional stress they have experienced. Working from the basis of knowledge sharing around the affects of trauma on the limbic system has helped clients with recognising their automatic reactions and working towards better coping strategies.'

The knowledge gained through trauma focussed training has helped cement this model into our practice; however there is recognition that there are limitations to our professional practice, in particular when there is comorbidity then a person who has experienced a trauma will need intervention by a specialist mental health team.

Author Notes

Karen Martin, Social Worker with 11 years experience working with people affected by trauma. Passionate about helping people reduce the impact of trauma and instrumental in developing current intervention model to address the long term effects of trauma.

Leeanne Rule, Social Worker with over 7years experience in generalist work and counselling. Brings a practical and grounding approach to working with people affected by trauma.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition. Washington DC: American Psychiatric Association.

Australian Association of Social Workers. (2013). *Practice Standards 2013*. Canberra: Australian Association of Social Workers

Australian Centre for Posttraumatic Mental Health. (2013). Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder. Melbourne: Australian Centre for Posttraumatic Mental Health.

Briere, J. and Scott, C. (2006).*Principles of Trauma Therapy: a Guide to Symptoms, Evaluation and Treatment*.London: SAGE.

Giarratano, L. (2004).*Clinical skills for Managing PTSD; Proven practical techniques for treating posttraumatic stress disorder.*Mascot Australia: Talomin Books.

Herman, J. (1992).*Trauma and Recovery: the aftermath of violence-from domestic abuse to political terror.* New York: Basic Books.

Levine, P. A. (2010). *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness*. California: North Atlantic Books.

McLeod, S. A. (2007). Maslow's Hierarchy of Needs - Simply Psychology. Retrieved 26 August 2013 from http://www.simplypsychology.org/maslow.html

Rothschild, B. (2000).*The Body Remembers, The psychophysiology of Trauma and Trauma Treatment.* New York:Norton & Company.

Rothschild, B. (2011).*Trauma Essentials: the go-to guide*. New York: Norton & Company.