Trauma resilience

Martin Weaver and **Felicity Biggart** outline a proactive programme designed to help those with an increased risk of exposure to traumatic events

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From the attack on the World Trade Centre in New York, 2001, to war-torn conflicts around the globe and our own terrorist bombings in London on 7 July 2005, it might be assumed that we have learned all we can about trauma and post-traumatic stress disorder (PTSD). The question arises, however, about the possibility of psychological interventions that might prepare us for such events in the future. What if we could learn from people's experiences and apply beneficial thinking and positive strategies before the next event? That is what we have been working on for six years and we believe that we have a new and effective model: the Introduction to Trauma Resilience Training (TRT)©; we hope it will be the model for the future.

TRT evolved through our work for the government-funded 7th July Assistance Centre, set up in response to the London bombings of 2005. As the service became more established, we provided support for many natural disasters and terrorist incidents from around the world, personally working with clients affected by the Bali bombings in 2002, the Indian Ocean tsunami in 2004, the Sharm el-Sheikh bombings in 2005 and the Dahab bombings of 2006, and we were also part of a small team providing psychosocial support to the families and witnesses throughout the coroner's inquests into the London bombings.

The concept of 'trauma' has been with us for the whole of human history in one form or another. The word 'trauma' comes from the Greek word for a physical wound. However, it is only in modern times that such responses to traumatic events have been recognised, classified and treated.

Modern definitions only began to appear in the Diagnostic and Statistical Manual of Mental Disorders in 1980[1]. In 2005, the National Institute for Clinical Evidence (NICE) described PTSD as developing 'following a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone'[2].

Allied to PTSD is the concept of secondary traumatic stress[3]. The term has been used to refer to the observation that those who come into continued close contact with trauma survivors, including psychotherapists and counsellors, may experience considerable emotional disruption and may become indirect victims of the trauma themselves. It was this issue that first drew our attention to the need for some kind of preventive strategy to help and protect us in our work.

In our work with trauma clients, we have observed the damaging effects of trauma on individuals affected by terrorism and other critical incidents and worked closely with them to repair and restore their equilibrium and psychological health. For some, it was a hard battle that took over their lives and for others it was an easier journey.

What factors might influence the various different pathways and strategies for those caught up in the event? Factors such as the intensity of, and proximity to, a major critical incident cannot be anticipated or planned for, but other skills we observed could be replicated to aid individuals to survive trauma and return to their normal lives. The psychological distress felt by the professionals who had been trained to provide help in the event of a critical incident stood out as an area that needed to be addressed in the future when considering a comprehensive package of care.

We began to explore how this paradigm shift from predominantly retrospective care to proactive preparation might be achieved.

Our research followed two paths:

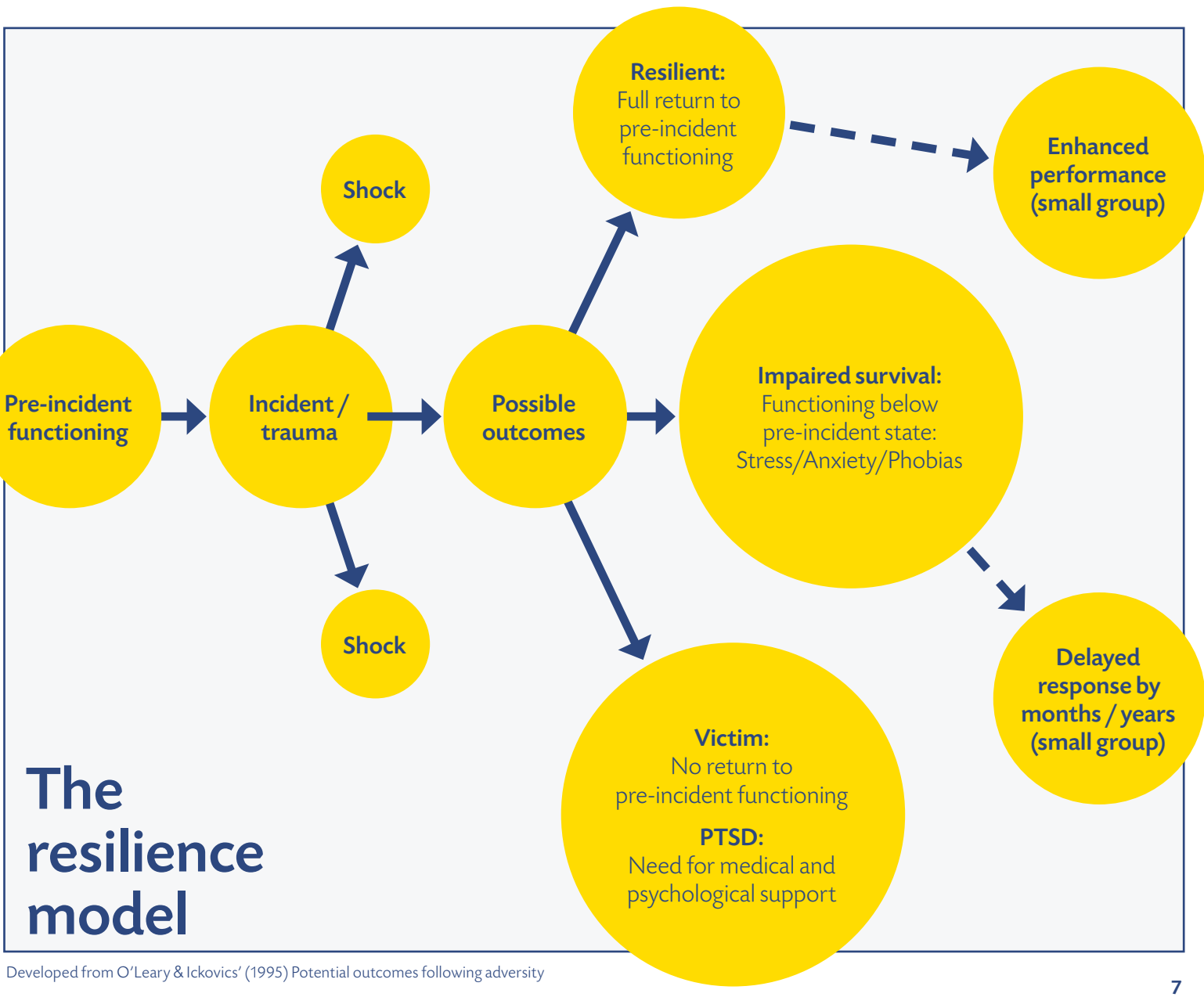
1. Which interventions had worked well for the clients of the 7th July Assistance Centre? What had been less beneficial? We collated the common responses and reactions to all the differing critical incidents to which our clients had been exposed.
2. We explored all the relevant research and academic studies[4-6] in this area, many originating from the field of combat psychiatry. We combined the interventions that might be useful from these studies with our own experiences.

Next, we sought a definition of 'resilience'[7]:

1. The ability to recover quickly from illness, change or misfortune.
2. The property of a material that enables it to resume its original shape or position after being bent, stretched or compressed.

Our developing ideas melded these two concepts together. There is the external event that bends the recipient out of shape psychologically, and the inner physiological change that occurs to prepare you for fight or flight. Statistically, by the process of homeostasis, most individuals eventually return to their original equilibrium and functioning in the world[8]. However, their recovery time changes according to the proximity and severity of the incident as well as their preparedness for the incident. Supporting the proposal that advance training aids recovery is the evidence that older people recover faster from adversity[9]. They have internal maps and previous experience that help them to adjust faster than young people.

Resilience training is designed for groups of people who fall into 'high-risk' category jobs, such as those in the armed forces, journalists, individuals travelling to high-risk countries, first response teams across the country, and therapists who have to cope with the risk of secondary trauma. It is for these groups of people that we developed the following model:



Developed from O'Leary & Ickovics' (1995) Potential outcomes following adversity

Felicity Biggart (MBPsS, MBACP) provided trauma and bereavement counselling for the 7th July Assistance Centre, working primarily with those involved in the London bombings in 2005. She provided counselling to both the bereaved and survivors of the Bali bombings of 2002, the Indian Ocean tsunami of 2004, the Sharm el-Sheikh bombings of 2005, the Dahab bombings of 2006 and the 2011 coroner's inquests into the London bombings. Her work for Hounslow Bereavement Services is ongoing and includes looking at innovative ways to expand the charity's field of enterprise, as well as providing one-to-one counselling.

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It is the premise of *TRT* that additional psychological preparation, combined with the specific work training such individuals already receive, can help such groups to perform to a higher level under the stress of the critical incident and make a swift return to their pre-incident state.

In the above model of *TRT*, we recognise that people come to an incident with their existing degree of functioning. This degree of functioning will vary between people. It is normal for everyone to experience a physical and psychological 'shock' in the immediate aftermath. There are several possible 'routes' out of this state:

- For some people, there is no return to their pre-incident functioning and health. They exhibit all the symptoms and behaviours now recognised as PTSD. For this group, medical and psychological interventions and support are beneficial.
- The middle group, as noted in our model, shows that people display varying degrees of 'impaired survival'. They experience stress, anxiety and phobias. There is a subgroup in whom these responses are not recognised for some months or years after the event.
- We believe that, through training, you can build and develop baseline resilience. For this final group, who have either natural or learned hardiness, there is a full return to their pre-incident state; some of this group experience enhanced performance that might be termed post-traumatic growth.

The content of our training has evolved over the last six years. Each part has been explored and considered and then used by our clients as they have approached critical moments in their lives.

Here are two practical accounts of how we helped our clients prepare. The first anecdotal account comes from Felicity Biggart's work as a psychotherapist for the 7th July Assistance Centre:

During our research, the beneficial effect of creating a 'defusing' network[10] in advance of a critical incident was flagged up repeatedly. It is used in both combat zones and by the police force in this country. Here is an anecdotal account of how this transformed a client's approach to difficult events.

The client was unfortunate enough to step onto the first carriage of the King's Cross train on that day in July 2005. Over the intervening years, she had valiantly dealt with many of the problems that resulted in being so close to the bomber. She recognised how lucky she was to survive when so many around her did not and her heart went out to all of the bereaved family members. However, as so many do, she faced 'compassion' fatigue from close family and friends as, each year, the anniversary and public exploration in the press raked up all the intimate details of pain, suffering and death. With the approach of the inquest, she became particularly worried about what new details and information might come to light. This coincided with a time of great change in her own life that made her feel particularly vulnerable. We discussed the general principles of 'defusing' and she felt this was a marvellous idea. This simply meant looking at the styles of support she liked to receive (for example, I personally don't like to be held when I am in pain – my family know to offer words of support from a fair distance if I howl in agony...), what time of day she felt most vulnerable, and who she would like to be on her 'support' network. She was very nervous of phoning and asking her friends in advance if they would mind being included on this list. She had the advantage of knowing the key dates on which the inquest would be exploring the bombing at King's Cross. This meant her friends knew exactly when they should highlight her potential need in their diaries and keep time free for her.

The response was heart-warming. Her friends felt 'honoured' to be included, and several planned simple activities like meeting for pizza on the night in question. This is in stark contrast to the client calling in distress and feeling let down when the recipients were so involved in their own lives that they did not recognise her needs.

'Defusing' requires no special skills, just a willingness to be available at a crisis moment and offering simple reassuring support and a cup of tea. Trauma often removes the feeling of being in control of one's life. TRT is about helping people regain control in a small way after an event. Here, my client felt far more in control of what was happening and well supported for the critical dates.

The second anecdotal account comes from Martin Weaver's work as a supervisor and trainer for the 7th July Assistance Centre:

As a supervisor, my role at the Assistance Centre was one of ensuring that the psychotherapists in my care were fully able to help their clients, while at the same time remaining safe themselves. Whilst listening to the client stories of survival or bereavement from terrorist activity or natural disaster, it was vital that therapists remained fully grounded in their own skill and expertise. At first, a number of the therapists became too associated with the client, their story and their pain, both physical and psychological. They became vulnerable to the dangers of secondary trauma.

The following example comes from a therapist working with her first client in the early days of the Centre. Her client had been in one of the underground carriages close to the bomb and described in some detail to her the sights, sounds and smells of

their journey to the surface. This included descriptions of injured people, people who were probably dead and various body parts that were distributed as a result of the explosion. The therapist recalled the 'standard' processes of maintaining rapport with the client, holding the space, reflective listening, and some Socratic questioning and reframing statements. At that time, she had not been attending to her own processing and had no awareness of her own internal responses. She recalled ending the session and leaving the Centre, and only then becoming aware that she was superimposing on her vision swirling images of the injured she had just been told about. Initially, she had no understanding of what was going on and no skills with which to intervene to resolve this very distressing effect.

There were two immediate interventions to be made. The first was to teach her how to manipulate the images that were being superimposed on her vision. Neurolinguistics holds that we create within us a map or blueprint of the world and that this blueprint has a structure, and therefore can be restructured. To stop the distressing images from moving, a simple instruction was given, and this immediately brought about a steadying response. Then she was encouraged to move the images out of sight or simply to shrink them to 'nothingness'. This she did and immediately relaxed and began to return to her usual sense of self.

The second intervention was to remind her of her skills and abilities and teach her to be able to guide herself to a sense of 'groundedness' and thus safety. In the moment, this was a physical sensation of warmth and solidity within her, located in her abdomen – this is a very common response. Together, we increased these sensations, which allowed her breathing to move to her diaphragm and helped her relax to a state where she could continue her day.

In the group session with the other therapists, I taught other grounding skills and visualisation techniques to prepare them for the information and stories that they were going to hear in the coming weeks. We defined these interventions and recognised their significance to building resilience in advance. Many of the therapists used these simple 'grounding' exercises to great beneficial effect with their clients and that is why we have included them in the 'tool box' for TRT.

Trauma Resilience Training is not a therapeutically based training. It involves a robust consideration of the skills individuals already have, their natural style of responding to difficult circumstances, and then a clear and very detailed look at the anticipated critical incident.

Our training day is divided into *Educational learning; creating a blueprint for action under stress;* and *Psychological Tools* to help mitigate distress post a critical incident.

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TRT – a typical training day

Pre-course exercises: the aim behind this task is for participants to think of a previous traumatic experience, such as a car accident or mugging; something they have come through and survived. We emphasise in the pre-course introduction pack that participants must feel comfortable about sharing this experience. During the training, we explore how they dealt with this incident and identify skills not held in current conscious awareness.

Normal physiological stress responses: this section is designed to teach how to 'turn off' the body's natural alarm response once danger has passed. To be able to do this, it helps to understand normal stress responses. Participants can then understand internal reactions to fear and appreciate that they are experiencing a perfectly normal adaptive response; this is modulated by the sympathetic and the parasympathetic nervous systems.

What is PTSD?: this part of the day explains normal responses to trauma and explores common early reactions and emotional responses. The aim is to help participants engage with and identify their own responses from an informed perspective.

Secondary trauma: this area highlights several potential dangers for therapists working with clients affected by trauma. We explore the need for increased vigilance for both supervisor and psychotherapist and the possibility of increased time for supervision.

Interactive exploration of what a normal stress response feels like: following the educational section, this interactive moment is designed to facilitate engaging participants in the actual voices of people who have experienced a major traumatic event. This is provided through the medium of an audio recording of different voices talking about how they felt and how it changed their lives. The aim is to move from dry academic knowledge to the reality of how it can feel.

Identifying potential future danger zones and developing an advance response plan using pre-course exercise: this relates to the second pre-course exercise where participants were asked to identify future potentially traumatic events. The idea is to develop a future plan of action, or 'blueprint' that participants can access at times of extreme stress.

During this exercise, we encourage participants to explore the best possible response to their critical incident. The aim is to connect with the initial training exercise and to work with natural skills and past ways of coping under stress, to form a workable practical plan of action.

For therapists, this might include identifying traumatic issues they might be particularly vulnerable to and identifying a possible map of action to inform and protect their own wellbeing; role-play can be used to work with the identified areas.

Practical 'grounding' exercises: these are a series of experiential exercises and are designed to aid conscious control of the sympathetic stress response. This direct experience reinforces confidence in their ability to guide their own thoughts and physical responses.

Risk checklist followed by construction of 'defusing'[10] *networks:* defusing networks introduce the concept of a pre-planned professional/lay support network drawn from all areas of the participants' lives.

Practical skills to aid control of intrusive images: using constructivist theories as developed by neurolinguistic psychotherapy (NLP)[11], this series of exercises develops practical skills in having greater control over memories, thoughts and feelings.

Cue-controlled relaxation: this skill can be useful for PTSD sufferers in learning how to 'switch off' the body's alarm mechanism; to move from the sympathetic to the parasympathetic state of healing and relaxation.

The aim is for participants to leave with an enhanced knowledge of their own skills, both innate and learnt, as well as a blueprint for future action to anticipated life events.

Inherent to the concept of TRT is the belief that these skills are acquired far more fluidly before a state of crisis than after, and can help prevent the development of more serious long-term stress reactions.

We consider that TRT fills the gap beyond existing training and retrospective care. Participants are prepared both psychologically and physically with key skills for before, during and after a critical incident. We have developed this course to help therapists and first responders involved in traumatic events. Now we are testing and developing both our model and the techniques that we use to create the most effective strategies that develop and enhance resilience. Our task for the future is to take these new resilience strategies into different contexts to learn more about how we can influence our own responses to trauma and its consequences, and so, perhaps in some measure, change the world around us for the better.

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