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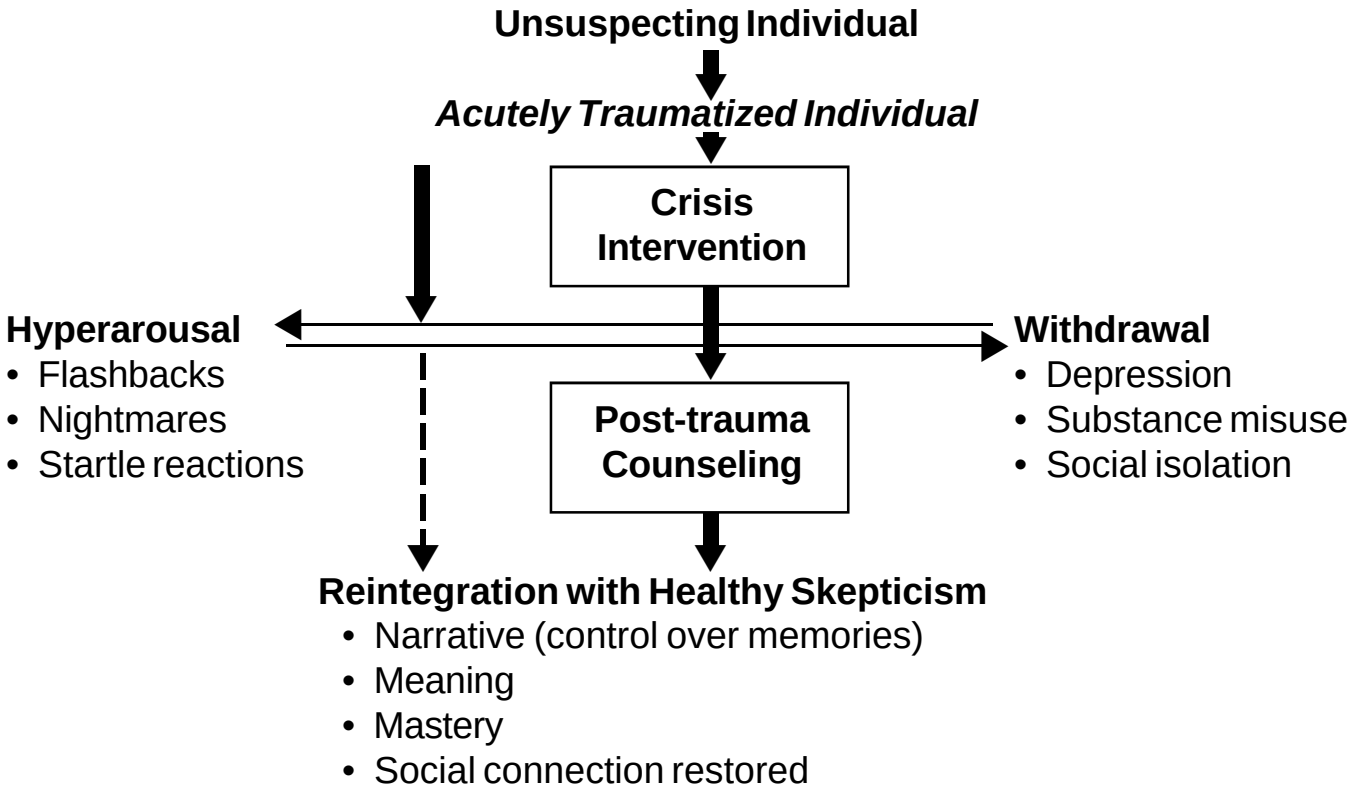
Chapter Nine: Post-Trauma Counseling

I. Why Do Crisis Responders Need to Know About Post-Trauma Counselling?

A. In many communities, immediate crisis responders are also caregivers.

1. They will continue to provide supportive counseling after a major community catastrophe.

2. Post-trauma counseling is related to crisis intervention in the integration of an individual's health with new hope and meaning. [See the chart below.]



– Adapted from materials developed by CDR Michael Dinneen, M.D., Ph.D.

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B. Crisis responders from other communities need to understand the dimensions of the long-term stress effects.

C. Crisis responders are often called on to provide community members with an understanding of coping strategies.

D. Crisis responders should not provide trauma counselling unless they have had specific training and education on each technique or therapy that they try to provide.

II. Foundations of Post-Trauma Counseling

A. Trauma specific counseling

The focus of counseling interventions should be directed at the trauma itself. Other pre-existing problems such as marital issues, alcoholism, drug abuse, employment problems, and the like should not be addressed except as they relate to this trauma. If there is a need for counseling or help in those areas, the survivors should be referred to an additional counselor for assistance.

An exception to the trauma-specific nature of counseling intervention is when there are other traumas in the individual's life that may affect that victim's coping abilities in dealing with the current trauma.

B. Normalization

Post-trauma counseling should focus on reassuring the survivors that they are not "crazy" and that their traumatic reactions are not uncommon. In this way, post-trauma counseling is an extension of crisis intervention. The goal of post-trauma counseling is to assist individuals mobilize their own capacities to deal with the experience. Labels that are used to describe those who have experienced trauma as "victims" or "survivors" may be counter-productive. Counselors should follow the lead of individuals as they describe themselves.

C. Collaboration with the victims or survivors

The post-trauma counselor serves as a partner to the sur-

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vivors in their effort to reconstruct a new life. The counselor should be involved as a listener and as a resource in developing and suggesting options – not a decision-maker – in response to the survivors' questions. Trauma focused counseling is an extension of the natural processes of mutual support which occurs in post-disaster contexts.

D. Unique pathway to reconstruction or healing

Each survivor will find a unique way to develop a new life. Counselors should be non-judgmental, supportive and open in their response to decisions. Some survivors choose negative coping methods – becoming involved in substance abuse, considering suicide, or destroying existing relationships. Counselors should be prepared to deal with ethical issues and to refer survivors for appropriate in-depth mental health counseling if necessary.

III. Elements of Post-Trauma Counseling

A. Education, experience and energy are keys to learning to live with trauma and its aftermath.

1. Education

a. Content of education

- Safety education

  Traumatized people are unable to regain a sense of equilibrium or master to the trauma experiences if they continue to feel unsafe. Counselors should help survivors assess their safety and to develop safety plans if they remain in dangerous situations. Safety plans are also useful for confronting trigger events such as "anniversary" dates or holidays. Education about the importance of routines, boundaries, social activities, and self-destructive behaviors is also crucial to re-establishing feelings of safety.

- Trauma education

  Survivors of traumatic experiences also need to know that exposure to trauma affects their physical, emotional and mental abilities. Information useful for survivors include understanding of the crisis reaction

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and long-term stress reactions. Symptoms of PTSD, grief, or depression do not mean that they are going crazy. They may be suffering from pain and anxiety but these are the result of trauma. It is also important to underscore that the impact of trauma varies. While there is much to be learned from the experience of others, each person will have their own reactions based on the dimensions of the trauma, their adaptive capacities, pre-existing sources of stress, and post-trauma experiences.

- Second assault education

  Survivors also need to know what happens after a disaster and how they might deal with it. Knowledge of civil and criminal law or legal proceedings, social institutions, media behavior, financial options, and useful resources or referrals can be helpful as they plan their lives.

- Symptom management

  Strategies for handling trauma related symptoms should be discussed. These may include prescribed medications when symptoms are severe enough to diminish the functional capacity of individuals. However, education in behavioral and cognitive techniques such as arousal management, stress innoculation, modication of sleep patterns, relaxation exercises or biofeedback can help survivors regain a sense of control and diminish symptom anxiety.

b. Methods of education

- It is helpful for survivors to educate themselves by reading articles or books on the effects of trauma and its aftermath. Not only can such readings stimulate the processing of individual trauma experiences, they can form the basis of discussion sessions in which experiences can be compared and contrasted. Going to classes or

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seminars often provides additional educational stimulus.

- Some people find that watching tapes or films on disasters or educational tapes on trauma experiences is also useful. However, for some this can be re-traumatizing if survivors do not have caring, understanding support from counselors, family members or friends.
- Similarly, writing or dictating journals or stories of their experiences, tape recording their thoughts or reactions can be helpful. Writing about trauma experiences is educational and serves as testimony for many victims. It helps them to preserve their memories as well as to bear witness to what happened.

Jean Paul Sartre, in What is Literature?, *asserts that the writer does not write for himself alone. Writing is a fundamental act of commitment to the world; through writing, the person is thrown into the world. In contrast, the act of the trauma separates the person from the world. Writing is thus a public act that represents the return of the victim to the world, confronting the sufferer with the reality that bad things can happen for which responsibility must be taken. Writing gives this testimonial solidity and validation, which provide a foundation for transcending shame …*

– Feldman, S.C., Johnson, D.R., and Ollays, M., "The Use of Writing in the Treatment of Post-Traumatic Stress Disorders," in *Handbook of Post-Traumatic Therapy*, eds. Williams, M.B. and Sommer, Jr., J.F., Greenwood Press, CT, 1994.

- Some survivors find taking self-administered personal assessment tests to be revealing. Such tests help to focus the survivor on thinking introspectively. Goal-set-

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ting challenges such as physical fitness exams or problem-solving quizzes are also helpful.

2. *Experience*
   a. It is useful to help survivors think of past experiences that have been traumatic or extremely stressful and to consider the coping strategies they have used with such experiences – whether they were helpful or harmful – to assess whether such strategies may be relied upon in the present. A poignant example of this appeared in an Ann Landers column:

Dear Ann Landers:

On October 15, 1983, my 21-year-old son, Kevin, was killed in an automobile accident. At that time I thought nothing could be as painful and devastating as that loss. I was wrong.

On March 3, 1989, my son, Leo, 28 years old, died suddenly. The death of this second son reopened the wounds of my previous loss. It was a struggle to hang on to my sanity. I knew in my heart that my sons would not want me to give up on life. They were so full of fun and laughter. They would expect me to pull myself together and carry on. I knew I had to do it for them. The night after Kevin died I wrote some words to be read at his funeral. When Leo died, I reread them. I would like to share them with your readers. Here they are:

"If God said to me, 'You can choose or not choose to have a son, Kevin. If you choose to have a son, Kevin, he will have red hair and shiny eyes and a great sense of humor. He will be a ray of sunshine in your life and cheer you on when you are down.

" 'But you can have him for only 21 years. And when he leaves, you must pay a great price for those 21 years. That price will be deep sorrow.'

"I would choose to have Kevin.

"And if God said to me, 'When he goes, you can choose for him to have a lingering, painful death, one that would help you adjust to his leaving and give you

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a chance to say goodbye …

" 'Or you can choose for him to go quickly and painlessly.

" 'But if you choose for him to go quickly and painlessly, you must pay a great price, and that price is deep sorrow.'

"I would choose a quick and painless death for Kevin."

These words were read at Kevin Brown's funeral. October 18, 1983."

– Barbara Brown, Millington, N.J.

b. Many survivors learn a great deal by talking with others who have experienced similar things in the past. Such survivor support is useful in identifying how to cope with holidays, anniversaries of the tragedy, everyday routine, and practical issues.
c. Survivors may also benefit from new experiences that help them learn new skills and practice new routines. Indeed action-based approaches in the treatment of PTSD have been very powerful for some survivors.

The origins of action-based approaches can be traced back to two main roots: the theories and philosophy of experiential education and the principles and techniques of the Outward Bound program. …Although hard evidence is lacking, the success of programs employing action-based therapy provides compelling testimony of their effectiveness.

– Stuhlmiller, C.M., "Action-Based Therapy for PTSD," *Handbook of Post-Traumatic Therapy*, eds., Williams, M.B. and Sommer, Jr., J.F., Greenwood Press, 1994.

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3. *Energy* is derived from general good health and helps survivors cope with trauma better.
   a. Physical activity

> *I believe there is an essential element of wellness that involves action … behaving, taking action, acting on the world …You're not just concerned with getting enough to eat or feeling safe, but you're reaching out for stimulation. You're seeking growth.*
>
> – Suter, S., in *Live Arts Experiences: Their Impact on Health and Wellness*, Spencer, M.J., Hospital Audiences, Inc., New York, NY, 1997.

- Exercise often heightens one's sense of self-esteem and self-discipline. It is also a way of integrating routine and control into life. Physical activity helps survivors establish a connection with life, and even small amounts of activity can help survivors to resume functioning in the midst of depression or sorrow.
- Exercise also may induce the physiological production of endorphins and opioids that heighten a sense of well-being as well as diminish the effects of physical pain.
- Physical activity should not be seen as limited to exercise but should include the engagement of survivors in the translation of their experiences into physical form through art, music, dance/movement, or psychodrama. Creative arts may serve as a method for expression, the reinforcement of positive beliefs, and the creation of new meanings. A three-stage model of treatment for the creative arts therapies, involving (1) access to the traumatic material, (2) working through, and (3) integration into society, has been proposed by one therapist. (Johnson, D., "The role of the creative arts

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therapies in the diagnosis and treatment of psychological trauma," *Arts in Psychotherapy*, Volume 14.) If the art form is also a method of communication between the artist and a counselor, peers, or an independent audience, then there is potential for even more dynamic transcendence of a trauma experience. Art may be the mode of reframing the experience and for eliciting new associations with traumatic memories.

Art elicits pleasure by acting on arousal, that is on a person's level of attention, alertness, or excitement. Art affects arousal through three different properties. First, its psychophysical properties, such as brightness, saturation, size, loudness, or pitch. The second is through its ecological properties, its association with experiences recognized as helpful or harmful to survival, such as food, war, sex, or death. The third is through 'collative' variables, such as arousal heightening devices as novelty, or the newness of the elements; surprise, or frustration of expectations; and complexity, or the heterogeneity, irregularity, and asymmetry of the elements. These elements are "collative" because, in order to determine the novelty, surprise, or complexity inherent in a pattern, the perceiver must compare, or collate, information from more than one source.

– Winner, E., *Invented Worlds*, Harvard University Press, Cambridge, MA, 1982.

b. Nutrition
   - Vitamins B and C are particularly important in reducing stress.
   - High fiber carbohydrates help maintain energy and health.
   - High intake of water and juices are stress reducers.

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- Large amounts of sugar in the diet may produce fatigue, weakness and confusion.
- Survivors should try to avoid large doses of caffeine, alcohol, cigarettes, and sugar.

c. Humor

Laughter and humor tend to invigorate and renew people's energies. Caregivers and survivors both testify to the relief that laughter can provide, even at the worst of times in catastrophes.

> *Jokes are no laughing matter to the brain. They are a type of release valve that enables us to think the unthinkable, accept the unacceptable, discover new relationships, adjust better and maintain our mental health. They are also funny. Without them we probably would be a dull, dimwitted society, trapped in a harsh world too serious to bear.*
>
> – Ronald Kotulak.

d. Tears

- Crying helps to cleanse the body of chemicals that build up during emotional stress.
- Studies by William Frey, director of the Dry Eye and Tear Research Center, include collections of tear samples on hundreds of women and men. He distinguishes between emotional tears and irritant tears. However, all tears remove manganese from the body a mineral that has been associated with mood alteration. Both kinds of tears also contain three chemicals known to be released by the body during stress: leucine-enkephalin, an endorphin thought to modulate pain sensation; ACTH, a hormone considered the body's most reliable indicator of stress; and prolactin, a hormone which also regulates milk production in mammals. (Frey, W., *Crying: The Mystery of Tears*, Minneapolis, MN:Winston Press, 1985.)

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B. Rehearsal, reassurance, and referral are functions of post-trauma counseling that relate directly to ventilation, validation, and preparation elements of crisis intervention. Counselors should continue the process as well as seek additional assistance, when necessary or appropriate.

1. Rehearsal

Rehearsal is accomplished by revisiting the trauma event in the mind, physical and mental review of the trauma, and going to the scene of the trauma to reframe the event. Rehearsal allows victims to begin to understand the event and to integrate positive thoughts or feelings with the event and its aftermath. Many of the therapeutic interventions that may be provided by trauma therapists and are described below focus on either mental or physical rehearsal of the event.

a. The elements of crisis intervention focus on "rehearsal" and "recall" when crisis intervenors assist victims or survivors to remember the event with clarity and in chronological fashion.

b. Counselors should be aware that safety of the survivors is critical any time that they may physically walk through a reenactment of what happened or mentally replay the scenes of what happened. Skilled support and assistance during those re-enactments should be available in case survivors re-experience the trauma with physical and emotional reactions. There are cautions about rehearsal that intervenors should consider when working with victims.

i. Rehearsal is a voluntary and controlled event when used as a post-trauma counselling tool. Survivors should be allowed to stop at anytime when their feelings or reaction become too painful or intense. They should be allowed to be in control of the rehearsal which also means that if they want to continue, even if in some distress, counsellors should support

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them. Controlled rehearsals also mean that relaxation exercises or other forms of soothing comfort should accompany the rehearsals to assist survivors in coping with the memories. Counselors should be aware of the possibility of intense reactions or flashbacks. They also should be aware that traumatic events do not have to be fully remembered for individuals to regain a sense of control.

ii. Involuntary or intrusive re-experiencing the event followed by diverting thoughts elsewhere or distressing emotional responses may indicate that not all aspects of the trauma are remembered.

iii. Initial avoidance of thoughts or experiences relating to the trauma may assist coping by allowing the mind and the body to gradually absorb the intense impact of the event.

iv. Continuation of thought avoidance over time is usually counterproductive.

v. Continuation of involuntary re-experiencing of the event is also counterproductive.

vi. Even controlled rehearsal may cause victims to feel revictimized so that any mental or physical rehearsal event should include a phase that focuses on defusing emotional reactions, restoring control in the present, and returning victims to a state of calm.

c. The value of such rehearsal is found when victims can begin to perceptually remember events so that they can complete their narratives. Then they are better able control their reactions as well as realize that they had, and have, the capacity to survive the tragedy.

2. *Reassurance* is derived from social support systems.

a. Reassurance is predicated on individuals reconnecting with social relationships. This means that some survivors must learn to establish or reestablish emotional intimacy. Inti-

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macy is based on trust and a capacity to reciprocally self-disclose, thoughts, feelings, and reactions with another. Non-traumatized people may fear intimacy for a number of reasons. Five types of fears have been identified all of which can be intensified due to a traumatic event.

- Fear of merger - losing one's identity or control over one's life.
- Fear of abandonment - losing someone who is loved.
- Fear of exposure - being rendered vulnerable, inadequate or inferior.
- Fear of attack - being emotionally or physically harmed.
- Fear of one's own destructive impulses - becoming angry and aware of the ability to hurt others who are close.

(Feldman, L.B., "Marital conflict and marital intimacy: An integrated psychodynamic-behavioral-systemic model," Family Process, vol. 18, 1979)

Counselors may help survivors overcome fears of intimacy by helping them develop intra- and interpersonal skills such as interpersonal communication, conflict management, anger management, assertiveness, or self-esteem. They may also assist survivors in exploring options for establishing or reestablishing social support systems.

b. Sources of reassurance and social support include the family, colleagues in the workplace or school, and peers, including peer support groups. One of the most important aspects of the ability to cope is the strength of an individual's social support system.

Of the things that frighten us, the fear of being left out of the flow of human interaction is certainly one of the worst. There is no question that we are social

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animals; only in the company of other people do we feel complete. In preliterate cultures solitude is thought to be so intolerable that a person makes a great effort never to be alone; only witches and shamans feel comfortable spending time by themselves. In many different human societies – Australian Aborigines, Amish farmers, West Point cadets – the worst sanction the community can issue is shunning. The person ignored grows rapidly depressed, and soon begins to doubt his or her very existence. In some societies the final outcome of being ostracized is death: the person who is left alone comes to accept the fact that he must be already dead, since no one pays attention to him any longer; little by little he stops taking care of his body, and eventually passes away. The Latin locution for 'being alive' was inter hominem esse, *which literally meant 'to be among men'; whereas 'to be dead' was* inter hominem esse disnere, *or 'to cease to be among men.' There is no question that we are programmed to seek out the company of others."*

– Csikszentmihalyi, Mihaly, *Flow: The Psychology of Optimal Experience*, New York, NY:Harper & Row, 1990.

c. One source of social support may be family members. However, it is important for counselors to assess whether the family is a positive source of support or a negative drain on an individual's energies. Families that are heavily involved in substance abuse, blame-oriented or violent are not helpful as a force for social integration. On the other hand, families that have open communication, are affectionate and tolerant in their relationships, and are committed to family-oriented problem-solving may be critical in the reconstruction of both an individual's life and family life as a whole.
d. Support of colleagues in the workplace or at school is another source of social integration.

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i. The workplace or school support systems can be as important as family support.
ii. If tensions exist in the workplace or school prior to a disaster, those tensions will increase the trauma of the catastrophe.
iii. The demands of the workplace or school may also mean that trauma is repressed and normal work is emphasized. Some elements of generating workplace support that employers might consider are:
    - Pre-existing policies that provide for temporary absence of employees suffering from a traumatic event.
    - Mandatory counseling for all employees involved in an event while doing work associated with their job or at the workplace.
    - Official recognition through newsletters or other communications that trauma has affected the workplace and acknowledgment that some people will have crisis reactions or long-term stress reactions to such trauma.
    - Group crisis interventions of high-risk populations within the workplace.
    - Peer counseling programs that address all aspects of trauma-inducing events and can be accessed by employees on request.
    - Health insurance that covers mental health and other counseling services.
    - Endorsement and support for absolute confidentiality in all communications concerning emotional reactions to trauma.

e. Peer support groups with family, friends, and community members who have suffered the same catastrophe, or with people in similar situations, can provide new opportunities for human connections. The post-trauma counselor may want to assist victims in establish support groups.

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i. Such groups provide people in similar circumstances with an opportunity to describe their experiences with the emotional aftermath of crime and to discuss effective coping strategies.
ii. The focus is on confrontation and acknowledgment of grief, crisis, and trauma, and on support for efforts to reconstruct new lives.
iii. Dr. Alan Wolfelt outlines the developmental stages of support groups as the following:
   - ***Stage One: Warm-up and establishing of group purpose and limits.*** Leadership roles: clarifying the purpose of the group; gently encouraging each member to tell his or her story; assisting in the creation of ground rules for the group; modeling listening and helping everyone feel as if they belong; facilitating details such as time of meetings, formats, etc.
   - ***Stage Two: Tentative self-disclosure and exploration of group boundaries.*** Leadership roles: continuing to model listening, openness and caring; continuing to clarify member expectations; reminding members of the ground rules; providing a group format and facilitating any activities or homework to be discussed; being responsive to conflicts and problems that might evolve.
   - ***Stage Three: In-depth self-exploration and encountering the pain of grief.*** Leadership roles: continuing to model listening, openness and caring; being supportive of continued participation of group members; assisting the group in dealing with any conflicts and problems that might evolve; making appropriate adjustments to content and format; allowing and encouraging the group to be more self-responsible.

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- ***Stage Four: Commitment to continued healing and growth.*** Primary leadership roles: continuing to model listening, openness and caring; being supportive of continued participation of group members; modeling of shared leadership principles; assisting the group in dealing with any conflicts and problems; and making appropriate adjustments to content and format as the group evolves.
- ***Stage Five: Preparation for, and leaving the group.*** Leadership roles: creating safe opportunities for members to say good-bye to each other and to the group; recognizing the dynamics that occur when a group begins to end; encouraging reflection on individual group growth; providing referral for additional resources to those in need; conducting a summary evaluation of the group.

3. *Referral* to mental health professionals may be needed for victims who are suffering intense trauma or who have other complicating conditions.
   a. It is advisable for post-trauma counselors who are not mental health therapists to develop a reciprocal referral network with mental health professionals in their area. Such a network should include professionals who are educated in trauma work and have experience in working with survivors of trauma events. They should be willing to work with counselors, peer support groups or victim advocates if the survivors so desire. Some referral networks involve reciprocal trainings for mental health professionals and trauma counselors or advocates so that partnerships can be formed in the best interest of the survivors.
   b. Symptoms of the need for referral include:
      - Sustained decrease in physical functioning or physical illnesses.

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- Sustained or repetitive thoughts of suicide or one's own death.
- Substance abuse or self-injury.
- Inability to move beyond the trauma event or traumatic events in the aftermath.
- Sustained depression or sadness.
- Sustained impairment of daily functioning
- Constriction of activities.
- Constriction of social circles.
- Lack of spiritual beliefs or a connection with former beliefs.
- Despair over the future.

C. Advocacy, activism and actualization

1. *Advocacy* refers to focused efforts to accomplish specific goals on behalf of victims or survivors either by them or their representatives.
   a. As a tool in crisis counseling is predicated on three things.
      - Often the second injuries perpetuated in the aftermath of catastrophe force survivors or their advocates to fight back.
      - Advocacy may be the only avenue to solving problems faced by victims or survivors.
      - The search for meaning in life is often inextricably connected with trying to change things so that the tragedy cannot be repeated in the future.
   b. Sometimes dealing with secondary assaults involves *case advocacy*.
      i. Victims or survivors may be their own advocates but also may want or need assistance. (Guideline: The more control survivors have over choices and solutions, the better.)
      ii. Elements of *case advocacy* include:
         - working with individuals or collections of individual clients;
         - direct, defined and tangible conflict with another individual or agency because of behaviors, attitudes, values, traditions, regulations, or laws;

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- focus on behaviors, attitudes, values, or policies that can be an example for the future;
- a resulting action that may be explicitly restricted to one case with no affect on other cases, or can be used as precedent, or can be merged with system advocacy.

iii. An advocate's purpose is to change behaviors, attitudes, values, traditions, or laws through specific actions that apply to this one specific case.

c. Advocacy that focuses on seeking change as a part of a search for meaning will become *system advocacy*.
   i. working on behalf of classes of individuals or society as a whole.
   ii. seeking changes in the system after an actual conflict and prior to the repeat of a similar conflict.
   iii. working in a legislative, legal, programmatic or educational arena.
   iv. merging with case advocacy after general change has occurred.

   Victim rights legislation have been expanded significantly in the last two decades due to advocacy by victims and survivors. In most states, victims have rights to information, participation, and restitution in criminal cases. A federal constitutional amendment is now being sought to provide victims of all crimes – state or federal – such rights in adult, juvenile, administrative, and military criminal proceedings. The importance to victims of such an amendment was underscored when a survivor of a daughter killed in the Oklahoma City bombing, testified in a hearing before the U.S. Senate Judiciary Committee:

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> *In my mind, there were only three other times when the need for constitutional change was so pressing: when the Bill of Rights was written; when slavery was abolished; and when women were granted the right to vote."*
> – Marsha Kight, Testimony before the U.S. Senate Committee on the Judiciary, April 16, 1997.

2. *Activism*
   a. Activism may be employed as a part of advocacy but does not need to be limited to it. Charlotte and Bob Hullinger became activists when they founded Parents of Murdered Children as a system of peer support groups. Many victims and survivors become activists when they choose to tell their stories at forums or conferences to help others learn about trauma. Some people employ activism as a basis for choosing new vocations or avocations in life.
   b. There are ten reasons why victim activism can be therapeutic for survivors.
      - ***Focus*** – When one's world has been thrown into chaos by trauma, there is a need to restructure order through focus on specific functional activities.
      - ***Catharsis*** – Activism can provide a way to express intensely frightening emotions in a safe and socially-acceptable way. For instance, anger may be expressed in outrage at laws and a determination to change them – instead of venting at family members.
      - ***Relationships*** – Many victims and survivors lose touch with once-close friends and family. Those friends or relations may be afraid of the emotional upheaval in the victim's life, may not know what to do or say, or may blame the victim. Victim activism often gives survivors a chance to form new "families" and relationships bound together by trauma and commitment.

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- ***Repetition*** – A vital part of healing is "telling your story." Victim impact panels, legislative testimony, speak-outs, support groups and so forth, all provide opportunity for telling and retelling the story.
- ***Self-Esteem*** – Victimization is often a humiliating, degrading experience. Activism can give victims tangible evidence of their accomplishments and self-worth.
- ***Testimony*** – Victims not only need to tell their story but to have it validated through the knowledge that someone listened to and believed the story, and it made a difference.
- ***Insight*** – Activism provides a way to hear from others who have suffered similar traumas as well as from people who work in the field. Hearing other people's experiences can help clarify one's own experiences.
- ***Integration*** – An important therapeutic goal for many is to be able to incorporate the story of their own tragedy into their lives. Activism allows victims to restructure their lives and recognize how their victimization and survival has altered them forever.
- ***Purpose*** – For many, the impact of crime shatters their sense of meaning and purpose in life. Their plans are thrown asunder. A person whose life has been centered around her child dies a special kind of death when the child is murdered. Activism can be the key to developing a sense of triumph over tragedy and providing meaning for both that woman's life and her deceased child.
- ***Hope*** – Activism may provide survivors with hope. The nine elements of activism described above and its positive benefits lead to a re-establishment of hope and a new life for victims and survivors.

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To suffer woes which Hope thinks infinite;
To forgive wrongs darker than death or night;
To defy Power, which seems omnipotent;
To love and bear; to hope till Hope creates
From its own wreck the thing it contemplates;
Neither to change, nor falter, nor repent:
This, like thy glory, Titan, is to be
Good, great and joyous, beautiful and free;
This is alone Life, Joy, Empire, and Victory.
Percy Bysshe Shelley.

3. *Actualization*

It is difficult to describe the concept of self-actualization, but essentially it seems to represent the goal that survivors have of integrating their lives such that they include the past, the present, and future visions. Recognition of the ability, capacity and tenacity to survive and the perpetuation of faith in the existence of one's self, one's children, and others is central to most human lives. But actualization goes beyond simple survival, it involves finding meaning in the trauma event and drawing upon the positive aspects of it that can lead to personal growth and transformation.

IV. Therapeutic Interventions

Some crisis responders may also be mental health therapists experienced in trauma. Others may be experienced in law enforcement, nursing care, teaching, victim assistance, or other professions. However, no matter what their background, all should be acquainted with some of the therapeutic mental health interventions that might be available to survivors with long-term stress reactions in order to more effectively respond to questions about appropriate treatment. This manual does not attempt to describe all such interventions but outlines some of the newer techniques used over the last decade. These techniques are presented with no attempt to evaluate their effectiveness but rather to describe some of the protocols involved, and to alert crisis responders to the

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fact that therapists certified or trained in these techniques are available for referrals. Counselors should not attempt to employ such techniques without comprehensive training. In most cases, such training is provided only to mental health professionals so that the techniques can be used in conjunction with other therapy, as needed.

A. Eye Movement Desensitization and Reprocessing (EMDR)

1. EMDR seems to have effect due to physiological and cognitive processes of the brain. The explanation for its effect is not fully understood. According to the EMDR Institute's Training Manual,

The EMDR methodology, as a form of Accelerated Information Processing, may unblock the brain's information processing system through a number of ways. It may tap into the same mechanisms used in learning and memory now identified with REM sleep. Another possibility is that blocked processing is manifested as phase discrepancies between equivalent areas in the brain's hemispheres and that the EMDR rhythmic intervention results in improved hemispheric communication with the result that the blocked material is finally processed (Nicosia, 1994). On the other hand, EMDR may initiate an orienting reflex change in neurophysiological functioning leading directly to desensitization (Armstrong and Vaughan, 1994; Lipke, 1992).

– Citations to Armstrong, N., and Vaughan, K. (1994). "An orienting response model for EMDR." Paper presented at the meeting of the New South Wales Behavior Therapy Interest Group, Sydney, Australia; Lipke, H. (1992). "Manual for teaching of Shapiro's EMDR in the treatment of combat-related PTSD." EMDR Institute; Nicosia, G.J. (1994). "The QEEG of PTSD with EMDR" Paper presented at the International EMDR Conference, Sunnyvale, California. Reprints available from Neuro Diagnostics, 4927 Center Ave., Pittsburgh, Pennsylvania, 15213

– Shapiro, F., May, 1997.

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2. The model for treatment involves eight phases that are all predicated upon a therapist with certification in psychology, social work, or psychiatry doing the work with clients. This emphasis on mental health professionals relates to the need for assessment and care in treating any trauma victim, and the fact that not all trauma victims will respond to the treatment.
3. The following description of EMDR is included as a summary of what happens and is not intended to be used without full training in EMDR techniques.
   a. Phase One: establishing the history of the traumatic event.
      i. What happened.
      ii. What caused the person to seek additional help.
      iii. How he or she learned of the possibility of EMDR.
      iv. What he or she would like to accomplish.
   b. Phase Two: preparation for treatment.
      i. Obtaining informed consent.
      ii. Providing information on when the person can stop the treatment or intervene.
      iii. Education on relaxation techniques and how people can find a safe place to go in and out of distress.
   c. Phase Three: assessment of distress and beliefs caused by the trauma.
      i. Distress over a memory of trauma is assessed through the survivors' attribution of the measurement of the disturbing emotion on a subjective scale of 1-10, rating a neutral or no disturbance as one and the highest level of disturbance as ten. It is called the SUDS (Subjective Units of Disturbance Scale) measurement.
      ii. Survivors' beliefs regarding their own self-assessment and positive cognition about themselves as a result of the original trauma is measured by a seven point scale where one is completely false and seven is completely

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true. The scale is referred to as the Validity of Cognition (VoC). It allows survivors to present in their own words the worst belief they have about themselves now because of this disaster, and provides clinicians with an opportunity to measure how this belief may change after intervention.

d. Phase Four: desensitization of negative reactions to the traumatic event.
   i. Eye, sound, or touch movement from left to right is used to trigger brain reactions.
   ii. Survivors are asked to focus on an image of the event or if they do not have a "picture" in their minds, the sense of the event.
   iii. Simultaneously they are asked to remember the negative cognition and where they have bodily sensations.
   iv. The caregiver guides the eye, sound, or touch movement while the survivor thinks of the image and the negative thought and gradually the distress decreases.
e. Phase five: installation.
   i. The survivor is asked to focus on the original event and the positive cognition.
   ii. Eye, sound, or touch movement is once again used to "install" the positive thought and gradually the positive cognition strengthens.
f. Phase six: body scan.
   i. The survivor is asked to focus on the original event and the positive cognition, and mentally "scan" the body.
   ii. If any sensation is reported, eye, sound, or touch movement is once again used. If it is a positive or comfortable sensation, then the movement assists in strengthening the positive feeling. If it is a negative sensation, then the movement and reprocessing are used until the discomfort subsides.

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g. Phase seven: closure.
   i. The survivor is provided with information about what may happen after the reprocessing and asked to keep notes or to remember thoughts over the next few days or weeks.
   ii. The survivor is given a telephone number where he or she can get in touch with the clinician if further distress occurs.
h. Phase eight: re-evaluation.
   i. Survivors are encouraged to check in with the clinician again to evaluate the elimination of the distress.
   ii. At this time, survivors may report that distress over the traumatic event has not occurred again or they may report additional distressful memories that can be addressed through additional EMDR techniques.

B. Traumatic Incident Reduction (TIR) Technique

1. This technique focuses on traumatic events through cognitive measures designed to allow survivors to generate their own insights.
2. The following overview of the technique is provided to give readers an understanding of the nature of the technique but it should not be employed without appropriate education and training.
   a. Survivors are asked to "view" in their mind a specific trauma – one traumatic incident is viewed at a time.
   b. The clinician gives survivors instructions that are formulaic, specific and neutral.
      i. Survivors are asked to focus on when the incident happened.
      ii. They are instructed to close their eyes.
      iii. They are asked to move to the start of the incident and begin viewing without talking or explaining what they are seeing.
      iv. They are asked to report when they are at the event in their mind.
      v. After they have a chance to look at and think about the start of the event, they are

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asked to tell the clinician what they are aware of at the beginning of the event.

vi. They are then asked to move the scene in their mind to the end of the event without talking or explaining what they are seeing.

vii. After they have had an opportunity to review the event from the perspective of its ending, they are asked to tell the clinician what happened.

viii. Finally, they are asked to report on how the incident seems to them now.

c. This process of viewing the event is repeated over and over again, sometimes as many as twenty times.

d. There is no validation, questions, comments or encouragement to the survivors during the process.

e. The repetition of viewing is done until a point of closure when survivors may report relief, insight, or a reframing of the event.

C. Visual Kinesthetic Dissociation (VKD) Technique

1. The premise for this technique of intervention is that trauma survivors are often locked in a sense that time stopped when the trauma happened. They can only act in the present, as though the trauma is still continuing. They are too associated with the trauma memory to relinquish it.
2. VKD has a basis in Neuro-Linguistic Programming and represents an attempt to "deprogram" the trauma survivor.
3. Again, the description here is not meant to provide crisis responders with the training needed to conduct VKD but to give them an understanding of what a trained clinician might do when using the technique.
4. VKD is a step-by-step process of dissociation.
   a. The clinician first establishes a rapport with survivors by taking a history of their lives before the traumatic event and their lives after the event.

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b. Survivors are asked to describe what they lost as a result of the trauma. Such losses may include physical, material or intangible losses.
c. Survivors are asked what they would like to have back after the trauma.
d. They are then asked what they have to gain by keeping the trauma alive in their minds.
e. During this process, the clinician is always monitoring the physical reactions of the survivors to ensure their safety as well as to note manifestations of trauma.
f. Then survivors are asked to establish in their minds a "here and now" anchor. Such an anchor may be physical contact or a mental image.
g. Survivors are then asked to view the trauma as a movie, and to watch the movie of what happened.
h. After they have watched the movie, they are instructed to look at it again, but in reverse.
i. When they have looked at the movie both as it occurred chronologically and then backwards, they are asked what they know now about that event that they did not know then.
j. Survivors are instructed to think about their lives now, what they have learned in thinking about the trauma, to go back to their younger selves who underwent the trauma, and to retrieve any information that might have been helpful to them then. This information might involve positive changes in their lives since the trauma, information on how they might have reacted, or information on how they might have prevented either the trauma or certain aspects of its aftermath.
k. Finally, survivors are instructed to bring the younger person back to their current life and to "fold them into their hearts."

D. The Counting Method

1. The counting method was developed by psychiatrist

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Frank Ochberg; an instructional videotape is available entitled, "Frank Ochberg on post-traumatic therapy: The counting method," *Varied Directions & Gift from Within*, Camden, ME, 800-888-5236. The first description of it was published in the *Journal of Traumatic Stress* in 1996.

2. Theoretically, the counting method works because it ties the traumatic memory to the therapist's voice and the security, dignity and partnership of therapy; it involves a brief encounter with the traumatic memory; and deliberately, through the self-control of the survivors, it allows them to begin to master their distress.
3. The counting method is used as a technique within a more generalized plan of post-traumatic therapy.
4. Ochberg describes the counting method as follows:

> *Counting affords the client a relatively short interval (100 sec), with a beginning, middle, and end, in which to deliberately recall an intrusive recollection.*
>
> *1. Silent recall allows privacy.*
>
> *2. Hearing the therapist's voice links the painful past to the relatively secure present.*
>
> *3. Feelings of terror, horror and helplessness may recur during counting, but they will be time limited and, most likely, modulated by connection to the therapist.*
>
> *4. The traumatic memory itself may be modified. That, after all, is the ultimate objective. If and when the memory emerges spontaneously at some future time, it may be attenuated by the experience of the Counting Method. The client will associate the dignity and security of therapy with the intrusive recollection."*
>
> –Ochberg, F., "The Counting Method for Ameliorating Traumatic Memories," *Journal of Traumatic Stress*, October, 1996.

5. Guidelines for the counting method.
   a. The therapist counts at a steady pace of one number a second from the number 1 to 100.

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b. The survivors are instructed to think of the memory from the time the trauma happened until its end.
c. At about the numbers of 93 or 94, the therapist may remind the survivors to come back to current reality.
d. After the survivors return to the present, it is advisable to wait until they begin to talk about their experience, but if they do not, they should be asked if they can describe what they just remembered.
e. In closing, the therapist and survivors discuss what happened and end the session on a positive note, reassuring survivors of their control over the memory as well as a plan for future sessions with or without the use of the counting method.

V. Counseling Suggestions

A. Counselors should be aware of, and accept, traumatic reactions.

Fighting emotional flooding or numbing is doomed to failure by the survivor. Emotions are integral and physiological. The counselor should be aware that survivors may not like their own reactions, but they will have reactions, and such reactions need to be acknowledged. They may not be able to define their reactions. The counselor can suggest words or alternative ways to describe sensations.

B. Reviewing the traumatic event may involve thinking about the event, telling about the event, or revisiting the site of the event.

Re-exposure to the trauma is most likely to be helpful when the re-exposure is voluntary and the survivors are in control of the process. Even then re-exposure to the trauma may cause distress or discomfort.

C. Stress inoculation programs are helpful to some survivors.

Such counseling programs involve identifying the

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primary causes of stress reactions and helping survivors to modify their responses to these causes through relaxation techniques and deep breathing exercises.

D. Sometimes mental health professionals consider medication to suppress certain disturbing symptoms associated with the trauma.

Suppressing symptoms may be useful if the symptoms are causing survivors to become dysfunctional in daily life. However, medication should only be used under a doctor's supervision and trauma counselors should be alert for signs of over-medication.

> *As a general principle, I feel psychotropic medications in both civilian and military stress syndromes should not be prescribed as a matter of routine. They should be used to treat those symptoms of anxiety, depression, and sleep disturbance that seriously interfere with other modalities of treatment and so impair the individual that he or she cannot function adequately in the work place or in daily social activities.*
>
> – Yost, J. F., "The Psychopharmacologic Management of Post-Traumatic Stress Disorder (PTSD) in Vietnam Veterans and in Civilian Situations," *Post-Traumatic Stress Disorders: a handbook for clinicians*, ed. Williams, T., Disabled American Veterans, Cincinnati, Ohio, 1987.

E. Counselors may encourage survivors to confront trauma-related cues or issues in order to make them less intrusive and bothersome to the survivors.

Often people behave in a manner contradictory to their intentions. For instance, if survivors are told to avoid thinking about something, they may find it impossible to do so. On the other hand, if they are told to think only about something that bothers them, they may find it impossible to keep their minds from wandering on to other things.

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"Stand in the corner," his brother told young Leo Tolstoy, "until you stop thinking of a white bear." It seems a simple enough command, but Tolstoy was unable to do it. Instead he found himself standing helplessly in the corner, consumed with thoughts of a white bear. Innocent child or experienced adult, we don't have much luck suppressing unwanted thoughts. They keep flooding back, becoming more insistent the more we push them away… The idea that thinking unwanted thoughts might be good for us seems a little like prescribing a disease as a cure for itself. But this therapeutic technique has a successful history…Victor Frankl reasoned that if people accept their unacceptable thoughts they would then have to begin to think through what those thoughts meant. But most of the time, remember that an unwelcome thought will go away only when you welcome it back. Then, like a child with a bedraggled toy, you will tire of carrying it around and lose track of it quite naturally.

– Wegner, D.M., "Try Not to Think of a White Bear…" *Psychology Today*, June, 1989.

F. The sense of meaninglessness or emptiness may create barriers to a reconstruction of life.

If survivors can identify unique meanings in their lives, they are better able to begin a new life. For some, the recognition that they still have choices in life and still have control over some aspect of their life is important. Choice and control may be limited to one's own attitude. Survivors may not have control over environmental circumstances or biological or physiological characteristics but they can have a choice over how they decide a traumatic event will affect their attitudes and responses to their situation. Attitude is a product of awareness, imagination, will, and conscience.

To be sure, man's search for meaning may arouse inner tension rather than inner equilibrium. However, precisely such tension is an indispensable prerequisite

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of mental health. There is nothing in the world, I venture to say, that would so effectively help one to survive even the worst of conditions as the knowledge that there is a meaning in one's life. There is much wisdom in the words of Nietzsche: "He who has a why to live for can bear almost any how."

– Frankl, V., *Man's Search for Meaning*, New York, NY:Washington Square Press, 1959.

VI. Hints for Helping

A. Be aware of the range of traumatic reactions and assist victims in putting words or names to their emotions.

B. Try to ensure that rehearsal or re-exposure to the event is voluntary and that the survivors are in control of the process.

C. Try to ensure that there is support for survivors whenever they are re-exposed to the event.

D. Provide survivors with information and relaxation techniques, deep breathing exercises, and other forms of physical stress reduction.

E. Help survivors re-establish routines and maintain daily schedules.

F. Make sure that the physical needs of survivors are being met when they face potential second injuries in the aftermath of the event.

G. Remind survivors to predict and prepare for issues that might arise.

H. Plan 24-hour safety-nets on which survivors can rely, including protection action plans.

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I. Encourage and facilitate peer support groups.

J. Encourage survivors to confront trauma-related cues or issues.

K. Provide survivors with educational materials to help them understand long-term stress reactions and to develop personal coping strategies.

L. Encourage survivors to explore issues associated with the meaning of life or the sense of meaninglessness.

M. Refer survivors to mental health therapists or consult with mental health professionals when needed.

VII. Conclusion

Crisis responders do not have to know how to provide post-trauma counseling, but they should know about methods and know how to make good referrals for survivors after a crisis or trauma event. Counseling or therapy may be the only option for some survivors who find it difficult to overcome trauma reactions or to integrate traumatic memories. When someone seeks such help it should be encouraged. Some people may not seek such help because of the fear of being stigmatized. A good referral entails identifying an appropriate person to which to refer. It also involves explaining the referral option in a positive way that focuses on the concrete building blocks of surviving and integrating a traumatic event. It has often been said that the willingness to seek or accept help when life seems most desolate is the first step in survival. It reflects a hope that things might get better. The goal of trauma therapy or counseling is to nurture that hope to help rebuild lives after disaster.

Hope, it is the lifeblood of therapy – the vital force motivating the client and the most valuable inducement the therapist can offer; without hope, therapy hardly makes sense. Even the unhappy, desperate act of calling a therapist is an act of hope: the client not only

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wants, but expects, to feel better. Almost necessarily, the client's hope rests upon trust – in the goodness of human beings and in the possibility for mutual connection. It is hard to imagine anyone beginning therapy without a belief, however tattered and ragged, that life can be worthwhile, that joy, peace, freedom, love are still part of the natural order of things. People come to therapy not because they don't believe in life's possibilities, but because they themselves are unable to share in these riches.

– Jeffrey Jay, "Terrible Knowledge," *Networker*, November, December, 1991.