The work of a Clinical Psychologist in Major Trauma

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Overview

- Types of psychological trauma
- Common emotional and physical reactions – what we are looking for
- Reducing psychological impact – what we do at RSCH
- A psychological therapy intervention for trauma
- A psychological intervention for chronic pain in trauma

Types of Trauma - Type 1

- **Type 1:**
- Single, discrete traumatic event that can occur suddenly and without warning
- Involve "Exposure to actual or threatened death, serious injury or sexual violation"
  - Road Traffic Collisions
  - Falls
  - Suicide Events
  - Physical Assaults with or without weapons
  - Sexual Assaults or Rapes

Types of Trauma - Type 2

- **Type 2:**
- A person experiencing traumatic stressors that are sustained and prolonged
- typically involve chronic, repeated, and ongoing exposure.
  - Childhood sexual, physical and emotional abuse
  - Domestic Abuse
  - Torture
  - Human trafficking

Common emotional reactions (1)

- Shock and disbelief
- fear and/or anxiety
- grief, sadness,
- disorientation/ confusion
- **hyper-alertness or hypervigilance**
- **irritability, restlessness and/or outbursts of anger or rage**
- sudden changes in mood– i.e. crying then laughing
- worrying or ruminating
- **repetitive thoughts about the trauma**
- **nightmares**
- **flashbacks- feeling like the trauma is happening again in that moment**
- feelings of helplessness, panic, feeling out of control
- increased need to control everyday experiences

Common emotional reactions (2)

- minimizing the experience and/or denial
- **attempts to avoid anything associated with trauma**
- tendency to isolate oneself
- feelings of detachment
- concern over burdening others with problems
- **feeling numb/ less emotional than usual**
- difficulty trusting and/or feelings of betrayal
- difficulty concentrating or remembering
- **feelings of self-blame and/or survivor guilt**
- **shame**
- diminished interest in everyday activities or depression
- **unpleasant past memories resurfacing**
- loss of a sense of order or fairness in the world
- expectation of doom and fear of the future

Physical manifestations

- aches and pains i.e. headaches, backaches, stomach aches
- sudden sweating and/or heart palpitations (fluttering)
- changes in sleep patterns, appetite and/or interest in sex
- constipation or diarrhoea
- easily startled by noises or unexpected touch
- weakened immune system/ more susceptible to colds and illnesses
- increased cravings for and/or use of drugs or alcohol
- the person or things around them feeling unreal/ dreamlike

People's experience of major trauma can be very different

- People recover from major trauma in different ways.
- The following have an impact on a person's recovery:
  - Life before the trauma
  - The type of trauma experienced and the circumstances
  - Beliefs, thoughts and expectations about themselves in relation to the trauma
  - The physical extent of injuries and their prognosis
  - Their treatment after the trauma
- Around 25–30% of people experiencing a traumatic event may go on to develop PTSD

What the patients say… (1)

- Many people report that the most difficult part of their trauma was coming into hospital/ A&E or being in ITU

i.e.

- "I was taken straight for surgery, I thought I would die without ever seeing my family again"
- "All I could see were wires hanging across my face- there were blocks either side of my head. I felt claustrophic and certain that this was the end for me"

What the patients say… (2)

- "I woke up and had no idea what was wrong with me. I kept trying to look at my body and touch different areas to find out what my injuries were and what surgery I had had"
- "Every time I was rolled I screamed in agony. I was horrid (verbally aggressive) to some staff because of the pain. I feel so guilty now. I'm an awful person. Staff tried to help me and I lashed out at them. I wish I could turn back time or at least apologise"

Timing

- Processing trauma can take up to 4 weeks. Consequently, the emotional reaction can last a long time too and/or patients may be very up and down whilst on the ward.

- It is important not to push someone to "get over it" before they are ready because:
  - They may not be able to
  - They are likely to feel misunderstood, upset, angry, critical of themselves and/or you
  - As a result… their emotional reaction/ anxiety may exacerbate
  - They become even less likely to engage
  - …and it may further reduce their ability to 'get over it' and frustrate you both!

Reducing psychological impact:
what we do in psychology at RSUH

Direct patient and family work relates to three areas:

1. Ward-based Distress Screening

- Support and psycho-education*
- Screening for patients considered to be 'at high risk' of developing PTSD and/or depression
- One off and/or going emotional support*
- Risk assessments (in collaboration with liaison team)
- Psychological assessment* (sometimes with a view to referring on to community services)

*For patients and relatives

2. Telephone follow-up one month post-discharge

- Find out how patients considered to be ‘at high risk’ of developing psychological difficulties are managing post-discharge
- Link them into local services/ refer on/ advise how to seek further support
- Or arrange for them to attend outpatients
- Provide support (one-off or ongoing, in person and/or on phone)

3. Psychology outpatient clinics

- Psychological assessments
- Psychological therapy
- Support for relatives
- On-going patient support
- Stabilisation/ to learn coping strategies (sometimes prior to being referred on to other services)

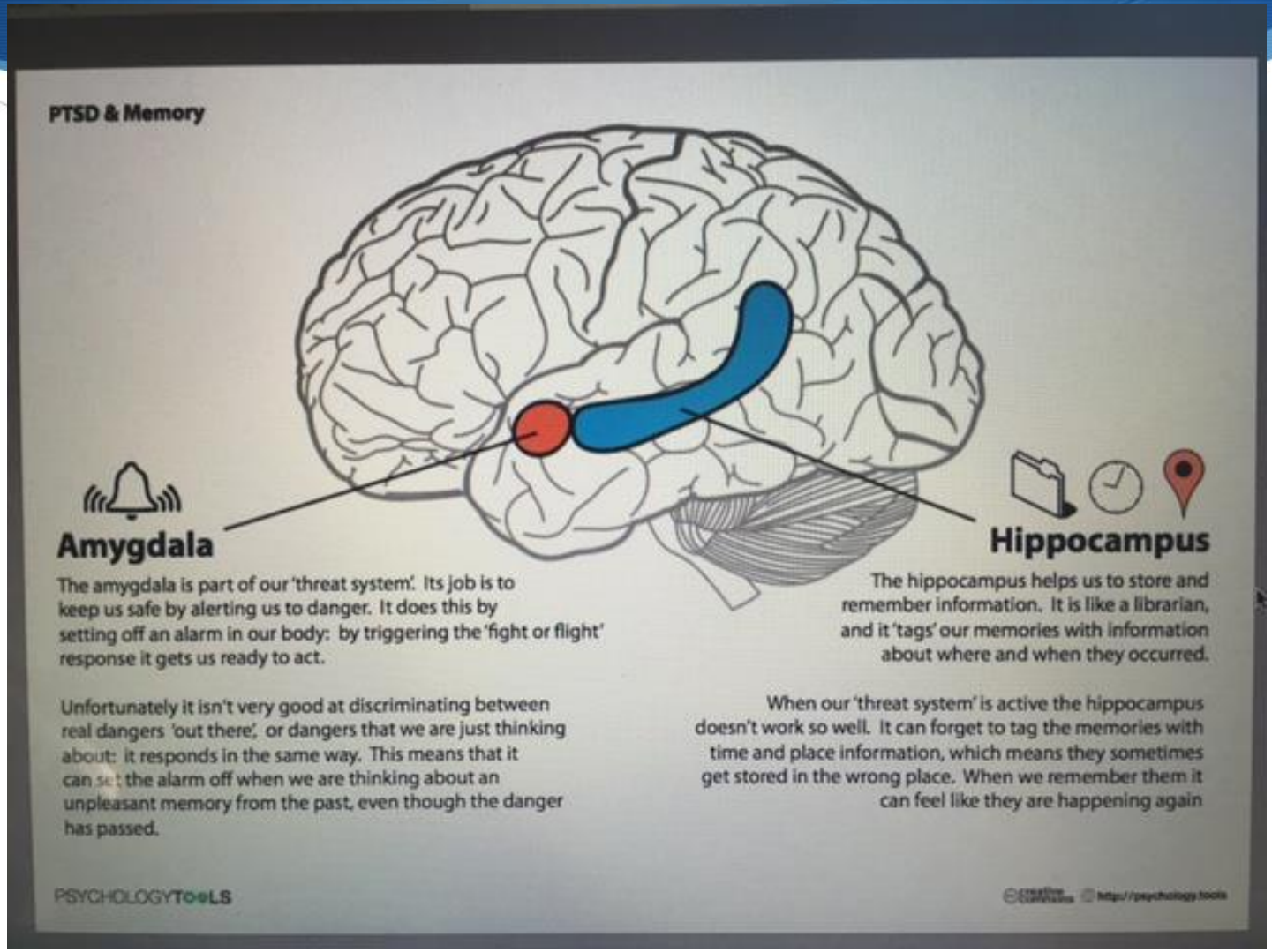
We also offer a range of services which aim to indirectly help influence patient care:

- Informal support for colleagues
- Case consultation
- Teaching/ training
- Recruitment
- CPD

A closer look at what therapy can look like in major trauma

1. Trauma Focused Cognitive Behavioral Therapy (TF:CBT)
2. The aim of therapy is to extinguish the reliving memories which have a ‘here and now’ quality (hence the experiences of hyper-arousal, emotional numbing/ disassociation, hyper-vigilance, flashbacks and intrusive images)

Processing at the time of a traumatic event



Theory of how TF-CBT works

- Memories of the traumatic incident are stored more as amygdala-based s-reps (sensory representations)
- These memories, there unpredictability, strength and the distress associated with s-reps are thought to be maintained by attempts to avoid the memories (which actually reinforces them)
- So the therapy addresses the difficulties by 'reprocessing' the memories to move the memories into hippocampus-based c-reps (contextualized representation).

TF-CBT (1)

1. Psycho-education of trauma reactions and trauma therapy
2. Safe place/ grounding exercise
3. Impact of Events Scale – Revised (IES-R) measure

IES – R (Impact of Event Scale Revised)

The following is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST 7 DAYS with respect to the traumatic event that you have experienced. How much were you distressed or bothered by these difficulties?

		Not at all	A little bit	Mod-erately	Quite a bit	Extremely
1.	Any reminder brought back feelings about it.	0	1	2	3	4
2.	I had trouble staying asleep.	0	1	2	3	4
3.	Other things kept making me think about it.	0	1	2	3	4
4.	I felt irritable and angry.	0	1	2	3	4
5.	I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3	4
6.	I thought about it when I didn't mean to.	0	1	2	3	4
7.	I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8.	I stayed away from reminders about it.	0	1	2	3	4
9.	Pictures about it popped into my mind.	0	1	2	3	4
10.	I was jumpy and easily startled.	0	1	2	3	4
11.	I tried not to think about it.	0	1	2	3	4
12.	I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13.	My feelings about it were kind of numb.	0	1	2	3	4
14.	I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15.	I had trouble falling asleep.	0	1	2	3	4
16.	I had waves of strong feelings about it.	0	1	2	3	4
17.	I tried to remove it from my memory.	0	1	2	3	4
18.	I had trouble concentrating.	0	1	2	3	4
19.	Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20.	I had dreams about it.	0	1	2	3	4
21.	I felt watchful and on guard.	0	1	2	3	4
22.	I tried not to talk about it.	0	1	2	3	4

Weiss, D.S. & Marmar, C.R. (1997). The Impact of Event Scale - Revised. In J.P. Wilson & T.M. Keane (Eds.), Assessing psychological trauma and PTSD. New York: Guilford Press.

TF-CBT (2)

4. Telling the trauma story in first person and present tense while client audio-records and therapists writes narrative
5. Elicit ‘hot cognitions’ using ‘SUDs’
6. Cognitive restructuring – hot cognitions, shame, guilt, blame, loss/grief, …

[redacted] - funeral

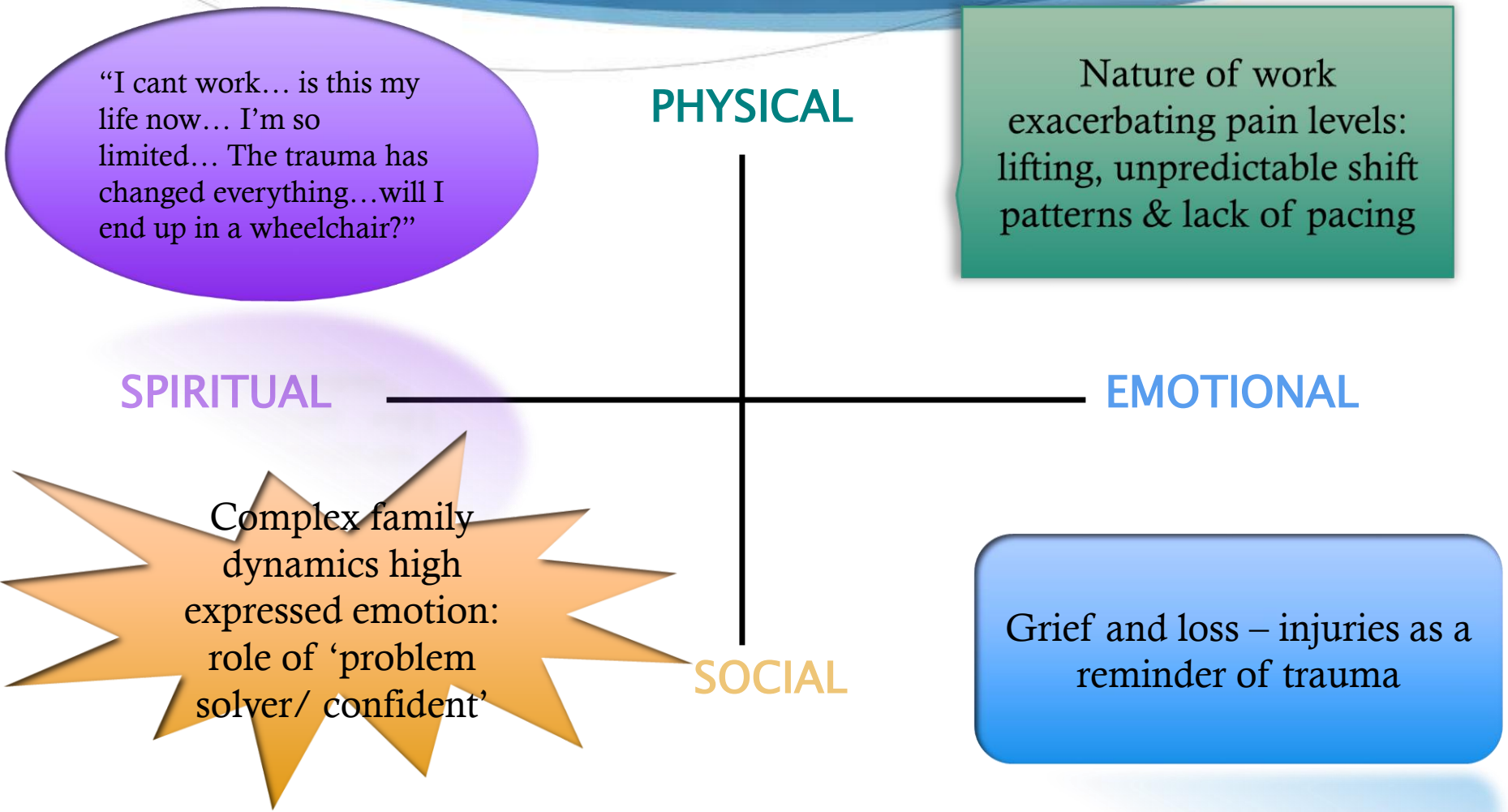
SUDS *

lying in bed
waiting for nurses to come in to give me a wash
playing on my phone
2 nurse came in stripping the bed + washing me 5-10 mins
mother walked in with clothes. - helps me put bra on
not allowed stand as I - foot but had stumbled a bit.
while trying to dress
text Paul.
mother does hair for me. + make-up
I do my teeth
I can hear Ant's voice, they say they are ready.
Ant is now pushing me to the van. - I want him to push me
- blank -
disc used to help me get into van. mom sitting next to me
wheelchair being put into back of van
3 we are going to Paul's house. - takes 5 mins
arrive at Paul's - carry me into wheelchair
pushed me into the house.
3 Quite a few people in the house
I see a small box
5 Paul gives me the box says Alex told me to give it to me
it's a bag. - I say thank you. but didn't have to.
We try and joke - trying to make time go quicker
Pushed to front door.
I'm outside Paul's - so many people - I feel embarrassed.
We go down to the cars
8 Alex is there in his coffin, flowers all around
Ant holding me up from behind - we cry
We get into the car - Me & Ant + Scott, Paul, Fi + family in front
Drive past my house, racecourse, where accident occured,
Alm Grove. to Cemetery
Arrived at cemetery - so many people - very hard

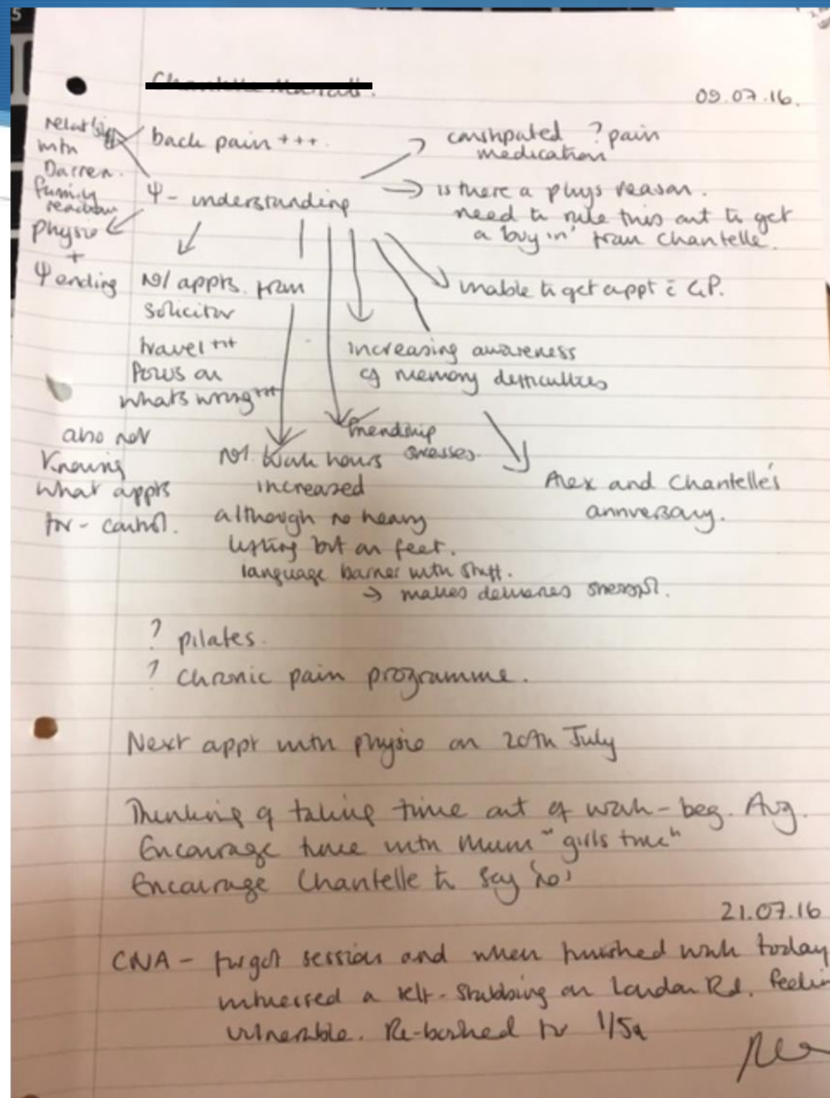
TF-CBT (3)

7. Repeat safe place/ grounding exercise
8. Homework – listening to recording on daily basis
9. Repeat until IES-R scores reduces

An example of a therapeutic intervention for trauma and chronic pain: Total pain formulation



Formulating the psychosocial elements in more depth….



[redacted]

09.07.16.

relat'ship with Darren.
Family reaction
Physio
+
Ψ ending

back pain +++
Ψ - understanding
→ constipated ? pain medication
→ is there a phys reason. need to rule this out to get a 'buy in' from Chantelle.
unable to get appt c GP.
N/ appts. from solicitor
travel +++
focus on what's wrong +++
increasing awareness of memory difficulties
also not knowing what appts for - control.
N/ work hours increased although no heavy lifting but on feet. language barrier with staff. → makes deliveries stressful.
friendship stresses.
Alex and Chantelle's anniversary.

? pilates.
? chronic pain programme.

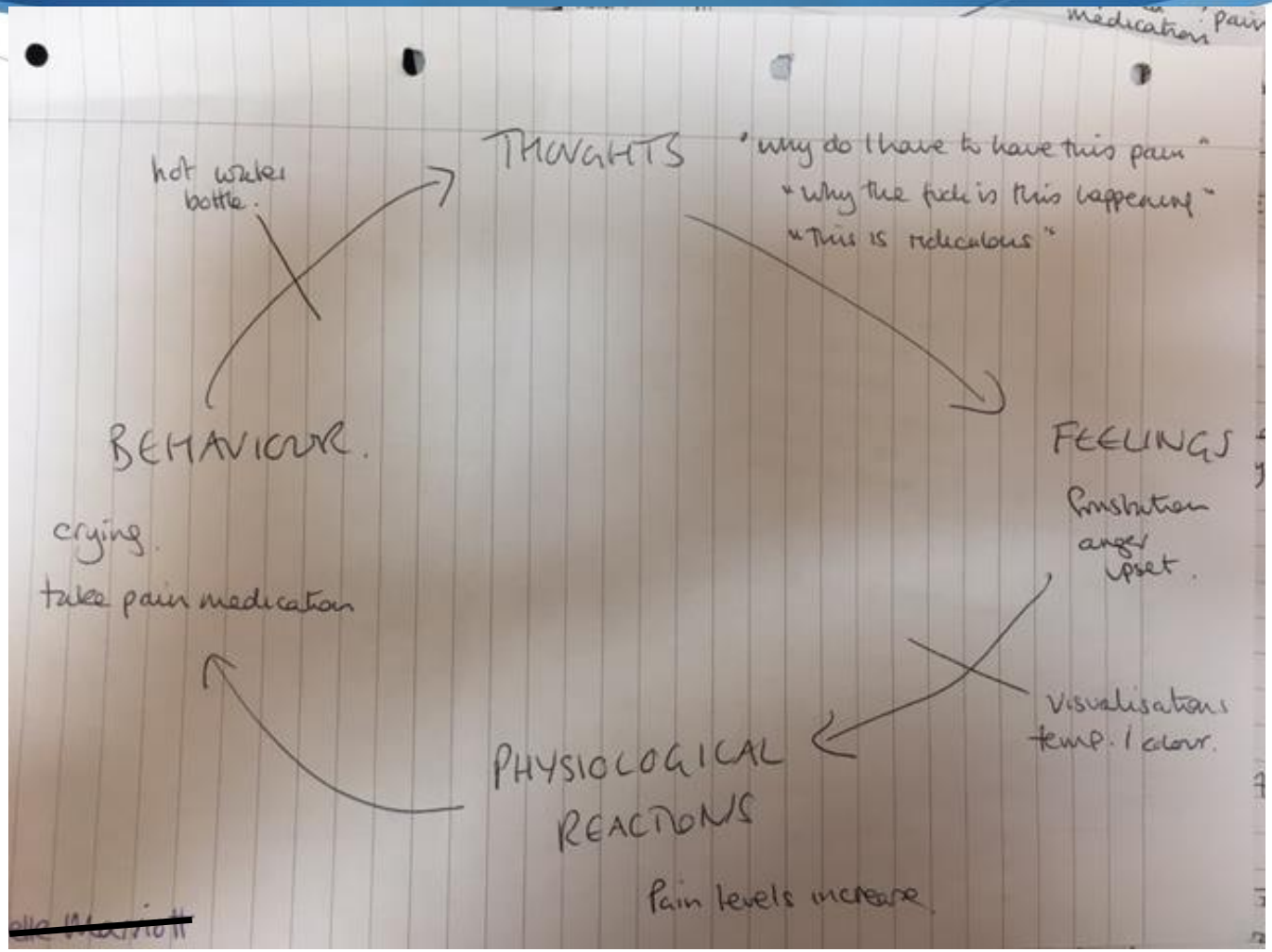
Next appt with physio on 20th July

Thinking of taking time out of work - beg. Aug.
Encourage time with Mum "girls time"
Encourage Chantelle to say 'no'

21.07.16

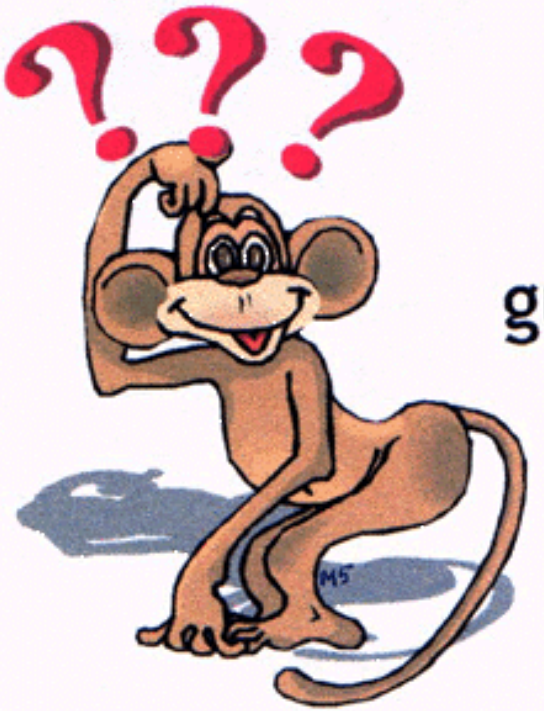
CNA - forgot session and when finished work today witnessed a KLF - stabbing on London Rd, feeling vulnerable. Re-booked for 1/52

Vicious Cycle: linking thoughts, feelings and behaviour to the experience of chronic pain



Actions Points from Therapeutic Intervention

- Letter to GP to review medication, requesting 'LTC patient' status if possible
- Referral to local PMP Team
- Discuss with Physio benefits of Pilates
- Visualisation using colour imagery to reduce sensations of pain and increase sense of control, while also providing distraction
- Pacing and saying 'no'



Questions
are
guaranteed in
life;
Answers
aren't.


Thank
You!