Psychological trauma

Keith Guy and **Nicola Guy** introduce the Rewind trauma intervention model

A valued member of staff presents in your office 'unable to cope' after witnessing a colleague's suicide. An administration assistant is suffering from panic attacks and unable to return to her duties after experiencing a difficult birth. Psychological trauma injury is a specific injury, with specific symptoms that requires the right psychological treatment.

Working originally as counsellors in the occupational health department of a busy city council with a workforce of 17,000 people, we were inundated with employees diagnosed with depression, stress, anxiety, panic attacks, phobias, alcohol problems, eating disorders and ME. These clients came from all departments and all job descriptions. There is nothing unusual in this and it is no doubt fairly typical of any large occupational health department. However what did surprise us was how frequently the cause of these symptoms was associated with post trauma stress following workplace incidents. Time after time we discovered that the client had experienced a single or multiple trauma and had gone on to develop a whole range of mental health and addiction difficulties. We now recognise that doctors and caring professionals, as well as work colleagues, family and friends, often do not notice the effects of trauma.

What is psychological trauma?

Psychological trauma is something that can happen to anyone at any time. It is estimated[1] that 90 per cent of the population will experience a trauma at some time and that a combination of distress, intrusive memories (flashbacks, nightmares), avoidance and numbing will occur in 20-50 per cent of those who have suffered major trauma.

Psychological trauma is any sudden, shocking, unexpected event that overwhelms our ability to respond adequately. These events include:

- road traffic accidents; car, train or plane crashes
- terrorism and bombings
- accidents at work
- violent assaults
- physical or verbal abuse including bullying
- rape or sexual abuse
- heart attacks, serious illness, loss of body part or a fall
- miscarriage, still birth or difficult birth.

Post traumatic stress disorder (PTSD)

PTSD is a psychological condition with specific criteria[2] – the individual needs to have experienced a major traumatic event such as a serious road accident or assault. The DSM-IV[2] defines PTSD as resulting from an event of significant magnitude associated with intense fear, helplessness and/or horror. The critical discriminator here is the person's emotional response to such an event as characterised in DSM-IV. If the event does not produce an intense emotional response, then it is not considered traumatic and cannot cause PTSD. There are six main clinical criteria:

- witnessing or experiencing the event, causing intense fear, helplessness or horror
- re-experiencing it involuntarily
- avoiding stimuli associated with the event
- persistent symptoms of increased arousal
- these symptoms need to be experienced for more than one month
- the disturbance causes significant clinical distress or impairment to social, occupational or other important areas of functioning.

Five in 100 men and 10 in 100 women will experience PTSD, and up to 30 per cent of people exposed to a stressful event or threatening situation will develop PTSD[3]. The National Institute for Health and Clinical Excellence (NICE)[3] states that there is under-recognition of the condition in the NHS, yet PTSD is treatable even when problems present many years after the traumatic event. NICE goes on to state that only a fraction of these cases are spotted and treated; Dr Jonathon Bisson (NICE guideline development group) says many people have not been diagnosed or treated.

What are the symptoms?

- **Intrusion** The sufferer will relive the event in some way and this will include flashbacks, nightmares or hallucinations. The memory will be easily triggered by smells, sights, situations, anything that in any way reminds the victim of the original traumatic event.
- **Avoidance** Individuals close down socially and emotionally in a bid to cut themselves off from situations or feelings that might remind them of the traumatic event. Sufferers may find themselves withdrawing from friends, family and social life; some activities will feel impossible to do.

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■ **Emotional and behavioural difficulties** These include short temper, anger, aggression, violence, antisocial behaviour, depression, suicidal feelings, phobias, self-harm, disturbed sleep, anxiety attacks.
■ **Addiction** PTSD does not abate untreated and in an attempt to cope with the highly intrusive and disturbing symptoms victims will frequently abuse alcohol and drugs.
■ **Effects on family, friends and wider community** The sufferer is no longer in control, they struggle to cope with the responsibilities of life. They turn to drink, become aggressive or suicidal. Their support networks can break down under the strain; some sufferers will end up in prison, others as chronic mental health patients. Some in a downward spiral will commit suicide, become homeless or become chronic users of the social care system. Violence spills over in to the home and children become the victims. One in three people who accept treatment from the Trauma Aftercare Trust will also request additional help for other family members who are indirectly suffering from the same trauma.

Individuals who do not fulfil the criteria for PTSD may still be suffering with post trauma symptoms that significantly impair their occupational and social functioning. In this context the Impact of Events Scale[4] (IES-E), a self-report measure for post trauma stress, is an extremely useful clinical tool. It measures intrusion, avoidance and arousal, the classic PTSD symptoms. It is acceptable to employees, being easy to understand and quick to complete and score. This tool measures symptoms and the need for treatment; it cannot be used to diagnose PTSD.

In the workplace

'Organisations need to be able to assess the magnitude and range of the psychological harm suffered by employees exposed to a traumatic event at work. This assessment will enable them to meet their duty of care by identifying which employees require psychological help and to make sure that appropriate psychological support and treatment is provided'.[4]

We were surprised to discover how many employees were suffering from this disorder and conducted a two-year research study looking at incidence and treatment. Types of trauma included rape, sexual abuse, physical and sexual assaults, psychological bullying, muggings, car accidents, stillbirth and war experiences. 'For most employees, exposure to traumatic incidents is much less dramatic than a major incident. Events such as workplace violence, bullying and victimisation together with exposure to a wide range of other stressful incidents including accidental injuries can lead to traumatic stress.'[4]

The list is not exhaustive and any employee in any organisation can be affected. The effects can be devastating to the organisation as their employee is on long-term sick leave, or is at work but struggling and maybe abusing alcohol or taking medication as a means of coping.
■ It is estimated that following workplace trauma 25-33 per cent of workers will have long-term coping problems[5].
■ It is not uncommon for PTSD sufferers to lose their jobs either because re-experiencing symptoms, sleep and concentration problems make regular work difficult, or because they are unable to cope with reminders of the traumatic event they encounter at work.
■ PTSD sufferers are at greater risk of medical problems, including circulatory and musculoskeletal disorders, and have a greater number of medical conditions than people without PTSD.
■ In any serious disaster situation 25 per cent of survivors will go on to develop PTSD and 25 per cent will develop anxiety and problems of substance abuse[6].

Current treatments

Psychological trauma injury is a specific injury, with specific symptoms, that requires the right psychological treatment. Currently NICE recommends the following treatments for PTSD and psychological trauma injury:
■ trauma-focused cognitive behaviour therapy (CBT) and exposure CBT
■ eye movement and desensitisation reprocessing (EMDR).

Medication should not be a routine first-line treatment but antidepressants such as paroxetine and sertraline have a role in treating PTSD and should be offered when CBT and EMDR have shown limited improvement.

The costs

PTSD has been estimated to cost the NHS up to £5,600 million a year. In 2003/4 social and welfare costs of claims for incapacitation and severe disablement from severe stress and PTSD amounted to £103 million, £55 million more than five years previously[7]. Therefore PTSD presents an excessive health and economic burden on patients, families, healthcare workers, hospitals and society as a whole. PTSD extends far beyond the healthcare sector, affecting people's quality of life and ability to function socially and occupationally. The economic and social impact of PTSD is not only felt by those

who experience the disorder but also by families, co-workers, employers and society generally. To remedy this situation NICE states that there is a need for efficacy data and reliable cost estimates for alternative treatments.

Rewind treatment

A little acknowledged breakthrough has been the development of an effective treatment for PTSD and post trauma symptoms, called Rewind (also called visual kinaesthetic dissociation, VKD), which can successfully treat this injury in three sessions. The treatment is non-drugs based, safe and works with the way in which memory is stored. Simply described, the technique allows the traumatised individual, while in a safe relaxed state, to reprocess the traumatic memory so that it becomes stored as an 'ordinary', albeit unpleasant and non-threatening, memory rather than one that continually activates a terror response. This is achieved by enabling the memory to be shifted in the brain from the amygdala to the neocortex. This treatment is recommended by the European Therapy Studies Institute (ETSI). Clinical experience and research shows that it works reliably with almost all cases of PTSD and phobias[8].

It is essential to note that PTSD and trauma symptoms are not suitable for counselling; indeed talking therapies will embed the trauma further and possibly vicariously traumatise the counsellor.

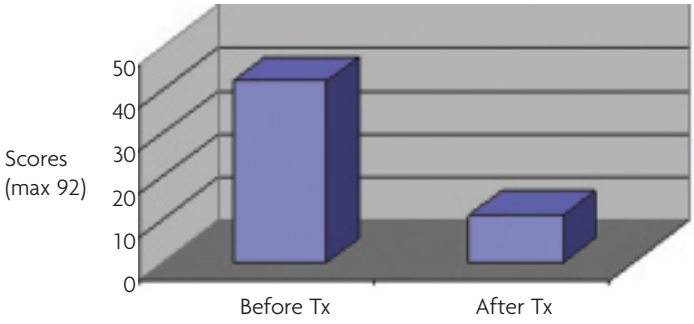
In the interests of finding alternative effective treatments the IES-E measurement was used on 97 individual clients using the Rewind treatment. The IES is a widely recognised measure and is used by clinical psychologists and expert witnesses, and is accepted by NICE. Employees from occupational health who were suffering post trauma symptoms to the extent their work and/or social functioning was impaired were treated. The IES-E measures the key trauma symptoms of avoidance, arousal and intrusion. If an individual has a combined total score of 50 then a need for support and treatment is indicated. The clients completed the IES-E scale before and after treatment and the outcomes were measured. The IES scale is useful in that it visibly shows the client their symptoms prior to treatment and the improvement made after treatment. The results are reproduced on the right.

The scores indicate that routinely the Rewind treatment significantly reduces post trauma symptoms to a level where they become clinically insignificant and most importantly to a level where the individual is no longer impaired either socially or in the workplace. Twenty-one cases had scores of less than 50; however, to the

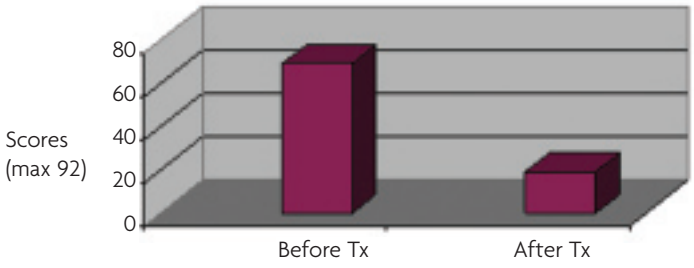
Total number	Average IES-E score before treatment	Average IES-E score after treatment
All cases	68	18
Mild cases of under 50 (21)	42	11
Severe cases of over 50 (76)	69	18

Average IES-E score before and after Rewind treatment

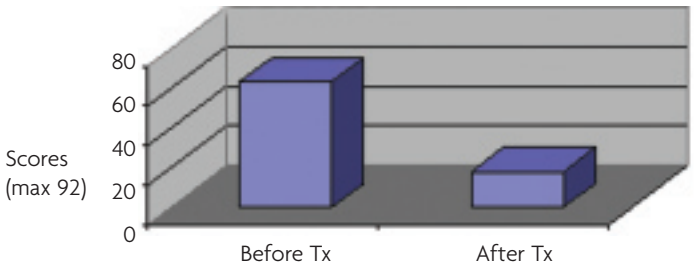
Mean impact of events scores for clients with symptoms of PTSD scoring in the non-clinical range (below 50) treated using Rewind (VKD). n=21



Mean impact of events scores for clients with severe symptoms of PTSD who have been treated using Rewind. n=76



Mean impact of events scores for clients with PTSD symptoms treated using Rewind. n=97



How does Rewind work?

Once relaxed, clients are asked to recall or imagine a place where they feel totally safe and at ease. Their relaxed state is then deepened and they are asked to imagine that, in their safe place, they have a TV set, a video player and a remote control. They are then asked to step to one side of themselves, in essence, out of body and watch themselves watching the TV screen, without actually seeing the picture (enabling them to create a significant emotional distance). Clients are then asked to watch themselves watching a 'film' of the traumatic event they encountered. The film begins at a point at which the trauma took place and finishes at the point at which the trauma ends and they feel safe again. They are then asked to float back into their body and imagine pressing the remote control rewind button, enabling them to see themselves travelling very quickly back through the traumatic event from safe point to safe point. Then they watch the same images but with their fingers pressed firmly on the fast forward button.

This process is repeated at a speed dictated by the individual concerned and as many times as needed until the scenes evoke no emotion. If it is desirable to instil confidence for facing the feared circumstance in the future – for instance, driving a car or getting into a lift – the client is then asked to imagine a scenario in which they are experiencing the circumstance in question but doing so in a confident and relaxed manner. Once accomplished, the client is brought out of relaxation and the Rewind is complete. Besides being safe, quick, painless and side effect free, the Rewind technique has the added advantage of being non-voyeuristic. There is no need for intimate details to be voiced, as it is the client who watches the 'film' and not the counsellor.

employee the symptoms were causing them sufficient discomfort to require a referral for some kind of psychological intervention.

Case study

Sarah, a finance clerk from a large local authority was involved in a serious road traffic accident where there were two fatalities and several severe injuries. Sarah was unhurt but began to experience anxiety and panic attacks; she became tearful and struggled with her daily journey to work. Sarah's GP diagnosed depression and anxiety and she was prescribed antidepressants but the symptoms continued. Sarah reached a point where she was unable to continue at work and she went on sick leave. Sarah was treated with Rewind, there was significant improvement within a week, and she was able to return to work.

The need for a trauma service in the workplace

PTSD and psychological trauma form a significant proportion of stress illness and absenteeism in the workplace. Untreated sufferers are likely to develop depression, phobias and alcohol abuse thus spiralling the cost to their employer, so it makes sound business and commercial sense to introduce this specialist service.

Current NICE guidelines highlight the prevalence of PTSD and psychological trauma injury. Tehrani[4] states: 'The workplace as the theatre in which the traumatic experience is played has been largely under researched.' This lack of recognition is surprising given that the number of people exposed to life threatening events in the workplace is over 1.5 per cent of the working population each year. This condition is affecting the workplace both in terms of sickness absence and impaired performance, directly affecting the organisation's bottom line.

Dr Paul Yarnley, occupational physician and founder of IMASS, a private occupational health provider, recognises that the incidence of psychological trauma is vastly under-recognised and under-reported in the workplace. He further states: 'We recognised the need for a psychological service that can assess and treat trauma, and the three-session Rewind treatment consistently works. However it is not enough to refer an employee to a counsellor, it is essential that the counselling team and occupational health provider work closely together as a cohesive team, discuss issues and feed back the important workplace issues to the client organisation.' ■

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