Approaching

Trauma

Debriefing

Volunteer
Training Manual
**Acknowledgements**

This manual is an abbreviation of the Trauma Training Manual used by the Midrand Trauma Support volunteers in conjunction with the Midrand Police Station Victim Empowerment Programme.

This manual has been compiled from a number of sources. Primarily from the work of Mrs Carol Jackson from the Sandton Victim Support Unit, with some additional input from Ms Trishka Govendar and the Revd Gavin Lock. Thank you to all of our contributors who have assisted in making this possible.
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SECTION TWO: WHAT IS THE NATURE OF TRAUMA?

1. TOWARDS A DEFINITION OF TRAUMA

A traumatic situation is one in which a person is rendered powerless and where great danger is involved. The person experiences or witnesses an event that involves actual, perceived or threatened death, violence or serious injury. It is an event which is out of the ordinary that is of such a magnitude and/or intensity that it overwhelms the person’s ability to cope. The following will be present in each trauma situation:

- “A sudden, unexpected (unprepared for) event that
  - is outside the range of normal human experience
  - involves actual or threatened death or serious injury or a threat to the physical integrity of self or others
  - and would be markedly distressing to anyone”
- The event is so unpleasant and shocking that the human mind and body react in an autonomic defensive manner
- The traumatisation is caused by the event, not because of some failing or weakness in the person, and thereby
- Marks a loss of control of the situation by the traumatised.

Types of Trauma

a. Critical Incident Trauma

Critical Incident Trauma refers to a traumatic event that is defined and has a definite conclusion or ending. Once the event is over the client is then able to process his or her experience of the event.

b. Process Trauma

Process Trauma relates to an indefinite stressor or event. For example, someone in an abusive relationship continues to be traumatized indefinitely because the situation itself is not being resolved.

c. Traumatic Bereavement
Any death is or can be traumatic and one would then usually expect the bereaved to engage in the normal process of grief, which can take up to two years, on average. When a death is particularly traumatic, for example: a shock death of a young child, a car accident or suicide, then it has trauma implications for the survivors.

**Examples of Traumatic Events**

Assault, murder, hijacking, rape, sexual assault, abuse, car accidents, suicide, war, bomb blasts, natural disasters, near death experiences – medical or otherwise, witnessing shocking events, kidnapping, armed robbery ... the list is endless.

2. **TRAUMA’S REACH**

The effects of trauma are not restricted to the victim directly involved. Witnesses, anyone in close association with the victim, care-workers, police and even strangers in the community will be impacted by the news of the event. For those close to the victim the concern would be primarily for the victim, for those foreign to victim the concern would surround the fact that this could happen to them.

This is known as secondary, indirect or vicarious traumatisation and its victim’s symptoms will mimic those of a traumatized client, only usually less severely.
Important!

What is of critical importance is that Trauma Debriefers are aware that they are not immune in their exposure to the traumatic event through their clients.

SECTION THREE: WHAT IS THE IMPACT OF TRAUMA?

3. BRAIN STRUCTURE

Our brains are structured into three main parts, long observed in autopsies:

- The cortex (the outer surface, where higher thinking skills arise; includes the frontal cortex, the most recently evolved portion of the brain)
- The limbic system (the center of the brain, where emotions evolve)
- The brain stem (the reptilian brain that controls basic survival functions)

Because of the development of brain scan technology, scientists can now observe the brain in action, without waiting for an autopsy. These scans reveal that trauma actually changes the structure and function of the brain, at the point where the frontal cortex, the emotional brain and the survival brain converge.

4. PHYSIOLOGICAL RESPONSE

Automated Response

An individual exposed to a traumatic stressor bypasses the normal cognitive processes and instead the thalamus activates the amygdala which immediately gears the body for four possible autonomic reactions:

- Flight
- Fight
- Freeze, or
- Submit
It is critical to understand that these reactions cannot be predetermined by training, circumstance, gender but are purely instinctive reactions. This factor often causes complications in managing the post-trauma event as Trauma Survivor’s sometimes have to deal with reactions contrary to stereotypical expectations that they have no control over, e.g. fear in a young fit man or great bravery in a timid aged woman.

The Impact of the Flight or Fight Response

Effects include:

- Our senses sharpening. Pupils dilate (open out) so we can see more clearly, even in darkness. Our hairs stand on end, making us more sensitive to our environment (and also making us appear larger, hopefully intimidating our opponent).
- The cardio-vascular system leaping into action, with the heart pump rate going from one up to five gallons per minutes and our arteries constricting to maximize pressure around the system whilst the veins open out to ease return of blood to the heart.
- The respiratory system joining in as the lungs, throat and nostrils open up and breathing speeding up to get more air in the system so the increased blood flow can be re-oxygenated. The blood carries oxygen to the muscles, allowing them to work harder. Deeper breathing also helps us to scream more loudly!
- Fat from fatty cells and glucose from the liver being metabolized to create instant energy.
- Blood vessels to the kidney and digestive system being constricted, effectively shutting down systems that are not essential. A part of this effect is reduction of saliva in the mouth. The bowels and bladder may also open out to reduce the need for other internal actions (this might also dissuade our attackers!).
- Blood vessels to the skin being constricted reducing any potential blood loss. Sweat glands also open, providing an external cooling liquid to our over-worked system. (this makes the skin look pale and clammy).
- Endorphins, which are the body's natural pain killers, are released (when you are fighting, you do not want be bothered with pain—that can be put off until later.)
- The natural judgment system is also turned down and more primitive responses take over—this is a time for action rather than deep thought.

The Impact of the Freezing/Submit Response

This often comes before fight or flight; but may also be the definitive response in a dangerous situation. This approach is often used as a tactic in the wild; but may result in guilt issues amongst alpha-type or maternal Crime Survivors.
The Impact on the Body

In order to gear the body for a fight or flight response the adrenal glands secret excessive amounts of the hormones adrenaline and cortisol which for all practical purposes poisons the body in a sustained ling term presence in the body. In addition to this blood flow is diverted to strategic areas of the body in order to equip them for action, depriving other areas of normal function. These instinctive survival reactions are geared to offering the body maximum benefit at a time of crises but can have serious adverse effects thereafter. For example, increased blood flow to the limbs would aid in muscle activity but then also promote severe bruising. The positive effects are super-sensory perceptions, hyper arousal and acute altertness. Apart from the shutting down of the cortex (mammalian part of the brain) the flight or fight response impacts other areas of the body:

- **The Digestive System** – Blood flows to the limbs in order to supply the muscles for quick action. This essentially shuts down the digestive system and will impact appetite. The body may also instinctively evacuate the bowels or empty the bladder in order to limit the diversion of resources from the areas of the body which may need them most. Adrenaline also affects the secretion of saliva causing a dry mouth and sore throat.

- **The Immune System** – The immune system is faced with the task of eliminating the excess hormones from body resulting which makes the individual more susceptible to illness, colds and flu, etc.

- **Reproductive System** – The impact on the reproductive system is varied but Trauma Survivors may experience variations in libido, menstruation and even impacting on pregnancies.

All of this giving rise to the following physiological symptoms of trauma can manifest after the event:

- Sleeping Difficulties - insomnia or sleeping too much
- Eating Irregularities - due to affect of trauma on the digestive system
- Nausea – the body ridding itself of adrenaline
- Restlessness - try keep busy as a form of avoidance
- Trembling Hands - residual high adrenaline levels
- Bowel reactions - expulsion of adrenaline
- Sexual Dysfunction
- Low Energy Levels or Lethargy
- Chronic Unexplained Pain

Some of these physiological manifestations may occur immediately after the event and continue for days, weeks or months; others may only appear long after the event. It’s important to note that in older victims certain hormones don’t kick in as effectively and they may remain in a state of hyper arousal for longer.
5. PSYCHO-EMOTIONAL RESPONSE

The psycho-emotional response to trauma-related events is complex as it involves a reaction to the event, a reaction to the body’s reflexive response and a reaction to after-effects. The psychological impact can be divided into two main areas: the uncontrolled experience of the event and the post critical moment when the cognitive elements of the brain begin to process the experience.

‘Normal’ Memory

In generally non-stressed states the human being absorbs data from external stimuli and files this information through a process of unconscious and conscious sifting into neural pathways or synapses which constitute short and then long term memory. This memory is stored in either the neocortex or limbic areas of the mammalian brain (cf 5.) depending on the type of memory and its stimulus.

Memory During a Traumatic Event

When an individual is embroiled in a traumatic event the normal memory storage process is bypassed by the flight or fight response, the shock and additional physiological factors such as the draining of blood from the brain in order to equip the limbs for action. Thus the normal process of cognition is suspended.

The events that take place physically affect the brain and are stored in the brain stem or reptilian part of the brain. The images, events and senses of the trauma incident imprints itself in the mammalian brain in a disconnected kaleidoscope of emotions, senses (taste, smell, touch, noise, etc) and images. These are not stored in the conventional manner and once cannot access them or manage them as one would conventional short or long-term memory. These smells, images and senses then intrude on the individual randomly and intermittently creating flashbacks which are one of the fundamental indicators of trauma.

The Critical Moment

The critical moment occurs when the victim thinks, ‘I’m going to die’. This is when the brain, overwhelmed by emotions and still sluggish begins to start thinking more rationally. This marks the transition from the automated response to reactive phase of the experience.
The Shattering of Worldview

Any traumatic event shatters four fundamental assumptions embraced by most human beings:

- ‘It will never happen to me’
- A belief that people are fundamentally good, harmless and rational
- The world is orderly and predictable
- ‘I am good and worthwhile and I don’t deserve to have bad things happen to me’

The reality of the trauma event exhibits that

- Anything can happen
- to anyone.
- anytime,
- anywhere.

This shatters the individual’s self-esteem and re-orientates their place in the universe, their impact on earth and often their role within the family. It is important to rebuild the four assumptions above in order to help the individual find healing and to cope with life again.

The Emotional Impact of Trauma Events

Given the above the following outlines the psycho-emotional impact of a trauma event:

a. Emotional

- Depression, spontaneous crying, despair and hopelessness
- Anxiety
- Panic attacks
- Fearfulness
- Compulsive and obsessive behaviours
- Feeling out of control
- Irritability, angry and resentment
- Emotional numbness
- Withdrawal from normal routine and relationships

b. Cognitive

- Memory lapses, especially about the trauma
- Difficulty making decisions
- Decreased ability to concentrate
- Feeling distracted
- ADHD symptoms

**Severe Trauma Reactions**

The following additional symptoms of emotional trauma are commonly associated with a severe precipitating event, such as a natural disaster, exposure to war, rape, assault, violent crime, major car or airplane crashes, or child abuse. Extreme symptoms can also occur as a delayed reaction to the traumatic event.

a. **Re-experiencing the Trauma**
   - Intrusive thoughts
   - Flashbacks or nightmares
   - Sudden floods of emotions or images related to the traumatic event

b. **Emotional Numbing and Avoidance**
   - Amnesia
   - Avoidance of situations that resemble the initial event
   - Detachment
   - Depression
   - Guilt feelings
   - Grief reactions
   - An altered sense of time
   - Increased Arousal
   - Hyper-vigilance, jumpiness, an extreme sense of being "on guard"
- Overreactions, including sudden unprovoked anger
- General anxiety
- Insomnia
- Obsessions with death

Repeated Trauma Impact

When a Trauma Survivor experiences multiple trauma events the memories which form the apex of each negative experience - (b) above - become a chain of defining memories and states to the detriment of the intervening ‘normalised’ experiences, memories and states.

Symptoms and Timing

After six to eight weeks the Trauma Survivor should be experiencing a reduction in symptoms and will return back to normal functioning, perhaps with a heightened vigilance and learned response in terms of avoiding a similar situation. Should the symptoms continue the individual may be showing signs of Post Traumatic Stress.

Post Traumatic Stress
Trauma Survivor’s may develop features of Post Traumatic Stress. These symptoms are a normal response to an abnormal situation. There are three main types of reaction:

- **Intrusion** – takes the form of repeated, unwanted and uncontrollable thoughts of the trauma and can include nightmares or flashbacks.
- **Avoidance** – a person's attempt to reduce exposure to people or places that may elicit memories of the event. This includes symptoms such as social withdrawal, emotional numbing and a sense of the loss of pleasure.
- **Hyper-arousal** – psychological signs of increased arousal such as hyper-vigilance, increased startle reactions, anger and increased aggressiveness, poor concentration and memory.

Other symptoms include feelings of depression, grief and loss, helplessness, bodily aches and pains and substance abuse. Should this continue for longer than three months it develops into Acute Stress Syndrome which is a Post Traumatic Stress Disorder.

**Checking for Post Traumatic Stress**

If five or more of the following are present then it is an indicator of post traumatic stress:

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<thead>
<tr>
<th>Symptom</th>
<th>Yes / No?</th>
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<tr>
<td>Emotional Numbing</td>
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<td>Anger(Fear)</td>
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<td>Crying</td>
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<td>Feeling Dazed</td>
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<td>Depersonalisation</td>
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<td>Inability to recall a part of the trauma</td>
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<td>Flashbacks</td>
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<td>Avoidance of arousal inducing stimuli</td>
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<tr>
<td>Anxiety</td>
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<td>Nausea</td>
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Untreated Trauma Symptomology

Even when unrecognised, emotional trauma can create lasting difficulties in an individual’s life. One way to determine whether an emotional or psychological trauma has occurred, perhaps even early in life before language or conscious awareness were in place, is to look at the kinds of recurring problems one might be experiencing. These can serve as clues to an earlier situation that caused a dis-regulation in the structure or function of the brain.

a. Common personal and behavioural effects of emotional trauma
   - Substance abuse
   - Compulsive behaviour patterns
   - Self-destructive and impulsive behaviour
   - Uncontrollable reactive thoughts
   - Inability to make healthy professional or lifestyle choices
   - Dissociative symptoms ("splitting off" parts of the self)
   - Feelings of ineffectiveness, shame, despair, hopelessness
   - Feeling permanently damaged
   - A loss of previously sustained beliefs

b. Common effects of emotional trauma on interpersonal relationships
   - Inability to maintain close relationships or choose appropriate friends and mates
   - Sexual problems
   - Hostility
   - Arguments with family members, employers or co-workers
• Social withdrawal
• Feeling constantly threatened

The Goal of Debriefing

The goal of Trauma debriefing is to facilitate an opportunity to process the event, understand its impact, encourage a coping strategy and affirm the legitimacy of the experience that the Trauma Survivor may work through the event and thereby prevent the development of PTSD.

6. PHASES OF CRISES AND TRAUMA

THE FOUR PHASES OF CRISSES

In general one can determine four different reactions to a crises situation. Individuals may oscillate between one phase and the next and may even overlap certain phases, which do not necessarily operate in a specific chronology.

a. High Anxiety or Emotional Shock Phase

Definition

Victims in this phase of the crisis reaction fall into two main groups:

• Hysterical and very active.
• Stunned, inactive and depressed.

Physical Symptoms

The hysterical or active crisis victim may show or complain of one or more of these signs (similar to the signs of shock):

• Empty feeling in the stomach.
• Intense, subjective pain or tension.
• Nausea, vomiting.
• Fainting.
• Lack of muscular control
• Need for sighing.
• Agitation (such as wringing of the hands).
• Screaming or crying
• Hyperactivity.
• Feeling of tightness in the throat (difficulty breathing, swallowing).
• Rapid speech. xii. Rapid breathing. xiii. Flushed face. xiv. Dull eyes.
• Sparing into space.
• Emotionally out of control.

Psychological Symptoms
The anxious crisis victim may display the following psychological symptoms:
• General feeling of distress and loss.
• Guilt feelings ("If only I had...").
• Hostile reactions that come from a need to assuage the feelings of guilt.
• The loss of patterns of conduct or reason.
• A general feeling of helplessness or taking on some of the traits/behaviours of the deceased.

Suggestions for Managing the High-Anxiety Victim of a Crisis
• Remove the victim from the scene to a less threatening, more secure environment.
• Reassure the victim that you are there to help.
• Talk to the victim.
• Touch the victim, if appropriate.
• Direct the victim to specific, task-orientated actions. For example, tell them to "Move", "Sit down", "Hold this", or answer your questions.

b. Denial Phase

Definition
Denial is a normal response to a stressful situation in which the victim can or will not acknowledge the existence of a crisis.
• It is a protection mechanism, preventing too much from happening too fast.
• Even very sick or seriously injured people tend to deny a crisis. For example, a heart attack victim may attribute pain to indigestion.
• Another example: Parents of a drug abuser may deny involvement in crime because "He is such a good boy".

Suggestions for Managing the Denying Victim of Crisis
• Allow the person to deny without agreeing with him/her.
• Gently and carefully tell the facts.
• Repeat again and again, if necessary.
• Don’t making empty promises ("Everything is OK.").
• Show genuine compassion and understanding.

c. Anger Phase

Definition
Anger, a normal response to frustration, is expressed when people feel they cannot cope with a situation and feel overwhelmed by it.

• An angry person may blame him/herself, others, the deceased, or God (possibly using blasphemous language).
• Guilt and anger sometimes cause family problems.
• Crisis not only creates problems, but also reveals them.

Suggestions for Managing the Angry Victim of Crisis
• Don’t take the anger personally. It is really not directed at you.
• Allow the victim verbal expression.
• Show confidence. Tell the victim you realise he/she is angry, but that you are there now and will do your best to help him/her.
• Don’t argue. You cannot win against an emotion.
• Recognize that anger is normal, although unpleasant.

d. Remorse, Grief and Reconciliation Phases

Definition
This phase is filled with feelings and expression of guilt and sorrow. The victim often blames him or herself and may repeat "if only" statements (such as, "If only he’d seen a doctor sooner" or "if only she had taken the other highway").

• Victims blame themselves for suicides.
• Victims tend to idealize the deceased person and exaggerate their own bad points ("I should have").
• Grief opens old wounds and memories.

Suggestions for Managing the Remorseful Victim of Crisis
• Listen carefully.
• Reassure the victim.
• Avoid judgmental statements.
• Allow the victim to express him/herself.
THE THREE PHASES OF TRAUMA

When it comes to trauma events in particular three specific phases have been identified, each with their own appropriate response:

**a. THE IMPACT PHASE (24 to 36 Hours)**

This phase is characterized by general chaos. It can last from a few seconds to 3 days. In this phase the victim appears emotionally numb, disorientated, confused, irrational and disorganized. The victim is in a state of shock and may not be entirely aware of the reality of what has happened to them. Some people show a lot of emotion and may scream or cry. Others may be completely calm and behave as though nothing has happened. The victim may seek assurance and direction. The victim is temporarily helpless in this phase and their low level of functioning can be compared to that of a young child.

**Indicators**

- Actual event
- Physical reactions
- Survival instinct
- Fight or Flight
- Numbness (physical and emotional)
- Shock
- Adrenaline

**How to help**

- The intervention needs to be ‘parental’ – calming and reassuring.
- The Trauma Survivor needs to be in a safe environment with structure and support.
- Due to temporary helplessness the Trauma Survivor may need practical assistance.

**What should you do?**

- Allow the victim to tell their story, if they want to, but don’t force them if they don’t want to.
- Avoid all artificial stimulants and drugs; no smoking, drinking, alcohol or artificial chemicals – the body is still poisoned by adrenaline and must resume its natural processes.
- Options: Rescue remedy, Birol and / or Vitmain B injection.
- Discourage ‘unorthodox’ behaviour and responses.
b. THE RECOIL PHASE (36 hours to 3 Months)
This is the best time for debriefing. It is much less chaotic and more controlled. In this phase the victim begins to realise the traumatic nature of their experience and will express some emotion (anger, sadness, guilt, etc). Most of the post traumatic stress symptoms begin to develop during this phase and most victims want to talk about their experience. Referring to a counselling agency may be necessary. As the victim experiences intrusive ideas and very often relives the event, they may recall information that has been omitted from the police statement.

**Indicators**
- Shock
- Easing of impact reactions
- Emotional
- Less heightened than the actual event

**How to help**
- Nurture and comfort and support the victim
- Encourage the victim to resume daily activities to tolerable degrees
- Support with active listening (remember the victim’s need to tell the story)
- Problem solving
- Coping mechanism

**NB:** Symptoms should not continue beyond 90 days otherwise referral is imperative.

c. REINTEGRATION / REORGANISATION PHASE (3 Months+)
During this phase the person re-establishes him/herself in former patterns of life.

### SECTION THREE: HOW DO WE MANAGE TRAUMA?

#### 7. THE DEBRIEFING PROCESS

**Suspending Self**
As human beings we suffer from equilibrium obsession. Each of us can be placed at variable positions on a continuum of negativity and positivity. Some may be more negative than others, vice versa or somewhere in the middle. This is our personal equilibrium. When we deal with someone who’s equilibrium is different from ours we instinctively attempt to draw them to our own position on the equilibrium, thus we may become impatient with someone more negative or more cynical with some more positive than us.
It is critical that we show each Trauma Survivor unconditional positive regard and assist them to find their way to their own equilibrium.

Throughout the communication process it is imperative that the entire process is focused on the Trauma Survivor and not the Volunteer; this is enacted most effectively through an attitude of empathy, as opposed to sympathy. The latter often places the Volunteer’s ego at the centre of the process with the Debriefee quick to offer advice, tell her/his own stories and taking power from the Trauma Survivor continuously proving her/his value to Trauma Survivor.

Empathy is a form of drawing alongside the Trauma Survivor and in an attitude of grace, opening a series of doors which they are invited to walk through; empowering them to understand their experience of the event and to take the necessary steps and decisions to manage the post-event effects.

M Mayerhoff writes in ‘On Caring’, “To care for another person, I must be able to understand him and his world as if I were inside it. I must be able to see, as it were, with his eyes what his world is like to him and how he sees himself. Instead of merely looking at him in a detached way from outside as if he were a specimen, must be able to be with him in his world, ‘going’ into his world in order to sense from ‘inside’ what life is like for him, what he is striving to be and what he requires to grow.”

In order for this to happen during the debriefing process it demands effective communication.

Communication
The ability to communicate carefully is, by far, the most essential element of all crisis intervention. The following defines some of the skills necessary to become an effective debriefer. There are four basic movements to effective communication: listening, responding, questioning and observing:

a. LISTENING

Listen to the Victim
- Show and have the desire to listen
- Unconditional Positive Regard
- Prepare to listen
  - Choose appropriate time & location
- Show interest
- Freudian hour

Focus Your Attention
- Centre your attention on the victim and the current situation
- Avoid distractions
Active Listening (None Verbal Language)

i. Body Language
   • Conveys to the other person what you are really intending
   • Carries a very strong message

ii. Physical Attending Behaviour (S-O-L-E-R)
   – Sit Squarely: Face the victim directly
   – Open body posture: Avoid crossed arms and legs
   – Lean: Lean forward to show involvement
   – Eye Contact: Maintain eye contact, but avoid staring
   – Relaxed: Forward posture & eye contact may feel unusual and you may appear tense, attempt to maintain a comfortable relaxed environment

iii. Other Components
   – Body Boundaries: Ensure comfort and appropriateness for both parties
   – Facial Expression: Can be facilitating or hampering
   – Tone of Voice: Gentle, clear and concise
   – Warm Relations: Convey genuineness, congruence, acceptance and understanding

Active Listening involves...

• Listen to both verbal and non-verbal messages
• Listen attentively to victim’s words, even if they don’t always make sense
• Listen to the message conveyed in victim’s tone, silences, gestures, facial expressions and posture
• Active listening involves answering the following questions:
  – What is the victim saying about the experience?
  – What is the victim saying about his/her behaviour?
  – What is the victim saying about hi/her feelings?

Four Types of Listening

i. Defensive listening is the process of hearing by either filtering the message so as to hear only that which is perceived or to place personal and negative values on the message. This type of listening inhibits spontaneity and rapport. A client often expects "to hear the worst" or to be "accused" by the counselor,
resulting in misinterpretation or confusion. The sources of defensive listening are often guilt, shame, fear and feelings of inadequacy or worthlessness. When a counsellor engages in defensive listening he prevents the real message from being heard and distorts its meaning.

ii. **Selective Listening** is an inherent practice. We all like to hear what we want to hear even though the other person may not have said it. Also, we have the habit of hearing only part of what is being said or communicated. It is obvious that arbitrary selective listening in the therapeutic setting is detrimental.

iii. **Deliberate listening** may accompany selective listening. Often one hears the expression, "I heard every word he said" to emphasise that the listener got the message clearly, distinctly and without error. Another example is that of the listener replaying, "I understand". Both of these statements illustrate the deliberate attentiveness of the listener and demonstrate the absence of defensive and selective hearing. They represent a type of hearing that excludes placing personal value judgment upon what is being said. Attentiveness is the essence of deliberate listening. In therapy deliberate listening is vital. If the client knows he is being heard and understood, he is at ease, his anxiety decreases and he willingly volunteers more information about himself and his emotions.

iv. **Empathic listening** is the core of therapeutic intervention. To state it simply, it means to listen with empathy. It includes the ability to feel and understand what the counselee is saying without losing objectivity. Empathic listening also means simply to listen to what the person has to say and offer no comments unless directly requested to do so.

You Are Not Listening to Me When ...

- You don’t care about me
- You say you understand me before you know me
- You have an answer before I have finished telling you my problem
- You cut me off or finish my sentences for me
- You are critical of my vocabulary, grammar or accent
- You dwell on your experience – making mine seem insignificant
- You communicate with someone else in the room

You Are Listening to Me When

- You come quietly into my world and let me be
- You really try to understand even if I am not making sense
- You grasp my point of view even if its against your own convictions
- You realize that the hour I took from you left you tired and drained
- You allow me the dignity of making my own decisions
- You allow me to deal with the problem in my own way
- You do not offer me religious solace when you sense I am not ready for it
• You give me enough room to discover for myself what is going on
• You accept my gratitude

b. RESPONDING

Know when to speak & when to be silent
• Allow the victim time to process and respond to questions
• Silence is not a bad thing
• Do not attempt to minimise the crisis with clichés and pat answers.
• Do not respond with your own stories and distract attention from the Trauma Survivor’s experience.

Accept silence
• Don’t force conversation
• Avoid trivial subjects – focus on matter at hand
• Positive physical gestures, were appropriate may be utilised

Wait, Think and Respond
• Don’t interrupt
• Waiting helps you to think
• Thinking increases chance of providing appropriate response

Repeat and Provide Feedback
• Repeat the general story – not everything the victim says
• Allows you to convey understanding & check accuracy – seek clarification
• Develop a ‘feeling words’ vocabulary

Be Honest
• Always tell victim the truth
• Dishonesty can destroy a working relationship

Give Hope
• Attempt to comfort but avoid giving false hope

Suspend Your Frame of Reference
• Don’t tell the victim how he/she should feel
• Try to see the crisis through the victim’s eyes

Comfort the Victim
• Provide encouragement and comfort

Respect
• Manifested in both you attitude & behaviour towards victim
• Your attitude is respectful if you:
  – Care about the victim’s welfare
  – Consider each victim to be unique human being – not another case
  – View victims as capable of determining their own fate
  – Assume the goodwill of victims until shown otherwise.
• Your behaviour is respectful if you:
  – Develop competence in helping and use it
  – Attend and listen actively
  – Suspend critical judgment
  – Communicate empathetic understanding
Express reasonable warmth and friendliness
Help victims identify and cultivate own resources
Provide encouragement, support & appropriate challenge

Genuineness
• **You are genuine in your relationship with the victim when you:**
  – Do not over-emphasize your professional role
  – Avoid stereo-typed role behaviour
  – Are spontaneous but not uncontrolled
  – Are consistent and avoid discrepancies between your values and behaviour, and between your thoughts and your words
  – Are willing to share yourself and your experiences if helpful

c. QUESTIONING

Ask Questions
• Know why you are asking question
• Purpose? Necessary?
• Do not convey judgment or suspicion in your questions

Use questions to:
• Seek clarity on facts
• Explore emotions or feelings
• Guide direction and focus

Keep questions simple and specific
• Clear and unambiguous
• Restate or reframe if necessary

Types of Questions
Closed Questions
• Require person to recall facts
• Easy to formulate and there is generally only one possible answer

Open Questions
• Requires the person to think and give an opinion
• May have many possible answers
• Use the ‘five whisky’s and an hotel’:
  - What?
  - When?
  - Where?
  - Who?
  - Why? (avoid this one as it smacks of judgement)
  - How?

d. OBSERVING

• Observing is an important way of gathering additional information
• Don’t stare – be aware!

Observe physical behaviour on 4 levels
• Energy levels
Inactivity implies shock or depression
- The quiet trauma victim may require help than the crying, screaming victim

- Health
- Appearance
- Behaviour

**Observe Incongruity**
- Check incongruity between verbal and non-verbal language
- Listen for feelings and facts

**THE DEBRIEFING PROCESS**

The overall aim of the debriefing is to reduce and minimise the occurrence of unnecessary psychological suffering through:

- The ventilation of impressions, reactions and feelings
- Develop a clear understanding of the events and reactions, resulting in cognitive organisation
- Decreasing individual and group tension
- Normalising reactions and reducing feelings of isolation and uniqueness
- Providing an opportunity for stress reduction, education and emotional reassurance
- Preparing participants for emotional reactions and symptoms which may arise
- Identifying avenues of further assistance if required (and if possible)

**When Should Debriefing Take Place?**

Debriefing is most effective when it is offered after **24 hours** and before **72 hours** following the traumatic incident. This is not always possible, and debriefing conducted days or weeks later can still help in reducing levels of stress.

**Limitations on Debriefing**

The Debriefing Model is **not** appropriate for rape victims, nor for relationship counselling, in the case of the former, the victim should be referred immediately to a hospital rape unit and referred to a specifically qualified professional.

**Initial Telephone Contact**

- Be confident and clear on the phone
- Explain who you are
- Explain it’s a voluntary service, and you would like to help in any way
If a person declines, explain to them what trauma symptoms they can expect and make sure they have your number if they change their mind.

Most of your debriefing will be informal and over the telephone

**Initiating the Debriefing Process**

- Set the client at ease and make sure that they are comfortable, perhaps offering some water, tea or coffee
- Introduce yourself and your role and confirm that this session is for debriefing purposes only.
- Assure the client of confidentiality but explain that a report will be completed confirming that the process has taken place.
- Explain that you are a trained volunteer but will make referrals if necessary
- Explain that it is important to complete all four steps in the process.

**Briefly Outline the Process**

- Explain to the Trauma Survivor that you will:
  - Ask them to tell the story
  - Explore their experience of it
  - Explain some of their reactions, and
  - Help them in managing the process
- Ask if they have any preliminary questions about the process

**THE FOUR PHASES OF DEBRIEFING**

**A. The Fact Phase**

**Retelling the Story**

- Ask them to tell you what happened
  - Let them tell story as they remember it
  - Following the correct sequence of events
  - Including as much detail as possible
- Find out who was involved and what they did
- Try to establish the time sequence of events
  - Include what happened before, during and after the event
- Ask victim to repeat story, adding as much detail as possible
  - Recall sufficient factual information to bring incident into vivid memory
  - Also include emotional memories through each stage of incident
Purpose of Retelling the Story

- To allow for emotional catharsis
- The encourage the recall of what happened
- To reduce fear and anger by allowing emotions to surface in a safe environment
- To help victim get in touch with feelings or thought that may have been present at time – moving the memories from the reptilian brain to the mammalian brain.
- To allow expression of helplessness and control issues
- To reduce sense of isolation and dislocation
- To show that even the worst images can be tolerated by the counsellor and in this way leave the victim less overwhelmed by these images

B. Exploring the Emotion and Thought Phase

Normalising and Reassuring

- Questions about thoughts, impressions and actions lead to answers about feelings
- The process of sharing feelings to establish normality of reaction.
- Focus on decisions & thought processes during the incident
  - What were your first thoughts?
  - What did you do? What do you think made you decide to...?
- Encourage victims to share the feelings they experienced at the time and that they are having now regarding the incident
- Revisit the events, and ask feeling-orientated questions
  - How did you feel when that happened?
  - How do you feel now?
- Help victim to verbalise their emotions
- Listen actively and reflect their emotions

Purpose of Normalising and Reassuring

- To reassure the victim that he/she is experiencing a normal reaction to an abnormal event— you prove it through citing the physiological reactions
- To assist the victim to accept and understand what happened to them
- To assist victim to realise that the symptoms will pass in time
- To show the victim that their reactions are normal and not going crazy

This process could take from 6 weeks to three months in extreme cases. Its important not to normalize the symptoms prematurely as you could block details of the event and leave the Trauma Survivor feeling dismissed.

C. Structured Reaction Phase

Reframing

- Focus on and reframe psychological and physical effects that victim has described
• Start attributing symptoms to the specific sequence of events
  – Link emotions to specific events
• Explore perceived versus the real lapse of time
• Urge victims to discuss symptoms (emotional, cognitive & physical) that they experienced then or are experiencing right now
  – At the incident, after the incident, at home, at work etc
• Summarise victim’s reactions – note similarities and differences
• Be on the look-out for self-blame.
• Explore ways of reframing the experience so as to
  – Acknowledge difficult feelings (guilt, self-blame)
  – Re-affirm coping mechanisms

**Purpose of Reframing**
• To reassure the victim that he/she responded as best they could under the circumstances
  – Work through the alternatives and explore consequences thereof
• To restore self esteem through affirmation
  – Even though victim survived, there is still a legitimate reason to feel traumatised
• To address concerns about the effects on others involved in the incident
• If victim is feeling genuinely guilty...
  – Do not attempt to take it away or minimise it – be prepared to listen
  – Your acceptance & acknowledgment will help victim to deal with guilt

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**Dealing with guilt**

- What was your **intention**?
- What was the actual **result**?
- If it was **successful**, it worked!
- Is your guilt still **rational**?

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**D. Re-entry Phase**

**Encouraging Mastery**
- Allows for the discussion of future planning and coping
  – Family and peer group support
  – Get in touch with external support network
- Explore coping strategies, such as relaxation, deep breathing exercises, distraction techniques, and anger management
- Explore the meaning the victim attaches to the incident
- Clarify what they think they can do to overcome the situation
- Help them to re-interpret their behaviour and re-evaluate themselves
- Tough love is not appropriate for trauma incidents
• Encourage them to talk about their experiences
• Explain the expected symptoms and what to look out for in future
  – Suggest activities to help manage these symptoms
  – Tell them who to call for assistance

**Purpose of Mastery**
• To restore the coping capacity of the victim
• To encourage connection with support systems, such as family, friends, church etc
• Determine if there was anything that victim has learnt about himself/herself from the experience that they didn’t know before
• Reinforce all the positive aspects
• Religion is the most significant coping mechanism

**FOLLOW UP**
• A week after debriefing a follow-up phone call is required.
• Should symptoms not ease off over the short-term the Trauma Survivor should be referred to a mental health professional.
• Should symptoms continue beyond six to eight weeks then further professional intervention is critical

**VOLUNTEER DEBRIEFING**

In order to prevent vicarious or secondary trauma it is imperative that debriefers maintaining regular debriefing themselves.
**Phases of Recovery**

**TRAUMATIC INCIDENT**
Minutes to hours, sometimes days, after incident

**IMPACT PHASE**
Numbness, unreality, dream-like, helpless, confused and disorganised

**NORMAL RECOVERY**
1-10 days / 2 weeks

**RECOIL PHASE**
Emotional turmoil: fear, anger, guilt, extreme nervousness, pre-occupation
2 - 14 days

**RE-ORGANISING PHASE**
Gradually regaining control, resuming daily routines
- 4 weeks

**RECOVERY PHASE**
Gradual relief from symptoms; emotions become manageable; return to normal life; regaining sense of control, mastery and relative security
3 - 8 weeks

**FULL RECOVERY**
Some symptoms may remain, but do not interfere with daily life. The traumatic experience is integrated as a learning experience

**DEVELOPMENT OF PTSD**
(Post-Traumatic Stress Disorder)
Avoiding and repressing emotions, resisting own reactions trying to remain numb. Starts using chemical substances (to sleep, calm down). Own reactions are pathologised (defined as Abnormal).

Not able to re-organise, remaining in victim mode. Avoidance patterns set in. Feeling inadequate because of failure to control emotions and thoughts. Anxiety and Depression increasing. Sees self as damaged, helpless and incapable.

Symptoms become established or get worse. Avoidance patterns increase, self esteem Deteriorates.

**POST TRAUMATIC STRESS DISORDER**
Depressed, anxious, withdrawn, apathetic. The traumatic event is seen as damaging, representing loss in various ways. Persistent intrusive thoughts, re-living the event, avoidance strategies, panic and rage reactions. Reliant on chemical substances for short-lived relief. May take months to recover, may become chronic.