Psychosocial Aspects of Trauma Care

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Is there a psychosocial aspect to trauma?

• Studies have shown significant psychosocial symptoms in cases involving trauma from vehicular accidents

• Psychosocial factors are a large part of burn care

• Stress reactions to accidents and catastrophes are well documented

• Changes in physical appearance and function can be psychologically devastating
Research Findings

Psychosocial Factors Limit Outcomes after Trauma
Michaels, A. J. MD, MPH; Michaels, C. E. MD; Moon, C. H. BA; Zimmerman, M. A. PhD; Peterson, C. PhD; Rodriguez, J. L. MD
Journal of Trauma-Injury Infection & Critical Care:
April 1998 - Volume 44 - Issue 4 - pp 644-648

- Conclusion: Psychological morbidity after injury compromises return to work independent of preinjury employment and psychopathologic condition, Injury Severity Score, or ambulation. A high Impact of Events Scale score or peritraumatic dissociation at admission predicts this morbidity.

Research Findings

Psychosocial Aspects of Burn Injuries
Shelley A Wiechman, David R Patterson
British Medical Journal 2004; 329:391

- “With the increased survival of patients with large burns comes a new focus on the psychological challenges and recovery that such patients must face. Most burn centres employ social workers, vocational counsellors, and psychologists as part of the multidisciplinary burn team. Physiological recovery of burn patients is seen as a continual process divided into three stages—resuscitative or critical, acute, and long term rehabilitation. The psychological needs of burn patients differ at each stage.”
Premorbid personality factors that affect psychosocial recovery from physical trauma

- Presence or absence of premorbid psychiatric illness
- Financial and social status
- Family history of psychiatric morbidity
- Family members involved in the same accidental event
- Family approach to the trauma and recovery
- General resilience of the individual
- Response to major life events in the past
- Survivor guilt— if present after the accident
- Accidental trauma versus an industrial or workplace trauma
- Compensation and litigation issues

Stress Reactions in Humans

- Joseph LeDoux, PhD  SUNY
- Fear Pathways
  - Sub-Cortical
    - Fear Stimulus
    - Arousal of response system
    - Increase in Cortisol activates behavioral response
    - Very fast
  - Cortical
    - Fear Stimulus
    - Sub-Cortical Response
    - Activation of evaluation systems
    - Down or up regulation of the arousal of the response system
    - Much slower
Stress Reactions in Humans

What mediates the fear response after a shock or trauma?

Quality of relationships
  Attachment Type
  Resiliency
  Relationship history

Affect Regulation
  Locus of control
  Capacity to recover equilibrium

Attachment Patterns

• Secure

• Insecure-Avoidant

• Insecure-Preoccupied

• Disorganized
Resiliency and Relationships

• Resiliency – that inherent emotional quality that allows an individual to “bounce back” from setbacks

• Quality of relationships – history of long-term stable relationships that are viewed as positive is a good prognostic indicator

Affect Regulation

• The capacity to experience emotional states and process them and return to an emotional equilibrium

• Not hard wired into the development of the brain

• Dependent on the quality and consistency of early emotional care-giving
Trauma Disrupts the System

• By its very nature a traumatic event disrupts the equilibrium of the self’s response system to emotional distress

• Nature of the trauma

• Long-term or short-term

Acute vs Chronic Psychosocial Consequences

• Acute
  – Peritraumatic Dissociation
  – Agitation and distress
  – Combativeness and anger
  – Regression
  – Stabilization

• Chronic
  – Full Recovery
  – Anxiety or Panic Disorders
  – Depression
  – Post-Traumatic Stress Disorder
Peritraumatic Dissociation

• A dissociative response
  – Very primitive defense mechanism
  – Shell shock
  – Not due to physical trauma to the brain

• Seen at time of admission

• Poor prognostic indicator

Other Acute Reactions

• Agitation and distress
  – Loss of orientation to time and place
  – Confusion
  – Highly anxious
  – Unable to stop crying

• Combativeness and anger
  – Fear response fight or flight
  – Untrusting
  – Verbally or physically aggressive
  – Non-compliance with care

• Regression
  – Return to early styles of coping
  – Helpless
  – Dependent
  – Unable to make decisions

• Stabilization
  – Reestablishment of equilibrium
  – Locking in to a defended emotional state
Chronic Reactions

- Emotional responses are normal but if they are blocked in some way they can become pathological responses

- Fear to anxiety

- Grief to depression

Chronic Reactions

- Anxiety disorders
  - Panic attacks
  - Anxiety that won’t subside

- Depression
  - Disturbance in sleep
  - Disturbance in appetite
  - Crying all the time for no reason
  - Deadened responses and shut down

- Post-traumatic stress disorder
  - Nightmares
  - Flashbacks
  - Preoccupation with effects of trauma
  - Avoidance of normal emotional responses
Responses to Acute Reactions

- Be calm and reassuring with emotional reactions
  - Assure patient you are there
  - Listen to patient’s concerns
  - Don’t take the patient’s reactions personally
  - Don’t lie

- Encourage adaptive coping even if it is defensive
  - Allow some denial in early stages of care
  - Watch for dissociation
  - Encourage interactions with soothing staff or family members
  - Make sure that routines get established

Responses to Chronic Reactions

- On follow up ask about return to regular activities

- Don’t be afraid to pursue more in-depth questions if patient seems vague about how things are going

- Ask about how others see their adjustment
Tell tale signs and symptoms when a referral to a psychiatrist or psychotherapist is needed

- Anger that persists or is unreasonable
- Irritability that is not situation specific
- Poor social and family support
- Crying spells
- Loss of hope of recovery
- Long in-patient stay
- Multiple surgeries
- Depressed mood
- Poor financial support
- Loss of loved ones and family in the same traumatic event
- Loss of job
- Flashbacks and dreams regarding the event
- Sleep problems
- Chronic pain
- History of psychiatric illness in the past
- History of psychiatric illness in the family
- Preoccupation with appearance and function after recovery

Admission

<table>
<thead>
<tr>
<th>Expected Symptoms</th>
<th>Recommended Treatments</th>
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</thead>
<tbody>
<tr>
<td>Anxiety, Terror</td>
<td>Antianxiety Medication</td>
</tr>
<tr>
<td>Pain</td>
<td>Analgesic Medication</td>
</tr>
<tr>
<td>Sadness, grief</td>
<td>Psychological Support</td>
</tr>
<tr>
<td>Acute stress disorder</td>
<td>Reassurance</td>
</tr>
<tr>
<td></td>
<td>Normalization</td>
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<td></td>
<td>Relaxation Techniques</td>
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Psychosocial Care of Persons with Burn Injuries
Patricia E. Blakeney PhD, Laura Rosenberg PhD, Marta Rosenberg PhD, Prof. Dr. A.W. Faber PhD
In-Hospital Recuperation

<table>
<thead>
<tr>
<th>Expected Symptoms</th>
<th>Recommended Treatments</th>
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</thead>
<tbody>
<tr>
<td>• Increased pain with exercise</td>
<td>• Targeted administration of analgesics</td>
</tr>
<tr>
<td>• anger, rage</td>
<td>• Psychotherapy (Cognitive-Behavioral and Family Therapy)</td>
</tr>
<tr>
<td>• grief</td>
<td>• Pharmacological treatment of anxiety and depression</td>
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<tr>
<td>• depressive episodes, rapid emotional shifting</td>
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Rehabilitation and Reintegration

<table>
<thead>
<tr>
<th>Expected Symptoms</th>
<th>Recommended Treatments</th>
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</thead>
<tbody>
<tr>
<td>• Adjustment difficulties</td>
<td>• Re-entry program</td>
</tr>
<tr>
<td>• Post-traumatic stress disorder</td>
<td>• Medication targeting Post-traumatic stress disorder (Psychiatry)</td>
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<tr>
<td>• Anxiety (including phobic response)</td>
<td>• Psychotherapy (Cognitive-Behavioral and Family Therapy, social skills)</td>
</tr>
<tr>
<td>• Depression</td>
<td>• Anxiolytics tapered off over time</td>
</tr>
<tr>
<td></td>
<td>• Anti-depressant medication</td>
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</tbody>
</table>
Guidelines for Treatment

1. The patient is assumed to be a normal person and is expected to fully recover, and full recovery involves going through a difficult process over an estimated period of about two years.

From: Psychological and Physical Trauma: Treating the Whole Person by Patricia Blakeney, Ph.D. and Daniel Creson, M.D., Ph.D.

Guidelines for Treatment

2. Difficulties during the adaptation process are normal experiences of persons struggling to develop new lives, new body images, new ways of feeling good about themselves. Uncomfortable symptoms may be managed with medication when available to facilitate the patient’s work; for example, symptoms of sleep disturbance and/or flashbacks may be treated with low doses of an antidepressant so that the patients can sleep better, concentrate and be actively involved in their lives.

We do not treat them as if we expect them to remain trauma victims with symptoms which must be medicated for a long period of time. In fact, most of our patients remain on very low doses for less than one year.
Guidelines for Treatment

3. The family group, however the patient defines “family,” must be included in the patient’s treatment; in fact, the family (as a unit including the individual) becomes the patient for the psychotherapist. It is not always possible to include all members of a family in actual sessions, but it is always important to remember the whole family.

The needs of each member should be addressed as the family system changes to adapt to the new constellation, which includes a physically disfigured, physically injured person.

The long-term well-being of the patient depends very much on the well-being of the others in the family. Work with the family should promote autonomy as well as cohesion, so that each member can feel valued and supported by the others.

Guidelines for Treatment

4. Training and practice toward self-efficacy, particularly in the domain of social skills and social risk-taking, are important elements of treatment for physically disfigured persons. They must learn to deal with predictable hurtful reactions from naive observers, and learn to find positive relationship experiences in a realistic way.
Guidelines for Treatment

• 5. The psychotherapist can help the patient in defining a new self-image. In the early months or years, the patient is encouraged to overcompensate and enjoy the positive identification of “hero.” The survivor is commended for rehabilitation gains and social accomplishments. Each victory is celebrated.

• As the patient’s physical and psychological adaptation stabilizes, the psychotherapist can assist the patient in resisting the temptation to remain satisfied with the identity of “heroic survivor.” This role invites the survivor to strive to achieve expectations that are unrealistic, attempting to deny unhappiness or anger or pain.

• The task of the psychotherapist is to make explicit the expectation that each survivor is a human individual who can be strong and competent, optimistic and autonomous and also can have moments of sadness, despair or rage. Such uncomfortable human feelings must be validated.

• The psychotherapist can guide the patient to accept vulnerabilities and flaws without detracting from the overall positive evaluation of “self.” The person who has been the “heroic trauma survivor” can become a competent, interesting individual who also once survived a serious injury and a terrifying experience.

Web Resources

• Psychological issues in acquired facial trauma
  Avinash De Sousa

  http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3010784/

• Psychosocial Care of Persons with Burn Injuries
  Patricia E. Blakeney PhD, Laura Rosenberg PhD, Marta Rosenberg PhD, Prof. Dr. A.W. Faber PhD


• Psychological and Physical Trauma: Treating the Whole Person
  Patricia Blakeney, Ph.D. and Daniel Creson, M.D., Ph.D.

  http://maic.jmu.edu/journal/6.3/focus/blakeneyCreson/blakeneyCreson.htm