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# APS ACT Bushfire Talk

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# Questions (1)

- How psychologically and physically close were you to the worst impact of the ACT bushfires?
- How are you currently? Really?
- Why are you interested in the impact of ACT bushfires and the trauma area more generally? Really?
- How cognitively complex, differentiated and flexible are you?
- Are you able and willing to meet people where they are following exposure to life-threatening traumatic stressors?
- How do you or will you really look after yourself in undertaking this work?
- Do you know how to identify, collaboratively negotiate and regularly review a therapeutic plan with a potentially traumatised person?
- Can you offer a sound professional opinion on the nature and timing of contextualised best-practice strategies with potential clients who may be experiencing every area of their lives as significantly disrupted, who currently meet multiple diagnostic criteria and who are likely to act out their issues concerning control, power, anger and hopelessness in relationship with you?

# Questions (2)

- ☛ What are your usual primary goals in treating traumatic stress reactions? Are they surviving the session physically and psychologically intact; reducing PTSD symptoms; those of associated disorders; socially or vocationally unhelpful behaviours; and/or successfully managing the degree of impairment?

- ☛ What are the fundamental assumptions that underlie your understanding of human change processes? Do you have implicit assumptions of psychological or biological determinism or do you think people can really change in fundamental ways after exposure to severe traumatic stressors or more generally? Where do you draw the line in deciding who can change? What is your role in this change process? Is it you who makes the change happen?

- ☛ Are you a well-trained technician or a personally integrated professional who is committed, compassionate, theoretically informed, technically skilled, flexible and boundaried? Do you know the difference?

# Myths Concerning Traumatic stress reactions (PTSD and associated challenges)

- ☛ Everyone who is exposed to severe traumatic stressors will develop PTSD or some sort of psychopathology

- ☛ Community and personal recovery can be most helpfully understood as occurring in sequential and linear stages

- ☛ There are singular or simplistic explanations or answers for health and vocational outcomes following exposure to traumatic stressors

- ☛ The occurrence, severity and duration of PTSD and associated difficulties can be completely explained by pre-morbid and recovery factors

- ☛ The psychiatric profession is necessarily best equipped to assess or effectively treat severe traumatic stress reactions and clinical psychologists are only their handmaidens

- ☛ Anyone can effectively treat traumatic stress reactions if only they would use the correct assessment and treatment protocol without variation

# Closer Approximations to Factual Information (1)

- The aetiology of trauma stress reactions is informed by complex biopsychoscial realities (personal, trauma, recovery factors). These factors all reciprocally inform health, social and vocational outcomes
- There appears to be a robust scientific reality (in methodologically sophisticated epidemiological studies) that demonstrates a dose-response in trauma stress reactions
- Disasters vary in severity and nature and often involve massive personal and community disruption, disorganisation and loss
- Research efforts following disasters are frequently mounted without sufficient time and are beset with severe methodological difficulties
- It is scientifically invalid to compare the prevalence rates of psychological distress following disasters with each other or with other traumatic events
- Research reviews indicate that a considerable number of people experiencing disasters may develop PTSD and other persistent psychosocial difficulties
- Disaster prevalence rates of PTSD vary considerably
- The diagnostic criteria for PTSD continue to have severe limitations
- There few adequate theoretical models to explain the process of relationships between personal, trauma and recovery variables

# Closer Approximations to Factual Information (2)

- The evidence convincingly demonstrates that about half those people who are initially diagnosed with PTSD will continue to reach diagnostic criteria for long periods of time and sometimes for decades
- Many people diagnosed with PTSD concurrently meet criteria for other diagnosable psychiatric conditions ie. substance abuse, depression, social adjustment problems, other anxiety disorders, obsessive- compulsive disorder and sexual difficulties
- Accelerated psychological development and functioning can and does happen in response to successful accommodation of traumatic stressors and their impact
- There are factors that appear to promote and facilitate individual and community resilience to disasters and other traumatic stressors
- The most severely distressed are the least likely to reach out for help or to access resources.
- People with PTSD commit suicide eight times more frequently than those without PTSD even after the influence of depression is statistically controlled
- Early co-morbid depressive symptoms are strong predictors of the development of chronic PTSD

# Some essential features of successful treatment for traumatic stress reactions (1)

Comprehensive assessment that includes thorough identification of presenting difficulties and strengths across the major areas of functioning and:

- generational psychosocial history
- generational and personal history of trauma,
- substance use and medical history,
- occupational history,
- relationship history,
- previous therapeutic history,
- current social networks and their perceived quality,
- concurrent life stressors,
- rationale and feelings associated with the traumatised person seeking help,
- the traumatised person's account of precipitating events leading up to this current presentation,
- current personal attempts to heal and restraints to progress.
- Process will usually include both structured interviews and formal psychometric testing depending on the needs and priorities of the particular traumatised person and treatment setting.
- Such a process may uncover various co morbid problems which are commonly associated with traumatisation

# Some essential features of successful treatment for traumatic stress reactions (2)

- ☛ Becoming knowledgeable and informed about best practice in the assessment and treatment of traumatic stress reactions

- ☛ Exposure Therapy, Stress Inoculation training, Cognitive processing therapy and Cognitive therapy are best supported by the available randomised controlled outcome studies (RCT's) (see ISTSS Guidelines for Treatment of PTSD, 2000)

- ☛ Effective therapy is a process, within a relationship, that is understood to act as a significant catalyst to enable traumatised people to re-formulate more complex meanings about their identity, personal power, reality, value and fundamental social roles that incorporate but are no longer entirely informed or dominated by their traumatising experiences as manifested in symptoms

- ☛ Therapy assists traumatised people to enact these new meanings in the ways they think, feel, behave, relate and experience their bodies. This process is not linear and sequential but circular and interactive

- ☛ Practitioners remember that therapeutic techniques do not exist independently of the way they are understood by the traumatised person

# What are the benefits of evidence-based treatment?

- Probably helped to stop some harm
- R C T's can challenge conventional wisdom
- Identified a multitude of interrelated predictor variables and complex sequelae
- Appears to be some alleviation in suffering that is apparently maintained at follow-up
- Helped to identify the common elements of successful treatments i.e. emotional and cognitive processing of the traumatising experience, gradual re-exposure to the event/s and reformulation of its meaning

# Are there limitations to the evidence base?

Well Yes!

- Often focus on select populations rather than the more complex cases in clinical practice
- Most distressed clients generally do not volunteer or drop out of such studies
- Traumatic incidents may precipitate consequences associated with unresolved but different traumatic experiences and amplify traumatic symptomatology.
- Dominated by the experimenter orientation model. There is little recognition of the need for collaborative co-operation between the data contributor and the data collector
- A failure to identify consistent correlations between specific aspects of therapeutic process and treatment outcomes because of repeated attempts to find simple direct associations to the neglect of more complex research conceptualisation of process that adequately reflect the interaction of multiple influences in clinical treatments
- The confounding of quite divergent meta-theoretical assumptions underpinning therapeutic interventions within treatment classifications may partially account for the difficulty meta-analytic reviewers have experienced in demonstrating significant differences between treatments
- Ethical concerns about the effects of research interaction on psychological health. Research demonstrates that those maltreated in these research projects tend to underestimate its impact.

# What are dangers of generalising from the evidence base? (1)

- Might suit the pecuniary interest of some organisations and some treatment outcome researchers
- Often presumed that these findings are in some way absolute, timeless and relatively simple
- Unique clinical capacity of those providing treatment is often assumed to be a given and far less important that the techniques they use
- Risk of indulging in logical fallacies (e.g. a psychiatric drug appears to help this condition therefore the condition must be caused by biology).
- Training, supervision, accreditation, research funding and treatment becomes informed almost exclusively by the dominant paradigms and power brokers
- Risk of effectively filtering the traumatised person's world to fit within our preconceptions, our knowledge base, group differences and the forced choices of our standardised outcome measures
- "spontaneous recovery" has been reported to occur in 60% of cases of recent PTSD within 1 to 6 years following trauma exposure and the symptoms intensity in chronic PTSD is fluctuating and unstable
- PTSD symptoms (re-experiencing, avoidance and hyper arousal may not capture other clinically relevant aspects of treatment (reduction in co-morbid symptoms and social and vocational impairment).

# What are dangers of generalising from the evidence base? (2)

- Adverse living, conditions, ongoing direct trauma exposure or exposure to reminders can confound the impact of treatment
- Non-specific and uncontrolled effects of interventions (placebo, repeated assessment may simulate desensitising of trauma, sampling bias and patient selection)
- Factors related to natural course of the disorder (may be claimed as a success when still has many residual symptoms but does not meet diagnostic criteria for PTSD)
- Often ignores evidence of the crucial rather than incidental role for therapeutic process issues or non-specific factors in treatment outcome (unmeasured therapist variables, the nature and impact of the therapeutic alliance, the true ownership of the recovery process, the nature, timing, order and frequency of interventions, distinguishing between apparent recovery vs avoidance and dissociation, termination issues)
- In ethical practice clinicians must find an appropriate balance between the development of individual, social and vocational resources and a focus on current life events and traumatic material