11 COPING WITH TRAUMA

AIM OF THIS CHAPTER

The aim of this chapter is to explore current understandings of trauma. We look at:

- how stress and traumatic experiences are defined
- what some of the key inner and outer world dimensions are to consider in terms of risk and protective factors
- what trauma-informed care is, and how it reflects a multidimensional approach to working with trauma survivors.

KEY TERMS

acute stress disorder (ASD)
appraisal
approach coping
assets
avoidant coping
betrayal trauma theory (BTT)
conservation of resources (COR) theory
coping strategies
coping style
crisis
critical incident stress management (CISM)
defence mechanisms
distress
fight-or-flight response
freeze response
hope
memory
optimism
potentially traumatic events (PTEs)
psychological first aid (PFA)
shattered assumptions
stress
stressor
trauma

As social workers, we are often involved in people's lives at key points of **stress** and trauma. In this chapter, we look at how a multidimensional approach can help us assess what is going on in these situations, and inform our practice approaches. We will look at each of the inner and outer world dimensions and begin to integrate this into an understanding of trauma. Before we do this, we explore what sorts of experiences or events we are referring to when we talk about trauma.

stress demands placed on a person that cause them to use resources to respond in some way.

THE NATURE OF TRAUMATIC EXPERIENCES

'Trauma' is a word that is used in everyday language to refer to a wide variety of experiences that disrupt and punctuate our lives. The word 'trauma' is derived from the Greek word

traumata meaning 'to wound'. It conveys a strong sense that a wounding or injury, rather than just a demand or disruption, has occurred. As with a physical wound, in many instances there is a need for intervention. But in using the image of a wound we can also recognise the fact that human beings, like many wounds, are capable of healing, given the right conditions.

trauma the major psychosocial impact of events that overwhelm our coping capacity.

Trauma refers to experiences where a person is confronted with demands that exceed and overwhelm coping capacities. Given that traumatic experiences are those that threaten physical and psychological integrity, typically there is a significant impact on at least immediate if not long-term functioning, involving distress and disturbance.

There is a lot of debate in the practice and research literature about what constitutes a traumatic event, or a trauma. Factors to consider include 'the frequency, severity and duration of the event/s experienced, the degree of physical violence and bodily violation involved, the extent of terror and humiliation endured and whether the trauma was experienced alone or in the company of others' (Harvey, 1996, p. 8).

The DSM-5 (APA, 2013) puts forward strict criteria for what constitutes a traumatic event under the diagnostic label of post-traumatic stress disorder (PTSD). The current criteria are outlined in Figure 11.1.

FIGURE 11.1 Traumatic event/s exposure criteria for a PTSD diagnosis

A Exposure to actual or threatened death, serious injury, or sexual violence, in one (or more) of the following ways:

1 Directly experiencing the traumatic event(s)

2 Witnessing, in person, the event(s) as it occurred to others

3 Learning that the event(s) occurred to a close relative or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

4 Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

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These criteria typically change in each edition of the DSM-5, reflective of the ongoing evidence-building and also debates in relation to defining traumatic events—for example, does this definition adequately speak to the traumas of colonisation for many Indigenous Australians, given the emphasis in this definition of single incident and embodied trauma, rather than cumulative and intergenerational trauma experiences?

stressor a particular demand on a person, such as an event or an expectation held by others.

Trying to set a threshold and description as to what constitutes a trauma is complex, as the research findings are mixed in relation to the negative impacts of particular traumatic events. It has not been possible to confirm 'the powerful relationship between the **stressor** and subsequent symptoms' (McFarlane, 1995, p. 40). It is possible that events experienced as traumatic by one person are not experienced that way by another. A number of

counterintuitive findings have emerged in relation to the effect of proximity to the stressor on distress outcomes. This emerged from studies of Vietnam veterans, which showed that those with least proximity to the traumatic events were the most traumatised (Boscarino, 1995). Similarly, McFarlane (1992) in his follow-up of 469 firefighters at 4, 11 and 29 months after the Ash Wednesday bushfires found that, 'neither the magnitude of people's losses nor the intensity of their exposure was a direct cause of disorder'. On the other hand, Biernat and Herkov (1994) found in a study of student reactions to campus murders that negative consequences *were* related to proximity to the stressor. Those closest to the event experienced greater levels of distress. This proximity finding was similarly found in a study of longer-term recovery from the 2009 Black Saturday bushfires, where those in the highest impacted communities in terms of loss of life and property were more likely to have higher levels of PTSD (Bryant et al., 2014; 2018).

One way of acknowledging this complex relationship is to refer to **potentially traumatic events (PTEs)** rather than assuming all events of a particular type are traumatic and are experienced as such by all people who encounter them (Phoenix Australia, 2013).

potentially traumatic events (PTEs) a categorisation of events that recognises that events experienced as traumatic by one person may not be experienced that way by another.

Therefore, listening to people's lived experiences is critical, given the many factors that are interacting. In these examples alone, you can hear that traumatic events can be experienced at individual through to community, national and international levels: as single incidents or multiple, compounding experiences. Traumatic experiences also always occur in the critical dimensions of time and place—in the external realities of physical and political contexts, for example. A multidimensional approach encourages a broad focus on all of these personal and environmental factors that influence both these trauma events in the first place, and people's reactions both during and in the aftermath of such experiences.

INNER-WORLD DIMENSIONS OF TRAUMA REACTIONS AND RECOVERY

In this section, we look closely at how trauma impacts our biological, psychological and spiritual dimensions.

BIOLOGICAL DIMENSIONS

As we have explored in the earlier chapters, biological age can influence profoundly the exposure to different traumatic experiences and the coping capacities and resources available to a person at that point in their life. In that context, extensive work has been undertaken over the past two decades to understand the biological and neurobiological processes involved in the trauma experience (Vermetten et al., 2018). The research has focused on the role of, particularly, the anterior hypothalamus, the amygdala and the hippocampus (van der Kolk, 2014; Szeszko & Yehuda, 2019). Of particular interest has been the way in which exposure to certain stressful situations activates these receptors. To understand these neurobiological processes, it is important, first, to understand the stress response.

FIGHT-OR-FLIGHT RESPONSE

When we experience increasing demands, we have what is termed a stress response, the common physiological response to stress (Selye, 1987). In the 1950s, Selye identified the general adaptation syndrome, which includes the three stages of non-specific physiological response outlined below. He argued that the stress response is non-specific in that the physiological response is the same, regardless of the source. Research over many years has identified two major systems as playing key roles in the stress response: *the sympathetic nervous system* and *the hypothalamus–pituitary–adrenaline system*. The sympathetic nervous system initiates what was originally called the **fight-or-flight response** (with freeze added later). With the release of noradrenaline and adrenaline from the hypothalamus, the heart rate increases (as does our blood pressure), sugar is released into the bloodstream, the blood flow increases to our legs and vital organs, our immune system is further activated, and our breathing rate increases (as does our sensory arousal of hearing and sight). While these systems switch into a heightened state of functioning, other systems, such as the digestive and sexual/reproductive systems, shut down as they are not required at this point in time (The American Institute of Stress, 2020). The hypothalamus–pituitary–adrenaline system then helps to convert the body's energy reserves into a form ready for immediate use. The changed biology of the stress response ensures that the human body is prepared for action: either to flee quickly from the threat, or to fight the imminent threat (Resick, 2001). A third response, the **freeze response**, has also been identified, whereby we are so overwhelmed by the stress that we become immobilised, unable to respond in any way. This is more consistent with a dissociative trauma response.

fight-or-flight response recognised by Selye as the key stress response in humans, whereby when under threat people respond automatically in ways that prepare them to physically and/or mentally fight the stressor or flee from it.

freeze response a stress response that occurs when stress is so overwhelming that a person's coping capacity shuts down.

The three phases of the stress response that Selye identified are:

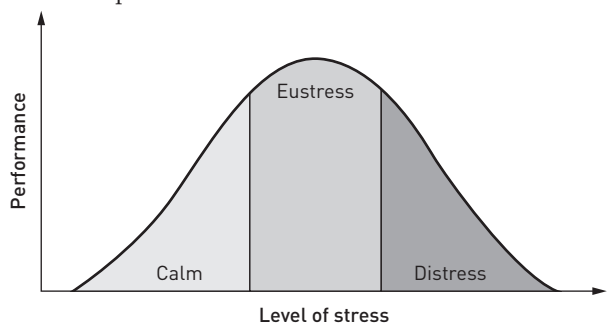
1 an alarm and mobilisation reaction, when hormones are mobilised for action
2 a stage of resistance, when response systems are activated to return the body to homeostasis
3 a stage of exhaustion, when the demands on the body's systems can be sustained no longer.

The stress response, biologically speaking, is intended to be a short-term response (The American Institute of Stress, 2020).

This response was particularly adaptive for humans thousands of years ago, when threats were tigers or invaders, requiring an immediate physical response. Many people today still live with a range of direct physical stressors. However, many stressors that we experience today, such as dealing with poverty, conflict in relationships or even completing essays, do not typically require a physical solution, yet the response is the same. We can exist in these states for short periods of time with little effect, but if we remain in these aroused states for prolonged periods of time, health difficulties arise.

The stress response has a critical survival function: it readies us for action, to take on or evade threat, or, when situations are acutely traumatic, enables a shutting down or 'freeze' response. This emphasises that stress is a normal part of human experience, and

FIGURE 11.2 The stress-performance curve



Source: The American Institute of Stress.

that different stress levels then have different impacts. Selye (1987) distinguished between four types of stress:

distress arises when stress has a harmful effect on us.

1 ***distress***, arising when stress has a harmful effect on us
2 *eustress*, being stress that has a beneficial effect
3 *hyperstress*, referring to an excessive amount of stress
4 *hypostress*, being insufficient stress.

Each of these distinctions is important in considering how people are adapting to the adversities that they face. Thus, stress does not necessarily mean dysfunction or distress. A moderate level of stress is necessary for motivation and for a heightened performance, as the widely accepted performance curve in Figure 11.2 suggests. However, distress and hyperstress have profound implications on our physical state of being as well as other dimensions.

Hyperarousal is the term used in a PTSD diagnosis to describe this hyperstressed state. Figure 11.3 outlines the definition of arousal and reactivity.

FIGURE 11.3 PTSD hyperarousal criteria

E Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:

1 Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression towards people or objects
2 Reckless or self-destructive behavior
3 Hypervigilance
4 Exaggerated startle response
5 Problems with concentration
6 Sleep disturbance (e.g. difficulty falling or staying asleep, or restless sleep).

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12 COPING WITH LOSS

AIM OF THIS CHAPTER

The aim of this chapter is to explore multidimensional understandings of loss and grief. We explore:

- definitions of loss and grief experiences
- inner- and outer-world risk and protective factors associated with grief experiences
- what some of the approaches are to working with people who are grieving.

KEY TERMS

anticipatory grief
bereavement
chronic sorrow
complicated grief
continuing bonds
disenfranchised grief
dual process model
grief
grief reaction
loss orientation
mourning
non-finite grief
prolonged grief disorder (PGD)
restoration orientation
traumatic bereavement

Experiences of attachments to people, places and ideas are critical to our survival and our sense of well-being, right across the lifespan. When we inevitably lose some of these attachments, we typically feel intense and distressing reactions to their absence: 'The pain of grief is just as much a part of life as the joy of love; it is, perhaps, the price we pay for love, the cost of commitment' (Parkes & Prigerson, 2010, p. 39). Theories about these losses are different from the understandings of stress and trauma, although there are points of commonality and intersection.

Most of the grief literature describes experiences that are associated with the loss of relationships with other people, most typically with the death of a significant person. Death takes many forms—from the sudden death of someone to an anticipated death following chronic illness. These deaths are sometimes in the context of relationships that have spanned lives, such as siblings who have known each other for 80 years or more, and partners who have been together some 50 or 60 years (Marshall & Winokuer, 2017). Other deaths take place in the context of extremely short-term but nevertheless significant relationships—with the birth and death of a child, for example, or in the context of recent partnerships.

Other interpersonal losses occur as a result of separation. Where a relationship has become stagnant or toxic, a person goes missing, an affair has occurred or there is mutual agreement that the relationship has run its course, experiences of loss can be profound. Other losses come about as a result of separation because of various life events: migration, moving communities, changing jobs, or moving to a nursing home, for example.

Losses can be associated with place and possessions, as a result of changes in both the social and the physical environment. Peter Read (1996), in his book *Returning to nothing*, portrays vividly the loss of place for people that occurred, for example through Cyclone Tracy, which devastated the city of Darwin on Christmas Day, 1974. Many other significant losses of place are part of the Australian psyche: through bushfires such as Ash Wednesday in 1983; Canberra in the summer of 2001; Black Saturday in Melbourne, 2009; and across most states and territories in 2019 and 2020; and cyclones that affected the northern areas of the country most; and the Newcastle earthquake, to name a few. In these instances, both the physical and social fabric of the communities involved has been significantly damaged (Ogie & Pradgan, 2019). Along with this loss of the physical environment can come a profound loss of a sense of belonging and connectedness (Harms et al., 2015). The reminders of past history can be gone in a matter of minutes.

Losses can also occur within the inner worlds we occupy, which are often invisible to those around us. We can experience the loss of dreams and hopes, the loss of a worldview or of a good sense of spirituality and connectedness. We can feel very profoundly the loss of an anticipated social role, through unemployment, or the death of a child or grandchild, or by missing a place at university. We can experience the loss of part of our bodily self or function, through injury, incapacity or ageing.

The language of grief tends more to be a language of feelings, related to the heart and soul, than the language of trauma and stress, which relates more to matters of the mind. In contrast, the language of our textbooks sanitises significantly the experience of grief, making it sound like an experience that is somehow much more contained and understandable than the existential crisis that it so often is. Some even medicalise it to such an extent that it sounds like a medical condition, not a response to psychosocial loss. This raises the critical question as to when, if ever, grief becomes a condition (Parkes & Prigerson, 2010) requiring treatment and intervention, as we will explore throughout this chapter.

SOME KEY DEFINITIONS

Within the grief literature, four key terms are frequently used, often interchangeably, in relation to these experiences, defining different but intersecting aspects: loss, grief, bereavement and mourning. Some of these definitions may seem a little dated, but they capture the essence of these experiences in ways that remain highly relevant in social work practice today.

Loss, according to Weiss (1988, p. 38), 'is an event that produces persisting inaccessibility of an emotionally important figure'. This definition can be expanded

to include the persisting inaccessibility of an emotionally important place, object or role. Additionally, it may not be about a single event as much as a change of attitude or inner world experience. Inaccessibility is the key feature of the loss experience—the inaccessibility of a relationship or a dream or whatever is desired—that makes loss so overwhelming and seemingly unbearable. What is loved, yearned for or familiar is no longer there and typically cannot be there again. Even though continuing connections with many aspects of the experience may be possible, loss brings about a new reality (Freud, 1984; Worden, 2009).

In response to these loss experiences, we have what is termed a **grief reaction** (Parkes, 1972): 'any loss which fundamentally disrupts the central purpose of our lives will normally provoke severe and long-lasting grief' (Marris, 1993, p. 81). This reaction is a complex biopsychosocial–spiritual one, determined by the nature of the loss, the context of the loss, and our own inner- and outer-world resources. Marris (1993, p. vii) describes grieving more specifically as referring to 'a process of psychological reintegration, impelled by the contradictory desires at once to search for and recover the lost relationship, and to escape from painful reminders of the loss'. This is in many ways consistent with theories of trauma: grieving is a process that involves both avoidance and intrusion. **Bereavement** refers to the experience of having lost someone or something as a result of death or separation—that is, someone who is grieving is bereaved.

Sometimes, a distinction is made between **grief**, referring to the emotional response to the loss, and **mourning**, as the behavioural and social processes that occur following grief (Raphael, 1984). A distinction is made also between bereavement and traumatic bereavement (Raphael & Meldrum, 1994), an important distinction in light of the discussion in the previous chapter. **Traumatic bereavement** emerges in the aftermath of trauma incidents, and it is argued that the reaction is more consistent initially with a trauma response in these instances, with grieving processes emerging later in the recovery experience.

grief reaction the bio-psychosocial-spiritual reactions to loss.

bereavement the experience of having lost something of significance. Most typically, having lost a significant relationship with a person through death.

grief the emotional response to loss.

mourning an individual's and community's rituals and social processes following loss experiences.

traumatic bereavement the experience of the death of someone through traumatic circumstances, resulting in both grief and trauma reactions and responses.

GRIEF AND LOSS EXPERIENCES

Many studies have highlighted specific event-related factors that seem to influence subsequent bereavement experiences to a greater or lesser degree: whether there is forewarning of its occurrence, whether it is an ongoing loss, and whether there are specific losses that are inherently more traumatic or stressful than others (Parkes & Prigerson, 2010). Some specific characteristics of events are frequently examined for their potential to be risk or protective factors, primarily in relation to loss situations involving the death of a significant person. These factors include the suddenness and unexpectedness of loss, the violence involved, whether the death was a result of suicide, and the perceived timeliness of the death. Deaths that are sudden and unexpected are regarded as causing greater difficulty in the mourning process. Whereas, as argued earlier, anticipated deaths prepare people in some ways for what will inevitably occur, sudden deaths occur with no warning and no time for such preparation. A sense of unfinished business and regret often lingers. We look at some of these factors now.

anticipatory grief grief experiences where the loss is known about before it occurs, such as someone dying from a terminal illness.

Anticipatory grief is observed as the process prior to the impending death or loss of a person. Anticipatory grief was a term developed by Rando (1986, p. 24), who defined it as:

> the phenomenon encompassing the processes of mourning, coping, interaction, planning and psychosocial reorganization that are stimulated and begun in part in response to the awareness of the impending loss of a loved one and the recognition of associated losses in the past, present and future.

Anticipatory grief has been explored in relation to many chronic illness situations. The understanding of anticipatory grief is that the knowledge of an impending death leads to a different grief reaction than if the loss experience has been sudden and unexpected. The argument is that the grief work has already begun prior to the death. It was therefore anticipated that those who were grieving as a result of anticipated situations might have a less severe grief reaction once the death occurred. Rando (1986, p. 24) suggests that the griever in this situation is 'pulled in opposing directions', with the task being to 'balance these incompatible demands and cope with the stress their incongruence generates' (Rando, 1986, p. 25). Others suggest that it is a more specific reaction, mourning parts of the relationship and/or roles, but maintaining an ongoing investment in the relationship and grieving its loss only after the death of the person.

chronic sorrow a term that was used to describe the experience of people living with constant loss and grief—e.g. the experience of parents with a child who has a disability or life-threatening illness.

Some situations of loss are considered to be more ongoing than others, with a capacity to involve persistent grieving. One area where this has been perceived to be relevant is in the experience of disability, where parents are reminded continually of what could have been and what has been lost. Olshansky (1962) developed the notion of **chronic sorrow** to refer to this experience of people living with constant loss and grief. This term has been reinterpreted by Bruce and Schultz (2001; 2002) as **non-finite grief**. This notion refers to grief that is recurrent throughout the lifespan in response to the losses associated particularly with disability. That is, they are the grief reactions evoked in response to 'what should have been' that are reawakened through anniversaries, significant developmental milestones and the 'lack of synchrony with hopes, wishes, ideals and expectations' (Bruce & Schultz, 2001, p. 7).

non-finite grief ongoing and recurrent grief that occurs in response to anniversaries or particular milestones that would have been reached had the loss not occurred.

As you can hear through these definitions, the perceived cause of the loss is also important. Following loss experiences, searching for answers to the question 'why?' is a common process. Where there has been a violent death as a result of homicide or suicide, the questions of why, and the trauma associated with such a death, are seen to be complicating factors in the mourning process (Currier et al., 2006).

As individuals and communities, we tend to hold assumptions about age- and stage-appropriate life events, particularly in relation to death and dying. That is, we tend to believe that there is a correct life sequence (Berger & Luckman, 1966; Neugarten, 1996), both for ourselves and for others. The death of a 90-year-old patient in a nursing home is viewed significantly differently by society than the death of a 3-year-old child, for example. We carry in our minds a sense of the 'correct' life sequence: parents predecease their children; older people predecease younger ones. This is sometimes referred to as the ranking of grief, in this instance in relation to biological age. It can also occur in relation to other social hierarchies of grief: the idea that 'we all carry within us monologues of

comparative bereavement wherein we take measure of our own need to mourn against our own right to mourn and do in light of others' needs and rights' (Peskin, 2000, p. 104).

These assumptions about death and dying reflect our meaning structures (Marris, 1996; Neimeyer, 2012), both individual and cultural, and highlight the ways in which different cultural contexts influence bereavement. In communities where infant mortality rates are very high, for example, very different cultural expectations around death and bereavement exist. Western cultures have come to expect that, with such significant advances in medical technology, death can be avoided, particularly in infancy and childhood. Similarly, with so much death and dying removed from everyday experience within many Western cultures, and managed within the context of hospitals and hospices, very few people come to witness death as a natural part of life.

Increasing recognition is being given to the impact of intergenerational loss experiences, primarily through the experiences of the Holocaust survivors and Australia's Indigenous populations. These experiences of oppression and persecution, involving the multiple losses of people, places and a sense of identity, have reverberated through to the next generation (Yehuda & Lehrner, 2018).

OUR OWN DEATH

The literature tends to focus on the experience of grief in the prelude or aftermath to someone else's death or to some external loss experience. Elisabeth Kübler-Ross, a Swiss psychiatrist who migrated to the USA, however, was a pioneer from the late 1960s onwards in highlighting the grief individuals experienced when facing their own death. Broaching issues that were previously taboo within the medical profession, she spoke with hundreds of dying patients and raised a critical awareness of the inner worlds of the dying person (Kübler-Ross, 1970). She observed five stages of grief experience that many patients seemed to experience (described later in this chapter—see 'Stages of grief'). While many practices have changed for individuals in the final phase of life, and for the ways in which hospitals and other health systems respond to them, there are still major taboos surrounding death and dying. Many Eastern cultures, for example, are protective of a patient being aware of their impending death. In Chapter 10, we looked at terror management theory (Pyszczynski et al., 1999; Solomon, 2012), which has been proposed as a way of theorising these taboos and responses, and explaining how people manage the knowledge that we will inevitably die.