

Information gathering after trauma: Considerations for human rights work, peacebuilding, and interviews about traumatic events

Laurie Leitch, PhD

Co-founder and Co-director, Trauma Resource Institute

Abstract

Efforts to collect information from victims of human cruelty (as well as survivors of natural disasters) can provide essential information to be used in promoting justice, enhancing peacebuilding, and developing preventive programs. Both victims and interviewers often believe that telling the story of what happened will not only provide needed evidence but also will be the beginning of healing. This article focuses on what neuroscience can contribute to the way that traumatic-events evidence is collected. The way that “the story” is told has a powerful impact on whether the interview or debriefing process will be re-traumatizing to the victim/survivor or will be a step toward healing. The way that evidence is collected can also promote or reduce the likelihood of secondary traumatization for the interviewer. Recommendations are presented, using the Trauma Resiliency Model (TRM), for collecting evidence or hearing “the story” in a way that manages high arousal, contributes to the healing and resiliency of survivors, and reduces potential secondary traumatization and burnout of the interviewer.

Introduction

When traumatic events occur the documentation of what happened from the point of view of survivors can provide valuable information for use by, for example, Truth and Reconciliation Commissions, courtrooms, the media, peacebuilders, and social service workers. Services for survivors often include debriefings in groups in which each person is able to “tell the story” of what happened. Individuals can begin to feel understood, “seen,” and supported when they know that their experience of what happened to them has been witnessed. There can be a sense of solidarity with others who have also experienced the event. There is, however, a serious underbelly to the process of being witnessed and giving evidence: there is the potential for re-traumatization of the survivor and secondary traumatization of the interviewer and/or debriefing group members.

Knowledge of the ways the human nervous system responds to trauma, including how it responds when *hearing* about the trauma of another person, can reshape interviewing and debriefing processes in ways that promote healing rather than reinforce nervous system dysregulation and re-traumatization. The Trauma Resiliency Model (TRM) is a skills-based

Leitch, Information gathering after trauma

intervention program that uses a manual (Miller-Karas, E. & Leitch, L., 2007) based on the biology rather than the psychology of traumatic response. The approach draws on neuroscience research, including neuroimaging studies (Lanius, 2004), which shows how trauma affects cortical and subcortical processing of information and, as a treatment modality, the resolution of post-traumatic stress activation through the completion of thwarted fight and flight responses and skills of self-regulation (Levine, 1996). TRM offers concrete guidance to individuals who collect evidence by interviewing survivors as well as to those whose role it is to initiate a process of healing from traumatic events that includes “telling the story” of what happened.

Effects of disasters and large-scale traumatic events

Carr, Lewin, Webster, Kennedy Hazell & Carter (1997) describe two sets of psychological consequences that arise from a disaster, but which can also characterize other catastrophic or large-scale traumatic events such as tribal and ethnic violence and terrorism: “threat effects” (those occurring in the immediate aftermath) and “disruption effects” (those extending weeks, months and sometimes years beyond the disaster). Disruption effects can include constant exposure to debris and damage of infrastructure, disillusionment with governmental agencies, living in resettlement housing and camps, displacement, fear of the next hurricane/flood/fire season, property and job loss, fragmentation of families, financial stress, on-going tensions with and danger from opposing political, ethnic, and tribal groups, and the array of emotional symptoms associated with each effect. The Carr, et.al. study highlights the fact that many traumatic events are not circumscribed events with a defined endpoint.

When left untreated, traumatic stress reactions have been found to lead to long-term negative mental-health effects (Bower & Sivers, 1998; Brady, Killeen, Brewenton & Lucerini, 2000; Mayou, Bryant & Ehlers, 2001). Further, symptoms from a traumatic event can still be present after many years and may not spontaneously remit (Kessler, Sonnega, Bromet, Hughes and Nelson, 1995). Levels of symptoms found early in the post-disaster period have been found to be strong prognosticators of later symptomatology (Norris, 2001).

The body and trauma

There is growing and substantial evidence that in addition to psychological trauma, survivors of trauma also suffer significant and often debilitating physical or somatic symptoms resulting from their experience. Thus, traumatic stress causes both mental health problems and a variety of serious somatic symptoms, including loss of bowel and bladder control (Solomon, Laor & McFarlane, 1996); shaking, trembling, and increased heart rate (Bernat, Ronfeldt & Calhoun, 1998; Shalev et al., 1998); myofascial pain (Scaer, 2006); diabetes (Golden, Williams & Ford,

Leitch, Information gathering after trauma

2004); heart disease (Musselman & Nemeroff, 2000), and a continuum of stress-related diseases (Green, Grace & Glesser, 1985; Scaer, 2006).

The trauma field is now seeing the arrival of body-focused interventions, such as TRM, in which the *primary* emphasis is on traumatic symptoms as patterns of dysregulation in the nervous system rather than on cognitions and emotions. Research using neuroimaging (Mujica-Parodi, Greenberg, & Kilpatrick, 2004) finds that even under relatively mild emotional challenge that negative emotion significantly affects many components of cognitive functioning. Biologically-based models focus on brain-stem survival responses and dysregulation in the autonomic nervous system (ANS) rather than neo-cortical cognition. These models have benefitted from advances in neuroimaging techniques which show Autonomic Nervous System arousal patterns following traumatic events (Lanius, et.al, 2004).

Patterns of dysregulation increase the risk of physical and psychological illnesses such as immune-system disorders, depression, anxiety, and cognitive impairment (Gunnar & Vazquez, 2001; McEwen, 1998; Sapolsky, 1994). Studies such as these highlight the importance of interventions that use knowledge of nervous system response to trauma and trauma processing and which target regulation of the ANS. Their findings also highlight the value of monitoring arousal patterns during interviewing and debriefing and using patterns of questioning which help maintain nervous system balance.

Secondary Traumatic Stress

During my work in Rwanda training mental health workers in 2006 (Leitch, 2007) in TRM a trainee described having lived with a sharp pain across the top of her head that she described as feeling like a machete slash. She had been checked by physicians and been told there was nothing physically wrong. While the woman had not directly been wounded by a machete during the genocide in 1994 that killed hundreds of thousands, nor had she actually witnessed people being slashed, she had heard many clients describe their terror as the genocide unfolded, their own wounds, and what they had seen happen to others. Her sensory experience of a slash on her head was, most likely, the result of secondary traumatization and had not lessened over many years.

Social service providers, human rights workers and other professionals are often thought to be immune from typical traumatic responses that characterize “ordinary people” (Bamber, 1994). However, even when an individual has not experienced trauma directly, listening to the

Leitch, Information gathering after trauma

aftereffects of traumatic events as described by clients can result in what is commonly referred to as “vicarious traumatization or Secondary Traumatic Stress (STS)” (Blair & Ramones, 1996; Schauben & Frazier, 1995; Figley, 1999; Sexton, 1999), and can in some instances result in traumatic stress (Lerner, 2005) and the development of PTSD (Zimering, Gulliver, Knight, Munroe & Keane., 2006). Bride’s (2007) study of STS symptoms in 282 social workers found that 25% of the sample reported the following STS symptoms occasionally to very often: intrusive thoughts about clients, avoidance of clients, diminished activity level, emotional numbing, foreshortened future, irritability, and difficulty concentrating. A study by Luce, Firth-Cozens, Midgley, & Burges (2002) found that individuals who experience a trauma both as a “civilian” and as a professional have higher levels of symptomatology than those that experience the traumatic event solely as a civilian or as a professional. The traumatic stress reactions that often follow a catastrophic event can hinder the ability of local responders to function at pre-event levels with their constituencies (Leitch, L., 2009). Secondary traumatization can also impair the willingness and ability to fully connect with clients and can lead to high levels of staff-turnover due to burnout.

During the training in Rwanda, the worker described above volunteered to do a demonstration with me. Using TRM skills, which are focused on releasing stored traumatic energy and re-setting the ANS, she was able to shift her awareness between the pain across the top of her head and places in her body that felt no pain or even felt positive (calm, relaxed). After about twenty minutes of this shifting of attention between the pain and no-pain she described sensations of warmth on the top of her head and down her face. The pain had disappeared completely. I continued to check with her about the pain over the several days of the training and it had not returned.

TRM skills are used in our training and treatment teams for self-care. Use of the skills helps stabilize the nervous system and maintain the resiliency of the team. Team members can then better respond to the needs of trainees and survivors.

The Story and Ways to Tell It

Simply put, what neuroscience has helped us understand is that when the nervous system is overwhelmed it becomes dysregulated and the dysregulation can cause a cascade of physical and psychological symptoms. Nervous system dysregulation can occur when an experience is perceived as frightening or life-threatening. It can also occur and be reinforced when someone is

Leitch, Information gathering after trauma

asked to tell the story of what happened and/or when listening to the stories being told. The question becomes, what can be done to minimize overwhelm while at the same time collecting necessary information or helping a survivor feel heard and understood? The answer lies in the way the story is told.

A core skill of TRM is called Titration. The term comes from chemistry where when making a chemical compound instead of adding the entirety of one chemical into another the chemical is added in titrated (small) increments...watching the reaction after each titration in order to modulate the chemical reactivity. Peter A. Levine (1997, 2005) adapted the concept to his biological model of intervention, Somatic Experiencing. TRM skills include the skills of Somatic Experiencing, including Titration, as well as other skills. Working with small increments of traumatic material (Titration) is a key component of TRM's intervention program as is the development of somatic resources. Resources are protective; they help make us sturdy and adaptable. Inside the body, Resources are places of less negative, or of neutral or positive sensation. Another way to put it is that Resources are places of nervous system organization in the body in contrast to places in the body of nervous system disorganization (such as pain, agitation, and numbness). Used together, the skills of Titration and Resourcing reduce the likelihood of escalation of arousal, flooding and/or re-traumatization and help develop a sense of mastery and self-management over intense somatic states.

Using TRM's model, the story of the traumatic events is collected in ways that titrate the traumatic aspects of the story and emphasize the survival or mastery parts of the story (Resource). A client/survivor is usually either reluctant or unwilling to tell the story or ready to tell it in its entirety all in one breath. Leadership is required of the interviewer. The goals of the interview or debriefing dictate the choicepoints and actions for the interviewer. Certainly the foremost goal is to do no harm. Ideally, we can even do some good. A second goal, is the collection of necessary information and/or the willingness to be a witness to the experience of the survivor.

Where in the story should we start? How many details need to be told in one titration? How do we handle strong emotion and/or high arousal levels? How do we even know when someone is in a state of high arousal? Sometimes survivors go into a freeze state where they may look calm on the outside but actually are in a high state of activation on the inside. Both hyper and hypo arousal are indicators of dysregulation and nervous system activation.

Leitch, Information gathering after trauma

The TRM model develops Resources first before starting with traumatic material. This is done in the sequencing of questions. For example, rather than start with a question such as “Tell me what happened to you” we would start with a titrated question such as:

- “Tell me about the moment when you knew you had survived” or
- “Tell me when you knew it was over” or
- “Tell me about when help arrived” or
- “Tell me what is helping you to get through this now.”

Questions such as these are considered Resourcing questions. They orient the survivor to aspects of the experience that are not as traumatic. They remind the individual that they have lived or survived or are managing in the face of all the challenges.

Because TRM is biologically-focused and we want to help the nervous system return to balance, during TRM treatment the survivor is helped to learn how to track the sensations associated with Resourcing. We say to the survivor, “And as you tell me about that moment when you realized it was over what do you notice inside right now?” Sensations are the language of the nervous system and we teach the skill of Sensory Tracking in TRM treatment sessions. During treatment if the survivor is not asked to track the sensations associated with the Resource but only to talk about the Resource the intervention is merely a cognitive intervention. We want the intervention to be at the sensory level. In interviews without a treatment component (i.e., those focused on information gathering) the interviewer monitors the survivor’s nervous system arousal by observing such things as posture, gestures, rate of breathing, changes in skin coloration, and muscle tension patterns. As the arousal level is observed to increase (an indicator of the Sympathetic branch of the ANS being activated or of the nervous system going into freeze), the interviewer shifts to questions focused on mastery, self-management, competency, or social engagement. Resourcing questions access the Parasympathetic branch of the ANS and help create calm or nervous system balance.

Recently, I was working in Sichuan Province, China following the earthquake of May 12, 2008. We had intended to provide TRM training to a group of first responders. However, when we arrived at the training site it was clear that most of the responders at the training were in a high state of distress or arousal. Cognitive functioning is impaired by high levels of distress and trainees who are themselves traumatized will not be able to learn effectively. We postponed our

Leitch, Information gathering after trauma

plans for training and, with their permission, provided TRM's stabilization treatment to the responders instead.

I worked with a man who had removed the bodies of more than 20 co-workers, friends, and others from the rubble. His wife had died in the quake. This was a situation in which asking the question "tell me about the moment when you knew you had survived" seemed inappropriate. So many had died that being a survivor was often something people felt guilty about. Instead I asked, "Tell me who else survived." The man pulled out his cell phone and showed me a photo of his young son. That was where we began the story. I asked him to tell me about his son and what they do together. I asked several questions along this line in order to intensify the resource sensations. Our brain is programmed for survival and is programmed to attend first and foremost to anything perceived as being threatening to survival. The TRM skill of Resource Intensification helps override a single-point focus on traumatic material and uncomfortable emotions and sensations in the body and encourage balance by accessing the Parasympathetic.

As the man began to tell me about his son I was monitoring (Sensory Tracking) his breathing and other nervous system indicators. I saw him becoming more relaxed. Since this was a treatment session I then worked with what I was seeing. Had it been an interview to collect information only, as I observed the relaxation or calming I would have known that I could then shift back to his story and begin to ask some questions about the traumatic event. I would alternate between questions about the traumatic event and questions about Resources: what was helping him get through each day, connections to others, and sources of support and even pleasure. Alternating sets of questions in this way helps maintain an individual in what we call "the Resilient Zone," that zone of nervous system rhythm in which there is congruence between thoughts, emotions, and sensations.

Managing arousal levels when the trauma story is being told is done by titrating the traumatic details of the story. This is accomplished by shifting between questions about Resources (and the corresponding sensations associated with a description of resources) and questions about the details of the traumatic event. Using the skills of Titration and Resourcing increases the likelihood of allowing trauma data to be collected without causing more trauma. The survivor stays in the Resilient Zone, or at least is helped to return to that zone if s/he becomes hyper or hypo aroused. In debriefing groups the facilitator can help group members titrate between traumatic details and resources in such a way that models, and even restores, the normal rhythm

Leitch, Information gathering after trauma

of the ANS (a balance between the Sympathetic and Parasympathetic branches). The process of telling the story or providing the data needed in investigations then becomes an experience of self-regulation and healing.

Conclusion

In situations where telling the story of trauma is deemed helpful for the healing of the survivor/client or is needed as part of information gathering (such as treatment intakes or a human rights or legal process) the way the story is told and the way trauma data is collected is extremely important. Biological models of traumatic response, such as TRM, which place primary importance on nervous system regulation and dysregulation have much to offer both survivors as well as interviewers and responders. Regardless of the treatment and healing modality being used...ritual, storytelling, debriefing, legal testimony, intake interviews...and regardless of the culture, our responsibility is to do no harm. Understanding the relationship between the Sympathetic and Parasympathetic branches of the Autonomic Nervous System and the ways to monitor arousal levels (including signs of hyper and hypo arousal) promotes interview and intervention techniques that stabilize rather than contribute to dysregulation and distress. In addition, when a survivor is helped to report information from within the Resilient Zone the accuracy of information provided is likely to be considerably better.

The human nervous system is the same in its response to threat and fear, regardless of the culture, country, or ethnic group. The *meaning* that symptoms of dysregulation and distress have can vary widely across cultures but the symptoms themselves are the same. TRM's biologically-based training and treatment are appropriate for use across cultures (Leitch, 2007; Leitch, 2008; Leitch, & Miller-Karas, 2009). Biologically-based interventions have much to contribute in the many arenas that focus on survivors of large-scale trauma. Benevolent, gentle yet efficient, methods of interviewing and treatment that enhance hope and resiliency are the very least that survivors and those who respond to them deserve.

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Leitch, Information gathering after trauma

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