

# The teaching and learning of psychological trauma – a moral dilemma

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## Introduction

**T**HE GLOBAL BURDEN of psychological trauma cannot be overstated. Both natural disasters and wars account for much of the global burden of trauma. Natural disasters affect some 250 million people each year. The World Bank (2011) estimates 1.5 billion people of the world's population currently live in countries afflicted by political or criminal violence and war. It has been estimated that some 500 million people worldwide suffer from Post-Traumatic Stress Disorders; a majority is women and children. Psychological trauma darkens and scars people's lives – it is a silent epidemic because much of that trauma

remains hidden, especially in the developing world: unrecognised, undiagnosed, and therefore untreated. Trauma and traumatic stress exact a human and socio-economic toll that is vast in its magnitude and immense in its consequences (Carriere, 2014). Figure 1 shows four distinct violences (Galtung et al., 1971) all of which contribute to trauma. This article focuses on direct violence.

Direct violence comprises acts intended to harm human beings. To understand the narratives and experiences of survivors requires coming face-to-face with the narratives and experiences of perpetrators – to understand one is to understand the other.

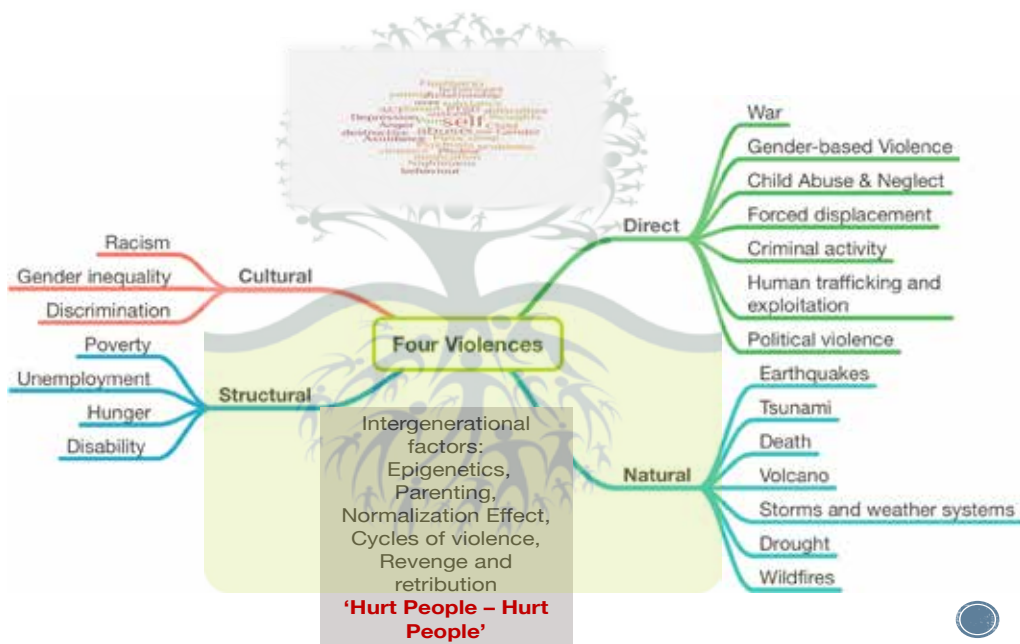


Figure 1: Understanding Trauma Psychology: The Four Violences (adapted from ref Carriere, 2014).

To truly understand the phenomenon and often multi-faceted dimension of direct violence is to acknowledge that there is often a pathology to the trauma which in turn requires exploring the cruelty of humans. Gilbert (2015) believes cruelty is the deliberate act of causing suffering citing Goodall (2010) in that although the basic aggressive patterns of chimpanzees are remarkably like that of humans their comprehension of the suffering they inflict on their victims is very different. Chimpanzees can demonstrate empathy but only humans are capable of deliberate cruelty. Cruelty requires advanced cognitive capabilities – a knowing intention to cause pain is a good example of this, a second is that of the ‘Empathic Torturer’ – pointing the gun at the bank manager’s child being more likely to strengthen a stronger desired effect – only humans have these advanced cognitive attributes which can so often be used to devastating impact. In pursuing this argument further women and children are victims of all kinds of physical and sexual abuse on an epidemic scale. Even in every day relations, cruelty haunts the lives of many. Taken together – compassion needs to start by being honest about the human potential for cruelty (Gilbert, 2015). Goldhagen (1996) states that within genocide there are common factors indicating an important distinction between different emotions and how these are exploited in the pursuit of genocide – groups are either dehumanised (moralised disgust), demonised (moralised anger) or both. In March 1942, almost three-quarters of those who perished in the Nazi Holocaust were still alive – some 11 months later the same proportion were dead (Bazalgette, 2017). The theme of holocausts will be returned to later however it is estimated some six million Jews were killed because of Nazi policies during WWII.

A similarly staggering magnitude of trauma relates to Adverse Childhood Experiences. During the late 1990s a seminal collaborative research between the Centres for Disease Control and Kaiser Permanente’s Health Appraisal Clinic in San Diego

surveyed more than 17,000 participants about Adverse Child Experiences (ACEs). This research explored the exposure to childhood maltreatment and family dysfunctions and its subsequent impact on health outcomes. The findings of the ACE Study suggested that adverse childhood experiences such as neglect, abuse, household violence and substance abuse were correlated with major risk factors for the leading causes of death as well as poor quality of life. Such stress arises from households where children are routinely exposed to issues such as domestic violence or individuals with alcohol and other substance use problems. It also discovered two other aspects – firstly, ACEs were enormously common within the general population; secondly, that negative outcomes are dose-dependent in that the higher the ACE score, the greater the risk of negative outcomes (Felitti et al., 1998; Felitti, 2002., Felitti & Anda, 2010a). Adverse Childhood Experiences (ACE’s) in Wales concluded that exposure to each ACE as follows: Verbal abuse 23 per cent, Parental separation 20 per cent, Domestic violence 16 per cent, Mental illness 14 per cent, Alcohol abuse 14 per cent, Drug use 5 per cent, and Incarceration 5 per cent (Bellis et al., 2016) – these represent significant numbers of people.

Given the massive prevalence of trauma, this then raises an important pedagogic question: how do you educate and inform individuals about psychological trauma without psychologically traumatising or re-traumatising them? As an educator in teaching and learning with regard to psychological trauma, there are several factors to consider:

1. Any participant audience will contain an ACE trauma population;
2. This trauma group may have either direct or indirect experiences of the psychological trauma under consideration;
3. There is the potential for re-triggering individuals by the exposure to often harrowing and disturbing narratives;
4. Part of an individual’s coping strategy may be to dissociate from the traumatic

experience/material – this, in turn, impacts on the teaching and learning experience;

5. Whether the teaching and learning is done as a ‘detached and theoretical’ exercise or as an ‘empathically connected’ one, it has both advantages and disadvantages.

To expand on this in more detail, let us consider a cogent and current case example.

### **The Yazidi Genocide**

Among the many victims of the advance of the Islamic State of Iraq and Levant (ISIL) is the Yazidi population in Kurdistan, Northern Iraq. The Yazidi is a historically misunderstood ethnic and religious minority who have kept their religion alive, despite many years of oppression and threatened extermination. This ancient religion was established in the 11th century and is a syncretistic derivative of Zoroastrianism, Christianity and Islam. During the Ottoman Empire, the Yazidis were subjected to over 70 genocidal massacres. Al-Qaida, the precursor of ISIL, consider the Yazidi to be ‘infidel Devil-worshippers’, and sanctioned indiscriminate terror and abuse. In June 2014 ISIL launched a military offensive in the region, and then in August directly turned its attention to the Yazidi population. ISIL jihadists carried out a deliberate campaign of killing, kidnapping, hostage taking, enslavement, sexual exploitation and rape of the Yazidi. When ISIL advanced, many Yazidis fled to Mount Sinjar, a place of enormous significance within their faith and community. Approximately 50,000 became trapped, before international community intervention. Estimates indicate that some 3500 women and young girls, captured by ISIL, were sold as ‘sex slaves’ to jihadist fighters involved in the Sinjar campaign. Upon capture it is believed many were initially taken to Mosul – before being moved to Syria or Saudi Arabia. A few, approximately 7 per cent, have managed to escape and safely return to their communities in Kurdistan. The premeditated attacks on the Yazidi population have been inter-

preted by the United Nations as indicative of ethnic cleansing. UNICEF has reported ‘appalling’ actions of killing, abduction and sexual violence against women and children.

In January 2015, at the invitation of the Free Yazidi Foundation (<https://www.freeyazidi.com/>) a scoping mission was carried out to determine the psychological needs of Yazidi survivors who had managed to escape their ISIL jihadist captors. Six in-depth interviews were carried out with young Yazidi women, each in turn recounting harrowing stories. These interviews were carried out in two refugee camps for displaced persons hosting Yazidi populations. Permission was sought, and granted, to gain access to each of the camps to carry out these interviews. Each interview was carried out using an interpreter. Assurances were given to respect anonymity, and that no identifiable features would be disclosed about any of the survivors. The age of the Yazidi survivors ranged from 13–30.

One of the Yazidi survivors recounts the following narrative:

#### **Khatoon’s narrative**

I am a Yazidi girl... before ISIL attacked Sinjar, my life was good and I enjoyed it. I went to school and had my family with me. They were supportive and wanted what’s best for me. We were blessed; we had a beautiful house and enough money to live.

My favourite moments were when everyone would come together and we had a good time with my family; there was laughter, music, dancing and of course good food and drinks. I felt safe and wanted within my community, but most importantly I was loved by all.

I can safely say that my life was good and normal like that of most girls

On 3 August 2014, ISIL entered Sinjar, and the killing, beheading and slavery began. I had to run for my life. Death was after my people.

As we were fleeing, I looked back and saw my neighbours being killed in cold blood, the people who were once like family to me were now lying there...dead. I tried to run as fast as I could, but I got caught and taken away from my family. My mother got killed right there, because she was too old to be sold as a sex slave. My brothers and father were beheaded in front of my own eyes. At that point my life was over, I died mentally. I became a sex slave for the ISIL militants; they would rape and beat me continuously. I was not allowed to fight the pain and what was being done to me. After all of this, they sold me to rich Islamic men, and the torture and pain gets worse.

I am a Yezidi girl... I was a nobody in the eyes of the men who bought me.

Khatoon then goes on and describes in graphic detail about her experiences of being a sex slave, and of multiple episodes of abuse, humiliation and torture.

### **Teaching and learning of trauma**

As psychology teachers, how do we educate and inform our psychology students about acts of extreme cruelty perpetrated by humans against fellow humans? One such strategy is to teach purely on a theoretical and abstract level, by reinforcing an element of clinical detachment from the material. An example would be the following:

The clinical psychological symptoms that the Yezidi survivors encountered were following the ISIL attacks include:

- Flashbacks and intrusive recollections.
- Nightmares and poor sleep pattern.
- Heightened anxiety.
- Helplessness.
- High levels of shame/guilt.
- Feelings of self-blame and ‘over-responsibility’.
- Powerlessness.
- Feeling detached.
- Suicidal thoughts and self-destructiveness.
- Low mood/depression.

- Phobic reactions.
- Low self-esteem.
- Difficulty managing emotions.
- Changes in ‘world view’.
- Changes in consciousness.
- Anger and resentment.

This, in turn, could be used to demonstrate significant features of Complex PTSD – its etiology, core features, hierarchy of symptoms, etc., and from then on pursue appropriate, evidence-based, culturally sensitive psychological treatment interventions. Overall, there is merit with such an approach. However, one of the strengths of psychology as a subject is its ability to address current real-life phenomena. Like it or not, the perpetration of trauma involves psychological processes which are important to investigate, understand and integrate, no matter how harrowing and uncomfortable the material.

So how does a reader/student/trainee engage, or otherwise, with this kind of material on a deeper level of knowledge and understanding? Empathy is one of the factors to consider. Empathy requires a perception of another person’s distress, which is influenced by interpersonal relationships, implicit attitudes, previous experiences, strengths and resilience (Bazalgette, 2017). Empathy can exist on many levels. It is possible to engage purely on the academic level, exploring the plethora of narratives available in these circumstances: perpetrator, victim, community, culture, politics, etc., all of which are pertinent and valid. But the victim/survivor narrative has the potential to be more powerful, more harrowing, more painful to bear witness to – after all, both individuals and communities use stories to better understand the world and our place in it. It would seem reasonable to assume that the victim/survivor narrative requires a higher level of empathy. Bearing witness to trauma narratives provides an opportunity for the sharing of testimony, and of being believed. As acts of cruelty often involve secrecy, breaking this silence can itself be

a powerful agent of change. Understanding trauma is not just about getting to grips with a phenomenon – genocide, child sexual abuse, gender-based violence, etc., but it also places the listener hearing these narratives at the heart of a dilemma where a choice is to be made – to either connect or disconnect with the narratives. Potentially, the more distressing the narrative, the harder it is for the listener to be neutral. There is an argument suggesting that trauma narratives should empower victim survivors, but as Ettinger (1980) highlights:

*‘War and victims are something the community wants to forget; a veil of oblivion is drawn over everything that is painful and unpleasant. We find the two sides face-to-face; on one side is the victim who perhaps wishes to forget but cannot, and on the other all those with strong, often-unconscious motives who intensely wish to forget and succeed in doing so. The contrast is painful to both sides. The weakest one remains the losing party in this silent and unequal dialogue.’*

Listeners to trauma narratives are also global citizens – these events happen in our world, in our time and therefore the telling of trauma stories helps us to create the world we desire. However, to see ourselves in this role is immensely challenging.

Yet hearing trauma narratives and bearing witness to them can be disturbing and confronting. One of the potential pitfalls is vicarious trauma. Pearlman and Saakvitne (1995) define it as the permanent transformation of our inner experience because of empathic engagement with a person’s trauma material. Although symptoms of vicarious trauma are distinct in each individual, nonetheless there are typical patterns, many of which are outlined in Table 1.

Empathic connection between the narrative and the listener requires an attuned connection which is a form of energy – vicarious trauma is akin to this energy being in deficit or absent altogether. McCann and Pearlman (1990) consider that vicarious trauma is often viewed as an indication of weakness on the part of an individual. If enhancing our understanding of trauma psychology involves empathic connection to deepen our understanding of humanity, then vicarious trauma, they argue, is effectively an occupational hazard.

Another factor is that there is no such thing as a solitary narrative – narratives are multiple and exist on different levels. Regarding vicarious trauma, Farrell (2013) considers eight narrative perspectives:

1. The narrative – the story itself;
2. The narrator – who is telling the story;

**Table 1: Signs and Symptoms of Vicarious Trauma (Lansen, 1993; Lansen et al., 2004).**

|  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Symptoms of post-traumatic stress disorder: nightmares, sleeplessness, intrusions, avoidance behaviour, irritability</li> <li>• Denial of client's trauma</li> <li>• Over-identification with client</li> <li>• No time and energy for oneself</li> <li>• Feelings of great vulnerability</li> <li>• Insignificant daily events are experienced as threatening</li> <li>• Feelings of alienation</li> <li>• Social withdrawal</li> <li>• Disconnection from loved ones</li> </ul> | <ul style="list-style-type: none"> <li>• Loss of confidence that good is still possible in the world</li> <li>• Generalised despair and hopelessness</li> <li>• Loss of feeling secure</li> <li>• Increased sensitivity to violence</li> <li>• Cynicism</li> <li>• Feeling disillusioned by humanity</li> <li>• Disrupted frame of reference</li> <li>• Changes in identity, world view, spirituality</li> <li>• Diminished self-capacities</li> <li>• Impaired ego resources</li> <li>• Alterations in sensory experiences</li> </ul> |
|--|--|

3. The narration – how the story is being told in terms of affect;
4. The narrative medium – what methods are used to relate the narration;
5. Parallel narratives – narratives from the perspectives of significant others;
6. Mitigating narratives – what other narratives are going on at the same time;
7. The narrative ‘Here & Now/Time & Place’ – why is this story being told now and in this place?
8. The narrative transaction— how the narrative is heard by the listener from the view of the recipient.

Considering vicarious trauma from each of these narrative perspectives, potentially enables broader understanding. Returning to Khatoon’s story – this is more powerful if the story is told by Khatoon herself, she is in the room, she is looking directly at you, you see her pain and suffering, you connect with this, she shows you pictures/ videos to expand on

her narrative, and furthermore she is challenging you with ‘what are you going to do with my narrative’? Each of these levels can have a significant impact upon the recipient. As trauma psychology educators, we should be prepared to mitigated adverse reactions.

Table 2 highlights specific grounding techniques that could be used to address potential negative impacts when teaching about trauma.

**Summary**

Courtois and Gold (2009) consider that there is increased awareness and concern about trauma among the public— and yet for most professionals, including mental health clinicians, many have not received systematic or specialist training about trauma within their core training. Instead it is taught outside of the main (core) curriculum. Within core textbooks in psychology, sociology, nursing, social work, criminology, law, health care, education and medicine, information about trauma

**Table 2: Grounding techniques when closing trauma psychology teaching sessions.**

| Physical grounding techniques  | Psychological grounding techniques   |
|--|--|
| <p>Touching objects that are around you, noticing their texture, shape, temperature, etc.</p> <p>Concentrating on the way in which your feet contacts the floor, allowing yourself to connect with the ground beneath you.</p> <p>Taking a sip of water and allowing yourself to experience the sense of taste.</p> <p>Running cool or warm water over your hands.</p> <p>Allowing yourself to feel the chair that you are sitting on, noticing how it contacts your body and how it supports you.</p> <p>Focusing upon your breathing and imagining that you are breathing in and out through your heart.</p> | <p>Describing your current environment in detail including objects, sounds, smells, textures, atmosphere, temperature, etc.</p> <p>Describing an everyday activity in detail: how to make tea, how to light a fire, how to plant corn/ yams, etc.</p> <p>Imagery: Creating an image in your mind that for you represents comfort, security, being ‘at peace’, etc.</p> <p>Expressing a ‘safety statement’: ‘My name is _____; and at this moment of time, I am safe. I am safe because I am in the present and I am not in the past.’</p> <p>Speaking your favourite poem, lyrics to a song, lines from a book or play, etc.</p> <p>Counting to 1 backwards from 10, or saying the alphabet very slowly.</p> |

is often missing, inaccurate, inconsistent, non-contemporary, and not evidence-based (Kissee et al., 2014). By imparting accurate information about trauma, particularly childhood maltreatment, the next generation of professionals is better equipped to recognise the effects of trauma, and to understand how best to assist traumatised individuals, with evidence-based treatment interventions.

There are several factors to consider when teaching about trauma:

1. Provide an initial signpost about the trauma material that is going to be presented during the teaching session;
2. Give attendees the choice to exercise their right to decide if they want to participate/contribute, or not;
3. Be sensitive to the needs of the audience by staying attuned to the atmosphere/vibe/ every level within the room;
4. Provide regular breaks from the material;
5. Utilise pendulation strategies ('one foot in the past, one foot in the present') to reinforce the difference between 'there and then' and 'here and now';
6. Encourage dialogue and promote discussion within the teaching session;
7. Provide regular 'check-ins' and reality checks: 'How are you doing?', 'I know this is difficult material to hear', etc.;
8. Consider the grounding techniques outlined in Table 2 when concluding the teaching session;
9. Promote self-care and resilience strategies;
10. Always finish with a debrief.

As educators of trauma psychology, the key messages are:

1. Teach about trauma with reference to the 'Four Violences';
2. Direct learners specifically to those textbooks that accurately convey up-to-date and empirical knowledge about trauma;
3. Provide guidelines about current research and best clinical practice in the treatment of trauma;
4. Encourage publishers and authors to include trauma within core text books in psychology;

5. Direct authors and publishers to the latest research.

Trauma and the multiple disabilities it causes have not received the attention they deserve from the international community. Recent innovations in the field of trauma psychology have opened new possibilities for scaling up that could benefit not only traumatised populations, but also traumatised field staff involved in development work, humanitarian aid or peace operations. The single biggest constraint to large-scale trauma treatment is the huge shortage of mental health professionals. Simply put, there is presently insufficient professional capacity available worldwide to address the magnitude of the trauma problem. Increasing knowledge about the importance and significance of trauma will be an important step towards addressing this global burden.

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