

Post-trauma: Is evidence-based practice a fantasy?

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Abstract

Trauma, bereavement, and loss are universal human experiences. Much has been written about the process that the bereaved go through following the loss of a loved one. Recent events such as 9/11, earthquakes in Turkey, genocides in Rwanda, community conflict in Northern Ireland, and the Asian Tsunami Disaster have drawn unprecedented public attention to the subject of traumatic bereavement. Increasingly, it is recognised that while most people are able to cope with loss generally by eventually restructuring their lives, those bereaved in traumatic circumstance often find it extremely difficult. As a consequence, a plethora of interventions have emerged, however, to-date, little is known about their actual effectiveness in helping the bereaved. With the emphasis of health and welfare professions on evidence-based practice (EBP) greater than ever and a raising awareness of accountability as key element of ethical practice, the call for EBP in traumatic bereavement is compelling. Using examples from work carried out in Northern Ireland, we look at the backdrop of the issues involved, describe some of the most commonly used therapeutic interventions, and explore the possibility of evidence-based practice.

Keywords: evidence-based practice; bereavement; Northern Ireland

Introduction

On September 11, 2001 the death toll of the attacks on the Twin Towers reached 2,752 (CNN, 2003). On December 26, 2004 the Asian Tsunami disaster claimed an estimated 283,000 lives (Fairfax, 2005). During April-June 1994, the Genocide in Rwanda caused at least 800,000 deaths, and this is recognised as a conservative estimate (CTV, 2004). The official death toll of the Turkish earthquake on August 17, 1999 exceeded 3,700 (WSWS, 1999). Community conflict in Northern Ireland caused the death of more than 3,600 people (Fay, Morrissey, & Smyth, 1999). These are just some examples of recent man-made or natural disasters that caused large-scale traumatic death. Intensive cover on television and the Internet has meant that the world has taken part in these events in an unprecedented fashion and in near real time and thus, today there is a previously unmatched awareness of the physical and psychological effects of traumatic death, including Post Traumatic Stress Disorder (PTSD).

Under normal circumstances, the prevalence of PTSD is estimated at about 8% of the adult population, but following a traumatic event about 33% to 50% of the victims experience PTSD (Pfefferbaum, 1997). Despite this, it has been acknowledged that literature and research with regard to psychological effects of violent death is "early and meagre" (Violent Death Bereavement Society, 2005), mainly anecdotal, and that few studies include objective measures on the management and effectiveness of interventions (Jordan & Neimeyer, 2003; Kato & Mann, 1999; Litterer Allumbaugh & Hoyt, 1999; Schut, Stroebe, Van Den Bout, & Terheggen, 2001). Using Northern Ireland as a case in point, in this paper we first examine research concerned with the impact of trauma, examine social policy measures regarding victims' issues, and look at voluntary sector provision. We then explore intervention strategies that have been developed to help people who have experienced trauma and look for available evidence of treatment effectiveness.

Trauma in Northern Ireland

Northern Ireland has lived in a situation of persistent civil unrest and political violence since the late 1960s. Over 3,600 deaths, mostly young male adults, have meant that over 7,000 parents have lost a child, over 14,000 grandparents have lost a grandchild, and an estimated 3,000 people have lost a spouse, on the whole, about 115,000 people have lost a close relative (Dillenburg & Keenan, 2001). In addition, over 40,000 people have suffered injuries, thus issues related to trauma, victimhood, and therapeutic interventions are very much at the forefront of debate (Dillenburg, Fargas, & Akhonzada, 2005a).

In the 1970s, psychiatrists argued that people affected by community violence generally reacted with astonishing resilience to the continuing violence (Fraser, 1973). Overall, data collected during this period showed a relatively low impact of trauma on psychological health. For instance, there was no increase in psychiatric patient numbers (McCreary, 1976) and family doctors dealt with minor symptoms. It was generally concluded that the majority of people dealt effectively with community violence and trauma either through denial (Cairns & Wilson, 1984) or intra-community support (McCreary, 1976).

Early reports that showed a different picture were largely ignored. For example, the study of survivors of the Remembrance Day bomb in Enniskillen in 1987 (Curran, Bell, Murray, Loughrey, Roddy, & Roche, 1990) had shown that six months after the incident nearly 50% of people who had witnessed the bomb showed symptoms of post-traumatic stress disorder (PTSD). Dillenburg (1992) showed that by 1985, over two thirds of the violently bereaved widows in her sample suffered significant psychological health problems, with a mean score of 9.8 on the General Health Questionnaire (GHQ; Goldberg, McDowell, & Newell, 1996) and therefore, being classified as *cases* requiring psychological assessment even 10 years after their loss.

It was not until the beginning of the Peace Process in the mid 1990's, more specifically the Good Friday Agreement in 1998, that substantial attention was paid to researching the impact of trauma on people in Northern Ireland (Figure 1). Previous evidence of significant long-term effects and psychological suffering now was confirmed. The Cost of the Troubles Study (COTTS; Fay, Morrissey, Smyth, & Wong, 1999), one of the main initiatives, used two measures of experiential intensity of trauma:

- 1 - *severe experience*; exposure to at least three of the following events: being close to a bomb explosion, witnessing a shooting, a neighbour killed, seeing people killed or seriously injured, having to leave home permanently;
- 2 - *very severe experience*; exposure to any two of the following events: a close friend killed, being physically attacked, being injured in a bomb explosion or in a shooting, a member of the immediate family injured or killed and another relative killed.

COTTS considered two measures of impact intensity of trauma:

- 1 - *severe impact of trauma*; respondents agree on at least two of the following conditions: The trauma caused me a great deal of distress and emotional upset; made violence more a part of my life; left me feeling helpless; provoked strong feelings of rage in me.
- 2 - *very severe impact of trauma*; respondents agree to any of the following statements: The trauma completely ruined my life; damaged my health; caused me to lose loved ones through death; physically damaged me/my family.

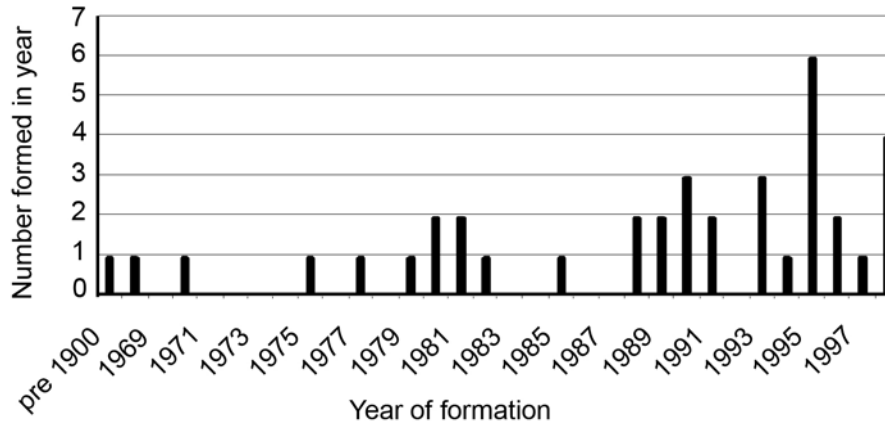


Figure 1: Year of formation of groups (adapted from Kelly & Smyth, 1999).

About half of a sample of 1348 Northern Irish residents reported that the trauma of the Troubles had a significant impact on their lives, presenting with symptoms of emotional distress, including sleep disturbance (Smyth, 1997). The relationship between degree of experience and impact however is not linear (Morrissey & Smyth, 2002). The majority of those who reported direct experience with community violence declared that the trauma had no major impact on their lives, requiring only some adjustments (Figure 2). Others, however, found that a positive and graded relationship existed between the extent to which people are affected by community violence and psychological ill-health (O'Reilly & Stevenson, 2003).

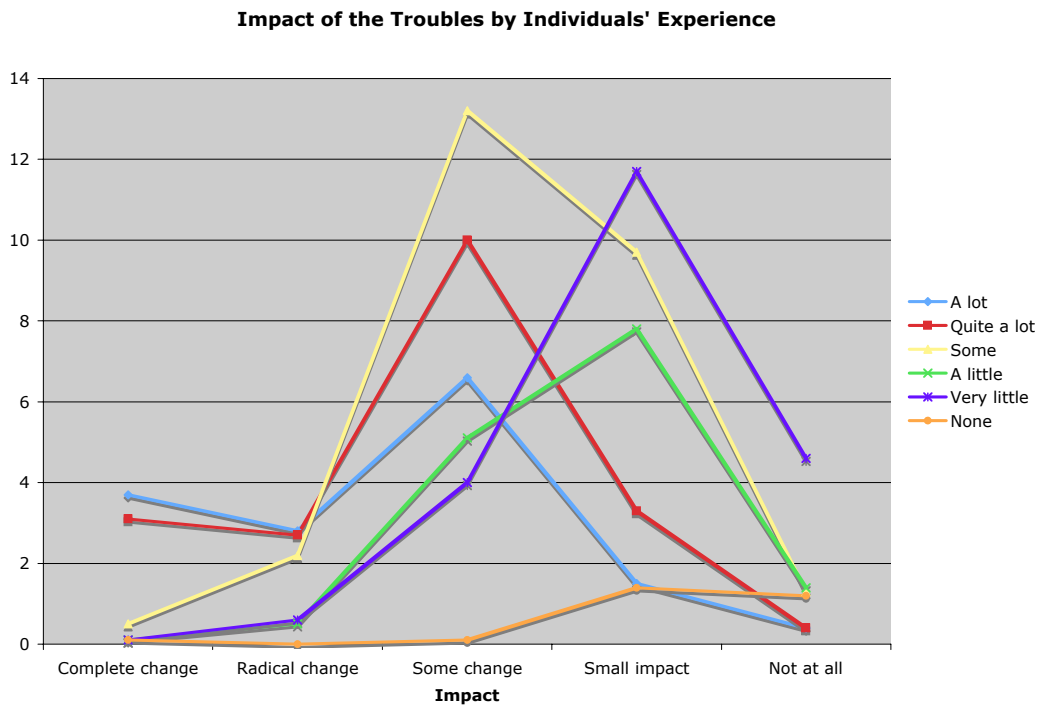


Figure 2: Impact of the Troubles by Individuals' Experience (adapted from Morrissey & Smyth, 2002, p. 121)

Clearly the experience of trauma related physical and psychological injury and bereavement is much more complex than previously thought. Trauma is not a discrete experience. For example, in Northern Ireland political violence varied considerably across time and space (Fay, Morrissey, & Smyth, 1999) with periods of intense violence bringing about many death, explosions, and shootings, while during other periods relative calmness prevailed. On the other hand, some areas, such as inner city Belfast, experienced consistently high rates of death and violent incidents, while other areas such as small villages along the coast were relatively peaceful throughout the Troubles. This uneven demographic distribution of community violence undoubtedly affects psychological health outcome. Per thousand inhabitants, high intensity areas experienced over seven trauma-related deaths, medium intensity areas between two and seven deaths, and low intensity areas experienced fewer than one death. COTTS found that people living in high intensity areas suffered from more severe effects, 28% had their home attacked and one third had painful memories, compared to one fifth of those living in medium intensity areas (Fay, Morrissey, Smyth, & Wong 1999).

Clearly then, over thirty years of community violence have not constituted a homogeneous experience for all of the people. Each person has had different and unique experiences that, in turn, produced different impacts and effects on their lives and health. Consequently, it has been argued that a great number of different realities exist (Darby, 1986). For example, psychological health and PTSD for relatives of those who died on Bloody Sunday in 1972 are prevalent even 25 years after the incident (Hayes & Campbell, 2000), and 30 years after their husbands' violent death widows show significantly higher levels psychological problems than would be expected of otherwise bereaved widows (Dillenburger & Keenan, 2001).

At the same time, not everybody responds in the same way to the same traumatic experience, that is to say, similar experiences do not cause identical effects in different people. How people cope with bereavement and other traumata depends on the context in which people find themselves. While some people are well supported and may experience adversarial growth (Joseph & Lindley, 2004), others find it difficult to put their lives back together after a traumatic incidence.

The way in which people cope with community violence depends on vulnerability as well as protective factors. For example, there are correlations between psychiatric morbidity and social deprivation, social isolation, and exposure to violence (McConnell, Bebbington, McClelland, Gillespie, & Houghton, 2002), and psychological vulnerability increases if children, friends, relatives, or oneself are in danger of being physically harmed (Moynahan, 2001). Protective factors include family and social support and adequate service provision.

Interventions

During early phases of community violence there was a significant lack of structured support for those affected by violence in Northern Ireland (Darby & Williamson, 1978). However, since the ceasefires, a rapid growth of statutory as well as voluntary services has been experienced (Deloitte & Touche, 2001; Kelly & Smyth, 1999; Morrissey & Smyth, 2002). While some of these groups are at an 'emerging capacity stage', others form 'umbrella groups' that support smaller emerging groups, or are considered 'parallel providers' (i.e., parallel to statutory service providers) (Deloitte & Touche, 2001). Overall, voluntary community groups are now the main service providers for victims and survivors (Smyth, 1997). These developments are a reflection of a shift in government policy and the beginning of a process of recognition of victim's issues as priority in Governmental policy agenda (Bloomfield, 1998). Only recently, the

term *victim* was officially defined as follows: “The surviving physically and psychologically injured of violent, conflict-related incidents and those close relatives and partners who care for them, along with those close relatives or partners who mourn their dead” (Reshape, Rebuild, Achieve (RRA), 2002, p. 1) and funding was made available to support victims of violence.

Yet today, service provision still is limited and patchy, and while 22% of voluntary groups offer a wide range of services, only 16% offer structured counselling, therapeutic services, or emotional support, and 24% offer services only to particular categories of people, e.g., women, young people (Kelly & Smyth, 1999). More importantly, despite the fact that nearly all the groups are inclusive on paper, in reality, many of them have political and/or sectarian motives, and at times, adapt their paper work in line with funding requirements (Hamber, 2003; Kulle, 2001).

Several different kinds of interventions are used to address psychological and physical consequences that can be associated with trauma and community violence. Traditionally, the emotional aspect of a grief process was the focus of interventions principally based in psychoanalytic theory. Anger, depression, shame, and guilt were used as indicators for understanding and evaluating short- and long-term bereavement outcome as well as complicated forms of bereavement (Rando, 1993). Today, intervention strategies based on cognitive-behavioural theories are frequently utilised (Malkinson, 2001). Most recently, behaviour analytic concepts of bereavement have been developed that address private and public behaviours within a functional, contextual analysis (Dillenburger & Keenan, 2001; in press).

On the whole, interventions offered to people who experienced trauma and community violence can be largely categorised into five groups:

- 1) *Psychology-based*: Intervention carried out by professionally trained and accredited therapists who work from a clear psychological, theoretical, and methodological basis. In the main these are either psycho-analytically, humanist, or behaviourally oriented;
- 2) *Medicine-based*: Intervention based on psycho-pharmaca or alternative medicine, including homeopathy.
- 3) *Philosophy-based*: Interventions carried out from a certain philosophical stance, such as Eastern Philosophy (meditation, yoga, aroma therapy, reflexology, shiatsu), or religion (prayer, worship);
- 4) *Education-based*: Interventions primarily concerned with education, such as critical incident debriefing, advice and information giving;
- 5) *Community-based*: Interventions based on initiatives from an individual or a community groups, such as self-help projects, befriending, respite, group holidays, often initiated by people who have experienced bereavement themselves.

Evidence Based Practice

Little is known about the effectiveness of services offered by the community sector (Figure 3; Dillenburger, 2001; Smyth, 2001), mainly because of problems with agreement on evaluation methods, content to be evaluated, outcome measures, theoretical perspectives, heterogeneity of type of interventions, and complex political contexts (Forte, Hill, Pazder, & Feudtner, 2004; Lavoie, 1990).

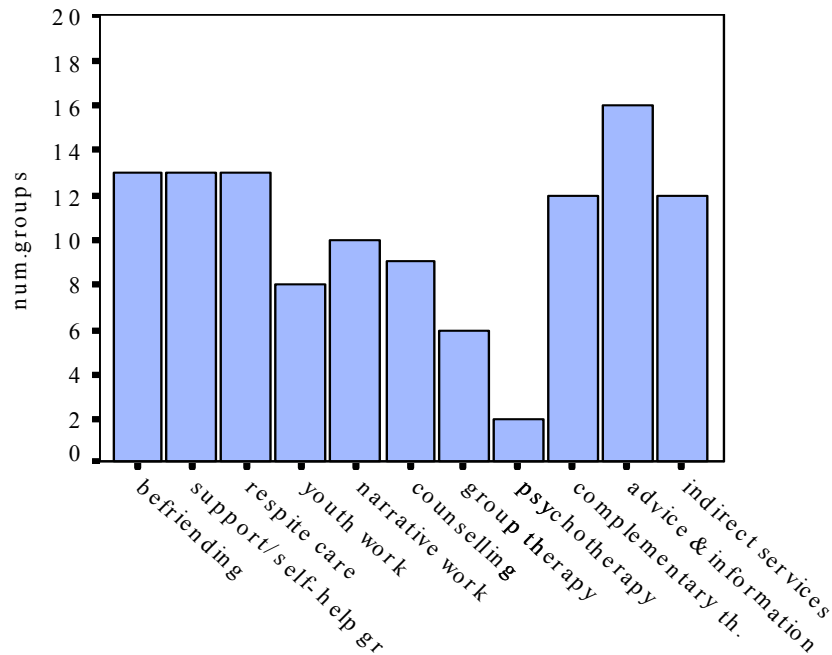


Figure 3: Services provided by voluntary groups in Northern Ireland (Dillenburger, Fargas, & Akhonzada, 2005c)

Psychology-based interventions

The evidence for psychology-based interventions in bereavement varies considerably. For example, with regard to psychoanalytic or psychodynamic therapies (Fonagy, 2000; Milrod et al., 1997; Shapiro et al., 1995; Zimbardo, 2005), a comprehensive review of outcome studies conducted by Research Committee of the International Psychoanalytical Association showed that there is no clear evidence that psychoanalysis is effective when compared to either alternative treatments or placebos (Fonagy, 2000, p.622). Similarly, while there are some qualitative reports and preliminary evaluations regarding systemic therapies (Boss, Beaulieu, Wieling, Turner, & LaCruz, 2003), there is no reliable quantitative research evidence of its effectiveness. Client-centred bereavement counselling has found favour with a large number of agencies and is probably one of the most widely used approaches for the treatment of the bereaved (Zimbardo, 2005). However, ultimately, there is not much rigorous research evidence of its effectiveness either (Cutcliffe, 2004; Doermann, 2002).

Probably the best evidence of effectiveness comes from behaviour therapy. There are research findings that suggest that a number of different behavioural protocols, including Rational Emotive Behaviour Therapy (REBT), Dialectic Behaviour Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), Solution Focussed Therapy; Motivational Interviewing; Task Centred Work (Follette, Ruzek, & Abueg, 2001) can be effective in bereavement and trauma related treatment (AABT, 1991; Gillespie, Duffy, Hackmann, & Clark, 2002; Gray & Litz, 2005), however availability of these services varies widely across the sector.

Medicine-based intervention

The use of psycho-pharmacological medicine may be useful in the early phases of grief when shock is intense and pain acute (WHO, 2005). When medications are used to relieve acute anxiety and distress in a crisis, there is some evidence that they can provide a therapeutic relief to the bereaved by slowing central nervous activity and providing a temporary respite from severe psychic pain (Green & Goldberg, 1986). Herbal medicines or homeopathy can relieve the severity of emotions shortly after the traumatic bereavement and, as long as they are not used too long or as substitute for actually dealing with the loss, there is no evidence that they do harm. However, generally, adults are advised to avoid medication, and the use of medication for children is not recommended at all (WHO, 2005).

Philosophy based intervention

There is a very wide range of complementary treatments based on Eastern philosophy, such as acupressure, acupuncture, aromatherapy, autogenic training, biorhythms, massage, meditation, neuro-linguistic programming, reflexology, reiki healing, shiatsu, yoga (Chris-UK, 2005). While subjective reports of wellbeing abound, there is very little quantitative evidence of effectiveness (Ernst, 2000).

Religious funerals are the main way of lying to rest the body of the deceased. Across cultures, religious leaders contend that pastoral interventions can weaken the effects of PTSD (Makhale-Mahlangu, 1996; Weaver, Smith, & Larson, 2005), however there is no scientific evidence of effectiveness of interventions based on religion (Mantala-Bozos, 2003).

Education oriented intervention

Education based interventions are used to disseminate information about the loss, explaining the usual response to trauma, suggesting coping strategies, offering practical, and financial help. Oftentimes, these interventions are very welcomed by the bereaved, who do not know how to respond in a traumatic situation, what to do next, and require practical help, such as making a telephone call to friends and relatives, or need help to realise that their response is normal and expected, given the experience they are going through (Dillenburg, 1992).

One educational approach that is more structured than most is Critical Incident Debriefing (CISD). CISD is a generic protocol used often by briefly trained practitioners, originally developed to mitigate stress for emergency staff. There is some anecdotal evidence to suggest that CISD may lead to symptom mitigation (Hiley-Young & Gerrity, 1994) however, a recent review of random controlled trials found evidence that CISD actually had detrimental effects (Hall, 2000).

Community-based intervention

Most people who have experienced trauma do not require specialised mental health interventions, what they need is community and family support and contact networks (Caserta & Lund, 1993; Gilligan, 2003; Kyrouz & Humphreys, 1997; Marmar, Horowitz, Weiss, Wilner & Kaltreider, 1988; Sanders, 1989), such as self-help group, befriending, respite, group holidays, or weekend breaks (Smyth, 2001). However, there is no clear evidence of the benefits of these interventions (Bradshaw & Haddock, 1998; Harris, Brown, & Robinson, 1999; Heslop, 2005; Mohr, 2004; Taggart, Short, & Barclay, 2000).

Conclusion

People who have experienced traumatic loss often require some help to cope. In this paper we argued that to-date, there is not enough structured reliable evidence of effectiveness for almost all of the community based approaches that are commonly used to help those who encounter complications in the bereavement process.

More worryingly, while there is limited evidence of the benefits of some kinds of intervention, most studies have found intervention to be on the whole ineffective (Barrett, 1978; Polak, Egan, Vandebergh, & Williams, 1975; Walls & Meyers, 1985). Even more disturbing are findings reported at the British Psychological Association Conference (Hall, 2000) and confirmed by Guerin (2001) that the most common forms of therapy for trauma victims might actually make people worse in some circumstances.

Against this background, an expanding victims' agenda has been developing not only in Northern Ireland (Gilligan, 2003). The rise of self-help groups is developing into a thriving *victims industry* and the need for evidence of effectiveness of services offered by these groups is undeniable. This call is not new. Deloitte and Touche (2001) as well as NICE (2004) demanded rigorous effectiveness research on trauma-focused psychological interventions including evidence of cost effectiveness. Recent research efforts are addressing this issue in Northern Ireland (Dillenburg, Fargas, & Akhonzada, 2005b), however until this happens internationally, on a large scale for all services, evidence based practice in bereavement remains a fantasy.

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