

Psychological Factors Following a Trauma: Experiences on a Continuum

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The DSM 5 or ICD10 (or 11) are frequently used to establish whether the difficulties described by a claimant meet the full criteria for a psychological disorder in a psychological assessment for civil litigation purposes.

The difficulty is that diagnosis is not a “tick box exercise” and considerable experience and clinical judgement is required in order to ascertain whether someone would be considered to meet the full criteria for a disorder. One of the difficulties faced by clinicians assessing individuals after a traumatic incident is distinguishing what is a “normal” reaction from a reaction that indicates clinically significant distress. There are a number of symptoms which we would expect an individual to experience following a trauma, which – depending on the level of severity or intensity – may range from a normal experience through to clinically relevant.

Considering psychological symptoms as being on a continuum can help to reduce the stigma of individuals suffering from diagnosable mental health conditions (Tebeka et al., 2018). Rather than using a categorical approach, a more dimensional view allows us to consider what is a normal response and can be helpful in identifying individuals at risk of worsening symptoms. It is difficult, however, for the courts to differentiate between a normal response to a trauma and symptoms which are indicative of a clinically significant response (or those which may not meet full clinical “criteria” but still require psychological inter-

vention) when the terminology used in reports does not reflect this continuum of experiences. Furthermore, for both the courts and claimants, correctly identifying where an individual’s psychological experiences lie on a continuum (and how long they have experienced their difficulties at that level) allows mental health practitioners to formulate and identify patterns of response that may indicate a diagnosable mental health condition (or what that requires treatment).

The Division of Clinical Psychology, a division of the British Psychological Society, have noted that there are considerable drawbacks to using a psychiatric diagnostic system to explain human behaviour and experience:

The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM and ICD, in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations. Consequently, there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system not based on a ‘disease’ model (DCP, 2013, p.1)

Considering difficulties on a continuum can be helpful to more accurately describe general patterns of behaviour and experience. This may still be utilized within a diagnostic framework, although such labels are not always helpful to the individual. As

noted by the authors of the British Psychological Society paper on the Power Threat Meaning Framework:

“people may find themselves at any point on the continuum, from mild and temporary discomfort to very severe struggles and disabling distress, at any given time and in any given situation. Contrary to the implication of global deficit imparted by a ‘mental illness’ label, no one should be seen as unable to function at all times and in all situations. Equally, we will all inevitably experience extreme forms of distress at some time in our lives, whether we have been psychiatrically labelled or not” (Johnson and Boyle, 2018, pg 216)

Psychological symptoms following a trauma

Considering how symptoms of Post-Traumatic Stress Disorder manifest following a trauma can be a helpful way to illustrate how someone’s psychological problems can be seen on a continuum from “normal” through to “severe psychological disorder”.

For 1-2 days most people experience shock, anxiety and depression following a major trauma such as an RTC, to the extent that it may resemble Post Traumatic Stress Disorder or depression (Shalev et al., 1998; Shalev, 2002). Most people find that after 1 week, these symptoms settle and only mild difficulties remain (O’Donnell et al., 2007b). Several studies indicate that if these symptoms remain high, this is predicative of the likely development of depression/PTSD (Mellman et al., 2001; Schnyder et al., 2001b; O’Donnell et al., 2004a; Schell et al., 2004).

PTSD is only diagnosable when the trauma involved exposure to actual or threatened death, serious injury, or sexual violence and where symptoms have continued for more than 1 month after a trauma. Prior to this, severe symptoms may indicate an Acute Stress Disorder (ASD), or they may indicate a normal adjustment period following a significant event. It is of note that “subsyndromal PTSD” (where there are features of the disorder, but the full criteria are not met) may also develop into “full blown” PTSD at a later date (Carty et al., 2006), especially if this goes untreated.

Symptoms of PTSD include intrusive thoughts and nightmares; avoidance; Negative alterations in cognitions and mood associated with the trauma; and alterations in arousal and reactivity associated with the traumatic event. All of these symptoms may be experienced to a greater or lesser extent by anyone following a trauma. The intensity and severity of these symptoms are of utmost importance when assessing whether the individual is reacting in a “normal” way, or one which has clinically significant implications.

Intrusions

Considering intrusive phenomenon – the term “Flashbacks” – is a commonly used term in non-psychological reports and general vernacular, often intended to describe sudden unwanted thoughts of an event. It is not unusual to see the terms “thoughts

about the accident,” “intrusive memories,” and “flashbacks” used interchangeably. However, memory-type intrusions are on a continuum that may look some-



thing like this:

Ruminations are experienced by most individuals at some point in their day. These are thoughts which are controlled by the individual, where often negative cognitions are dwelled upon and considered. In the middle of this continuum may sit involuntary, intrusive memories – those which come unbidden into the mind and are often distressing. Ruminations and intrusive memories are essentially part of normal autobiographical memory system and are often associated with feelings of sadness, anger, or guilt. These can and do occur in the general population (and experienced by people with anxiety or depression). In contrast, Flashbacks can only be recalled involuntarily, in response to internal or external triggers, and consist predominantly of visual perceptual images. However, olfactory and auditory flashbacks are sometimes reported. “Flashbacks” refer to a very specific type of intrusive phenomena, associated with an intense sense of current threat (as if the trauma is recurring) and involves, in extreme cases, complete loss of sense of current reality and control of one’s situation. Flashbacks appear to be a key characteristic feature of PTSD (Brewin et al., 1996; Reynolds & Brewin, 1998).

Even at the extreme end of this “reliving” continuum, there can be considered to be a micro-continuum: historically there has been a lack of formal definition of flashbacks or dissociative re-experiencing. However, both DSM-5 and ICD-11 PTSD have opted for a relatively inclusive definition in which flashbacks are seen as existing on a continuum between the two extremes of (at one end) intrusive memories that are accompanied by a sense of reliving the event in the present through to extreme episodes in which individuals completely lose contact with their surroundings for periods of minutes or more. The key here, though, is that flashbacks always have an element of reliving the event in the present, and this differentiates them from other types of re-experiencing.

Brewin (2014) notes that there is considerable evidence supporting the idea that flashbacks depend on the involvement of an involuntary perceptual memory system that is distinct from ordinary episodic memory. He notes that normal episodic memory depends on consciously focussing attention onto objects and scenes such that, by virtue of sharing the same location in space, individual features are bound together to create a stable, contextualised representation that can be retrieved or inhibited at will. However, during a traumatic event, attention tends to be restricted and focused on the main source of danger, so that sensory elements from the wider scene

encoded by the perceptual memory system will be less effectively bound together, producing fragmented and poorly contextualised memories that are difficult to control. Laboratory research has shown that such unattended patterns or events, providing they are sufficiently novel, produce long-lasting memory traces. The existence of these traces can be detected, for example, through facilitation or negative priming effects on re-presentation of the stimuli, even though a memory of the original pattern cannot be deliberately retrieved

Another type of intrusion symptom would be dreams or nightmares. Dreaming about an event that has caused us stress is very normal. Many people who have sat important exams will dream about that exam, sometimes years later – dreaming about that final exam, where you find yourself sitting at a desk in an echoing room only to turn the page and realise you forgot to take the course, or study, or put your clothes on that morning. One common theory of dreaming is that it allows us to consolidate memories or work through events or difficult feelings and thoughts. It is hypothesised that it is important to dream about a trauma as this allows the brain to process the event (Hartmann, 1998). Bad dreams have a degree of intensity that makes them unpleasant to experience, but if the memory that is being worked through is negative, inevitably the dream will be viewed as “bad” or unpleasant. Nightmares are distinguished by the threat to self or others and, upon waking, waking feeling ongoing emotions or continued disturbance. It is of note that “night terrors” are sometimes described but these are quantifiably different to dreams or nightmares – they generally occur at the same time every night (often around 2am when a particular part of the REM cycle is hit), the dreamer does not recall their dream, but they may shout out, move violently, and are hard to rouse. Importantly, night terrors are not recalled by the dreamer in the morning, and so are far more distressing for those living with the person. They would not be considered



Dreams Bad dreams Nightmares
part of this continuum.

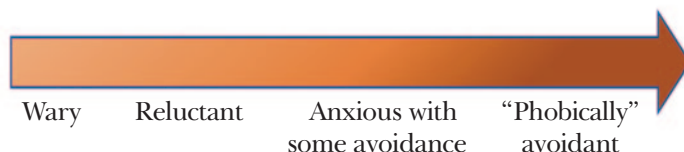
Avoidance.

Considering psychological difficulties following an RTC, driving anxiety and avoidance can be on a continuum, ranging from reluctance to drive through to full inability to drive due to anxiety. Blanchard et al (1995b) define driving reluctance has as the discretionary, situation- specific avoidance of driving (e.g., avoiding driving in the rain or snow), and avoidance of driving in near proximity to the index accident site. They estimate this occurs in 62% to 100% of RTC survivors.

On a continuum, we might expect to see a client with minimal psychological concerns about travel to be wary when in a car but not avoidant. Some clients with slightly more significant symptoms may be re-

luctant to drive in particular situations (a “situation-specific” avoidance but perhaps, at the lower end of this part of the continuum, this might be considered reasonably normal for the general population such as not driving in the snow, and further up the continuum the avoidance might be of driving on certain roads, such as motorways or “b” roads. At this stage the avoidance becomes more impactful on life. As we move further up the continuum, individuals with more significant avoidance may only drive when essential, or change their hours of work to avoid certain roads or traffic conditions (such as rush hour). At the furthest end we see claimants unable to sit in the driver’s seat of the car due to anxiety.

The role of the clinical psychologist in these cases is to determine whether these symptoms are representative of a PTSD symptom, or of a Specific Phobia. Or both.



Negative alterations in cognitions and mood

Many people use the word “depressed” in the same way that people say “flashbacks” (but mean ruminations). “Depressed” may mean one of a multitude of presentations when used by a Claimant – they may be referring to feeling sad, “stressed” or even feels more aligned to anxiousness. Therefore, careful clinical interview is required in order to ensure that the right symptoms being described. It is also important to note that for PTSD, alterations in cognitions or mood may include feelings of detachment from others; unreasonable feelings of guilt or fear that the world is now a dangerous place; or self-blame.

Considering feelings of sadness through to depression, a large scale study of 11,299 subjects, Moreno-Kustner et al (2016) found the 12.5% experienced sadness and/or anhedonia, but did not have depression (i.e. a major depressive disorder). Tebeka et al (2018) notes how an isolated episode of sadness is not sufficient to reach diagnostic criteria for depression but that sadness is a symptom which lies on the continuum ranging from well-being to a major depressive disorder. It may indicate an “at risk” mental state, but is so frequently experienced by the general population that it must be viewed as a normal experience.



Arousal and Reactivity

A common symptom of “alterations in arousal and reactivity” is anxiety. Anxiety has been conceptualised on a continuum ranging from “high calmness” to “high anxiety” (Siddaway, Taylor & Wood, 2018). Babette Rothschild’s image of autonomic nervous system regulation helpfully demonstrates this continuum, highlighting differences between active/alert, and anxiety symptoms indicative of clinically significant

Table 2: Autonomic Nervous System Regulation: Precision Regulation. From Rothschild, 2016

AUTONOMIC NERVOUS SYSTEM: PRECISION REGULATION						
** WHAT TO LOOK FOR **						
	LETHARGIC Parasympathetic I (PNS I)	CALM Parasympathetic II (PNS II) Ventral Vagus	ACTIVE/ALERT Sympathetic I (SNS I)	FLIGHT/FIGHT Sympathetic II (SNS II)	HYPER FREEZE Sympathetic III (SNS III)	HYPO FREEZE Parasympathetic III (PNS III) Dorsal Vagus Collapse
		"Normal" Life		Threat to Life		
PRIMARY STATE	Apathy, Depression	Safe, Clear Thinking, Social Engagement	Alert, Ready to Act	React to Danger	Await Opportunity to Escape	Prepare for Death
AROUSAL	Too Low	Low	Moderate	High	Extreme Overload	Excessive Overwhelm Induces Hypoarousal
MUSCLES	Slack	Relaxed/toned	Toned	Tense	Rigid (door in the headlights)	Flaccid
RESPIRATION	Shallow	Easy, often into belly	Increasing rate	Fast, often in upper chest	Hyperventilation	Hypo-ventilation
HEART RATE	Slow	Resting	Quicker or more forceful On the rise	Quick and/or forceful Elevated	Tachycardia (very fast)	Bradycardia (very slow)
BLOOD PRESSURE	Likely low	Normal			Significantly high	Significantly low
PUPILS, EYES, EYE LIDS	Pupils smaller, lids may be heavy	Pupils smaller, eyes moist, eye lids relaxed	Pupils widening, eyes less moist, eye lids toned	Pupils very dilated, eyes dry, eye lids tensed/raised	Pupils very small or dilated, eyes very dry, lids very tense May be pale and/or flushed	Lids drooping, eyes closed or open and fixed Noticeably pale
SKIN TONE	Variable	Rosy hue, despite skin color (blood flows to skin)	Less rosy hue, despite skin color (blood flows to skin)	Pale hue, despite skin color (blood flow to muscles)	Increased sweat, may be cold	Cold sweat
HUMIDITY	Skin Dry	Moist	Less moist	Dry	Cold sweat	Cold sweat
HANDS & FEET (TEMPERATURE)	Variable May be warm or cool	Warm	Cool	Cold	Extremes of cold & hot	Dry Cold
EMOTIONS (LIKELY)	Variable Grief, sadness, shame, disgust	Increase Calm, pleasure, love, sexual arousal, "good" grief Probable	Decrease Anger, shame, disgust, anxiety, excitement, sexual climax Possible	Stops Rage, fear	Evacuate bowel & bladder Terror, may be dissociation	Stopped May be too dissociated to feel anything Impossible
CONTACT WITH SELF & OTHERS	Withdrawn			Limited	Not likely	Impossible
FRONTAL CORTEX	May or may not be accessible	Should be accessible	Should be accessible	May or may not be accessible	Likely inaccessible	Inaccessible
INTEGRATION	Not likely	Likely	Likely	Not likely	Impossible	Impossible
RECOMMENDED INTERVENTION	Activate, Gently Increase Energy	Continue Therapy Direction	Continue Therapy Direction	Put on Brakes	Slam on Brakes	Medical Emergency CALL PARAMEDICS
*Observe client states: To modulate arousal with brakes. Adjust in yourself: To think clearly & prevent vicarious trauma & compassion fatigue.						
© 2000, 2014, 2016 Babette Rothschild Sources: Multiple medical & physiology texts; P. Levine 2010; S. Porges, 2011 Reprinted with permission from The Body Remembers, Volume 2: Rethinking Trauma Treatment (B.R. Norton, 2017).						

anxiety. It is worth considering this when claimants describe feeling anxiety when driving, for example, they often refer to feeling “active/alert”, which is not a clinically significant issue, but rather a normal response to a situation now experienced as somewhat stressful.

For individuals with PTSD, adjustment disorder with anxiety, or a specific anxiety disorder, they may experience symptoms at the more severe end of the continuum at other times (rather than only when faced with a reminder of the accident).

The drawbacks of diagnostic labels: What if we conceptualised this in a different way?

As can be seen from these descriptions, psychological distress is on a continuum, and the presence of even several symptoms does not necessarily mean full clinical criteria is met for a diagnostic disorder. However, as the above continuum examples demonstrate, some people may not meet the full criteria for a disorder such as PTSD but may still experience significant debilitating symptoms. This is consistent with research which has indicated that those with symptoms not meeting a full diagnosis for this disorder do still have comparable levels of impairment to those with a full diagnosis (Amsel & Marshall, 2003). Often, someone may have subsyndromal symptoms, but still require therapeutic intervention to return to a pre-accident level of functioning.

Clinical Psychologists are in an ideal position to formulate the presenting problems – explaining to the court why an individual may have developed these particular difficulties, the impact on their daily lives, and what is maintaining them. In many ways this is more helpful than a simple “label” which seldom reflects the full picture.

The British Psychological Society has recently written about the Power Threat Meaning Framework (John-

son and Boyle, 2018) to aid with conceptualising the psychological mechanisms developed by individuals following trauma, in an attempt to move away from a category-based overly-medical diagnostic system of labelling. The Framework is based on psychological and sociological knowledge along with recent biological research. Rather than symptoms, the framework suggests conceptualising these as “threat responses”, and rather than considering individuals to be “mentally ill” the focus is on creating a narrative for the individual.

The Power Threat Meaning Framework acknowledges:

“Abnormal” behaviour and experience exist on a continuum with ‘normal’ behaviour and experience and are subject to similar frameworks of understanding and interpretation. These include the assumption that, unless there is strong evidence to the contrary, our behaviour and experience can be seen as intelligible responses to our current circumstances, history, belief systems, culture, and bodily capacities, although the links amongst these may not always be obvious or straightforward” (pg 8)

For the time being, the litigation process and courts rely on expert diagnosis using a classification system such as the DSM 5 or ICD. However, the drawbacks of these systems, and the difficulty of utilising these labels to fully capture the full psychological experience of an individual must be acknowledged.

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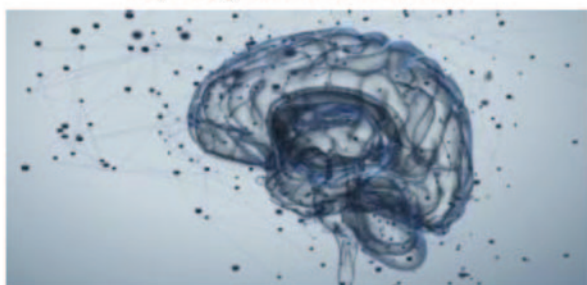
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